

Integrating a Health Justice Framework in Clinical Social Work: Aligning Ethics, Competencies, and Practice

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ABSTRACT

Health inequities remain persistent across health care systems, reflecting deeply embedded structural, social, and political determinants of health [1,2]. Health justice has emerged as a framework that explicitly addresses these structural inequities by centering community power, equity, and systemic reform [3,4]. Clinical social workers practicing in health care settings are uniquely positioned to operationalize health justice through direct clinical intervention, organizational advocacy and policy engagement [5,6].

This manuscript expands upon existing health justice scholarship by aligning health justice principles with the Council on Social Work Education (CSWE) Educational Policy and Accreditation Standards (EPAS) competencies and NASW Code of Ethics [7,8].

Keywords

Health justice, Clinical social work, CSWE EPAS, Health equity, Social determinants of health.

Introduction

Health inequities in the United States continue to disproportionately affect communities historically marginalized by race, class, disability, immigration status, gender identity, and geographic location [1,2]. These inequities are not accidental but are produced and sustained by structural forces such as systemic racism, economic inequality, and exclusionary policy frameworks [1,9]. Clinical encounters often represent the downstream effects of these inequities, yet traditional health care models frequently emphasize individual responsibility rather than structural causation. Moreover, these clinical encounters are often the location where structural inequities become psychologically internalized.

Health justice offers a paradigm shift by reframing health inequities as consequences of structural subordination and power imbalance rather than individual pathology [3,4]. Clinical social work, with its long-standing commitment to social justice and person-in-

environment practice, is uniquely positioned to integrate health justice into health care delivery [5,10]. Despite this alignment, there remains a gap in the literature articulating how health justice can be operationalized within clinical social work practice while meeting professional competency standards [11,12].

Health Justice: Conceptual and Theoretical Foundations

Health justice builds upon public health, legal scholarship, critical race theory, and community organizing traditions [1,3]. Unlike traditional health equity frameworks that emphasize outcome disparities, health justice centers power redistribution and structural accountability [9,13].

Key principles of health justice include:

- Recognition of structural determinants of health
- Centering of community expertise and lived experience.
- Cross-sector collaboration
- Accountability for institutional and policy-level inequities
- Commitment to systemic change rather than isolated interventions

This framework explicitly rejects neutrality, asserting that health care systems must actively address inequities through systemic change [1,12].

Integrating the NASW Code of Ethics with a Health Justice Framework

The NASW Code of Ethics provides a foundational ethical mandate for clinical social work practice [8]. A health justice framework operationalizes these ethical principles by explicitly addressing structural determinants of health [3,5].

Ethical Principles and Health Justice Alignment

- Service (Ethical Principle 1)**
 Health justice extends service beyond individual intervention by requiring clinicians to address systemic barriers that undermine client well-being. Advocacy for equitable access to care is a core expression of ethical service.
- Social Justice (Ethical Principle 2)**
 The Code mandates that social workers challenge social injustice. Health justice provides a concrete framework for identifying and dismantling institutional practices that produce inequitable health outcomes.
- Dignity and Worth of the Person (Ethical Principle 3)**
 Health justice emphasizes centering patient voice, lived experience, and self-determination, particularly for communities historically excluded from decision-making power.
- Importance of Human Relationships (Ethical Principle 4)**
 Collaborative partnerships with patients, families, interdisciplinary teams, and communities are essential to health justice practice.
- Integrity and Competence (Ethical Principles 5 and 6)**
 Health justice requires clinicians to practice with transparency, cultural humility, and ongoing development of structural competency to ethically address complex inequities.

Health justice extends service beyond individual intervention by requiring clinicians to address systemic barriers [11]. The Code mandates that social workers challenge social injustice, and health justice provides a framework for identifying institutional inequities [10,12].

Table 1: Integration of NASW Code of Ethics and Health Justice in Clinical Practice.

NASW Ethical Principle	Health Justice Application	Clinical Action
Social Justice	Structural accountability	Policy advocacy
Dignity and Worth	Centering patient voice	Shared decision-making
Service	Addressing root causes	SDOH interventions
Human Relationships	Community collaboration	Interdisciplinary care
Competence	Structural competency	Ongoing training

Implications for Clinical Practice and Professional Accountability

Integrating health justice with the NASW Code of Ethics affirms that advocacy and systems change are not optional extensions of clinical work but ethical imperatives. Clinical social workers must be supported through organizational policies, supervision, and education to sustain this work without role strain or burnout.

Clinical Social Work and the CSWE EPAS Competencies

The CSWE EPAS identifies core competencies required for professional practice. Health justice provides a framework through which these competencies can be enacted [7].

Alignment With Key EPAS Competencies

- Competency 1: Demonstrate Ethical and Professional Behavior**
 Health justice reinforces ethical obligations to address systemic inequities affecting clients' health and access to care.
- Competency 2: Engage Diversity and Difference in Practice**
 Centering marginalized voices and recognizing structural oppression aligns directly with health justice principles.
- Competency 3: Advance Human Rights and Social, Economic, and Environmental Justice**
 Health justice operationalizes Competency 3 by linking clinical care to advocacy for structural reform [6,12]
- Competency 4: Engage in Practice-Informed Research and Research-Informed Practice**
 Data on social determinants and inequitable outcomes guide practice-informed research [2,14].
- Competencies 6–9: Engagement, Assessment, Intervention, and Evaluation**
 Health justice expands these competencies beyond individual-level change to include systemic responsiveness and accountability.

Table 2: Alignment of Health Justice Principles with CSWE EPAS Competencies.

Health Justice Principle	Relevant EPAS Competency	Application in Clinical Social Work
Structural analysis of inequities	Competencies 1 & 3	Ethical advocacy for policy and systems changes
Centering community voice	Competency 2	Culturally responsive engagement and shared decision-making
Addressing social determinants	Competencies 6 & 7	Equity-centered biopsychosocial assessment
Systems accountability	Competencies 8 & 9	Organizational advocacy and policy reform
Use of data for equity	Competency 4	Evaluation of inequitable outcomes and practices

A Health Justice–Informed Clinical Practice Framework

Health justice–informed clinical social work operates across three interconnected levels:

Micro-Level Practice

- Equity-centered biopsychosocial assessments
- Recognition of structural trauma and chronic stress
- Validation of client experiences of oppression

Mezzo-Level Practice

- Advocacy within health care organizations
- Interdisciplinary collaboration
- Program development addressing social needs.

Macro-Level Practice

- Policy advocacy
- Community partnerships
- Institutional accountability initiatives

Conceptual Model: Health Justice in Clinical Social Work Practice

Figure 1: (Conceptual Description).



Note: Figure created by the author using generative AI-assisted visualization tools.

The conceptual model places Health Justice at the center, surrounded by three concentric practice levels (micro, mezzo, macro). These levels are informed by:

- Social determinants of health
- Structural oppression
- Community power

Bidirectional arrows illustrate continuous feedback between clinical practice, organizational change, and policy reform. The NASW Code of Ethics and CSWE EPAS competencies function as the ethical and professional foundation supporting all levels of practice.

Case Scenarios: Application across Practice Levels

Case Scenario 1: Food Insecurity and Chronic Disease Management

Practice Level: Micro → Mezzo

Relevant NASW Ethical Standards: 1.01 (Commitment to Clients), 6.04 (Social and Political Action)

Clinical Context

Case Scenario

A 55-year-old patient with Type 2 diabetes is admitted for uncontrolled blood glucose levels. Structural determinants such as

food insecurity significantly influence chronic disease outcomes [5,15].

Using a health justice lens, the clinician reframes “noncompliance” as a systemic issue rather than individual failure [1,2].

Step-by-Step Health Justice Resolution Process

Step 1: Equity-Centered Assessment

Using a health justice lens, the clinical social worker conducts a comprehensive biopsychosocial assessment that includes screening for food insecurity, housing stability, transportation access, and financial strain. The patient discloses reliance on low-cost, calorie-dense foods due to limited income and lack of access to grocery stores.

Ethical Integration

This step reflects the NASW ethical commitment to dignity and worth of the person by rejecting deficit-based assumptions and validating structural constraints rather than labeling the patient as noncompliant.

Step 2: Structural Analysis

The social worker identifies food insecurity as a structural determinant of health contributing directly to medical outcomes. The clinician reframes the issue within the interdisciplinary team, challenging the individual-blame narrative.

Step 3: Collaborative Intervention Planning

The patient is actively engaged in identifying culturally preferred foods and feasible options. The social worker coordinates:

- Enrollment in nutrition assistance programs
- Transportation vouchers
- Referral to a hospital-affiliated food pharmacy

Step 4: Mezzo-Level Advocacy

The social worker documents the pattern of readmissions linked to food insecurity and advocates for routine SDOH screening in discharge planning.

Potential Impacts

The patient’s glycemic control stabilizes, hospital readmissions decrease, and institutional practice changes begin to address food insecurity proactively.

Case Scenario 2: Linguistic Marginalization in Mental Health Care

Practice Level: Micro → Mezzo

Relevant NASW Ethical Standards: 1.05 (Cultural Competence), 1.02 (Self-Determination)

Clinical Context

A non-English-speaking immigrant patient with major depressive disorder misses multiple therapy appointments and appears disengaged. Chart notes suggest “lack of motivation”.

Step-by-Step Health Justice Resolution Process

Step 1: Identification of Structural Barrier

The social worker recognizes limited language access as a structural exclusion, not a clinical deficit. Interpreter services are inconsistently available, and sessions are shortened or rescheduled.

Step 2: Ethical Reframing

Grounded in the NASW standard on cultural competence, the clinician challenges the interpretation of disengagement and reframes it as systemic failure to provide equitable access.

Step 3: Patient-Centered Engagement

With an interpreter present, the social worker explores the patient's prior experiences with authority and health systems, acknowledging historical and cultural trauma.

Step 4: Organizational Advocacy

The clinician advocates for:

- Integrated interpreter scheduling
- Policy requiring language access documentation.
- Staff training on linguistically inclusive practice

Step 5: Community Partnership

A community cultural liaison is incorporated into care planning to support trust and continuity.

Potential Impacts

Therapeutic engagement improves, depressive symptoms decrease, and clinic-level practices are revised to ensure language equity.

Case Scenario 3: Inequitable Appointment Policies and Loss of Care

Practice Level: Mezzo → Macro

Relevant NASW Ethical Standards: 6.01 (Social Welfare), 6.04 (Social and Political Action)

Clinical Context

A health clinic enforces a strict “three missed appointments” policy, disproportionately disenrolling low-income patients with unstable employment and caregiving responsibilities.

Step-by-Step Health Justice Resolution Process

Step 1: Data Collection and Equity Analysis

The social worker reviews clinic data and identifies a disproportionate impact on patients living below the poverty line.

Step 2: Ethical Accountability

Guided by the NASW commitment to social justice, the clinician frames the policy as structurally discriminatory rather than neutral.

Step 3: Interdisciplinary Advocacy

Findings are presented to leadership, emphasizing health justice principles and patient harm.

Step 4: Policy Reform

The clinic implements:

- Flexible scheduling

- Telehealth options
- A grace period for cancellations related to structural barriers.

Step 5: Evaluation and Accountability

The social worker participates in ongoing monitoring to assess equity outcomes.

Potential Impacts

Access to care improves, retention increases, and the clinic institutionalizes equity-based policy review.

Table 3: Health Justice Interventions Across Practice Levels.

Practice Level	Intervention	Health Justice Outcome
Micro	Equity-centered assessment	Improved engagement and outcomes
Mezzo	Policy advocacy within clinics	Reduced structural barriers
Macro	Data-driven institutional reform	Sustainable health equity

Related Clinical Models and Practice Approaches

The Liberation Health Model

Clinical social work has long integrated person-in-environment perspectives with a commitment to social justice, positioning it as inherently aligned with health justice principles. Contemporary clinical frameworks, particularly the Liberation Health Model, emphasize the importance of incorporating sociopolitical analysis into assessment and intervention. This model supports clinicians in contextualizing individual distress within broader structural, cultural, and institutional forces, such as systemic racism, poverty, immigration policy, and dominant ideological narratives, while fostering critical consciousness and reducing internalized blame. An integrated approach underscores that individual problems cannot be understood in isolation but must be situated within intersecting economic, political, and cultural contexts. Accordingly, effective clinical practice requires an integrated response that addresses both personal experiences and the broader social conditions shaping them, reinforcing the role of social workers in linking micro-level care with macro-level change [16].

Structural Competency Informed Practice

Structural competency extends beyond “culture” to focus on upstream forces, such as housing, labor markets, criminal legal systems, and health policy, that pattern illness and inequitable access to care. Metzl and Hansen [17] argue for clinical training that equips practitioners to recognize how social, political, and economic structures produce stigma and health disparities, and to intervene through interdisciplinary collaboration and institutional advocacy. Structural competency is therefore a natural bridge between micro-level treatment planning and mezzo/macro change efforts central to health justice.

Socioeducation and Socially Engineered Trauma

Shaia and colleagues [18] describe socially engineered trauma as trauma exposure patterned by systems of oppression rather than random misfortune. Their socioeducation approach helps clients contextualize symptoms as understandable responses to structural

violence while supporting collective meaning-making, advocacy, and resource mobilization; an orientation consistent with health justice's rejection of individual-blame narratives.

Aligning Cultural Practice with Health Justice

The American Medical Association (AMA) and Association of American Medical Colleges (AAMC) advocate for equity-centered approaches, including cultural humility, structural competency, and cultural safety. Cultural humility emphasizes an ongoing process of self-reflection, recognition of power differentials, and the development of respectful, collaborative partnerships with patients and communities [19]. Structural competency expands this lens by encouraging health professionals to recognize and address the broader social, economic, and institutional structures that shape health inequities and access to care [17]. Cultural safety further reinforces these approaches by promoting care environments that are responsive to individuals' lived realities, including the social, political, historical, and economic contexts that influence health and well-being.

Aligning cultural practice with health justice requires integrating cultural humility and structural competency into a unified clinical framework: cultural humility advances relational accountability and power-sharing in clinical encounters [19], while structural competency equips clinicians to recognize and intervene on upstream drivers of inequity [17]. Emerging scholarship on structural humility reinforces this integration by emphasizing critical reflection on systemic oppression and disenfranchisement beyond the interpersonal level [20].

Implications for Social Work Education and Practice

Embedding health justice into social work education strengthens competency-based learning by connecting ethics, diversity, and justice to concrete clinical actions. Health care organizations benefit from improved patient outcomes, reduced disparities, and enhanced accountability.

Future Research Directions

Further empirical research is needed to:

- Measure outcomes of health justice-informed clinical interventions
- Evaluate organizational change processes.
- Develop validated tools for equity-centered assessment.

Conclusion

Health justice offers a transformative framework for advancing clinical social work practice [1,3]. By aligning with the NASW Code of Ethics and CSWE EPAS competencies, clinical social workers can operationalize equity across practice levels [7,8]. This alignment reinforces that addressing structural determinants of health is not ancillary to clinical care but central to ethical and competent practice.

Embedding health justice into clinical social work not only enhances patient-centered care but also advances institutional accountability and systemic reform. Clinical social workers

are uniquely positioned to lead efforts that integrate direct care, organizational advocacy, and policy reform [5,6,12]. Future research and practice innovation should continue to refine and evaluate health justice-informed approaches, ensuring their sustainability and impact across diverse health care contexts.

References

1. Yearby R. Social determinants and health justice. *Journal of Law Medicine Ethics*. 2022; 50: 641-649.
2. Egede LE, Walker RJ, Williams JS. Addressing structural inequalities and racism. *J Gen Intern Med*. 2024; 39: 487-491.
3. Wiley LF, Yearby R, Clark B, et al. What is health justice. *Journal of Law Medicine Ethics*. 2022; 50: 636-640.
4. Michener J. Health justice and power. *Journal of Law Medicine Ethics*. 2022; 50: 656-661.
5. Berkowitz A, Schlehofer MM. Addressing social determinants of health A framework for interdisciplinary action. *Health. Soc Work*. 2025; 50: 199-205.
6. Bussey SR, Dobrof J. Social work's opportunity and obligation to achieve population health equity. *Soc work Health Care*. 2024; 63: 154-167.
7. Council on Social Work Education. Educational policy and accreditation standards EPAS. 2022.
8. National Association of Social Workers. Code of ethics of the National Association of Social Workers. 2021.
9. Dorfman L, Sarah E Gollust, Makani Themba, et al. Changing the story on health and racial equity Narrative and structural analysis. *Milbank Q*. 2025; 103: 724-754.
10. Atteberry-Ash BE. Social work and social justice: A conceptual review of the literature. *Soc Work*. 2022; 67: 323-333.
11. Marmo S, Leff SS, Kim JS. Social work innovation and SDOH. *Soc Work Health Care*. 2024; 63: 89-105.
12. Flanagan K, Chatman A. Promoting antiracism in healthcare systems. *Health. Soc Work*. 2025; 50: 173-178.
13. Alberti PM. Health equity benefits all communities (including White ones). *Milbank Q*. 2025; 103: 955-965.
14. Long KA. Screening for health-related social needs. *JAMA Network Open*. 2025.
15. Braveman P. The social determinants of health and health disparities *Health. Soc Work*. 2024; 49: 131-132.
16. Belkin Martinez D, Fleck-Henderson A. *Social Justice in Clinical Practice A Liberation Health Framework for Social Work* 1st ed. Routledge. 2014; 218.
17. Metzl JM, Hansen H. Structural competency Theorizing a new medical engagement with stigma and inequality. *Soc Sci Med*. 2014; 103: 126-133.
18. Shaia WE, Avruch DO, Green K, et al. *Socially-Engineered Trauma and a New Social Work Pedagogy Socioeducation as a Critical Foundation of Social Work Practice*. *Smith College Studies in Social Work*. 2019; 89: 238-263.

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19. Gottlieb L. From cultural competence to structural humility in health care. 2021.
 20. Parente DJ. Structural humility in health professions practice. 2023.