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Organizational Climate and Treatment Outcomes for African American Clients Receiving Services at Community Mental Health Agencies

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ABSTRACT. The purpose of this study, which represents the second part of a two-part case study, is to develop a conceptual model that explains the multiple organizational, staff, and client factors that contribute to the creation of treatment outcomes for African American clients seeking services from community mental health agencies (CMHAs). *Method:* An agency identified in the first part of the case study by the authors (Larrison et al., 2004) as achieving similar positive treatment outcomes for African American and

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white clients is further examined in an attempt to understand the organizational and staff influence on these outcomes. A purposeful sample of staff and African American clients were asked to describe the agency's organizational climate and how that climate shaped the work of staff and the outcomes of treatment for African American clients. Both quantitative and qualitative descriptive data were collected and analyzed in an effort to develop an accurate understanding of how the agency created treatment outcomes for African American clients. *Findings:* The conceptual model developed suggests that organizational factors mediate the relationship between staff and clients. In particular, we posited that the high levels of involvement with clients, task orientation towards positive outcomes for all clients, clarity of tasks and goals, innovative interventions, and high levels of physical comfort at CMHAs helps to minimize disparities in treatment outcomes for African American clients.

INTRODUCTION

Community mental health treatment, like medical treatment, appears to be dissimilar for African American and white clients (USDHSS, 2001). This dissimilarity is thought to produce qualitative differences in treatment outcomes and represents a serious public health concern. However, existing data regarding treatment outcomes at community mental health agencies (CMHAs) for clients with racially, ethnically, or culturally diverse backgrounds are quite limited and do not adhere to any discernable pattern regarding the extent of outcome disparities or the potential causes of such disparities (Sue et al., 1991; Rosenheck & Fontana, 1994; Kuno & Rothbard, 1997; Baker et al., 1999; Angold et al., 2000; Ortega & Rosenheck, 2002;). The U.S. surgeon general's 2001 report on race, culture, and ethnicity in mental health further underscored the limited amount of research regarding predictors of disparate treatment outcomes for African American clients receiving services at CMHAs (Snowden, 2001; USDHSS, 2001).

A number of factors have been posited to explain outcome disparities at the level of the client (e.g., demographic and socioeconomic factors), the intervention (e.g., cultural appropriateness and efficacy of intervention, diagnostic issues), and the clinician or case manager (e.g., matching client and clinician ethnicity, level of cultural competency) (Snowden, 2003; Davis & Proctor, 1989). These three sets of factors are thought to intersect to produce disparities in client outcomes (Ridley, 2005). Underpinning the posited relationship between the three sets of factors are a number of human behavior theories including but not limited to group

dynamics theory, decision theory, and social capital theory (Davis & Proctor, 1989; USDHHS, 2001; Ridley, 2005). However, no current conceptual model arising out of these theories has accurately described how and why treatment and outcome disparities happen in CMHAs (USDHHS, 2001; Snowden, 2005). The focus of these theories on the client/therapist relationship to the exclusion of other possible factors, such as the role of organizational climate, may have led to limited knowledge about the reasons for disparities in treatment outcomes.

While the amount of literature examining the relationship between organizational factors and client outcomes in the social services is growing, there is little consensus regarding the conceptual model underpinning such investigations (Yoo & Brooks, 2005). This study is a continuation of a case study of a CMHA with an all-white professional staff that created similar positive outcomes for African American and white clients (Larrison et al., 2004). It responds to the critical lack of a conceptual model by attempting to better understand how this CMHA created similar treatment outcomes for African American and white clients. Rooted in a qualitative epistemology, the study seeks to produce from the in-depth study of one agency and an examination of the existing literature on organizational climate and health disparities, a conceptual model describing the relationship between organizational climate and outcome disparities.

FRAMEWORK FOR UNDERSTANDING HEALTH DISPARITIES RESEARCH

The study is best contextualized using the framework described by the Center for Health Equity Research and Promotion (CHERP) for advancing health disparities research, which envisions disparities research in a three-generation framework (Fine, Ibrahim & Thomas, 2005). The first generation of research in mental health disparities indicated the existence of disparities in treatment and outcomes for African American clients (Sue, 1977; Sue et al., 1991; USDHHS, 2001). Evidence suggests that a number of factors embedded in larger social structures of society, including the community and agency, interact with individual staff and client behavior and beliefs about mental health and race to produce disparities (Miller, 1984; ARC & NFCO, 2005; Borrell, 2005; Snowden, 2005).

This study is part of the second generation of disparities research, which builds on the first generation by attempting to better understand the causal factors underlying disparities. Our shift away from the analytic category of

race as the primary cause of disparities to a focus of the role of organizational factors is entirely consistent with a concentration on better understanding the causes of treatment and outcome disparities in light of the first-generation research. The conceptual model and hypotheses resulting from the present study will direct future research that should result in a better understanding of the reasons for disparities and help make meaningful progress toward third-generation research that concentrates on the development of interventions to reduce disparities, which in this case will focus on those organizational factors most amenable to change.

ORGANIZATIONAL CLIMATE

Surprisingly little is known about the linkages between organizational climate and treatment outcomes in CMHAs in general, and no research to date has examined the relationship between organizational climate and racial or ethnic disparities in outcomes among CMHAs' clients (Snowden, 2001, 2003; Yoo & Brooks, 2005). In one of the few studies examining agency level factors, Stiffman et al. (2001) found that provider perceptions play a far more significant role than client factors (such as need) in determining the use of services. Because CMHAs have a considerable amount of independence, their organizational climates may vary tremendously; the resulting variation may well contribute to the lack of consistency in research findings concerning treatment outcomes for African American clients.

Conceptualizations of organizational climate usually include aspects of shared history, expectations, unwritten rules, and social mores that affect the behavior of everyone in an organization and the underlying beliefs that shape the actions of staff (Frederickson, 1966; Glisson, 2000). Organizational climate is theorized to influence treatment outcomes through its relationship with staff behavior (Muldrow, Buckley & Schay, 2002). This relationship has been confirmed across a variety of settings. Organizational climate has been found to influence productivity levels and the level of predictability in employee behavior (Kaczka & Kirk, 1968; Schneider & Hall, 1972). More recently, Glisson (1989; Glisson & Durick, 1988) has successfully applied the concept of organizational climate to the study of human service organizations. The identification of a link between organizational climate, job performance, and treatment outcomes for children served within the child welfare system (Glisson & Hemmelgarn, 1997; Yoo & Brooks, 2005) has particular relevance since the clients demonstrated improved psychosocial functioning,

an outcome also sought for clients served by CMHAs (Chambers, 1986; Levin & Petrila, 1996).

Organizations and their climates are dynamic, evolving entities that naturally change over time. Such change is often incremental, and it may be unintentional and unplanned, or planned and intentional. The very fact of organizational change suggests that directed, intentional efforts at change have the potential to succeed in effecting substantive changes in organizational climate (Trice & Beyer, 1993). The idea of organizational change that is directed and substantive is well established in the management literature (Deal & Kennedy, 2000; Kotter, 1990; Schein, 1990; Trice & Beyer, 1993; Cameron & Quinn, 1999; Pratt & Foreman, 2000).

Glisson and colleagues (Glisson & James, 2002; Glisson, Duke & Green, 2006) rightly point out that, although organizational research in mental health is at the beginning of the knowledge-building process, research on the diffusion of innovation, technology transfer, and organizational and community development has much to contribute to understanding organizational change in agencies providing mental health services. Community development literature as far back as Lerner (1958) has examined how the introduction of new information changes social norms and behaviors. Glisson (Glisson & James 2002; Glisson & Schoenwald, 2005) has found that organizational-level change can be instituted using methods similar to those used for community change, such as social planning by outside experts, participatory or grassroots engagement with individuals directly impacted by changes, and advocacy by both outside experts and community residents (i.e., agency staff and clients). These methods have been successfully applied in other settings (Larrison, 2001; Larrison & Hadley-Ives, 2004).

Given the apparent existence of ethnic disparities in mental health treatment (USDHHS, 2001) and the relationship between organizational climate and client outcomes (Glisson & Hemmelgarn, 1997; Yoo & Brooks, 2005), it is reasonable to question whether the climate in which services are provided plays a role in creating disparate outcomes (Beckett & Dungee-Anderson, 1998). Further, the ability to direct organizational change indicates that interventions aimed at the organizational level may have a significant impact on disparities at agencies where they exist.

COMMUNITY MENTAL HEALTH AGENCIES

CMHAs are what remain of the federally funded community mental health centers created under the 1963 Community Mental Health Centers

Act. CMHAs provide services that are selected from an array of services reimbursable by Medicaid, Medicare, and other third parties. They serve a geographically defined catchment area and are expected to serve a wide range of individuals with various mental health problems and diverse racial, cultural, ethnic, and socioeconomic backgrounds. Approximately 45% of counties in the United States have access to a CMHA (Tevis, 2003), and the system provides outpatient mental health services to approximately 8% of the general adult population (USHHS, 1999), which represents a significant proportion of those seeking help for mental health problems.

Case Study CMHA

The CMHA that is the focus of this case study served six counties in the rural Southeast (Larrison et al., 2004). Most clients accessing services from the agency came from relatively impoverished socioeconomic backgrounds. The agency was located in a small town with a population of less than 15,000. Each county had a satellite office that provided services with some proximity to clients. The micro-area served by the agency was primarily a depressed agricultural and manufacturing region with weak ties to a metropolitan statistical area located 1 hour and 30 minutes away by car.

Approximately 35% of the population in the surrounding counties was African American and 62% was white. Other ethnic, racial, and cultural categories accounted for 3% or less of the population. The licensed staff and agency administrators were entirely white, while the unlicensed staff was approximately 60% African American and 40% white. The distribution of clients within the agency was approximately 55% African American and 45% white. Typically, 40% of the adult clients receiving services at the agency were diagnosed with depression, and 30% were diagnosed with schizophrenia and related disorders. The remaining cases (30%) had a range of diagnoses, including bipolar disorder, psychotic disorders, adjustment disorders, PTSD, and impulse control disorder. Medicare or Medicaid covered approximately 55% of clients receiving services from the agency, while the remaining clients were either self-pay (2.3%) or covered under a private insurance plan (43%). The agency's client population was predominantly female, with males comprising 35% of the client base.

The agency typically provided multiple interventions focusing on community-based services. These included individual counseling, group therapy, medication, psychiatrists' services, day treatment, client-run peer groups, and case management services. A variety of therapeutic models

shaped individual and group interventions, as is often the case at CMHAs. Cognitive behavioral, solution-focused therapy, family therapy, and insight-oriented psychotherapy were the predominant modalities used by professional staff at the agency.

CASE STUDY PART ONE

The case study began as an evaluation of services conducted by the lead author for the state agency overseeing the CMHA. Throughout the evaluation process, which entailed long-term interactions with staff, clients, and administrators of the agency, the agency exhibited a consistent organizational climate. The administrative staff appeared to actively manage the workplace climate and ensured that it permeated most aspects of agency life. This observation was confirmed by a number of other professionals and state officials that had knowledge of the agency.

Although the agency appeared to have a positive work environment, little was known about treatment outcomes for clients. The goal of the first part of the case study was to determine the pattern of treatment outcomes experienced by African-American and white clients, and in particular to look for disparities related to the race of clients (Larrison et al, 2004). This was accomplished using hierarchical linear modeling (HLM) to examine repeated-measures data on client outcomes over a nine-month period from a convenience sample (N = 130, 16.8%) of adult clients receiving treatment as usual at the agency. An individual growth model representing change in each client's observed level of symptom severity over time as measured by the BASIS-32 (Eisen, Dill & Grob, 1994) and a between-client model modeling the possible differences in growth trajectories between different demographic groups were examined. The only client-level variable significantly related to variation in symptom patterns was diagnosis. Because schizophrenia and major depression are likely to have different courses of treatment and patterns of outcomes, this was not surprising. What was surprising was that the results indicated no difference in treatment outcomes attributable to race, gender, age, or method of payment (Larrison et al, 2004).

An agency such as the one in this case study, where clients of diverse racial backgrounds experience equivalent outcomes, may be atypical of CMHAs and therefore worthy of further study. An examination of the particular features of the agency's organizational climate that set it apart from other health care agencies providing outpatient services may prove

useful in identifying organizational features and practices related to a lack of racial disparities in treatment outcomes.

METHODS

In this, the second part of the case study, the primary aim is to develop a conceptual model by better understanding the organizational climate of an agency that successfully served African American clients without producing the outcome disparities commonly seen or purported to exist among CMHAs. The authors used a general induction method in that they had some tentative thoughts about the importance of organizational climate, but did not approach the study with strong preconceived ideas regarding which organizational factors would prove most salient (Thomas, 2006).

Data Collection Method

Data collection was accomplished through four focus groups, one for each category of stakeholder (client, administrators, licensed staff, unlicensed staff), held in rooms provided by the CMHA during a one-week period in early August 2003. The focus groups lasted between 2 hours and 2 hours and 45 minutes and were conducted by the lead author. The groups consisted of an initial consent to participate process and completion of self-report scales, followed by a semi-structured interview engaging participants in a discussion about the agency's organizational climate and its relationship to treatment outcomes for African American clients. Narrative from the semi-structured interviews was recorded via handwritten notes composed by the lead author. Immediately following each focus group, the lead author additionally recorded detailed notes of the themes and perspectives expressed by participants, as well as observations relating to participants' interactions.

The mixed method approach to data collection served two purposes. First, it helped identify the organizational, staff, and client factors that created the positive treatment outcomes found in the first part of the case study as seen through the eyes of staff and clients. The intent was to "elaborate, enhance, illustrate, and clarify" the results from the first part of the case study (Greene, 2001, p. 253). Second, the mixing of data collection modes offered an opportunity to discover new perspectives by using a different set of methodologies to recast the findings from the first

part of the case study (Caracelli & Greene, 1997; Greene, 2001). This process allowed for new insights that confirmed the findings from the first part of the case study as well as those insights that expanded the meanings of findings from the first part to “generate more relevant, useful, and discerning inferences” from the data (Caracelli & Greene, 1997, p. 19). The intention was to achieve the most in-depth description of the agency from the broadest possible perspectives. The mixing of data collection methods to insure a high level of accuracy in the description of a case is increasingly more common among field researchers (Fontana & Frey, 2000).

Participants

Consistent with the objective of more closely examining the agency’s organizational climate from the perspective of clients and staff, a purposeful sample was used. Individuals were invited to participate in the research based upon their relationship with outpatient adult services at the CMHA and their ability to speak to the impact that organizational climate could have on treatment outcomes for African American clients. The client portion of participants therefore contained only African Americans who were asked to reflect upon their treatment experiences and relationships with the staff and the agency. All staff that had regular interactions with adult clients receiving outpatient mental health services were invited to participate.

Clients

All adult African American clients presenting at the agency during a 30-day period were asked for permission to release their names to the researchers. Thirty-two clients agreed to do so. Of the 32 clients, 20 were able and willing to participate in the focus group. These 20 clients represent 4.7% of the average monthly population ($N = 427$) of adult African American clients receiving outpatient services. The client participants were similar to the population of clients served at the agency in terms of gender distributions (30% male) and average age (48.6 years, $SD = 9.75$ years).

Staff

Twenty-two staff members agreed to participate in the research (Table 1). The population of staff working with adult outpatient clients was 56, including everyone from van drivers to psychiatrists. The sampling frame for the focus groups comprised only 32 staff members, however, because

TABLE 1. Demographic characteristics of staff sample

	N	Administrators	Licensed Staff	Unlicensed Staff	Total
Ethnicity	22				
% African American		0%	0%	83.3%	45.5%
Gender	22				
% Female		66.7%	100%	83.3%	81.8%
Age	22				
Mean (SD)		42.3 (13.5)	48.3 (11.9)	45.5 (8.0)	44.9 (10.1)
Years at agency	22				
Mean (SD)		5.0 (4.2)	8.0 (6.4)	5.0 (5.8)	5.6 (5.4)

some staff was working with clients (N = 18) during the scheduled focus group time and other staff (N = 6) was on vacation. Slightly more than two-thirds (69%) of the staff members available at the time of the focus groups participated. Among those who did not participate, two reported not having been informed of the focus groups in advance and eight stated no reason for not participating.

Instruments

Participants' perceptions of the organizational climate were measured quantitatively through one of two methods. Administrators and staff completed the Work Environment Scale (WES), a 91-item measure of the social environment in work settings (Moos, 1994). The WES measures ten aspects of work environment. Clients completed the 28-item adult version of the Mental Health Statistics Improvement Program consumer survey (MHSIP). In addition to these self-report instruments, subjects participated in semi-structured interviews.

The WES and the MHSIP provided two views of the agency's functioning, the first measuring how supportive and cohesive the agency was for its employees, and the second measuring how supportive and helpful the agency was for its clients. These parallel measures were well suited to examining links between organizational climate and treatment experiences for clients.

The Work Environment Scale

The Real Form of the WES (WES-R) was used because it evaluates individuals' perception of their work place, helps to formulate case

descriptions and can be used to understand the impact of organizational climate on clients (Moos, 1994). The WES-R was normed on a total of 8,146 employees in a variety of industries. The group most similar to CMHA staff was 4,879 health care workers from outpatient medical settings, psychiatric clinics, CMHAs, children's residential treatment centers, state mental hospitals, general hospital units, and Department of Veterans Affairs' medical centers.

The WES has 10 subscales that comprise three broad dimensions of relationship, personal growth, and system maintenance/change. The relationship dimension includes the involvement, coworker cohesion, and supervisor support subscales. The autonomy, task orientation, and work pressure subscales comprise the personal growth dimension. The subscales encompassed in the system maintenance and change dimension are clarity, managerial control, innovation, and physical comfort (Moos, 1994).

The subscales are described by Moos (1994) as follows: "1) Involvement is the extent to which employees are concerned about and committed to their jobs; 2) cohesion is how much employees are friendly and supportive of one another; 3) support is the extent to which management is supportive of employees and encourages employees to be supportive of one another; 4) autonomy is how much employees are encouraged to be self-sufficient and to make their own decisions; 5) task orientation is the emphasis on good planning, efficiency, and getting the job done; 6) work pressure is the degree to which high work demands and time pressure dominate the job milieu; 7) clarity is whether employees know what to expect in their daily routine and how explicitly rules and policies are communicated; 8) managerial control is how much management uses rules and procedures to keep employees under control; 9) innovation is the emphasis on variety, change, and new approaches; and 10) physical comfort is the extent to which the physical surroundings contribute to a pleasant work environment." (p. 1)

The WES has been used to study organizational factors related to burnout among mental health professionals (Savicki & Cooley, 1987), health care workers (Turnipseed, 1998), and nurses (Schaefer & Moos, 1996), and has been shown to have adequate internal consistency and test-retest reliability (Moos, 1994).

The Mental Health Statistics Improvement Program Survey

The MHSIP survey was developed in an effort to provide states with a consumer-oriented survey for adult clients with serious mental illness

(Hall, 2002). This 28-item survey (version 1.1) is available at the MHSIP Web site (www.mhsip.org), where it is more fully described. The MHSIP survey measures five domains: 1) accessibility; 2) quality and appropriateness of care; 3) outcomes of care; 4) participation in treatment; and 5) general satisfaction. The five domains have been confirmed through factor analysis, and the questionnaire possesses adequate reliability and validity (Teague et al., 1997; Eisen et al., 2001). Each domain is made up of a series of statements with Likert-type responses ranging from strongly agree (scored as 1) to strongly disagree (scored as 5). The domain scores for an organization are calculated by first obtaining an average score for each subject within each of the five domains and then calculating the percentage of respondents whose domain scores were less than the midpoint of 2.5. The questionnaire's five domains are usually reported on their own without a total MHSIP score.

Semi-Structured Interviews

The focus group interviews for staff and administrators were structured using 15 questions intended to elicit information in two general areas: the relationship between employees and the agency, and the relationship between employees and clients. Within these two general areas, issues of innovative and evidence-based services, the use of cultural competency training, and the influence of race, culture, and ethnicity on staff/client relationships were also examined. Examples of questions include: 1) Do clients feel comfortable coming to you with problems? Please give examples. 2) What kind of innovative interventions have you used with African American clients during your employment at the agency? 3) Thinking about your caseload, how would you compare and contrast your African American and white clients on treatment outcomes, behavior, symptoms, and personality? 4) Would you describe your work place as top-down or bottom-up? 5) Does your boss support treatment approaches that may be unusual, but are beneficial to clients?

The focus group interviews for clients was structured using 16 questions intended to elicit information in three general areas: the quality of treatment, the relationship between clients and staff, and the impact of treatment on clients' problems. Examples of questions include: 1) Do the services provided to you fit your needs? 2) What advice would you have for the staff and supervisors at the agency about how to work with African American clients? 3) Do the people providing you services regularly listen to your opinions? 4) Has the quality of your life improved as a result

of treatment? 5) On a scale of 1 to 10, how would you rate the quality of services? Please explain your rating.

Data Analysis

Quantitative Data

The data from the WES and the MHSIP were used to develop a case description of the CMHA included in the study (Moos, 1994). This description was then compared with two nonequivalent control groups. The client description was compared to a 16-state sample of mental health clients receiving outpatient services (Lutterman et al., 2003). The staff and administrator description was compared to a group of 4,879 health care workers (Moos, 1994). While the primary purpose of the study was to describe the organizational climate from the perspectives of both staff and clients, differences between staff subgroups defined by several factors (type of position within the agency, race, and tenure at the agency) on WES scores were examined through analysis of variance using SPSS (version 14.0). A relatively liberal alpha level of 0.10 (two-tailed) was used, given the exploratory nature of the present study. MHSIP data, because only summarized findings were available, were not amenable to statistical comparisons. The MHSIP data from the 16-state study are intended to give context for interpreting the MHSIP scores from the agency included in the study.

Qualitative Data

Using a general inductive approach (Thomas, 2006) and methods associated with grounded theory, the research team immersed themselves in the field notes by engaging in repeated sorting, coding, and comparisons of words, phrases, and sentences that were related to organizational climate, treatment outcomes, and racial relationships identified as having a significant impact on decreasing disparities. (Morrow & Smith, 1995).

The final analysis examined the meaning of the words, phrases, and sentences identified in the coding by reading, rereading, and reflecting upon the statements or phrases in the context of their original narrative. This process provided a level of accountability and was done so that the words, phrases, and sentences were not viewed out of context from the overall narrative (Riemen, 1986). The field notes and resulting analysis were also triangulated with data from the WES and MHSIP.

Limitations

The present study is a single case study design, and therefore is severely limited in its generalizability. This study design is entirely appropriate given the purpose of the research which, rather than seeking to prove the existence of a relationship between organizational climate and treatment outcomes, sought to generate a conceptual model to guide future investigations (Stake, 2000; Creswell, 1998).

Care should be taken when considering the client sample and the ability to generalize the findings from the 20 clients interviewed to the population of African American clients served by the CHMA. The sample was limited by the confidentiality rules outlined in Health Insurance Portability and Accountability Act of 1996 (HIPAA), which prohibited the CMHA from releasing a list of active clients without their consent (leaving no accurate sampling frame). Instead clients had to be willing to release their names to the research team, and only those individuals who released their names could be contacted. This meant that the clients were self-selecting in many ways. Because the first part of the case study identified positive outcomes for the general population of African American clients at the CMHA, the intent of this, the second part, was to elicit a more in-depth understanding of why those positive outcomes were occurring for African American clients. Therefore the need to generalize was limited, and the purposeful sampling method allowed for the in-depth perspective sought.

Concern must always be taken when considering the value and accuracy of field notes. Standard procedure when engaging individuals or groups in sensitive topics (like discussing racism with a group of white and African American staff working at a community-based agency in the rural South) is to create a level of comfort that allows for an honest discourse. Recording devices interfere with this process and, therefore, relying on the oldest tradition of recording observations in research, namely field notes, is preferable (Emerson, Fretz & Shaw, 1995).

The validity of the field notes is further strengthened by the triangulation afforded by the WES and the MHSIP. Participants completed these instruments at the beginning of the focus groups, but they were not scored until after the process of coding the field notes was complete. Because the results of the WES and the MHSIP were not known to the researchers while conducting the focus groups, writing the field notes, or analyzing the narrative data, these represent truly independent sources of information. The congruency between the findings from the focus groups and the

two instruments is reasonable in light of the findings from the first part of the case study.

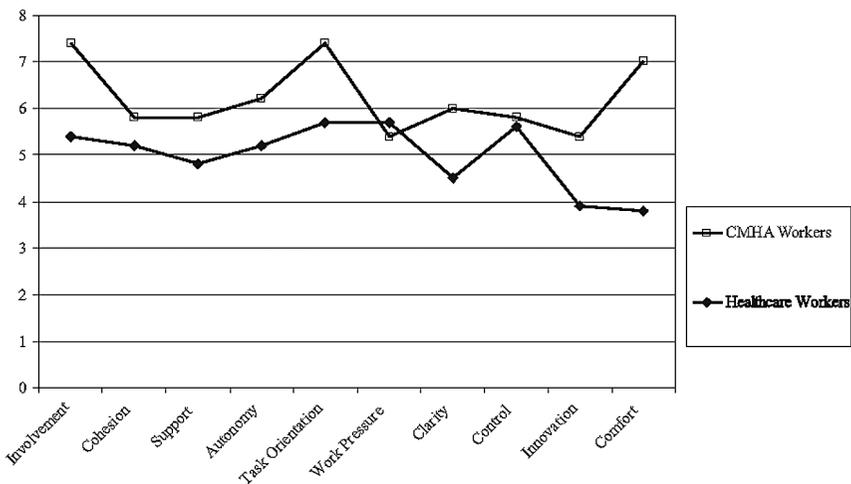
Finally, the statistical analyses conducted obviously suffer from limited statistical power to detect effects due to the small sample size.

FINDINGS

Work Environment Scale

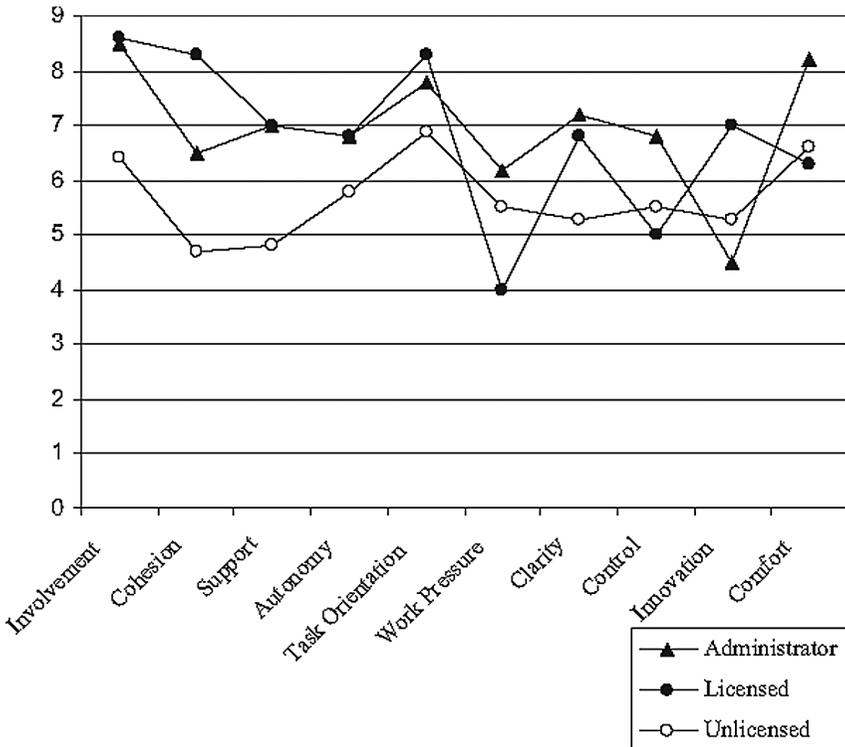
WES scores from agency staff were compared to scores reported for health care workers used to norm the scale. The mean scores of the study sample were higher than the health care workers described by Moos (1994) in terms of involvement, task orientation, clarity, innovation, and comfort, with differences greater than or equal to 1.5 points on the 10-point scale (Graph 1). The two groups were somewhat dissimilar in terms of supervisor support and autonomy, with differences of 1 point or more. Differences of greater than 1.5 points were deemed substantively significant in this context based on recommendations from Moos (1994) as well as the fact that this represents approximately one standard deviation for each of the subscales.

GRAPH 1. CMHA Compared to Healthcare Norms.



The sample was broken into groups according to job type, race, and tenure to examine potential differences in staff members' perceptions. As illustrated in Graph 2, the profile of licensed staff was generally more similar to that of administrative staff than to unlicensed staff. Results of the one-way ANOVA indicated that the three groups differed significantly on three domains: involvement ($F_{(2, 19)} = 3.93, p = .037$), cohesion ($F_{(2, 19)} = 4.97, p = .018$), and clarity ($F_{(2, 19)} = 2.81, p = .085$). Due to the small sample size, post-hoc comparisons were not conducted. Unlicensed staff averaged 1.5 or more points lower than at least one other group in terms of involvement, cohesion, support, and clarity. Consistent with their work roles, administrators scored higher on control and lower on innovation than the other two groups; administrators also scored relatively high in terms of comfort.

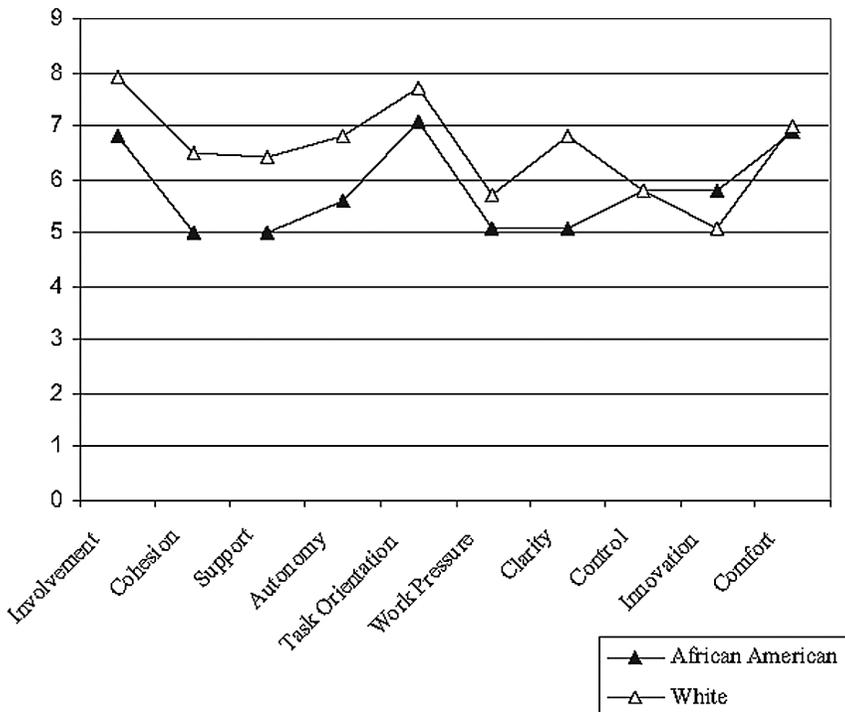
GRAPH 2. Job Type Differences on WES.



Overall, white and African American staff had similar profiles, although white staff scored higher on the domains of cohesion and support, and were significantly different in terms of both autonomy ($t = -2.04$, $df = 20$, $p = .055$) and clarity ($t = -2.37$, $df = 20$, $p = .028$; Graph 3). In research by McNeely (1992), African American staff reported dissatisfaction and lack of affiliations with the organization they worked for when they perceived racial discrimination as a factor in determining the distribution of goods. In this agency, impressions reported by African American staff indicate a high level of affiliation with clients and with the agency

The final comparison examined the effect of work tenure in the organization on staff members' perceptions of the organizational climate. Employees who had been with the agency for at least three years were compared to those who had been hired more recently. No statistically significant differences were found between the groups ($p < .10$, two-tailed),

GRAPH 3. Racial Differences on WES Scores.



suggesting that the organizational climate is being effectively communicated to new employees. New hires who are not able to adapt to the existing organizational climate may leave within a relatively short time. The results did not differ when the cutoff was set at two rather than three years. Overall, these results suggest that employee perceptions of organizational climate are shaped more by their job duties than by either race or tenure in the organization.

Mental Health Statistics Improvement Program Survey

In most domains, the proportion of respondents who were satisfied was higher than in the average state samples (Table 2). In particular, this small sample from rural Georgia seems to experience more positive change as a result of treatment than national averages.

The MHSIP adult consumer satisfaction scores in this sample, with high percentages agreeing that treatment has been accessible, appropriate, and beneficial, indicate that the agency is perceived as meeting clients' needs regardless of race.

Semi-Structured Interviews

Several consistent themes emerged within the two general areas explored in the focus group interviews with staff and administrators. The agency was characterized by staff as having a directive and clearly articulated administrative structure that was perceived as generally positive. This structure appeared to orient staff toward agency goals, which centered on improving the quality of clients' lives. African American staff expressed concern about the lack of African Americans in administrative

TABLE 2. Percent agreement on MHSIP survey domains

	Study Sample	16-State Study Median
Access	85.0%	81.8%
Quality & appropriateness	85.0%	80.1%
Positive change	95.0%	71.1%
Consumer participation in treatment planning	70.0%	72.3%
General satisfaction	95.0%	83.8%

Note: Figures for the 16-state study come from Hall (2002) and Lutterman et al. (2003).

positions. Both African American and white staff reported feeling comfortable asking each other questions pertaining to cultural issues.

All staff and administrators reported receiving cultural competency training as part of their employment experience. Approximately 60% of staff and administrators stated that cultural competency training was part of their formal education. All reported positive feelings about the training and felt they had learned something from the training, although a number of staff stated that the training seemed “canned.” Further, few staff associated the training with improved outcomes with clients, but a number did indicate that it had a positive impact on staff interactions around the agency. Staff reported supervisory support for providing innovative and unique treatment to clients as long as standard treatments had been exhausted and proven ineffective. Innovation was therefore encouraged under a carefully supervised set of rules.

Race did have some influence on relationships between staff and clients. African American staff reported that they sometimes observed African American clients being treated differently than white clients. Typical incidents cited were peripheral to the services being delivered and tended to indicate that, among clients who were especially uncooperative, African American clients were treated in a less flexible manner than white clients. White staff was less likely to report these types of incidents and was more likely to report feeling that all clients were treated equally. All staff stated that there was recognition that client treatment was varied and individualized, and that this variation was determined by a number of factors beyond race.

The interviews did identify that the agency is not devoid of problems concerning the treatment of African American clients and staff. Many of the reported behaviors are expected as part of society’s incomplete progress towards racial harmony. However, the data on the whole reveal a more positive picture than these complaints might suggest.

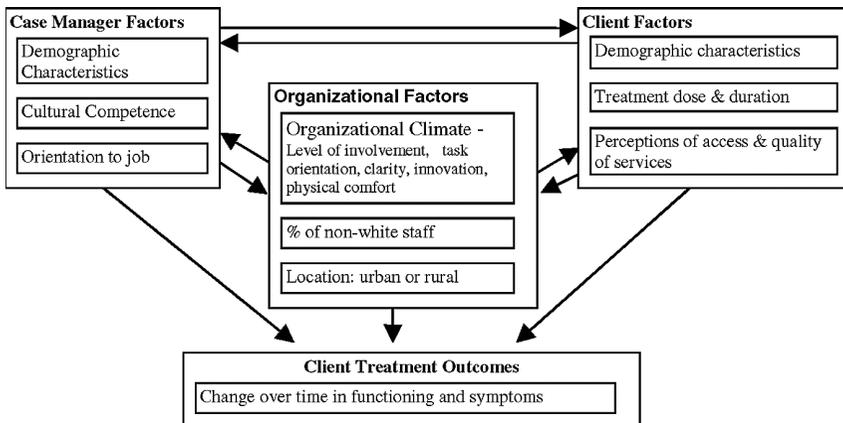
The three general areas examined in the semi-structured interviews with clients elicited the following themes. Clients consistently cited the high quality of care, professional appearance of the facilities, and personalized treatment received from staff at all levels of the organization, which is consistent with the high levels of satisfaction reported on the MHSIP survey. Clients reported that staff was able to act in culturally appropriate ways, and also noted that staff was sensitive to the delicate balance between the needs of the client and the needs of the client’s family. Treatment in general was perceived as having a significant positive impact upon functioning and quality of life.

CONCEPTUAL MODEL

From the perspective of clients, staff, and administrators, the agency examined in this case study performed well in providing services that had moderately positive outcomes for African American clients. Within the field of mental health, which often lacks objective, tangible outcomes, this level of agreement is a good indicator of successful treatment. The measures of organizational climate at the CMHA also suggest several features that distinguish the agency from other health care organizations. These features could play an important role in explaining why African American and white clients experienced equivalent outcomes at the agency.

Based upon the findings of the case study, a conceptual model was developed that explains the role of organizational climate in the creation of outcomes (Figure 1). The model takes into account the current scholarly literature concerning health disparities, which indicates that the demographic characteristics of staff and clients, the clients' diagnosis, the dose and duration of treatment, and perceptions about access to and quality of treatment play roles in treatment outcomes (USDHHS, 2001). The model places organizational climate as a mediating force that influences the relationship between clients, staff, and outcomes. As a result, the model recognizes that every client-staff relationship may differ because of the demographic characteristics of the individuals

FIGURE 1. Conceptual Model.



involved, the treatment provided, and the perceptions of treatment within the context of the organizational climate. The model includes structural characteristics at each level, such as client diagnosis, case manager ethnicity, and agency organizational climate. The model also incorporates the interaction among these elements, because client and staff perceptions can also exert a powerful effect on the quality of the client-staff relationship.

In the model, the particular features of organizational climate that are thought to most influence outcomes for African American clients are involvement, task orientation, clarity, innovation, and physical comfort. Involvement denotes the commitment level staff members have to their jobs, which in CMHAs is often linked explicitly to how staff feel about clients. Because of the low pay, difficult tasks, and lack of prestige associated with mental health work, commitment to the job often translates into commitment to clients (Levin & Petrila, 1996). A mental health agency with high levels of involvement is therefore likely to encourage staff to have a commitment to all clients regardless of clients' racial, ethnic, or cultural background.

The incongruence in life experiences between white staff and African American clients requires a willingness to be open to different cultural norms and cues, as well as a willingness to explore treatment approaches that, while different, are culturally appropriate for the client (Davis & Proctor, 1989; Ridley, 2005). This desired practitioner behavior requires some level of innovation on the part of staff. Staff willingness to use creative approaches is not sufficient; the organizational climate must also value and support staff innovation. From an organizational standpoint, staff should be encouraged to respond in ways that are innovative and flexible, and that demonstrate openness to the unique needs of diverse clients.

In other employment settings, the level of task orientation has been a key factor in determining the difference between a positive work environment with mediocre results and one with good results (Hellriegel & Slocum, 1974). Task orientation in this case encompasses a commitment to delivering services that improve clients' functioning and quality of life rather than merely providing a specific number of service units (Chambers, 1986; Levin & Petrila, 1996). Coupled with a high level of task orientation, the agencies that are successful with diverse clients are also expected to have a high level of clarity about organizational goals. Other research has supported the notion that directive approaches to managing organizations improve service outcomes, presumably because clarity lends itself to understanding the tasks necessary to meet agency goals (Pennington,

2006; Neilson & Pasternack, 2005). Clarity of goals also frees staff from worrying about the conflicting demands on their time and may guide decision-making about resource allocation in the face of constraints.

Finally, the physical environment is thought to contribute to the perceptions of both clients and staff. Typically, CMHAs are not known for their physical appearance. Stiffman et al. (2001) suggested that an agency's appearance may influence clients' perception of the services they receive. To the extent that a dismal or shabby physical environment detracts or distracts from the services offered, this aspect of organizational climate may reasonably be expected to impact both client and staff perceptions.

The proposed conceptual model is rooted in a general framework for service excellence, which includes features that we theorize, informed by our research and the current literature, and are common to high-functioning CMHAs. The use of a general framework suggests that CMHAs should not take a uniform approach to African American clients, but instead should strive for a climate that encourages staff and clients to negotiate the services that best meet the needs of each client, which may differ by a number of factors, including race. Hernandez (2005, citing Aguirre, 1998) and Becket & Dungee-Anderson (1998) have similarly proposed that general service excellence, as demonstrated by enhancing client access to services, encouraging client input into organizational functioning, providing integrated services, promoting cultural competency among staff, creating cross-agency collaborative relationships that assist clients, improving customer relationship activities and grievance procedures, and regularly evaluating services, can help CMHAs achieve some level of cultural competency.

The model leads to two hypotheses: 1) CMHAs that have high levels of involvement, task orientation, clarity, innovation, and physical comfort as measured from the perspective of agency staff will produce low levels of disparities in treatment outcomes between African American and white clients. 2) CMHAs that demonstrate low levels of disparities in treatment outcomes between African American and white clients will have easy access to services, good quality of care, and generally positive treatment outcomes from the perspective of clients.

Because the unit of interest is the organization or agency, a multi-site sample of CMHAs is necessary to test these hypotheses. With data from multiple agencies, staff, and clients, variables at all three levels—client, staff, and agency—can be examined for their independent contribution to disparities in outcomes; in addition, the interaction among the three levels can be examined.

DISCUSSION

General human behavior theories help us understand some of the client and staff characteristics related to ethnic and racial disparities in outcomes at CMHAs, but they lack consideration of the organizational climate in which staff and clients interact. Organizational climate has been found to have a significant affect on staff performance, their emotions and attitudes about their workplace, and the quality of their relationships with clients (Glisson, 2000). These factors, in turn, have been shown to influence the quality of services provided and the outcomes of those services (Glisson, 1989; Yoo & Brooks, 2005).

There is growing interest in moving beyond understanding the role that the client/staff relationship plays in health disparities to the role of community. This interest in community risks ignoring the importance of agencies in determining outcomes. It may not be the characteristics of the community per se, but rather the way in which the agency responds—or fails to respond—to these characteristics that is of greater importance in determining client outcomes (McNeely, Sapp, & Meyer, 1998). This level of adaptation to the environment, which is typically thought of as resulting from a market environment and accompanying customer service orientation, may occur in CMHAs that have a strong organizational identity and a clear conceptualization of the agency's mission.

CONCLUSIONS

The organizational climate of the agency examined in this two-part case study differed substantially from other health care settings on involvement, task orientation, clarity, innovation, and physical comfort. African American clients perceived the agency as highly successful at meeting their treatment needs and creating positive treatment outcomes. When considered along with the finding from the first part of the case study, which confirmed that the agency did not produce disparities in treatment outcomes between African American and white clients (Larrison et al, 2004), the present findings provide insight into the specific aspects of organizational climate that may be causally related to this lack of outcome disparities. The findings of both parts of the case study therefore provide a valuable road map for future research into the role that organizational climate plays in minimizing outcome disparities for African American clients served by CMHAs.

REFERENCES

- Angold, A., Costello, J.E., Burns, B.J., Erkanli, A., & Farmer, E.M. (2000). Effectiveness of nonresidential specialty mental health services for children and adolescents in the "real world." *American Academy of Child and Adolescent Psychiatry*, 39, 154–160.
- American Psychiatric Association (APA). (2000). *Handbook of psychiatric measures*. Washington, DC: APA.
- Applied Research Center & Northwest Federation of Community Organizations (ARC & NFCO) (2005). *Closing the gap: Solutions to race-based health disparities*. Oakland, CA: ARC & NFCO.
- Baker, F.M., Stokes-Thompson, J., Davis, O.A., Gonzo, R., & Hishinuma, E.S. (1999). Two year outcomes of psychosocial rehabilitation of black clients with chronic mental illness. *Psychiatric Services*, 50, 535–539.
- Beckett, J.O. & Dungee-Anderson, D. (1998). Multicultural communication in human services organizations. In A. Daly (Ed.) *Workplace diversity issues & perspectives*. (pp. 191–214). NASW Press: Washington D.C.
- Boatright, S. & Bachtel, D.C. (2000). *The Georgia county guide*. Athens, GA: College of Agricultural and Environmental Sciences, Cooperative Extension Service, College of Family and Consumer Sciences, University of Georgia.
- Borrell, L.N. (2005). Racial identity among Hispanics: Implications for health and well-being. *American Journal of Public Health*, 95, 379–381.
- Cameron, K.S. & Quinn, R.E. (1999). *Diagnosing and changing organizational culture*. Reading, MA: Addison-Wesley.
- Caracelli, V.J. & Greene, J.C. (1997). Crafting mixed-method evaluation designs. *New Directions for Evaluation*, 74, 19–32.
- Chambers, D.E. (1986). *Social policy and social programs: A method for the practical policy analyst* (1st ed.). New York: Macmillan.
- Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.
- Davis, L.E. & Proctor, E.K. (1989). *Race, gender & class: Guidelines for practice with individuals, families, and groups*. Englewood Cliffs, NJ: Prentice Hall.
- Deal, T.E. & Kennedy, A.A. (2000) *Corporate cultures*. Philadelphia, PA: Perseus Book Group.
- Eisen, S., Dill, D.L., & Grob, M.C. (1994). Reliability and validity of a brief patient report instrument for psychiatric outcome evaluation. *Hospital and Community Psychiatry*, 45, 242–247.
- Eisen, S.V., Shaul, J.A., Leff, S.H., Stringfellow, V., Clarridge, B.R., & Cleary, P.D. (2001). Toward a national consumer survey: Evaluation of the CABHS and MHSIP instruments. *Journal of Behavioral Health Services & Research*, 28, 347–369.
- Emerson, R.M., Fretz, R.I., & Shaw, L.L. (1995). *Writing ethnographic field notes*. Chicago: University of Chicago Press.
- Fine, M.J., Ibrahim, S.A., & Thomas, S.B. (2005). The role of race and genetics in health disparities research. *American Journal of Public Health*, 95, 2125–2128.

- Fontana, A. and Frey, J.H. (2000). The interview: From structured questions to negotiated text. In N.K. Denzin and Y.S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 645–672). Thousand Oaks, CA: Sage Publications.
- Frederickson, N. (1966). *Some effects of organizational climates on administrative performance*. Research memorandum RM-66–21. Washington, DC: Educational Testing Services.
- Glisson, C. (1989). The effect of leadership on workers in human service organizations. *Administration in Social Work*, 13, 99–116.
- Glisson, C. (2000). Organizational climate and culture. In R.J. Pattie (Ed.), *The handbook of social welfare management*. (pp. 195–218). Thousand Oaks, CA: Sage Publications.
- Glisson, C., Dukes, D., & Green, P. (2006). The effects of the ARC organizational intervention on caseworker turnover, climate, and culture in children's services systems. *Child Abuse & Neglect*, 30, 849–854.
- Glisson, C. & Durick, M. (1988). Predictors of job satisfaction and organizational commitment in human service organizations. *Administrative Science Quarterly*, 33, 61–81.
- Glisson, C. & Hemmelgarn, A. (1997). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect*, 22(5), 401–421.
- Glisson, C. & James, L.R. (2002). The cross-level effects of culture and climate in human service teams. *Journal of Organizational Behavior*, 22, 401–421.
- Greene, J.C. (2001). Mixing social inquiry methodologies. In AERA (corporate author) and V. Richardson (Eds.), *Handbook of Research on Teaching*. 4th ed. (pp. 251–258). Washington DC: American Educational Research Association (AERA).
- Gutierrez, L., GlenMaye, L., & Delois, K. (1995). The organizational context for empowerment practice: Implications for social work administration. *Social Work*, 40, 249–258.
- Hall, J. (2002). *The MSHIP Family of Consumer Surveys*. MHSIP Policy Group Data Infrastructure Grant Meeting Oct. 3–4, 2002, Washington, DC. Retrieved November 2003 from http://nri.rdmc.org/SDICC/SDICC_DIGMeeting.cfm
- Hellriegel, D. & Slocum, J.W., Jr. (1974). Organizational climate: Measures, research and contingencies. *The Academy of Management Journal*, 17(2), 255–280.
- Hernandez, M. (2005). Identifying and measuring organizational factors that reduce mental health disparities. *Child and Family Policy Practice Review*, 1, 6–11.
- Hodge, B.J., Anthony, W.P., & Gales, L.M. (1996). *Organizational theory: A strategic approach*. 5th ed. Upper Saddle River, NJ: Prentice Hall.
- Holzer, C.E., Goldsmith, H.F., & Ciarlo, J.A. (1998). Effects of rural urban county type on the availability of health and mental health care providers. In R.W. Manderscheid & M.J. Henderson (Eds.), *Mental health, United States*. (pp. 204–314). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Kaczka, E. & Kirk, R. (1968). Managerial climate, work groups, and organizational performance. *Administrative Science Quarterly*, 12, 252–271.
- Kotter, J.P. (1990). *A force for change: How leadership differs from management*. New York: The Free Press
- Kuno, E. & Rothbard, A.B. (1997). Racial disparities in antipsychotic prescription for patients with schizophrenia. *American Journal of Psychiatry*, 159, 567–572.

- Larrison, C.R. (2002). *A comparison of top-down and bottom-up community development interventions in rural Mexico: Practical and theoretical implication for community development programs*. Lewiston, NY: Edwin Mellen.
- Larrison, C.R. & Hadley-Ives, E. (2004). Examining the relationship between community residents' economic status and the outcomes of community development programs. *Journal of Sociology and Social Welfare*, 31, 37–58.
- Larrison, C.R., Schoppelrey, S.L., Brantley, J.F., Leonard, M., Crooke, D., Barrett, D., McCollum, A., & Nowak M.G. (2004). Evaluating treatment outcomes for African American and white clients receiving treatment at a community mental health agency in the rural South. *Research on Social Work Practice*, 14, 137–146.
- Lerner, D. (1958). *The passing of traditional society*. New York: The Free Press.
- Levin, B.L. & Petrila, J. (1996). *Mental health services: A public health perspective*. New York: Oxford University Press
- Lutterman, T., Ganju, V., Schacht, L., Shaw, R., Monihan, K., & Huddle, M. (2003). *Sixteen state study on mental health performance measures* (DHHS Publication No. (SMA) 03–3835). Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- McNeely, R.L. (1992). Job satisfaction in the public social services workers: Perspectives on structure, situational factors, gender, and ethnicity. In Y. Hasenfeld (Ed.), *Human Services as Complex Organizations*. (pp. 2224–255). Newbury Park: Sage Publications.
- McNeely, R.L., Sapp, M., & Meyer, H.J. (1998). Conflict, cooperation, and institutional goal attainment in diversity: Improving relationships between urban organizations and neighborhood residents. In A. Daly (Ed.) *Workplace diversity issues & perspectives*. (pp. 176–190). NASW Press: Washington D.C.
- Melfi, C., Croghan, T., Hanna, M., & Robinson, R. (1997). Racial variation in antidepressant treatment in a Medicaid population. *Journal of Clinical Psychiatry*, 61, 16–21.
- Miller, J.G. (1984). Culture and the development of everyday social explanation. *Journal of Personality and Social Psychology* 46, 961–978.]
- Moos, R.H. (1994). *Work Environment Scale Manual*. 3rd ed. Palo Alto, CA: Consulting Psychologists Press.
- Morrow, S.L. & Smith, M.L. (1995). Constructions of survival and coping by women who have survived childhood sexual abuse. *Journal of Counseling Psychology*, 42, 24–33.
- Muldrow, T.W., Buckley, T., & Schay, B.W. (2002). Creating high-performance organizations in the public sector. *Human Resource Management*, 41(3), 341–354.
- Neilson, G.L. & Pasternack, B.A. (2005). *Results: Keep what's good, fix what's wrong, and unlock great performance*. New York: Crown Publishing Group.
- Ortega, A.N. & Rosenheck, R. (2002). Hispanic client-case manager matching: Differences in outcomes and service use in a program for homeless persons with severe mental illness. *The Journal of Nervous and Mental Disease*, 190(5), 315–325.
- O'Sullivan, M.J., Peterson, D.D., Cox, G.B., & Kirkeby, J. (1989). Ethnic populations: Community mental health service ten years later. *American Journal of Community Psychology*, 17, 17–30.
- Pennington, R.G. (2006). *Results rule! Building a culture that blows the competition away*. Hoboken, NJ: John Wiley & Sons Inc.

- Pratt, M.G. & Foreman, P.O. (2000). Classifying managerial responses to multiple organizational identities. *Academy Management Review*, 25(1), 18–42.
- Rieman, D.J. (1986). The essential structure of a caring interaction: Doing phenomenology. In P.M. Munhall & C.J. Oilers (Eds.), *Nursing Research: A Qualitative Perspective*. (pp. 85–105). Norwalk, CT: Appleton-Century Crafts.
- Rosenheck, R. & Fontana, A. (1994). Utilization of mental health services by minority veterans of the Vietnam era. *Journal of Nervous and Mental Disease*, 182, 685–691.
- Ridley, C.R. (2005). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention*. Thousand Oaks, CA: Sage Publications.
- Savicki, V. & Cooley, E. (1987). The relationship of work environment and client contact to burnout in mental health professionals. *Journal of Counseling and Development*, 65, 249–252.
- Schaefer, J.A. & Moos, R.H. (1996). Effects of work stressors and work climate on long-term care staff's job morale and functioning. *Research in Nursing and Health*, 19, 63–73.
- Schneider, B. & Hall, D. (1972). Toward specifying the concept of work climate: A study of Roman Catholic diocesan priests. *Journal of Applied Psychology*, 56, 447–456.
- Schein, E. (1990). Organizational culture. *American Psychologist*, 45, 109–119.
- Snowden, L.R. (2001). Barriers to effective mental health services for African Americans. *Mental Health Services Research*, 3, 181–187.
- Snowden, L.R. (2003). Bias in mental health assessment and intervention: Theory and evidence. *American Journal of Public Health*, 93, 239–243.
- Snowden, L.R. (2005). Racial, cultural and ethnic disparities in health and mental health: Toward theory and research at community levels. *American Journal of Community Psychology*, 35(12), 1–8.
- Stake, R.E. (2000). Case studies. In N.K. Denzin and Y.S. Lincoln (Eds.) *Handbook of qualitative research*. 2nd ed. pp. 435–454. Thousand Oaks, CA: Sage Publications
- Stiffman, A.R., Striley, C. Horvath, V.E., Hadley-Ives, E., Polgar, M., Elze, D., & Pescarino, R. (2001). Organizational context and provider perception as determinants of mental health service use. *Journal of Behavior Health Services and Research*, 28(2), 188–204.
- Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 32, 616–624.
- Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T. & Zane, N.W.S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, 59, 533–540.
- Teague, G.B., Ganju, V., Hornik, J.A., Johnson, J.R., & McKinney, J. (1997). The MHSIP mental health report card: A consumer-oriented approach to monitoring the quality of mental health plans. *Evaluation Review*, 21, 330–341.
- Tevis, C. (2003). Rural health: New help for rural mental health needs. *Successful Farming*, 101(3), 54.
- Thomas, D.R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27, 237–246.
- Trice, H. & Beyer, J. (1993). *The cultures of work organizations*. Englewood Cliffs, NJ: Prentice Hall.

- Turnipseed, D.L. (1998). Anxiety and burnout in the health care work environment. *Psychological Reports*, 82, 627–642.
- U.S. Department of Health and Human Services (2001). *Mental health: Culture, race and ethnicity* (A supplement to Mental health: A report of the Surgeon General). Rockville, MD: USDHSS.
- Yoo, J. & Brooks, D. (2005). The role of organizational variables in predicting service effectiveness: An analysis of a multilevel model. *Research on Social Work Practice*, 15, 267–277.