Improving Organizational Antiracism in a Community Mental Health Setting: Assessing Structural Racism Using Components of the SMART Tool

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Abstract

In this quality improvement project, an assessment of staff perception of structural racism in an urban substance use disorder treatment organization was performed to determine areas for evidence-based practice recommendations. The framework of the Self-Assessment for Modification of Antiracism Tool (SMART) developed by the American Association of Community Psychiatry (AACP) was used to assess elements of clinical care, client outcomes, and workplace culture. Survey findings were consistent with current literature on racial disparities in mental health and indicated a potential for structural racism impacting treatment and diagnosis. Evidence-based recommendations were made regarding enhanced racial demographic data tracking, improved racial trauma assessment, and implicit bias training. Thorough organizational assessment with periodic re-assessment may reveal additional areas for quality improvement in the delivery of care that counteracts the effects of structural racism.

Problem Description

Structural racism refers to a confluence of macro-level factors that limit resources, opportunities, power, and health for individuals from racial-ethnic minority populations (National Institute on Minority Health and Health Disparities, 2021). Community mental health historically has not been immune to structural racism, in some cases having actively supported surveillance and policing strategies such as the broken windows theory (Ramos, 2019). Access to mental health services remains a barrier to structural equity in community mental health, leaving many individuals from Black, Indigenous, and People of Color (BIPOC) populations unable to receive treatment for mental illness.

Up to 67% of Black Americans with any mental illness do not receive treatment, while 90% of those with substance use disorder and nearly 92% of those with co-occurring substance use disorder and any mental illness receive no treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Similarly, 66% of Latinx individuals with any mental illness do not receive treatment, while 92% of those with substance use disorder and 94% of those with co-occurring substance use disorder and any mental illness receive no treatment (SAMHSA, 2020). Compounding the issue, racial trauma related to discrimination and racism has been associated with higher rates of depression, substance use disorder, and PTSD amongst individuals from BIPOC populations (Seaton & Iida, 2019; Sibrava et al., 2019; Skewes & Blume, 2019).

In Oregon, BIPOC populations are impacted by disproportionate rates of mental health disorders. High rates of uninsured individuals in Latinx, Native American, and Black populations limit access to mental health services (Oregon Health Authority [OHA], 2018). The rate of heavy alcohol use is highest among Native Americans while traumatic adverse childhood events are highest amongst Black, Latinx, and Native American communities in Oregon (OHA, 2018). Additionally, Black Oregonians comprise 2.9% of the state's population, but fewer than 1% of psychologists, therapists, and counselors are Black. Similar clinician disparities compared to the overall racial-ethnic population are found in

mental health providers of Latinx and Native American descent. Meanwhile, nearly 90% of mental health care providers in Oregon are white despite white people accounting for approximately 75% of the state's population (Oregon Health Authority, 2019).

Available Knowledge

Structural racism in health care is multi-factorial and insidious. It has been rationalized since the 1600s by white racial-framing that has continually resulted in inequitable health practices (Feagin & Bennefield, 2014). Components of structural racism such as residential segregation and the "war on drugs" have contributed to mental health inequity, including overdiagnosis, misdiagnosis, over-medication, lack of evidence-based interventions, and generally poor treatment for BIPOC populations (Shim, 2021).

Several frameworks and organizational principles have been developed to address structural racism and inequity in health care delivery. However, rigorous evaluation of interventions is limited due to the complex nature by which structural interventions generate effects, the preference towards interpersonal or individualized approaches, and the limited training researchers receive in structural frameworks (Drevdahl, 2018). A scoping review on conceptual frameworks of organizational change to reduce inequity found limited guidance within frameworks for translating equity across multiple organizational departments and levels (Spitzer-Shohat & Chin, 2019). Additionally, many frameworks introduced guidance on evaluation measures focused on patient outcomes while organizational measures remained unassessed. These frameworks focused on outer contexts to guide change strategies and largely did not assess inner contexts such as organizational culture or perception of change.

Metzl & Hansen (2014) proposed transforming the conceptualization of patients through structural competence. Core structural competencies include recognizing how structure shapes clinical interactions, developing structural humility, and re-articulating cultural presentations in structural

terms. While many academic-medical institutions have drawn on this work to create curriculum materials, it has not previously been adapted to a format for quality improvement outside of training and education (Talley et al., 2021). Similarly, Drevdahl (2018) proposes that cultural competency theories do not adequately address health inequity, while structural theories effectively focus on the social determinants of health creating inequity.

Building on existing organizational tools to address inequity in healthcare, the American Association of Community Psychiatrists (AACP) created a quality improvement tool incorporating domains specific to structural racism and racial inequity in community mental healthcare (Talley et al., 2021). The Self-Assessment for Modification of Antiracism Tool (SMART) is intended to be used across organizational departments and levels and was created consistent with facets of racism at various levels including structural/systemic, institutional/organizational, and interpersonal/individual (Krieger, 1999). Domains in the SMART assessment tool include hiring/recruitment practices, clinical care, workplace culture, community advocacy, and population health outcomes.

Rationale

This project intended to understand the perception of structural racism and the current status of antiracist practices at a community mental health organization to provide recommendations for quality improvement in targeted domains. An initial overview of the organization revealed areas for potential improvement in mitigating components of structural racism commonly present in the delivery of mental health services. The organization had not previously utilized a standardized assessment tool to evaluate organizational adherence to antiracist practices broadly. A review of the literature determined that AACP's SMART tool provided promise as a comprehensive assessment of outer and inner contexts of antiracist organizational practices across multiple relevant domains. Utilization of components of the SMART tool was intended to allow a baseline assessment of antiracism within the organization and

provide a framework for future assessment of organizational modifications to disrupt the perpetuation of structural racism in community mental health (Talley et al., 2021).

The project was guided by the Institute for Healthcare Improvement (IHI) Model for Improvement (MFI). The MFI is an effective tool for quality improvement that delivers quick and substantial results in diverse settings (Langley et al., 2009). Utilizing Plan-Do-Study-Act (PDSA) cycles, the IHI MFI has been adopted by healthcare organizations in both small and large-scale projects to improve processes and outcomes (Picarello, 2018). It was intended that following the completion of a scaled-down assessment using components of SMART, evidence-based interventions for antiracism improvement could be recommended with future utilization of PDSA cycles to assess the impact of these interventions with SMART-based re-assessments.

Specific Aims

Providing equitable care by closing racial and ethnic gaps is one of the Institute of Medicine's six overarching aims for improvement in healthcare (Institute of Medicine, 2001). This quality improvement project was intended to assess the perception of structural racism and antiracist practices at an urban substance use treatment organization so that evidence-based recommendations could be made in identified areas for improvement. Primary objectives included distributing surveys across disciplines, analyzing survey data, and reporting results with possible evidence-based interventions to stakeholders who may ultimately decide upon areas for improvement to target with future interventions.

Context

This project was implemented at an urban substance use treatment organization providing residential and outpatient treatment to over 13,000 people per year. Services range from withdrawal management and medication-assisted treatment to outpatient group and family therapy. 82% of clients are from low-income households, with 33% having been unhoused prior to entering treatment. Over 30% of clients served are from a racial-ethnic minority group or mixed race.

The PARiHS (Promoting Action on Research Implementation in Health Services) framework divides context into three core elements: prevailing culture, leadership, and evaluation (Bergström et al., 2020). The culture at the implementation site was driven by a care philosophy of radical kindness with a commitment to fostering a welcoming and inclusive environment of respect and open communication. The organization employs an Equity Programs Manager to lead and integrate Diversity, Equity, and Inclusion (DEI) initiatives. Pre-existing qualitative and quantitative measures within the clinical services program intend to keep the organization accountable and ensure the services provided are equitable.

Intervention

The AACP created the Self-Assessment for Modification of Antiracism Tool (SMART) to assess the extent to which an organization's clinical and organizational processes are affected by elements of structural racism. The survey consists of Likert scale items to assess how the organization has tracked, identified, and addressed issues relevant to racism and inequity (Talley et al., 2021). The questions provide a framework for quality improvement in organizational antiracism by assessing five organizational domains including clinical care, workplace culture, community advocacy, client outcomes, and hiring practices such as recruitment, retention, and promotion.

In the first PDSA cycle, select Likert response questions from SMART were adapted to the population and assessed for site-specific relevancy before being sent to a small sample of stakeholders to assess the appropriateness of the survey design. Questions were selected from SMART domains of clinical care, workplace culture, and client outcomes. Feedback from the initial survey was incorporated into revisions prior to the second PDSA cycle. The second PDSA involved wider survey distribution amongst clinicians across the organization, as the AACP recommends using the SMART tool across a diverse range of staff representing different identities, roles, and levels of hierarchy. Final versions of the questions from the second PDSA cycle are included with question results in Appendix B.

The anonymous survey was delivered via email and made available from January 30-February 15, 2023. The survey was available through a dedicated link or QR code for staff members who preferred to use a mobile device rather than a work computer to complete the survey. Reminder emails were sent on February 6 and February 13.

Measures

Outcome measures were chosen to address the specific aim of assessing staff perception of structural racism and organizational antiracist practices. This included survey question response data from domains of the SMART assessment related to clinical care, workplace culture, and client outcomes. Additionally, demographic information was collected from survey respondents on their organizational roles. Process measures included feedback on the initial survey from a small sample of stakeholders during the first PDSA cycle and the overall survey response rate once the survey was more broadly disseminated to staff during the second PDSA cycle.

Analysis

Survey response data was compiled and analyzed using Qualtrics survey software. Presentation of the results included response rate and staff member departmental classification or provider type (see Appendix D). Quantitative data from Likert responses to SMART-derived questions were analyzed and visually represented in graphical form (Appendix B). Qualitative data derived from free-text responses were analyzed and presented in categorical form depending on the response theme (Appendix C). Data was utilized to determine the top three areas for potential improvement of antiracist practice based on staff responses. This ranking was used as guidance for suggesting targeted interventions for improvement per the AACP's recommendation for action after SMART assessment. Evidence-based recommendations for improving racial equity were provided to the organization with supporting references.

Ethical Considerations

Ethical considerations included maintaining the anonymity of survey respondents through the process of collecting, analyzing, and presenting data. Consideration of staff time commitments was honored by limiting the number of survey questions and reminders. Participation was optional and respondents had the ability to skip questions or not declare their role in the organization to honor individual preferences for anonymity. The Oregon Health & Science University Institutional Review Board deemed the project not to be research involving human subjects due to its intention as a quality improvement initiative. The author reports no conflicts of interest in the execution of this QI project.

Results

After the initial project development and design, it was revealed that the implementation site had hired an outside consulting firm to conduct a separate assessment to advance diversity, equity, and inclusion at the organization. This firm's assessment focused on domains including community engagement, workplace culture, and hiring practices. Therefore, this project was subsequently modified to limit SMART domains to client outcomes, clinical practice, and elements of workplace culture not covered by the consulting firm's assessment. Relevant survey questions were adapted from the SMART assessment and reviewed by stakeholders including the agency's medical director, project preceptor, and DEI manager during the first PDSA cycle. Feedback from this initial review resulted in the inclusion of a definition of structural racism within the survey as a reference for respondents prior to broader dissemination of the survey in the next PDSA cycle.

The second PDSA cycle was initially intended to survey respondents in departments including nursing, counseling, and medical providers. However, leadership in the counseling department decided not to involve counselors and therapists in the survey due to time management concerns related to understaffing. This contextual factor lowered the survey response rate leading to an overall response rate of 38.8%. This included 15% of nurses responding and 50% of medical providers responding. An option to not declare a work role was included in the survey to allow additional anonymity for those

who chose this option and was used by 50% of respondents. This created a challenge in connecting response themes to a role or department of origin, as many respondents did not declare role status.

Survey results to individual questions are included in Appendix B, including a breakdown of role demographics by discipline (Appendix D). Qualitative free-response data showed themes of racial disparities in access to care and potential biases in medication and diagnosis. A written report presented survey response data, evidence-based recommendations, and supporting literature to the organization's leadership and stakeholders. An excerpt from this report containing a summary of these recommendations is included in Appendix E.

Summary

Ultimately, this project aimed to provide evidence-based recommendations intended to counter components of structural racism in the delivery of care at an urban substance use treatment organization. To meet this goal, survey questions derived from the SMART tool were used to understand staff perception of current organizational antiracist measures and the overall impact of structural racism on clinical care. Overall themes in the survey response data showed several common elements of structural racism consistent with national data. This information guided the selected areas to target recommendations including racial trauma assessment, racial data tracking, and education related to unconscious bias.

Interpretation

Survey responses were consistent with current literature regarding structural racism in mental health services and elucidated the need for improvement in monitoring racial demographic data. Respondents were generally in strong agreement that racial disparities in diagnosis and treatment were present at the organization. This is consistent with overall trends showing higher diagnoses of psychotic disorders and higher prescription rates of antipsychotics in Black and Latinx populations compared to white populations (Cerdeña et al., 2021; Menand & Moster, 2021; Schwartz & Blankenship, 2014).

Similarly, Black and Latinx people with opioid use disorder have lower odds of receiving buprenorphine than white people despite the increased benefits of receiving this medication in short-term residential treatment including improved completion rates. (Dunphy et al., 2022; Stahler et al., 2021; Stahler & Mennis 2020). While buprenorphine treatment duration for white people has increased since 2017, treatment duration for Black and Latinx populations has decreased since 2014 and 2009 respectively (Dong et al, 2023). Longer Buprenorphine treatment duration is associated with superior clinical outcomes including lower risk of suicide, cancer, substance-related, and cardiac-related mortality during medication-assisted treatment (Santo et al., 2021; Williams et al., 2020).

Survey results showed a need for measures to mitigate potential implicit bias which research has shown may contribute to disparities in diagnosis, treatment, and quality of care (FitzGerald & Hurst, 2017). For example, psychotic disorders are disproportionately diagnosed in Black people, particularly by white providers with higher levels of training (Londono-Tobon et al., 2021). However, addressing the roots of implicit bias is complex as this bias acts on structural elements to perpetuate racial disparities, while structural elements of the healthcare system concurrently reinforce implicit bias in a mutually influencing relationship (Vela et al., 2022).

Similarly complex, racial trauma has several deleterious effects including the changes seen in white matter microarchitecture throughout the brain (Fani et al., 2022; Okeke et al., 2022). As this project highlighted a need for formal mechanisms to detect racial trauma, a recommendation was made to utilize the Racial Trauma Scale (RTS). The RTS is a psychometrically sound and valid means of quantifying racial trauma with excellent reliability (Williams et al., 2022). Additional recommendations made to the organization regarding implicit bias and racial demographic data can be found in Appendix E. This included recommendations based on the data collection framework provided by The Center for Antiracism at Boston University (2022) and implicit bias training themes such as transformational

learning theory, anti-oppression, and skills-based learning (Forscher et al., 2017; Sukhera et al., 2020; Wu et al., 2019).

Lastly, while it can be assumed that taking a brief survey may have come at the cost of employee time in a busy workplace, in taking the survey respondents were given an opportunity to examine how structural racism influences their practice individually. This reflective process may have created the added benefit of encouraging the use of structural thinking, which requires the ability to attribute racial inequity to structural causes (McCarty et al., 2023). This introspective process alone may have had the potential of improving equity in individual care delivery, and the possibility of this impact is worthy of future examination.

Limitations

This project had several limitations. Overall, the sample size of survey respondents was small and the response rate was limited by contextual and process factors. As was evidenced by the lack of participation from counseling team members due to staffing issues, a potential balancing measure that could have been included in this project was the potential for survey burden amongst staff members. To increase anonymity, an option to not declare a practice role was included in the demographic section of the survey. As many respondents selected "prefer not to answer" for this demographic piece, there are gaps in the data regarding which departments in the organization may be more susceptible to particular elements of structural racism. Additionally, the option to provide examples and opinions of structural racism in an open-text response was not utilized by many of the respondents which limited the amount of qualitative data collected in this element of the survey. Future iterations of this project could be improved upon by increasing organizational buy-in and processes around the full adoption of a SMART assessment and periodic reassessment processes.

Conclusions

This assessment of staff perception of structural racism at an urban substance use disorder treatment organization highlights that elements of structural racism continue to be present in community mental health. The value of this type of assessment continues to be relevant as providers may underestimate or deny the impact of structural racism on healthcare (Wilson, et al., 2021). AACP's SMART assessment provides a necessary framework for identifying areas of antiracist quality improvement that may begin to enhance the experience of racial-ethnic minority clients at community mental health organizations. Thorough, sincere assessment with continued reassessment over time may mitigate the impact of structural racism on client care in mental health.

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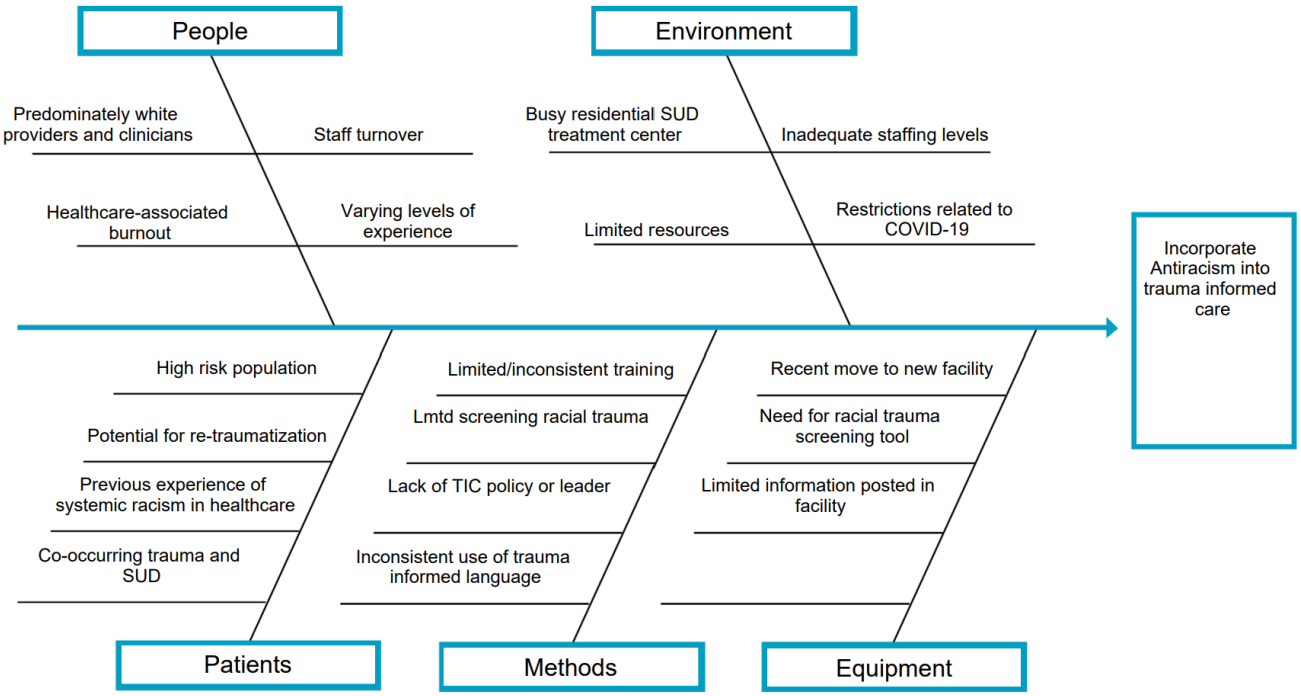
Appendix A

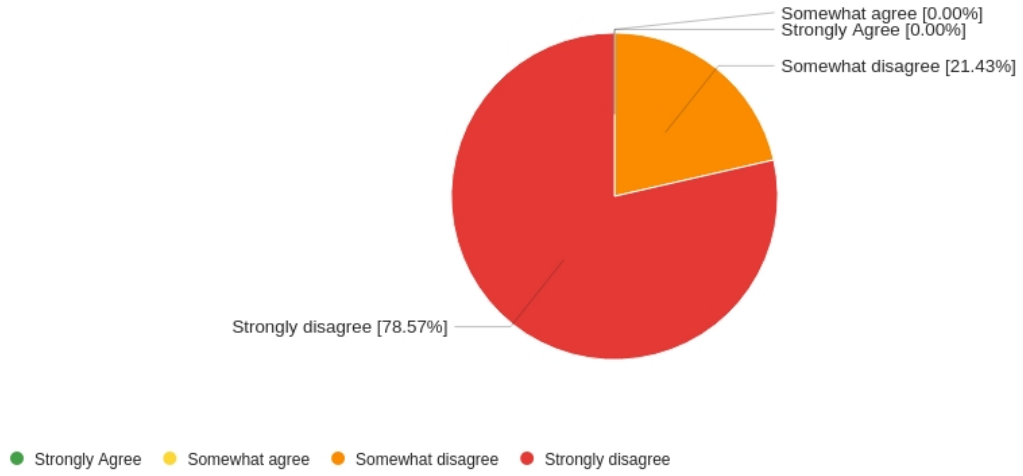
Cause and Effect Diagram



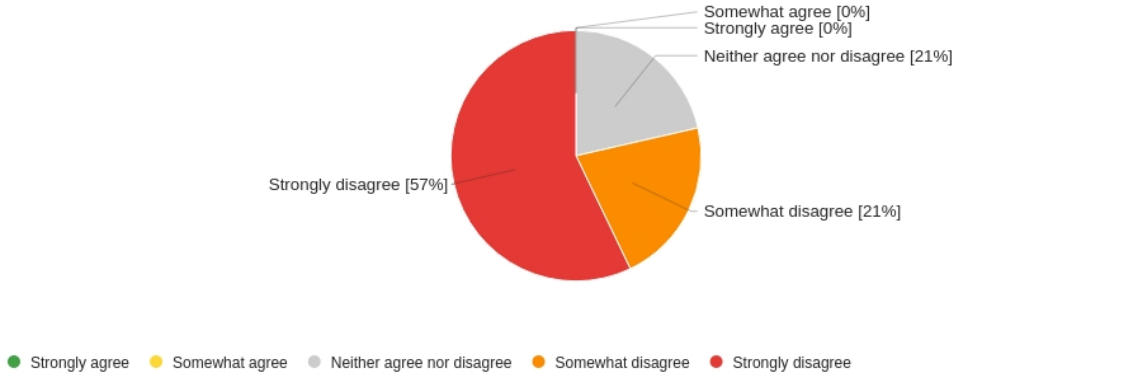
Appendix B

Survey Questions with Likert-Scaled Results

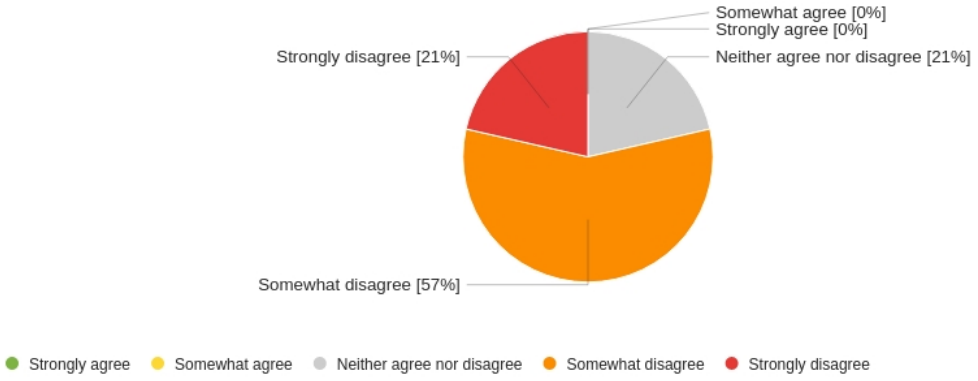
Q1 - I regularly use a formal self-assessment tool to identify and measure implicit bias.



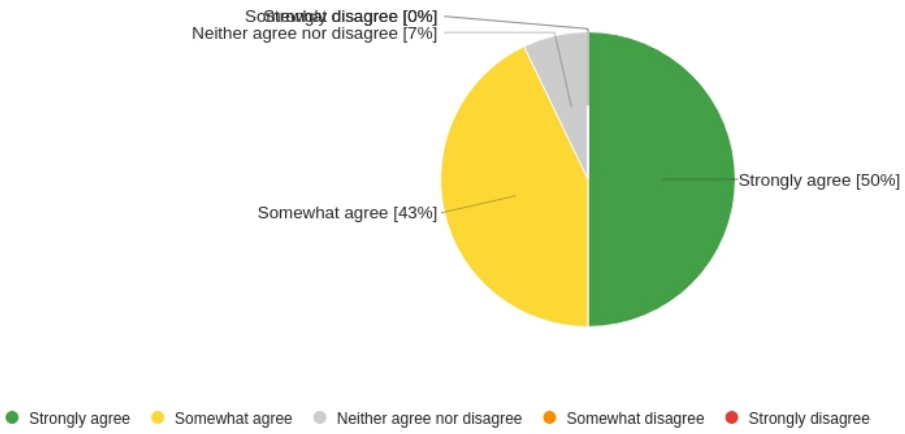
Q2 - Formal mechanisms at my organization allow me to explicitly identify racism as a form of trauma to be addressed in clients.



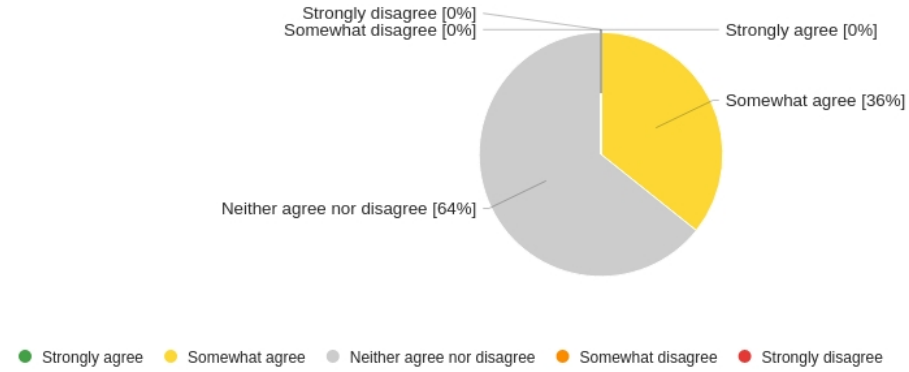
Q3 - My organization has provided adequate formal training opportunities to identify factors that contribute to racial disparities in mental health.



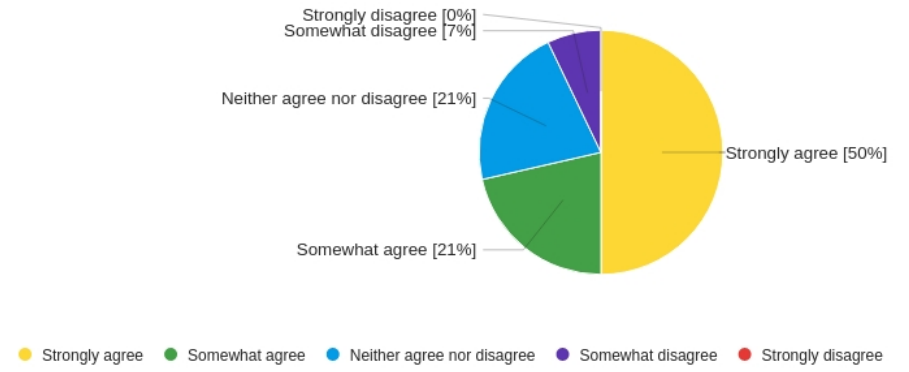
Q4 - Structural racism influences access to care for racially diverse populations at my organization. *Structural racism refers to the totality of ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems that in turn reinforce discriminatory beliefs, values, and distribution of resources.



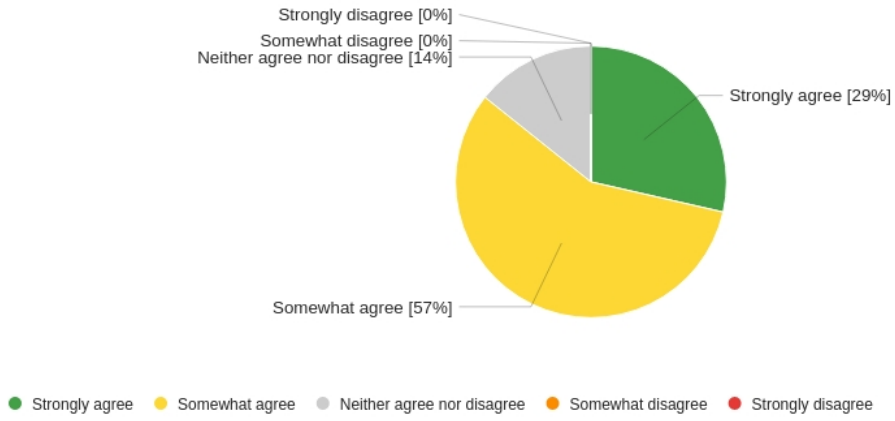
Q5 - Structural racism influences disparities in client engagement in my organization (i.e. attendance, no-show appointments, group participation etc.). *Structural racism refers to the totality of ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems that in turn reinforce discriminatory beliefs, values, and distribution of resources.



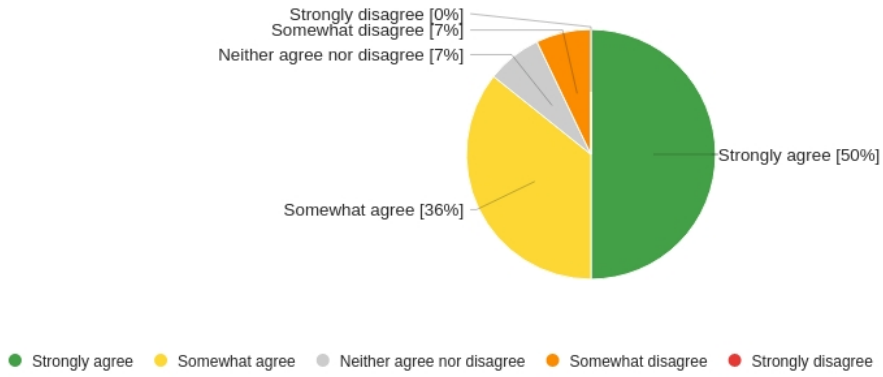
Q6 - Structural racism influences treatment approach at my organization (for example- choice of psychotherapy, type of intervention, choice of medication, etc) *Structural racism refers to the totality of ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems that in turn reinforce discriminatory beliefs, values, and distribution of resources.



Q7 - There is a potential for racial disparities in client satisfaction amongst clients at my organization.



Q8 - There is a potential for racial disparities in diagnosis amongst clients at my organization.



Appendix C

Free Text Responses with Themes

Results: How does structural racism affect clinical care?

- Themes from free text responses
  - Implicit bias
  - Disparities in treatment/Access to care

Implicit Bias:

"BIPOC patients sometimes face barriers that make it more difficult to successfully graduate from residential services - such as being perceived as threatening or aggressive"

"There's some subjectivity in nursing assessments, where I can see room for racism in play informing the degree to which people are medicated"

Results: How does structural racism affect clinical care?

- Free text responses continued:

Implicit Bias

"The recovery community is small and often operates on a who knows who basis which often favors white, straight, cis-gender people."

"I can see our patients of color moderating their report of symptoms, anticipating how they're being read by white nurses"

"Evidence shows that racism affects MH diagnoses, what medications are prescribed"

Results: How does structural racism affect clinical care?

- Free text responses continued:

Treatment disparities/Access to care:

"Structural racism may influence their experience of a therapeutic environment - such as if there's tension/discomfort driven by racism on the part of staff or fellow patients."

"Often BIPOC patients aren't even getting to residential"

"Just because I don't see it, doesn't mean it's not there. Because racism seems to be everywhere, ranging from subtle to overt, I err on assuming there's structural racism influencing our care at this facility"

"Access to care in the first place may be an issue influenced by structural racism"

Appendix D

Response Rates

Role	Number of Respondents (n=)	Response Rate (%)
Counseling	0	0%
Nursing	3	15%
Medical Provider/MD/NP/PA	3	50%
Other	1	N/A
Prefer not to answer	7	N/A
Total	14	38.8%

Appendix E

Summary of Recommendations Excerpt from Report