The Organizational Context of Mental Health

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The Organizational Context of Mental Health

Abstract
Researchers have argued that organizational context factors in mental health services should be a focus of research and intervention. This research examines client and provider perceptions of organizational climate and client perceptions of services at community mental health organizations (CMHOs). Existing quantitative and qualitative data were gathered by the Center for Psychotherapy Research (CPR) along with primary qualitative data collected by this researcher from four Philadelphia CMHO outpatient clinics. CPR administered the Organizational Readiness for Change Scale (ORC) to 17 providers and administrators and conducted 13 semi-structured interviews at these CMHOs. Of the 13, only provider interviews (n=10) were included. Subsequently, 20 semi-structured client interviews were conducted. Grounded theory provided analysis of descriptive data. Interviews revealed providers felt negatively toward conditions of employment and everyday aspects of work, and positively toward collegiality, autonomy, flexibility, and client interactions. Differences between fee-for-service and full-time providers were notable. Clients indicated generally positive impressions of the agency and mixed ones regarding other aspects of services. Staff turnover was a negative factor overall. At CMHOs with higher scores on the ORC, providers and clients described positive perceptions of organizational climate; however, organizational climate was poor across nearly all subscales. Findings are interpreted through the concept of parallel process, systems theory, and feminist theory to illustrate replications of systemic problems at CMHOs. They reveal tensions between providers and administrators contrasted with rich relationships among providers and between providers and clients.

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THE ORGANIZATIONAL CONTEXT OF
MENTAL HEALTH

Eric S. Stein

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2010

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ABSTRACT

Researchers have argued that organizational context factors in mental health services should be a focus of research and intervention. This research examines client and provider perceptions of organizational climate and client perceptions of services at community mental health organizations (CMHOs). Existing quantitative and qualitative data were gathered by the Center for Psychotherapy Research (CPR) along with primary qualitative data collected by this researcher from four Philadelphia CMHO outpatient clinics. CPR administered the Organizational Readiness for Change Scale (ORC) to 17 providers and administrators and conducted 13 semi-structured interviews at these CMHOs. Of the 13, only provider interviews (n=10) were included. Subsequently, 20 semi-structured client interviews were conducted. Grounded theory provided analysis of descriptive data. Interviews revealed providers felt negatively toward conditions of employment and everyday aspects of work, and positively toward collegiality, autonomy, flexibility, and client interactions. Differences between fee-for-service and full-time providers were notable. Clients indicated generally positive impressions of the agency and mixed ones regarding other aspects of services. Staff turnover was a negative factor overall. At CMHOs with higher scores on the ORC, providers and clients described positive perceptions of organizational climate; however, organizational climate was poor across nearly all subscales. Findings are interpreted through the concept of parallel process, systems theory, and feminist theory to illustrate replications of systemic problems at CMHOs. They reveal tensions between providers and administrators contrasted with rich relationships among providers and between providers and clients.
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Chapter I

The Community Mental Health System and Its System Components

Changes in the delivery of mental health services over the last 50 years have led to a shift from hospitals to communities, and more recently to the dominance of managed care. Previous research has been conducted on the mental health system itself and the impact on providers, but much less so on the impact on clients. Much of the organizational research on the context of social services has examined other types of organizations, particularly child welfare organizations. The proposed research aspires to contribute to knowledge about the organizational social context of mental health services and its impact on clients, and to add to knowledge regarding social workers who are major providers of mental health services. It is innovative in giving special attention to the perspectives of clients about their experiences with services in community mental health organizations in an urban setting, as much of the research on this topic has been conducted in rural areas.

Specifically, this study focuses on the organizational aspects of community mental health organizations (CMHOs), particularly providers’ perceptions of the organizational climate and clients’ views about the organization and the services they receive. This chapter gives an overview of the state of the mental health system, the development of community mental health policies and organizations, clinician perspectives, and the situation of mental health clients.

Community Mental Health System

According to recent reports, the community mental health system in the United States is crumbling, frustrating providers, and impeding the ability of clients to obtain
just and equitable services. As stated in the report of the President’s New Freedom
Commission on Mental Health (2002), “The mental health services system defies easy
description….Taken as a whole, the system is supposed to function in a coordinated
manner; it is supposed to deliver the best possible treatments, services, and supports-but
it often falls short” (A fragmented mental health system, Para. 1). The Bazelon Center for
Mental Health Law (2004) reports, “Fragmented care remains the norm for individuals
with serious mental disorders. The delivery systems for mental health, substance abuse
and physical health care are separate, often with different financing arrangements and
policy-setting” (www.bazelon.org/).

Depictions of the mental health system point to a situation characterized by stress
and disintegration. The conclusions of the Interim Report for the President’s New
Freedom Commission on Mental Health (2002) were that:

America’s mental health service delivery system is in shambles. We have found
that the system needs dramatic reform because it is incapable of efficiently
delivering and financing effective treatments – such as medications,
psychotherapies, and other services – that have taken decades to develop.
Responsibility for these services is scattered among agencies, programs, and
levels of government. There are so many programs operating under such different
rules that it is often impossible for families and consumers to find the care that
they urgently need. The efforts of countless skilled and caring professionals are
frustrated by the system’s fragmentation. As a result, too many Americans suffer
needless disability, and millions of dollars are spent unproductively in a
dysfunctional services system that
cannot deliver the treatments that work so well (Dear Mr. President, Para. 2)

The fragmentation of the mental health system, its lack of a clear purpose, and its stagnant development have been problematic for mental health settings arguably since experiencing a decline and shift in federal funding to the states and the onset of managed care in the 1980s.

Momentous changes occurred in mental health policies and practices in the second half of the twentieth century. In the early 1950s, therapeutic effects and symptom control by the antipsychotic drug chlorpromazine made it possible for hospitals to begin to discharge some of their residents (Sands, 2001). An ideology around community mental health was beginning to coalesce with the development of preventive strategies including strengthening social networks, providing mental health education, and restructuring communities (Klerman, 1986; Sands, 2001). The Mental Health Study Act of 1955 authorized a national study of mental health treatment, which was developed out of a growing concern regarding the high numbers of patients residing in public psychiatric mental hospitals and the costs of their care (Klerman, 1986; Sands, 2001).

The Joint Commission on Mental Illness and Mental Health established by the Mental Health Study Act recommended comprehensive mental health services in local communities, the continuation of state hospitals, and increased federal funding.

**Community Mental Health Organizations**

The construction of CMHOs began in earnest after 1964 with enactment of federal government legislation that provided funds for their establishment, and, between 1965 and 1980 a series of federal mental health bills promoting the implementation of the community mental health system was passed (Sands, 2001). The kinds of services
specified by the federal government to be included in a community mental health system were inpatient, outpatient, community education, partial hospitalization, and emergency services. Created to expand access to community-based mental health services, federal officials believed that CMHOs would become financially self-sufficient by attracting paying patients. However, CMHOs were obligated to treat the severely mentally ill who would otherwise have been admitted to state hospitals and who had fewer resources to cover the costs of treatment (Kanapaux, 2004).

Federal grants provided nearly all of the revenue for CMHOs at their inception. Most states excluded CMHO services from their Medicaid programs, but revenue streams began to change in the mid-1980s due to reductions in federal grant funding and federal legislation that expanded the types of services covered by Medicaid (Kanapaux, 2004). In addition, changes in eligibility criteria for Supplemental Security Income (SSI) program enabled a larger proportion of CMHO clients to obtain SSI benefits and, thus, qualify for Medicaid (Sands, 2001). Since that time, CMHOs have become increasingly dependent on Medicaid.

The Omnibus Budget Reconciliation Act of 1981 (PL 97-35) established block grants to states, which determined how these funds would be used, and was accompanied by a decline in federal funding, signaling a shift in responsibility from the federal government to the states. Since that time, CMHOs and other community-based organizations have had insufficient funds to treat all persons diverted from state hospitals. During the decade from 1988 and 1998, the public insurance system cut mental health and substance abuse benefits by more than half (Healthcare Plans Design, 1999).
Behavioral health spending dropped from 7.2 percent of total private health insurance spending in 1992 to 5.1 percent of total spending in 1999 (National Association of Psychiatric Health Systems, 2003). Overall health spending increased by 15.7 percent during this time while mental health and substance abuse spending decreased by 17.4 percent. These reductions were mainly the result of shifts in inpatient spending – 48 percent of total mental health spending in 1992 went down to 18 percent by 1999. The number of state mental hospitals declined by 29 percent, private psychiatric hospitals by 38 percent, and general hospital units by 14 percent. The result has been substantial increases (11 percent between 1992 and 1999) in admissions to the remaining hospitals (National Association of Psychiatric Health Systems).

While the number of mental health organizations providing 24-hour services (hospital inpatient and residential treatment) more than doubled in the United States over the twenty-eight year period between 1970 and 1998, the number of psychiatric beds provided by these organizations decreased by half, from 524,878 in 1970 to 261,903 in 1998. The corresponding bed rates per 100,000 civilian population dropped proportionally more in the same period, from 264 to 97. Beds in state mental hospitals accounted for most of this drop, their number representing only 24 percent of all psychiatric beds in 1998, compared to almost 80 percent in 1970 (Manderscheid et al., 2000).

Lack of coordination and inadequate resources have thwarted the development of seamless systems of community-based inpatient and outpatient services for persons with serious mental illness. According to a report issued by the Bazelon Center for Mental Health Law (2001), “…the squeeze on mental health systems is resulting in fewer and
fewer services in the community...most communities in nearly all states lack the necessary continuum of appropriate care” (p.5). Many persons who cannot obtain community-based outpatient care are treated in hospital emergency rooms. Poor coordination between general hospitals and CMHOs often leads to inadequate outpatient aftercare and repeated inpatient admissions for severely ill clients (Mechanic, 1997).

According to Bloom (2006), “The course of institutional psychiatry has been plagued by a seemingly terminal (sic) repetition: a positive vision of healing, empowerment, and recovery in all its complexity is washed away by ignorance, greed, and a social lack of commitment on the part of society as a whole” (p. 24). Thus, the system has moved from a paradigm of long-term hospitalization in environments with high staff-to-patient ratios during the era of Moral Treatment to the bureaucracy of the state hospitals, which have been continuously dismantled since the 1970s. The current era of managed care has, as Bloom stated, “slowly strangulate[d] inpatient treatment in all its forms, while laying all of the blame for systemic shortcomings on the mental health system for its own failures” (p. 25).

The move toward managed care in the 1980s was brought about by declining government support for public sector health care and by rising costs in the private sector (Cook & Wright, 1995; Mechanic, 1999). Proponents of managed mental health care claim that it provides the means to contain costs and at the same time improve access, quality, and outcomes (Corcoran, Gorin, & Moniz, 2005; Edmunds, 1997). Critics have been concerned with the financial incentives in managed care and its potential for poorer quality of care (Mechanic, 2001). The emphasis in managed care on the medical model of illness and decisions to reimburse services are based upon external determinations of
“medical necessity” (Birne-Stone, Cypres, & Winderbaum, 1997; Mechanic, 1999; Scheid, 2003). Treatment goals are set in terms of short-term improvements in functional ability and measurable outcomes rather than long-term goals of community stabilization and integration (Hoge, Davison, Griffith, & Jacobs, 1998). One study has referred to managed care as the “Walmart-ing of psychotherapy” (Donald, 2001).

Managed care has been shown to be effective in containing costs, and recent multi-state research looking at the effects of managed care on vulnerable populations in Medicaid managed care programs has indicated that there have been no major negative effects in the short run that would require significant policy changes (Leff et al., 2005). Research on the impact of managed care on quality, access to services, outcomes, and satisfaction, particularly in mental health, has grown substantially, while uncertainty still remains as to the impact on persons with mental illness (Dickey et al., 2003; Mason, Scammon, Huefner, 2002; Mowbray, Grazier, & Holter, 2002; Rothbard et al., 2002). Two studies have indicated that mental health outcomes for low-income and more severely ill clients have been worse under cost-containment strategies (Lurie, Moscovice, Finch, Christianson, & Popkin, 1992; Rogers, Wells, Meredith, Strum, & Burnam, 1993)

Researchers have found that services have become even more fragmented during the managed care era, that providers must limit and offer less intensive services, and that managed care has produced a system that is not able to provide effective services (e.g., Bloom, 2006; Scheid, 2003). The move to privatization has also advanced a shift in policy makers' beliefs that corporate management would promote efficient and transparent processes in the public sector with greater accountability, but it has subjected providers and clients to increased monitoring and greater restrictions on service delivery...
(Donald, 2001; Wagner, 2005; Ware, Lachicotte, Kirschner, Cortes, & Good, 2000; Willging, Waitzkin & Nicdao, 2008). The enormity of the changes the mental health system has undergone and the disintegration of the system as a whole have severely limited the capacity of organizations to experiment with and evaluate innovations. Healthcare organizations have made great efforts to develop outcome measures under managed care; however, most of these reflect the emphasis on evidence-based practice, rather than quality of care (McFarland, 2001).

**Clinicin Perspectives**

Perhaps the most illustrative examples of the impact of managed care in institutional settings have been the stories of mental health practitioners. The literature exploring the effects of managed care on mental health practitioners portrays a picture of “clinicians…under siege, demoralized, and powerless, and that these feelings inspire a need to respond through adaptation, resistance, or a combination of both” (Ware, Lachicotte, Kirschner, Cortes, & Good, 2000, p. 5). In a series of peer reviewed journal articles from the 1990s, several scholars found practitioners using battle metaphors and “survival” terminology in regard to the perceived threat (Brown, 1994); feeling “hobbled” (Jellinek & Nurcombe, 1993), experiencing “deep discouragement” (Pipal, 1995) and “despair” (Fink, 1993), and feeling as if they were assembly-line workers or “alienated labor” (Chipman, 1995, p. 565).

Kirschner and Lachicotte (2001), in their ethnographic study examining how clinicians at a county mental health center responded to changes in the health system, referred to the “hysteresis” that clinicians experience. As they explain, “The lag in practical effect of the changing circumstances under which persons act [which] is
produced and reproduced not only by dramatic labors of resistance, but also in the form of anxiety which clinicians express as ‘times lost’” (p. 455). Rather than making changes in the quality of their service to clients, clinicians feel displaced, or, as if they have lost their “grounds of action” (p. 455). In another empirical qualitative study (n = 18), Cohen, Maracek and Gillham (2006) found the root of clinicians’ negative feelings to be “a fundamental incompatibility between their ethos and what they understood to be the guiding philosophy of the managed care companies they worked for…a conflict of differing worldviews, differing concepts of the person, and differing ideals of psychological health” (p. 257).

Clinicians have perceived managed care as a threat for two reasons: (a) it challenges long-term psychotherapy and, thus, quality of care, and (b) it depprofessionalizes the clinician’s role (Ware et al., 2000). In the first instance, alternative or shorter-term therapies offer the promise of “reduction of costs by minimizing reliance upon therapist time…and resolution of the ‘presenting problem’ with the expectation that…other problems will present themselves in the future, at which time the patient will return for further treatment” (Ware et al., 2000, pp.6-7). The expectation is that managed care clinicians will be competent in several different modalities (Austad & Hoyt, 1992; Bennett, 1996; Sabin, 1995).

In regard to depprofessionalization, clinicians have moved from being central to the treatment process to playing a secondary role, as “adjuncts” to psychotherapy, “catalysts for change,” “consultants” (Bennett, 1996), or “psychologically minded coaches” (Sabin, 1995). According to an empirical study by Chambliss, Pinto, and McGuigan (1997) and other studies (Ware et al., 2000), clinicians have experienced a
loss of control and autonomy, conflicts of interest, rifts among colleagues based on where they are positioned with respect to the managed care controversy, and reduction in income (Chipman, 1995; Fink, 1993; Iglehart, 1996; Rodwin, 1995).

In their 2000 study of a community health clinic, Ware and colleagues discovered that clinicians had begun using the language of managed care and pointed up the profound effects of this change:

[T]he discourse of treatment seemed to be shifting, paperwork was proliferating, and clinicians had to obtain permission from external authorities before proceeding with care. But most of the essentials of clinical life, in particular the capacity to provide ‘good care,’ remained intact. And though they had to request approval prior to both initial and extended treatment…clinicians were quick to admit they rarely had been turned down. If they were refused, they could still rely on so-called ‘free care’ to provide compensation for services rendered. The fact that they had learned to package psychotherapy in the language of managed care with reasonable facility meant that the services for which they were requesting and obtaining reimbursement were ones they could in good conscience endorse. This suggests the disquiet…should be interpreted not so much as offense taken at their present circumstances as dread – the deeply disturbing suspicion that the worst is yet to come (p.18).

Hence clinicians experience strong negative feelings towards managed care protocol but strive to use different strategies to keep threats to good care at bay. Clinicians in this study were adopting the managed care lingo and potentially being “made over as…professional[s]” with care becoming “re-normed.” Ware and colleagues make the
case that “[c]linicians…fear… becoming first instruments and then advocates of a
managed care definition of good care” (Ware, et al. 2000, p. 19). The authors conclude
that clinicians’ dread came out of the threat to “the vision of good mental health care…of
corporate interests, a political economy of treatment that denies preferred modalities to
the disadvantaged, an emphasis on saving money at the expense of human needs to
improve psychological and social well-being” (p. 21). The moral and ethical dilemmas,
thus, strike at a deep level for clinicians.

Another area of concern with respect to clinicians’ experiences with managed
care is professional ethics. Danzinger and Welfel (2001) surveyed mental health
counselors in four states using the Ethics in Managed Care Questionnaire (EMCQ)
regarding their compliance with professional ethics. Licensure lists were obtained from
the four state boards and counselors were randomly selected from each licensure list (n =
108). They found “gaps in accuracy of diagnosis, appropriateness of treatment,
management of termination, and informed consent procedures with managed care clients”
(p. 137). They also found “limited use of codes of ethics and resources to help
practitioners resolve ethical dilemmas” (p. 147). Cohen et al. (2006) found similar results
in their study of 15 key informant mental health practitioners. The sense one gets from
these studies, thus, is that arrangements during the managed care era have created a
disincentive – whether it is the result of dissent, resistance, complacency, or otherwise –
for clinicians to comply with ethical standards.

Clinicians have exhibited two different responses to managed care: adaptation and
resistance (Ware et al., 2000). Through adaptation the clinician chooses to adjust to the
rules and regulations of managed care and to make efforts at clinical effectiveness and
productivity (Ware et al., 2000). In some cases, adaptation has meant that clinicians knowingly deceive third-party payers if the clinicians disagree with payers’ determination of appropriate coverage (Novack, 1989), or exaggerate patients’ symptoms for approval of extended coverage (Chambliss et al., 1997).

Resistance has occurred through professional organizations’ efforts to influence public legislation and formulate guidelines to preserve professional standards (Ware et al., 2000). Clinicians have made appeals to managed care officials in situations where treatment decisions are deemed inappropriate, or by reporting attempts to involve them in substandard clinical practices (Jellinek & Nurcombe, 1993), and in some cases these have been effective. Others have used strong language, and/or “horror stories”, to stimulate discussion and debate (Borenstein, 1990; Pipal, 1995; Westermeyer, 1991).

Kirschner and Lachicotte’s ethnographic study (2001) at an urban community mental health center found several forms of resistance. Clinicians rotated designated clients, for example, when there were several covered family members. They also changed modalities of care from individual to less expensive group therapies when limits approached. Clinicians “stopped the clock” when cases were terminated for ‘reasons unrelated to treatment’ and had it restarted, moving clients back to higher rates. Lastly, they strategically diagnosed, justifying treatment beyond usual protocols.

In one systems-focused empirical study done in New Mexico regarding mental health services under managed care, Willging (2005) examined the work of state officials, corporate administrators, and frontline service providers, and “illustrate[d] how the application of managed care accountability models can subvert the very phenomena that they claim to enforce, including the allocation of responsibility for delivering,
monitoring, and improving health services for the poor” and “reinforces preexisting blame ideologies against the poor” (pp. 85-86). Willging offered a perspective on how state officials “invoke ‘a ready-made rhetoric’ of devolution, contracting, and privatization to uphold the ‘current balance of power’” (p. 86). In many ways, therefore, an isomorphism seems to be occurring between what is happening at the organizational level and at the service delivery level. Thus, policies affecting organizations translate into organizational attempts to cope with the stresses and flaws of the mental health system, which, in turn, affect the quality of services for clients.

In a study on the practice of occupational therapy over a six-month period from seven adult mental health day programs, Townsend (1996) collected data through observation, interviews, and review of documents, illustrating how the organizational context invisibly shapes occupational therapy practice. She found that mental health services could be seen as organizationally subordinated so that practitioners often defined practice through the ideas prevalent in other professions, such as medicine. Townsend argues that mental health policies of de-institutionalization, case-recording techniques, funding prerequisites, and objectifying practices outweigh practitioners’ good intentions to encourage independent, self-reflexive, and assertive clients (Townsend, 1996).

**Mental Health Clients**

Serious mental illness often results in chronic cognitive, emotional, and behavioral difficulties that negatively impact a person’s ability to work, develop and maintain healthy relationships, and attain equal access to social institutions. According to a report issued by the Surgeon General, approximately one in five Americans experiences a mental disorder in the course of a year – roughly 44 million people per year (U.S.
Public Health Service, Epidemiology of Mental Illness: Adults, Para. 1, 1999). Five to seven percent of adults and five to nine percent of children have a serious mental illness in any given year (President’s New Freedom Commission, 2003). Based on estimates from two national epidemiological surveys, around 15 percent of all adults with a mental illness in one year also experience a co-occurring substance use disorder. Approximately 10 percent of the U.S. adult population seek mental health services in the health sector in any year, with another 5 percent receiving such services from social service agencies, schools, or religious or self-help groups (U.S. Public Health Service, Adults, Para. 2-3).

Several studies have looked at the effects of Medicaid capitation and their impact on mental health services. Cuffel, Bloom, Wallace, Hausman, and Hu (2002) looked at quality of life outcomes for mental health clients as a function of capitation (for-profit versus non-profit) compared to fee-for-services, and found few differences across these groups. Studies in Oregon (Bianconi, Mahler, & McFarland, 2006), Arizona (Leff, Mulkern, Lieberman, & Raab, 1994), Colorado (Bloom et al., 2002; Warner & Huxley, 1998), Massachusetts (Dickey et al., 2003), Nebraska (Bouchery & Harwood, 2003), Pennsylvania (Rothbard, Kuno, Hadley, & Dogin 2004), and Puerto Rico (Alegrie, McGuire, & Vera, 2001a; Alegrie et al., 2001b) suggested there was little impact from converting fee for service Medicaid mental health to managed care. By the same token, work in Florida (Boothroyd, Shern, & Bell, 2002), Minnesota (Lurie, Moscovice, Finch, Christianson, & Popkin, 1992), Tennessee (Chang et al., 1998; Ray, Daugherty, & Meador, 2003), Utah (Manning, Liu, & Stoner, 1999), and Virginia (Morrissey, Stroup, Ellis, & Merwin, 2002) raised concerns about the impact of Medicaid managed care on clients with serious mental disorders. In Florida, service use patterns among persons with
disabilities were found to be affected by financial risk arrangements (Boothroyd, Shern & Bell, 2002). A multi-state study (Leff et al., 2005, p. 1252) found that differences in outcome between managed care and fee-for-service programs varied between sites; one possible inference is that “managed care may affect vulnerable subgroups differently than the general population” because fee-for-service groups may attract healthier and therefore lower-cost clients.

While service outcomes for mental health clients have been examined in relation to managed care, there is less empirical literature with respect to the impact of organizational factors on client satisfaction with mental health services. Morris, Bloom, and Kang’s (2007) empirical study of 14 CMHOs in Colorado examined the impact of organizational factors on outcomes of care for adult clients with chronic mental illness (n = 424) over a 30-month period. The authors found organizational factors – behavioral norms and values about the delivery of services, and staff cohesion and morale – were associated with improvements in clients’ perceptions of their physical and mental health status, but not improvements in quality of life. The effects of organizational factors on clients, then, were evaluated using subjective measures. The authors conclude that even a well-run organization may not be able to succeed in the face of pervasive social and economic conditions affecting the lives of adults with serious mental illness.

**Summary**

Community mental health organizations (CMHOs) play a critical role in the delivery of mental health services for adults with serious mental illness. Addressing the needs of mental health clients in CMHOs requires a high level of dedication and resourcefulness on the part of administrators and staff, especially given agency fiscal
constraints (Morris et al., 2007). Considering that the quality of mental health services may be adversely affected by organizational factors, particularly given the complex relationship between the overall context of service provision and clients with serious mental illness, researchers have argued that organizational context factors in mental health services should be a primary focus of research and intervention in support of services that are responsive to client needs (Glisson, 2000, 2002; Glisson & Hemmelgarn, 1998). This research examines an under-investigated aspect of the organizational context of mental health services: organizational climate. Additionally, clients’ perceptions of services and parallel process, a concept related to aspects of organizational context, will be explored as an underlying force influencing clinician and client perceptions of the treatment provided at CMHOs.
Chapter II

Theoretical Framework and Research Questions

This chapter examines the core concepts and theories that underpin the overall study, beginning with organizational social context and the related concept of organizational climate. Descriptions of systems theory and the notion of parallel process are followed by the implications of the literature and theoretical constructs for the study. Figure 2.1 offers a general model of how the system functions based on the literature and theory. Finally, the research questions are set forth.

Organizational Social Context

In recent years, researchers and theorists have looked to organizational theory to gain an understanding of how context affects the implementation of treatments and the quality and outcomes of mental health services (Glisson, 2002; Hohmann & Shear, 2002; Schoenwald & Hoagwood, 2001). Empirical and theoretical work on organizational context has been developed abundantly in the private sector, mainly in industrial organizational psychology (Ashkanasy, Wilderom, & Peterson 2000; Ostroff, Kinicki, & Tamkins, 2003; Schneider, 1990). While this private sector work has shown some applicability in child welfare services, it has not been fully tested or explored in settings such as adult mental health services at CMHOs.

Organizational context has been seen as critical to the adoption, implementation, and effectiveness of new treatments and service protocols (Hohmann & Shear, 2002; Schoenwald & Hoagwood, 2001). An organization’s social context consists of “interpersonal relationship, social norms, behavioral expectations, individual perceptions, attitudes, and other psychosocial factors that govern how organizational members
approach their work, interact with others in their organization, interpret their work environment, collaborate with members of ‘referent’ organizations, and feel about their jobs” (Glisson, 2002, p. 234). Several studies have revealed the importance of organizational context factors with respect to innovation and effectiveness, specifically organizational culture, climate, structure, and interorganizational domains (see reviews in Glisson, 1992, 2000).

With the increased research on organizational culture and climate over the past decade, multiple definitions have been developed. The organizational literature includes a core concept for each (Glisson, 2002; Verbeke, Volgering, & Hessels, 1998). Generally speaking, “culture” is defined as the way things are done in an organization; and “climate” is the way individuals perceive their work environment (Glisson, 2002; Verbeke et al., 1998). Organizational culture and climate have been linked to employee job attitudes and organizational performance (Kopelman, Brief, & Guzzo, 1990; Larson & Fukami, 1984; Mathieu & Zajac, 1990; Ostroff, 1992). A demoralized, disaffected leadership and direct care staff would be unlikely to build and maintain effective collaborative relationships with clients and other constituents in the community that are essential to integrated service delivery and quality care (Glisson, 2000; Glisson & Durrick, 1988; Glisson & Hemmelgarn, 1998; Hemmelgarn, Glisson, & Dukes, 2001). Thus, it is critically important to examine organizational factors that may direct organizations to develop interventions, organizationally and at the service level, that would improve the quality of care to clients (e.g., Glisson & Hemmelgarn, 1998; Schneider, 1990; Shortell et al., 1995).
Organizational climate refers to the specific psychological or affective impact of the work environment on individuals (James & James, 1989; James & Jones, 1974; James, James, & Ashe, 1990). By the same token, psychological climate is the individual employee’s perception of the psychological impact of the work environment on his/her own well-being (James & James, 1989). When employees agree on their perceptions of the impact of the work environment on their attitude and well-being, their aggregate perceptions can be described as “organizational climate” (Jones & James, 1989; Joyce & Slocum, 1984). Climate remains a “property of the individuals” regardless of agreement or disagreement in individual perceptions (Glisson & James, 2002).

Climate and culture have been linked to qualitative changes in individual employees and organizations. Specifically, organizational climate has been linked to (a) employee job attitudes, well-being, and performance (Joyce & Slocum, 1982, 1990; Kopelman et al., 1990; Schneider, 1990); (b) outcomes of care in children’s mental health services (Glisson & Hemmelgarn, 1998); and (c) risk-adjusted mortality and rated technical quality of care in intensive care units (Shortell et al., 1995).

The core technology of an organization is defined as “…raw materials, knowledge, skills, techniques, and hardware that create the product or provide the service that is the organization’s raison d’être” (Glisson, 1992, p. 184). Thus, the core technology of CMHOs would include the individualization of treatment for persons with serious mental illness to address specific problems and needs, the development and implementation of appropriate interventions, and the utilization of the range of skills, equipment, and expertise in the field of mental health services (Glisson, 1992; Hasenfeld, 1992).
Service processes and outcomes, according to Glisson (2000) and Schorr (1997), often rely on “soft” technologies, such as specific psychotherapy modalities, producing results that are indeterminate, variable, and difficult to measure. Human service technologies generally and mental health technologies in particular are “soft” technologies (Glisson, 1978), in that they include few processes that can be determined in advance of treatment and are context specific to an organization. Staff in the public sector are often encouraged in the use of discretion, resourcefulness, innovation, and to think creatively within bureaucratic structures to meet the needs of clients (Glisson, 2002). Soft technologies are critical to understanding how the adoption, utilization, and effectiveness of mental health technologies can vary between different organizations (Glisson, 2002). Attempts to implement “soft” technologies in mental health treatment, for example, “often create social contexts that emphasize conformity, consensus, and subservience in a misguided effort to inject certainty into what is an inherently uncertain technology” (Glisson, 2002, p. 237).

**Systems Theory**

According to Hutchinson (2003), “the systems perspective sees human behavior as the outcome of reciprocal interactions of persons operating within organized and integrated social systems” (p. 51). The traditional systems perspective views social systems as stable and orderly, self-correcting and returning to equilibrium. Roles and rules act to maintain this balance. While useful in concept, traditional systems theory was criticized for its over-emphasis on stability, and alternatives emerged – chaos theory and complexity theory – which see systems as producers of “change, even sudden, rapid, radical change” (p. 52).
Positive and negative feedback loops bring about change by reflecting something different, an innovation, back into the system. External influences are the social, cultural, economic, and political environments in which the systems function. Subsystems inherent in all systems provide the loci for adjustments and changes that are fed back into the system, which presumes a more dynamic open systems conception.

Systems theory looks at relations among and between systems, suprasystems, and subsystems. Applied to complex societies, it provides tools to understand how they can become fragmented and isolated from one another. In the case of systems that become fragmented, feedback loops can explain breakdowns in communication because of differences in language and culture (Hutchinson, 2003). The technical language of managed care could be seen as communication that leads to a breakdown between policymakers, organizations, providers, and clients. Johnson (2005) writes that systems theory has “marginalized emotion,” but rejects the notion that emotion is unsystemic: “Indeed emotion and emotional communication can be viewed as an organizing or ‘leading element’ in social systems” (p. 92). In this regard, emotion is the catalyst for the parallel process that occurs between clients, service providers, and organizations, as it diffuses through and impacts the system.

Parallel Process

One neglected aspect of the overall dynamic in community mental health organizations is the notion that clients also impact providers and organizations by the issues that they struggle with – chaos, stress, trauma, and others – in transferential ways, known as parallel process. The concept of parallel process was originally applied to the supervisory relationship in psychotherapy in which that relationship can mirror an aspect
of what is going on in the relationship between therapist and client (Bloom, 2006; McNeill & Worthen, 1989; Smith & Zane, 1999).

Investigators have recognized that “conflicts belonging at one location are often displaced and enacted elsewhere because of a parallelism between the conflict at the place of origin and the place of expression” (Bloom, 2006, p. 37). Parallel processes, thus, can produce outcomes that run counter to the services these organizations seek to provide. The individual from a systems perspective is defined as “part of a dynamic interactive process, and not as an isolated unit…reliant on their context, constantly in communication with other individuals, with their boundaries being ‘permeable’ or receptive to input by others” (Silver, 1983, p.101). Individuals are, therefore, influenced by family interactional and behavior patterns, which “are a manifestation of its structure” (p. 102).

One important way of examining parallel process is through the lens of structural family therapy. Colapinto (1995) examines a process by which the intervention of child welfare and other agencies that work with abusive or neglectful families “loosen connections among family members” through interruption of their “existing relational process,” prevention of “new transactions from developing,” and negatively affecting “hierarchical arrangements” (pp. 61-62). The ultimate effect of these “regulatory” interventions (regulatory because these families are “managed” by their social environment through a variety of child and family serving agencies) is a “diluting effect”; thus, again, the agency and, perhaps even more apropos, the policies, unwittingly destabilize the very issue they seek to address.
Families’ service needs are broken into individual “needs” and so individual members get referred to separate services, leading to a “fragmented domain of interaction with expert services” and “the focus of activity shifts from the interpersonal dynamics to the interaction among the workers themselves” (p. 63). Colapinto views the interaction between workers and families as a “complementary collusion in which both collaborate to uphold a sociocultural trend” (p. 65). For disadvantaged families, therefore, placement out of the home may seem like a “normal” development.

Colapinto also speaks to the policy level when he states, “Federal, state, and local administrations periodically redesign their social programs and reallocate public monies in an effort to reduce fragmentation of services and families” (p. 64). However, the programs themselves often emerge and function contrary to what was intended. Colapinto sees the process of family dilution as “culturally syntonic with the trend in modern, urban, technologically specialized societies to displace the locus of rights and responsibilities vis à vis the individual from the family to public agents of control” (p. 64). A parallel trend is the public’s ambivalence toward mental health services, and perhaps toward anything referred to as “public,” which generates fragmentation in policy-making, funding priorities, and development of initiatives.

**Implications of Literature and Theory for the Proposed Research**

Given the fragmentation that has been developing within the community mental health system over the past three decades and its impact on CMHOs and on providers and clients, this study seeks to explore the dynamics occurring at the organizational level and individual provider/client levels. The organizational context variables of climate and
client perceptions of services are considered within the overall dynamics of parallel process.

From the perspective of sociologist, Pierre Bourdieu, the capitalist system produces structures that result in unequal social and economic power relationships, and these structures are reproduced through a presupposed framework for society, referred to as “doxa,” or “the societally accepted subtext about how the world works” (Fram, 2004, p.556). For the purposes of this study, community mental health has been produced by and reproduces features of our capitalist system and this framework trickles down to mental health administrators, providers, and clients, who implicitly accept it as part of their unspoken, daily experience. Bourdieu’s ideas are compatible with feminist approaches to studying social problems, particularly institutional ethnography with respect to its exploration of power relationships, focusing on every day practices, and following a thread to discover how these every day practices reflect institutional practices of domination (DeVault & McCoy, 2002; Smith, 1987, 1999; Townsend, 1996). This study also seeks to add to research using Bourdieusian and feminist theory by teasing out institutionally-molded relationships within CMHOs through its focus on parallel process.

Arrows pointing in both directions in Figure I (below) indicate the bi-directional nature of the system’s feedback loops and/or parallel process. The arrows do not connect one stakeholder to another because the process is not necessarily linear or mono-directional. When the impact of a policy is felt at the local level, for example, feedback is sent through the system and, depending on the source of the feedback, the nature of the feedback, its ability to influence through its “message,” and how it is received, it can be felt and have influence at different levels of the system. A parallel process occurs in that
stress and conflict from one element of the system is being experienced somewhere else in the system, with the potential for it to have impact on a broader scale and on the individual level.
Figure 2.1 Community Mental Health System

- Federal Mental Health Policies
- State Mental Health Policies
- County Mental Health Policies
- Capitalism: Forces of Oppression and Socioeconomic Inequalities
- Community Mental Health Organizations (Climate, Service Processes)
- Public Ambivalence
- CMHO Administrators
- Service Providers
- Mental Health Clients
- Collaborating Organizations
Research Questions

The literature on the mental health system, organizational theory, and related constructs points to the significance of the organizational social context of CMHOs and the myriad implications of examining problems inherent in them. Therefore, three research questions were posed: a) How do clients diagnosed with serious mental illness and providers perceive the organizational climate of the setting in which services take place?; b) How do clients perceive the services they participate in at CMHOs?; and, c) What parallel processes, if any, occur on the levels of providers and clients?
Chapter III

Methods

This is a mixed methods study that juxtaposes existing quantitative and qualitative data obtained from providers and primary data gathered by this researcher. Existing data were based on (1) a survey of providers that used quantitative methods and (2) qualitative face-to-face interviews with a subgroup of providers, both collected by the Penn Center for Psychotherapy Research (CPR) as part of a study funded by NIMH. The primary data collected by this researcher consisted of (1) in-person interviews with clients and (2) participant observation notes taken in the waiting rooms of CMHOs.

CPR’s research primarily seeks to examine the organizational context from the standpoint of the adoption of new practices, specifically the organizational social context factors in CMHOs in Philadelphia that lend themselves to the incorporation of new practices and those factors that hinder these efforts. Quantitative measures were used in survey data to examine the organizational context. The goal of interviews with providers that were conducted by CPR staff was to generate hypotheses regarding barriers specific to these organizations that may need to be addressed before dissemination efforts can be sustained. Providers were asked their opinions in interviews regarding their experiences working within the organization, their attitudes towards empirically-supported therapies, training, and the nature of the incentives that might be necessary for them to continue to use a new therapy. Although some of the provider interview data was peripheral to my study, much of the contents was relevant to my interest in providers’ experiences working within the organization.
The overall study had three phases or components. The first phase of the research involved the administration of a survey instrument to service providers (therapists) at CMHOs inquiring about the providers’ attitudes and the organizational context. The second phase entailed individual interviews with providers at outpatient clinics serving people with serious mental illness. CPR attempted to interview at every agency within the first year but some did not have participants who were interested, or CPR was unable to schedule those who indicated interest. The third phase involved interviews of clients and observations at the clients’ agencies. Quantitative survey data on providers were used to gain a clear sense of each agency’s perceived climate and to provide comparative data for the interview data gathered from providers and intensive interview data of clients. Qualitative data from these interviews were used to evaluate providers’ experiences of the agencies where they are providing services, to evaluate clients’ experiences of the agencies and of the services they are receiving, to explain and interpret survey findings, and to provide a context for the results of the surveys. Secondarily, qualitative data were used to explore the parallel processes occurring at various levels of the mental health system.

**Background**

Conducting research on organizational factors, such as culture and climate, requires an immense amount of time and resources beyond the scope of what I as an individual researcher can accomplish in a short time period. The Center for Psychotherapy Research at Penn (CPR) with which I collaborated gathered organizational and provider interview data from nine CMHOs in Philadelphia. I conducted intensive interviews with clients from four of these sites. My relationship with CPR began when I
discovered that the Center was conducting a similar study to one I had been interested in as part of my quantitative and qualitative research courses in the Penn DSW Program. I contacted the principal investigator of the study, we discussed our mutual interests and my desire to add a client interview component, and we decided that I would conduct a total of 20 client interviews at four sites.

CPR was able to acquire IRB approval for the client interviews in the Fall of 2008. I received approval from CPR to conduct 20 client interviews at four to five CMHOs as well as to write field notes of my observations at these CMHOs. Last fall, I completed the requisite CITI (Collaborative Institutional Training Initiative) and HIPAA trainings to comply with IRB protocols regarding research with human subjects. I completed interviews at the outpatient clinics of four CMHOs, which will be referred to here as Agencies A, B, C, and D.

The PI of the NIMH-funded study analyzed the quantitative survey data and the qualitative provider interview data. I independently coded the provider interviews and conducted an analysis of the qualitative data, including coding and performing a comparison of provider interviews with client interviews. I also transcribed and coded the client interviews and completed an analysis of the data. QSR NVivo 8 software was used as a tool for data storage, organization, coding, and analysis.

The neighborhood settings of the CMHOs differ. They are located in distinct areas of the city, including West, Northwest, Lower North, and North Philadelphia. Even though these neighborhoods have diverse racial and ethnic populations with various socioeconomic and political characteristics, the adult clients with serious mental illness that I interviewed were primarily African American and white, and a small number of
Hispanics, with a roughly equal representation of males and females, who receive Medicaid benefits.

Phase I: The Quantitative Survey

Because I used the quantitative data analysis as an integral part of the study of climate – in other words, as a means to triangulate two kinds of data on providers and as the backdrop for the cross-comparison between client and provider interviews – I include some basic information about the quantitative survey here that is pulled from CPR’s initial study description.

Target population and criteria for inclusion. The target population for the quantitative survey was master’s level providers in ten CMHOs that operate under the Department of Mental Health and Mental Retardation (DBH/MR). The CMHOs offer outpatient mental health services (among other services) to the mentally ill in Philadelphia, including individual, family, and group therapy and psychiatric outpatient services. Participants in this survey were volunteers recruited by the researchers. Roughly 150-200 providers and administrators were recruited by the PI and research assistants and 105 participated in the survey research across nine CMHOs. My study focused on providers and clients from four CMHOs. Of the 105 participants in the quantitative survey, 17 providers and administrators came from these four CMHOs.

Inclusion criteria for the quantitative survey were as follows: The provider had to be employed at a participating community mental health center with no exclusion based on the number of hours worked, active in their work with clients (not on any kind of administrative or personal leave), and active in their attendance of staff meetings. Administrators had to be employed at a participating community mental health center.
**Measures.** The survey instrument consisted of a set of questions on sociodemographic characteristics and two standardized instruments. The questionnaires were completed in writing by participants. The first standardized instrument, Organizational Climate Scale (OSC) (Glisson et al., 2008) was administered but not analyzed because there were not enough participants to achieve the 80% of the organizational unit required for analysis at some agencies.

The *Organizational Readiness for Change scale (ORC)* (Lehman, Greener, & Simpson, 2002), developed for substance abuse treatment services, provides a measure of the construct that is more specific to mental health agencies than many organizational change measures. It includes 115 Likert-type items to represent four major areas: motivational factors, program resources, and organizational dynamics. Motivational factors include program needs, training needs, and pressures for change, while program resources are evaluated in regard to office facilities, staffing, training, equipment, and Internet. Organizational dynamics include scales on staff attributes (growth, efficacy, influence, adaptability) and climate (mission, cohesion, autonomy, communication, stress, flexibility for change). For my study, I used the organizational climate measures to assess perceived climate and as a way to compare the quantitative findings with the interview findings.

Results of surveys of over 500 drug treatment personnel from more than 100 treatment units support the ORC’s validity, but testing and evaluation of the ORC is still in the early phases. Overall, 10 of the 18 scales had reliabilities above .70 at the director’s level. At the staff level, 11 of 18 scales had reliabilities of .70 or higher. At the program level for which the ORC scales were primarily developed, five of the 18 scales had a
reliability of less than .70 and three had an alpha coefficient of at least .66 with all of the climate subscale alphas above .70 except for one - mission .75, cohesion .92, autonomy .56, communication .82, stress .90, and change .76 (Lehman et al., 2002, p. 203; Saldana, Chapman, Henggeler, & Rowland, 2007).

**Phase II: Qualitative Interviews with Providers**

**Sample.** Of the 105 survey participants, 40 agreed to have a one-on-one qualitative interview. (Initially, the study called for focus groups, but most employees expressed a preference for individual interviews.) The demographics of the 105 were as follows: 68% female, 32% male; 61% White, 22% African American, and 15% Hispanic/Latino; 87% had a Master’s degree or above; 71% had 5 or more years of experience; 41% were employed at the agency less than 1 year and 37% at the agency more than 5 years. Of the 17 providers and administrators who came from the four CMHOs, 13 agreed to have individual interviews. Of the 13, I included 10 in this study because three interviews were with administrators. The sample consisted of 8 female and 2 male providers, all of whom were white. Half of the providers were full-time and the other half were fee-for-service (FFS).

**Procedures.** Before the survey questionnaires were distributed to providers, CPR staff requested that providers write down their names and phone numbers on a short form indicating their interest, or lack thereof, in participating in a one-on-one interview and/or a focus group. Only those who fit the inclusion criteria were contacted. Subsequently face-to-face interviews were arranged with 31 participants (including those in my study). Project staff conducted these interviews.
After informed consent was obtained, providers were asked a series of questions related to their attitudes and perceptions of their organization, community mental health, and particular psychotherapies. (See Appendix A for the interview guide that was used.) The sessions were digitally audiotaped. Providers were asked not to use identifying information during the interview. The transcripts of the interviews were made as soon as possible after the interviews were conducted. The audio recordings will be destroyed when the research is completed. Transcription of the provider interviews was arranged by the PI of the larger study.

In looking over the therapist interview guide and in helping to craft the interview guide for clients, the PI and I determined that there was methodological rigor to justify using these instruments for my own research. According to Fossey, Harvey, McDermott, and Davidson (2002), methodological rigor should be evaluated based on “congruence,” or the fit of the chosen methodology to the research issue; “responsiveness to social context” - whether the design developed and adapted to real-life situations, and if the researcher engaged with the participants and became familiar with the context; “appropriateness” – evaluating the sampling strategies and the suitability of data gathering methods to the research question; “adequacy,” or looking at, among other aspects, whether sufficient sources of information were sampled, were there detailed descriptions of respondents?, and was there description of data gathering and following of analytical processes?; “transparency” – examining the degree to which data gather and analysis were made clear, how competing accounts were handled in analysis, and the degree to which participants’ knowledge was privileged (p. 724). While several of the interview guide questions were specific to evidence based practices and the use of and
training in cognitive therapy, many of the them sought answers regarding organizational climate. Questions drew upon providers’ experiences working at the CMHOs, things they would like to see changed, professional development and training needs, unwritten rules, and responses to change, among others. (See Appendix A for further review).

**Phase III: Client Interviews**

The principal investigator (PI) of the larger study established initial contact with the clinic directors at each CMHO by email regarding the possibility of my coming to their respective agency to conduct the interviews. I explained that I would be exploring clients’ perceptions of treatment as part of the larger organizational study that had been completed at all four of the CMHOs. Subsequently, I contacted the clinic directors to set up a time to meet in person, answer questions they may have, and discuss recruitment procedures. In the process of meeting with the directors and sitting in the waiting rooms of the CMHOs, I was able to get an initial sense of what each agency is like with respect to the facilities and the general atmosphere, as well as the feel of the public spaces of the agency and the interview rooms.

I kept field notes of these impressions based on Gilgun’s (2004) structure: 1) “Preliminaries: a careful description of the setting, who was present, description of the interviewee and/or person observed…2) Descriptive text: a section on descriptions of what happened, who said what, the non-verbals, the tones of voice…3) Observer comments: a place for researchers to record their emotional reactions, their doubts, fears, and concerns…4) Memos: a section at the end of the fieldnotes where researchers record their reflections in a more leisurely way” (p. 7). These field notes, as well as additional ones I took when I conducted the interviews, comprised my participant observation data.
The agreed upon method of recruitment with clinic directors was through convenience sampling. The sample consists of adult clients with a serious mental illness, defined as over the age of 18 and having a DSM-IV TR Axis I disorder, including major depressive disorders, anxiety/trauma-related disorders, schizophrenia, and co-occurring disorders, all of whom were receiving services at the time of the interview at the agencies’ outpatient clinics. This sampling method was justified based on the feasibility of relying on people who need the services and who come to the agency for its services; however, this approach tends toward a low degree of external validity. The therapist or clinic director approached the clients with a recruitment flyer and asked them if they would like to participate in the study. In several cases, a flyer was posted by CMHO staff in the waiting room and directed to the front desk staff, who then sent the client to me. Clients were given a chance to read the flyer (Appendix B), and following verbal assent, came to the room the agency set up for me to conduct the interview. After going over the consent form and eliciting questions (Appendix C), I began the interview. Each interview lasted between 15 and 30 minutes depending on how talkative the clients were, their length of treatment at the agency, and the amount of feedback and information they had to share.

Five clients were interviewed at each of the 4 CMHOs. Demographics of the client sample were diverse as far as age and gender, racial make-up, and in terms of length of treatment at the CMHO. The sample consisted of the following age ranges with their corresponding percentages:
Table 3.1 Age Ranges of Client Sample

<table>
<thead>
<tr>
<th>Age</th>
<th>18-25</th>
<th>28-34</th>
<th>37-44</th>
<th>45-50</th>
<th>55-65</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage</td>
<td>20%</td>
<td>10%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Eleven clients were female and 9 male with 10 African American, 8 White, and 2 Hispanic/Latino clients. In terms of length of treatment, 4 clients had been coming to the CMHO for treatment for less than a year, 4 had been coming for 1 year, 3 clients for 2 years, 5 for 3-7 years, and 4 for 10 years or more. While they were not asked, many of the clients mentioned their diagnoses, which ranged from major depressive disorders to anxiety/trauma-related disorders, bipolar disorders, schizophrenia, as well as co-occurring substance abuse or dependency. Biopsychosocial issues ranged from homelessness to chronic medical conditions, in addition to relationship issues and problems in social interactions.

The interview guide (See Appendix C) consisted of two closed-ended questions and 17 open-ended questions that sought to examine clients’ perceptions of mental health services at the CMHO, barriers to receiving services, their perceptions of their therapist, their perceptions of the general type of therapy and the quality of the services they are receiving, a comparison of their perceptions of the CMHO with other agencies where they have received services, and if and how they would improve the services or treatment. The discussion during client interviews focused only on their experiences seeking and receiving treatment in CMHOs. The interviewer directed discussion away from topics such as symptoms, diagnoses, medication, or discussion of personal information. Clients were asked not to use information that identified themselves and
others during the interview. The interviews were tape recorded with clients’ consent (see Appendix D).

**Compensation for Participants in the Three Components**

Providers received $20 to participate in the quantitative survey research and were also offered refreshments while completing the surveys. They were given an envelope with payment and a receipt in it. They were then asked to fill out the receipt and return it to the researcher before they leave. Those providers who chose not to participate but wished to keep that decision confidential were handed an envelope with a note expressing appreciation for their consideration of the research. Providers who participated in interviews were compensated $40. Clients were given a $40 gift card for their participation in interviews after completion of a tax form and receipt.

**Role of the Researcher**

In attempting to foster reflexivity and a reflexive research design, this research included multiple investigators with respect to provider interviews and the coding of provider and client interviews, as well as the survey data. I produced a journal in which I wrote regular entries during the research process, recorded decisions about the methods I used, made notes about the study’s logistics, and reflected on my own values and interests throughout the process. Additionally, I am including my research perspectives, preconceptions, values, and beliefs in this dissertation, and plan to do the same in any reports or articles that may be published regarding this research (Lincoln & Guba, 1985).

My interest in the area of the organizational context of CMHOs began while I was in my MSW program in 2003 with an interest in the issue of the dichotomization
of social work practice with respect to direct/clinical and macro social work practice, and my growing belief that the break between the two areas was an artificial one. A question that came to my mind while I was reading about structural family therapy and the “dilution of family process”: How can one show through research that a system of providers can dilute and become “unwitting replicators” of a family’s already weak internal patterns/processes (Colapinto, 1995)? This question led me to think more about the organizational contexts in which I have worked or with which I have interacted since then.

I have worked in an outpatient community mental health clinic in a variety of capacities for the past five years as a full-time therapist/intake coordinator and a fee-for-service (FFS) therapist. I have had numerous conversations with staff at CMHOs – case managers, therapists, administrators, and clients – about agency services, interactions between staff and clients, issues related to documentation, interactions with other agencies (Philadelphia County, insurance providers, and other CMHOs), and other aspects of the work that seemed to relate directly to the organizational context of the services. Hence, I have an insider’s view as to what goes on in a CMHO that is part of the same system but different from the CMHOs that are part of my study.

In this way, I came to this research with a set of beliefs about CMHOs to which I had to pay careful attention, particularly in my observations at the agencies and in the client interviews in terms of the way I asked questions and the kind of probing that I did. These observations and probes may have been influenced by my knowledge of what goes on at different levels of the organizational hierarchy, from
management staff down to the receptionist. While this knowledge might have been a hindrance in that I ran into the issue of confirmatory bias, it was also helpful in allowing me to know what to look for and where to probe deeper.

Additionally, I am a white male and this may have affected interview subjects’ comfort levels, the types of responses they gave, and how open they were to revealing sensitive information. With that in mind, I might have had more difficulty eliciting responses than an interviewer of the same race, culture or gender as the participant would have been able to obtain. Seeing a white male researcher at the agency might also have influenced the behavior or attitudes of staff and clients at the agency, affecting my observations, although this might not have been as much of an issue over time. While I was at one of the agencies only one time, I went to three of the agencies on several occasions to interview clients and conduct observations.

**Methods to Enhance Rigor**

Triangulation by data source was possible given the number of sources of data – survey data, provider interviews, client interviews, and fieldnotes. In attempting to achieve confirmation and comprehensiveness of methods, data, and coding with respect to multiple triangulation, I worked in conjunction with my dissertation chair. According to Denzin (1989), the use of multiple investigators “expands the interpretive base of the research and reveals elements of the phenomenon that would not necessarily be seen by just one researcher” (p. 245). Hence, different investigators may come to different conclusions regarding the data, leading to a variety of perspectives. Negative case analysis was also be used to examine disconfirming cases or cases that refine an emerging theory (Padgett, 2008).
Methods of Data Analysis

**Quantitative data analysis.** The PI analyzed the quantitative data from the ORC. The organization, or team within an organization, was the unit of analysis. Scores were calculated for by domain: structure, culture, work attitudes, and organizational climate. Scores for each agency and for the total were compared to other agency scores and to national norms using analysis of variance. In addition, factors such as agency size, location, number of years under current leadership, turnover rate in the past year, and patient attrition were with the scores in each domain. I developed line graphs using Microsoft Excel (see ORC Results in Chapter IV, "Quantitative Findings") to depict the results of the quantitative analysis for the four organizations.

**Qualitative data analysis.** The PI and research assistants transcribed the provider interviews and I transcribed the audiotapes of each completed client interview verbatim. I then reviewed the written transcripts for accuracy. Initially, I reviewed all the data to develop a broad understanding of the content as it relates to the project's specific aims and to identify topics of discussion and observation. During this step, I prepared memos to document initial impressions of topics and themes and their relationships and to define the boundaries of the specific codes. NVivo8 software was used to store the data, allow for easy retrieval of the materials related to specific codes, and generate a series of categories arranged in a treelike structure connecting text segments grouped into separate categories or "tree nodes." Qualitative analysis software allows for the compact storage of transcription materials (Drisko, 2004).

Initially a process of open coding was conducted based on emergent themes and a small set of commonly recognized organizational climate barriers. Open coding is
designed to ‘‘open up the text and expose thoughts, ideas, and meanings contained therein’’ (Strauss & Corbin, 1998, p. 102). Lowenberg (1997) suggests that, in qualitative research, the meaning is constructed and negotiated during the interaction between researcher and informant. The researcher is therefore ‘‘a participant in creating meaning and analysis’’ (Lowenberg, p. 451). Although it may have been ideal to some extent to have had multiple individuals do the coding, the meaning generally lies in the interaction between researcher and informant. I worked in conjunction with my dissertation chair to discuss coding strategies, and combine and narrow down the final list of codes.

To give a clearer sense of the coding process, segments of text ranging from a phrase to several paragraphs were assigned codes on the basis emergent themes. Secondly, axial coding procedures were used to describe connections between categories and between categories and subcategories “whereby data are put back together in new ways…by utilizing a coding paradigm involving conditions, context, action/interactional strategies and consequences” (Strauss & Corbin, 1990, p. 97). Finally, the process of selective coding involved “selecting the core category, systematically relating it to other categories, validating those relationships, and filling in categories that need further refinement and development” (p. 116).

During the open coding process the interviewee’s (provider and client) comments were broken down into specific concepts relevant to the "tree nodes" of organizational climate, parallel process, and separately coded clients' perceptions of services. This process produced a total of 120 relevant codes for climate and 163 codes for clients' perceptions of services, which included researcher-labeled as well as in vivo codes taken directly from the language of respondents. These codes were merged until there were a
reasonable number of codes for synthesis of the findings. A similar process was followed in coding clients’ perceptions of services. Given the inductive nature of the concept of parallel process, codes under this "tree" were developed concurrently with the other main variables. However, I soon discovered that this process became too cumbersome and realized that parallel processes would emerge in my discussion of the other two variables, and, therefore, moved away from coding under this category.

I used the constant comparative method (Strauss & Corbin, 1998) to identify variations within those concepts and to identify broader categories of phenomena. For example, whereas I initially created codes such as Views of Management, Supervision, and Perception of Leadership, I later combined them into Providers’ Affective Experiences with Administration. From the iterative process of constant comparison, all open climate codes fell into three distinct areas: (a) Experiences of Working at Agency - providers (b) Aspects of Employment - providers, and (c) Physical Space - providers and clients. A similar process was followed for clients' perceptions of services. Additional theoretical comparisons revealed that problems related to turnover were common to both providers and clients. Through the process of rereading all 10 provider transcripts and 20 client transcripts and examining the codes in relation to the model, I obtained theoretical saturation (Glaser & Strauss, 1967). I considered any potential patterns concerning the research questions and then further examined those themes that were consistently identified by the informants.

The insights from the process of analysis informed the next round of coding until a strong theoretical understanding of the setting emerged. The final list of codes consisted
of themes, issues, accounts of behaviors, and opinions associated with organizational climate, parallel process, and client perception of services.

**Limitations.** This research used existing data from CPR, which had different purposes for its research. As a result, this study met with limitations based on the interview questions for both provider and client interview; however, there was sufficient overlap between the two studies to develop findings related to climate and perceptions of services. With respect to parallel processes, much of the information about administration and administrative processes was indirect. Quantitative data analysis was limited by small sample size, which impacts generalizability. Additionally, all provider participants were compensated with $40 and clients with a $40 gift card, and this could have influenced the willingness of some individuals to participate. The majority of participants, however, were eager to tell of their experiences regarding the CMHOs.

**Data management.** The audio recordings of provider and client interviews were transcribed. After completion of the study, the recordings will be destroyed. Transcripts have been stored electronically with a code indicating the agency and the date.

**Protection of Human Subjects**

**Confidentiality.** To ensure confidentiality, the following measures were employed: Paper-based records were kept in a secure location and were only accessible to personnel involved in the study. Computer-based files were only made available to personnel involved in the study through the use of access privileges and passwords. Prior to access to any study-related information, personnel were required to sign statements agreeing to protect the security and confidentiality of identifiable information. Identifiers were removed from study-related information. Audio recordings were transcribed and
will be destroyed after completion of the research to eliminate audible identification of subjects.

Participants were asked not to disclose information about what was discussed in the interview. Personally identifying information was not used during the interviews. Participants were asked to refer to their workplace and supervisors as “the agency” or “my employer” or “my supervisor”. They were also asked not to refer to one another by name. In the event that a participant used identifying information during the interview, the information was not transcribed. In addition, transcripts were stored without the agency’s name on it. A code was used for each agency, and the agency name was linked to the code on one electronic file, which was kept on a secure, password protected server. All electronic transcripts of sessions were also password-protected. The only situation in which clients’ personal information would have been revealed was if they were in imminent danger to themselves or others. None of the participants in the interviews were in imminent danger or in need of crisis treatment.

Research personnel included research assistants who completed the required CITI and HIPAA training, as determined by the City’s and University of Pennsylvania’s institutional review boards. They were trained to administer the surveys and to take steps to ensure the confidentiality of the participants. The research assistants conducted most of the provider interviews after they were trained. I conducted the client interviews.

**Ethical issues/risk benefit to participants.** One potential risk is that the confidentiality of a therapist’s responses is somehow compromised or that his or her participation or decision not to participate leads to negative consequences in the workplace. Measures were taken to prevent this from occurring. First, the administration
had to be willing to sign an agreement that participation in the research was not required and that participation or the decision not to participate would not be a part of the employment record. In addition, agency personnel were not permitted to have access to the surveys at any time after they were completed. Finally, the only link between the name of the therapist and his or her data is on the therapist’s consent form. The researchers did not keep any record of the participants’ names linked to a subject number. It is unlikely that participation in the study will pose any greater risk to clients than would be for their usual outpatient treatment, particularly given that this is not intervention research, and I am not inquiring about clients’ psychiatric status or history. The same procedures as were used for protecting the confidentiality of providers will be used for clients.

While there is no direct benefit to participants in the study, the anticipated benefits to subjects with respect to the knowledge that may reasonably be gained regarding organizational factors that influence outcomes in clients’ mental health are significant and have far reaching implications in the field of mental health. Given these benefits, the minimal risk to participants was justified.

Potential benefits include a better understanding of factors that have been associated with workplace satisfaction, treatment outcomes, and motivation for change in mental health agencies. This understanding may lead to the development of interventions designed to improve the context of the workplace. The benefits of the research appear to outweigh the risks. The research presented minimal risk. Measures as noted above, such as data storage procedures, transcript password protections, and avoidance and/or
deletion of personal pronouns, have been taken to ensure that there is little risk of a breach of confidentiality.

**Informed consent.** Before interviews for providers and clients began, the research staff explained the study and went over the consent form with the providers and clients, each of whom had a copy to read in front of them. They were also given the opportunity to read the consent form and ask questions, and were told that their participation was not required and that their decision to participate or not participate would not be made known to their employer. They were asked to sign the consent forms and keep one copy for themselves before the interview began. All subjects were competent to give informed consent. Participants in interviews were informed of their right not to participate, or to stop participation, at any time.

**Vulnerable populations.** Children, fetuses, neonates, or prisoners were not included in this research study. Pregnant women were included if they met the inclusion criteria. The study procedures, which consisted of conducting provider interviews related to experiences and attitudes towards their job and employer, and client interviews related to their perceptions of the agency and their treatment, were not considered to be harmful to pregnant women.

**Populations vulnerable to undue influence or coercion.** There was some risk that providers received pressure to from administrators to participate in the survey research. They were assured that they were not obligated to participate, and that their participation or decision not to participate would not be disclosed to their employer. Administrators signed an agreement to allow the recruitment of providers within the agency. The agreement specified that the administration would not have access to the
data collected, and that individual providers had the right to decline participation in the study without jeopardizing their employment status. The consent agreement with clients stated that the agency or their treatment provider would not have access to the data and that they could decline participation in the study without jeopardizing their treatment at the agency or their relationships with agency staff, unless the client was seen to be at risk of harm to self or others.
Chapter IV

Providers’ Perceptions of the Organizational Climate

This is the first of two chapters on findings. It has two parts: qualitative and quantitative. The qualitative findings related to providers’ perceptions of the organizational climate are organized under the following two major subheadings:

Conditions of Employment and Day-to-Day Experiences of Working at the Agency.

These are broken down further into subheadings, as illustrated by Figure 4.1.

![Figure 4.1 Organization of Chapter Headings and Subheadings](image-url)

**Qualitative Findings on Organizational Climate**

Findings related to the first heading in Figure 4.1, Conditions of Employment, speak to providers’ affective experiences of being employees at the CMHOs. The provider interview guide asked specific questions about what it is like to work at the
agency, what they would like to see change, and questions related to their development as employees at the agencies and as clinicians. Findings under the second heading, Day-to-Day Experiences of Working at Agency, reflect the way providers feel regarding everyday aspects of working at the CMHOs.

Conditions of Employment

Lack of adequate compensation. Providers at all four of the CMHOs express a lack of adequate compensation, and affective components of this issue emerge in the excerpts below that point to the organizational climates of the different agencies. These excerpts illustrate the complexity of this issue from the standpoint of values, beliefs, norms, expectations, and the practical realities of providers’ lives. They also shed light on systemic concerns in both explicit and implicit ways. One fee-for-service (FFS) provider relates the issue of inadequate compensation to licensure and continuing education:

    You know, they want licensed people, but we’re not getting compensated…And then we have to spend so much to maintain our license with all our continuing ed credits and sessions. And trainings are getting more and more expensive.

While not limited to social service disciplines, this provider points to the financial challenges of just maintaining her license, both in terms of the fee for licensure as well as the increasing expense of meeting continuing education requirements. Certainly, many other professions have difficulties with covering the costs of professional licensure, in addition to insurance protections.

    A full-time provider at the same agency reflects on compensation as an aspect of her struggle to pay off student loans:
Higher pay is always good because it’s hard to make ends meet, when you have a salary that’s low…With student loans and everything, you pay so much money to go to school, and then you get out of school and you can’t afford to make your student loan payments.

She points to the disparity between graduate school tuition and compensation for the work that graduate school has helped train her to do. Again, this is a challenge that those who have student loans face, particularly in the helping professions.

Some providers also link the problem of inadequate compensation to being FFS and to the number of no-shows:

I’d like to see that there be some sort of compensation for clients that don’t show up for their appointments because sometimes in public mental health, there’s no consequence sometimes for people not showing. We could stop seeing them, but sometimes they have very difficult circumstances so it’s hard for them to show.

These statements expose the tensions this provider feels between not getting paid and his care and concern for clients, whose life situations may prevent them from coming to appointments.

Another provider discusses the unpredictability of income, often because of factors beyond her control, and the personal financial concerns this raises for her:

I would love to see the structure of fee for service changed, because it’s really, you know, a bad day of snow or rain can destroy your whole caseload, your whole day, and you could literally be sitting there for eight hours and see two or three people…that’s the worse side of it, some days I have great days there and overall
I think I’ve a pretty good show rate…it’s hard to predict your income, and it’s hard to count on it....

The reasons that providers choose FFS positions are, perhaps, beyond the scope of this paper - some possibilities are: that they lack licensure; they seek work in community mental health but are unable to obtain a full-time position; they have family circumstances that only permit them to work part-time (i.e., child care needs); or they work at other jobs and are putting in clinical hours. For whatever reasons providers have chosen to work in this capacity, inadequate compensation becomes a greater issue that goes beyond just their personal finances.

These compensation-related issues affect providers regardless of their employment status. A full-time provider at another agency feels that inadequate compensation is something workers in general feel, and relates it to the problem of the agency having to hire unqualified, or under-qualified, staff:

I wish they would spend more money on salaries but I think this is probably true, everybody thinks that of every place they go to work…And that’s another problem here…we have a lot of different educational levels in the building, obviously they don’t pay people enough to get sometimes get really qualified staff.

Inadequate compensation and an inability to get raises are discouraging for providers, and the agency suffers because providers leave the agency, which is more strongly felt when even the most valued and longstanding ones quit. One provider sees this as a systemic problem:
Well our salaries are low and there’s not that much money, but [agency name] never raises salaries…and they make it look like for people that there’s no future there…This is more permanent staff. Everyone I know has been there five, six, seven years without one raise…So, I think that what happens is that community mental health are particularly, I think it’s true across the board, there’s too much…too many people leaving and going…there are not enough regular people to stay long periods of time, because they don’t get raises…The therapists just come and go.

Staff turnover is a major issue for CMHOs and many providers and clients point to its negative impact on organizational climate. What this provider illustrates is the sense is the psychological impact of the agency and the system not valuing one of their greatest assets: experienced and skilled providers.

Another provider (FFS) at this agency picks up on the topic of systemic issues with respect to compensation. This excerpt addresses how fee-for-service providers cope with system-wide policies and the stresses and tensions that FFS providers experience, particularly with respect to the arbitrary nature of compensation: “Well pay [is] horrible…Actually, they don’t pay so bad with individual therapy, and you do have a lot of flexibility in terms of how long of a session you can have, and you get paid more.” This tension swings to the negative, particularly with respect to poor compensation for group therapy, which this provider started on her own initiative because she saw a need, but she struggles with it: “I’m now running two groups, but…you only get paid for one person up until five people...After five, they give you six dollars and fifty cents extra per person. That seems ludicrous to me.” Reimbursement policies, therefore, produce a
disincentive for providers, even full-time providers, to offer group therapy. Ultimately, clients may suffer because only a small proportion may be getting a potentially very worthwhile service.

While the issue of inadequate compensation is a dilemma for providers in general, as noted above, it is also intertwined with their employment status as FFS or salaried providers. This is particularly true because it directly affects FFS providers’ incomes. Salaried providers on the other hand often have to meet monthly productivity quotas to justify their full-time status, but their pay remains stable over time. Whereas FFS providers bemoan the number of no-shows, salaried ones complain that their caseloads are too large.

In thinking about aspects of providers’ employment, the dynamics between FFS compensation versus that of salaried providers speaks vividly to their disparate challenges: FFS providers seem to be in the position of constantly increasing or maintaining the maximum number of clients they can see per week; salaried providers, on the other hand, seem to be attempting to find a balance between meeting their weekly/monthly quotas while not getting overwhelmed by their large caseloads. This situation seems to create stress for the two sets of employees, but for different reasons: FFS staff experience the stress of not having enough clients while full-timers experience the stress of having too many on their caseloads. Ideally, both types of providers would be maximizing the balance between scheduled hours and client hours, but this seems like a rarity and/or completely nonexistent.

One FFS provider, who is in her first year at the agency and having her first exposure to working in community mental health, refers to the experience of being FFS
versus a salaried employee:

I don’t feel so completely immersed there as full time employee would…I have a very… busy family life, so I’m sort of in and out…I’m there to do my work and to learn…so I don’t get so involved in politics.

This provider has chosen to be FFS based on life circumstances. Her comments, particularly her statement that full-time employees feel more “immersed,” reflect a tension that she’s experiencing, which, though unclear where this feeling comes from, speaks to her status as a FFS provider itself. Her statement about not getting involved in agency politics is fascinating because it may be those very politics that are impacting her affective experience of herself as an FFS provider, as an employee at the agency in general, or within the larger organizational social context. Nonetheless, the potential negative affective experiences may be minimized because she comes and goes and remains relatively uninvolved.

Another provider, new to the CMHO where he is working, expresses a deeper sense of frustration with the FFS model: “So it’s sort of unfair, I think, you know, how we get paid only if people show up…I’m not real happy with that situation.” The idea that it is “unfair” to not get paid if clients fail to show up may have multiple meanings for this provider that are reflective of values and affective experiences of the agency, as well as for the system as a whole. The expression of “not real happy” speaks directly to organizational climate.

As noted, client no-shows directly impact FFS providers financially and otherwise, as this provider explains: “[W]ith outpatient, you may have x amount scheduled but life goes on, and not everybody comes into every session…So it’s…a little
frustrating…I always say that we’re more concerned about their treatment than they are.”

This provider points to a common thread amongst the FFS providers, which is that no-shows also impact the services to clients. Perhaps, the provider’s concern about the welfare of the client is where some of the frustration comes in. One has to wonder whether and how the provider takes the time to express this concern to the client, when doing collateral work (phone calls, case resource/referral, paperwork) is unpaid time.

When a client does not show up for the appointment and/or cancels, it may very well become an hour of lost paid time for the provider, unless he/she is able to fit somebody else in that slot on short notice.

Some providers attempt to offer a balanced perspective regarding the FFS model. In this case, a provider attempts with some effort to propose changes to the model. A lengthy excerpt is used, here, to illustrate the internal and external tensions:

I’m sure there’s no way that makes sense for them because if they paid for every hour you were scheduled…the rate would be lower, and so that would work great for some and it would work badly for some…And some days I’d probably resent it [laughs] because I’d think it was great, so…I can’t think of a better way to do it … I think it keeps… therapists…to be really good, and think…and care about retention, and work hard to be better, and I think that’s the good side of it.

But…you have to pay your bills, so…The reality of it, it’s sort of a burden in that way…I don’t, I don’t know what the answer is and I don’t think they know either, they haven’t figured it out…I’ve talked to my supervisor about it who would also love to see it changed and doesn’t know where to start either. So I think it’s just kind of a dilemma.
This provider recognizes the complexity of making a change to a fee-based system that means being paid less per service to include failed appointments. His statements convey a tentativeness to the way he makes his proposal, perhaps because it seems that many providers seek to maintain their status FFS. This provider’s and others’ statements reflect general confusion about the FFS model itself and how one would go about changing it.

Interestingly, there is something about the “badness” of the FFS model that is not “off limits” in discussions between providers and their supervisors. While it is unclear whether the supervisor in this case is simply empathizing with the provider, or whether he/she truly dislikes the FFS model, this topic may also speak to the hierarchy at the agency in that clinic directors (assuming that his supervisor is at the level of clinic director) may not be seen as that far above the level of providers. In fact, in some instances at the CMHOs, clinic directors provide psychotherapy to clients.

Another statement in the above excerpt that stands out, too, is the idea that FFS “keeps therapists…to be really good, and to think about retention…and work hard to be better.” Many FFS and salaried providers might bristle at this notion because it implies that providers would not otherwise have an incentive to be motivated to see clients and to be good at what they do. One wonders whether the notions of incentives influencing provider behavior are built into the FFS structure.

**Professional development and training.** Another condition of employment that affects the provider’s perception of the climate is *professional development*. In this area, too, FFS staff are disadvantaged. As one provider said, “As at most settings…with FFS, which I’ve been involved with for many years…you have to be responsible for your own professional development.” For salaried employees, professional development may be a
perk of the job and seen as integrally related to a benefit, or an aspect of their employment. In cases where FFS providers are not entitled to professional development pay or reimbursement, they may be less motivated to get professional development outside the agency, and/or may feel the financial strain of paying for courses that are often quite expensive. Also, by going to trainings, providers are potentially giving up time they would otherwise be devoting to FFS work. This dynamic may very well lead to tensions between FFS and salaried providers, especially since all providers depend on training for licensure.

Not only do FFS providers struggle to get professional development training, but they are often faced with misguided and feeble attempts made by CMHOs to provide opportunities for free training at the agency, as this lengthy excerpt illustrates:

The only thing that we have at the clinic once in a while is…a drug rep come in and talk about some of the psychiatric medications…I have a bias—[Laughs]—so I really take it with a grain of salt…cause I know a representative is going to try to tell you that their medication is…the best thing. And…again, they’re not really addressing us too much. They’re really trying to dialogue with the M.D. because that’s the person who’s going to write the scripts.

The agency may attempt to give providers the false impression that these talks by pharmaceutical representatives are “trainings,” or perks of employment, and the provider’s laughter seems to reflect the absurdity of this. She is interested in learning about medication, but does not see the value in these in-services. What is clear from these statements, however, is the sheer lack of “clinical” training or supervision at the agency.
Many of the providers refer to the free trainings that occur at the agency, and these seem to be ones that are linked to compliance with agency and/or insurance mandates. While these are often mandated trainings, they pertain to the discussion of professional development as an attribute of climate because many of the providers conflate these two:

I would love them to have more money available for training which they really don’t…They offer some just bare-bones, in-house training…about…first aid and all things like that – I’d love more…just richer training, I mean…They do…offer training. But…on just the barest essentials…It’s training that pertains to all staff, not just the therapists…So that’s frustrating.

This provider expresses a clear desire to have more in-house training in areas that expand her knowledge base and practice skills. She also speaks to what many of the providers feel with respect to professional development and training, and the agency in general, which is a lack of commitment to them as providers and their intrinsic value to the agency.

The provider above uses terms like “bare-bones” and “barest” with respect to the trainings, and states that the trainings are for the whole staff, not dedicated in-service training for providers, which she finds frustrating, perhaps, reflecting providers’ perception that the agency does not see them as important in this regard. While these mandated trainings are often paid time for FFS staff at the agencies, what may also be at play is providers’ perceived ratio of time spent at these bare-bones trainings versus time spent working with clients, or attending more intensive trainings. In any case, providers
may feel mildly coerced into these trainings which may lead to a sense of apathy or resentment with respect to professional development, or otherwise.

A provider from another agency reiterates this sense of frustration with the in-house trainings and offers additional areas for development: “Anything that’s related, especially to our population…but really someone coming in and doing small group training on topics related to the clients…And not on treatment plans, progress notes, and that kind of BS.” The types of in-service trainings related to agency processes, documentation, and/or mandated topics, seem to vex providers, and seemingly never relate directly to client issues. Of course, this raises the question of whether providers are receiving clinical supervision at their agencies, but it also speaks to the way that providers feel clients are somehow neglected, making these in-service trainings seem ostensibly bureaucratic in nature. Providers, then, are left to their own devices for clinical trainings, and, in turn, FFS providers may feel squeezed when they lack the funds to pay for such trainings.

Providers speak about wanting training in a variety of therapeutic modalities, in making diagnoses, and in learning about medication. Their notions of professional development are not limited to clinical matters in a strict sense, however, and some feel a need to have greater understanding and knowledge about accessing resources for clients outside of the agency:

[T]hey tell you call Philadelphia Housing Authority, or, do this or that, but when you do that you don’t get anywhere because either the waiting list for housing is too long or…there isn’t money for services.
This excerpt reflects a training issue – that is, how to best access outside services for clients – and it also seems to be reflective of systemic problems; the issue, here, is the shortage of housing, and in general the provider’s statement speaks to a fragmentation in services. A clear link may be seen here with the climate of the organization, as well as with the organization’s social context, in that learning about outside resources would seem to be one solution, with additional training for providers in working in and across different systems, so that they do not feel helpless when attempting to access services.

Providers also speak about ways to better serve clients with respect to interactions at the agency. In this excerpt, a full-time provider objects to the lack of collaboration at her CMHO:

I also think that…again, because of the limited resources…we don’t get to do a lot of collaborating with the psychiatrists and other people who are working on the caseloads like if you’re kind of isolated in your experience of the client as opposed to being able to work as a team.

Here, the question of professional development opens the provider up to speaking about her sense of isolation in working with clients. She links her feelings about the lack of interaction between staff directly to addressing the needs of the client. On the other hand, she points to a lack of agency resources, or perhaps how the agency perceives its resources, to offer this type of training. This dynamic points to a strong tension between the agency’s resources and priorities and providers’ perceived ways of offering the best possible services.

Providers seek training in evidence-based approaches, as well as the challenges of staying current, as this excerpt of a FFS provider highlights:
Well, just sort of expand my awareness and…have more conferences
and…trainings that are about implementing interventions…backed up by
research. …I have good clinical supervision, but sometimes…it’s hard to stay
abreast of the treatments out there...But… sometimes trainings are…not the best
ways of gaining skills.

The provider has a positive attitude toward researched interventions and seeks to remain
up to date with his knowledge-base and skills. On the other hand, he points to the
difficulty of getting the skills necessary to implement the evidence-based treatments. The
provider expresses some ambivalence about going to trainings with the possibility that he
might not get the necessary skills. One might see this as a function of the feeling
discussed before that he does not have time or financial resources to engage in a lengthy
unpaid training process.

A case in point of the impact of bringing advanced clinical training to CMHOs is
an initiative begun in 2007 by the Beck Institute to offer cognitive therapy training and
supervision. One full-time provider spoke about the very positive impact of the training
with respect to her work in the agency’s partial program. The following excerpt is
revealing:

[T]his Beck Initiative was incredible. That is something that I admire about the
agency, I don’t know how they…did this, how they got it, why [agency name]
was chosen, but I did, say to the CEO, I appreciate the fact that you did this…This
is something that keeps me working here, is to have something like this, that and
my health insurance (laughs)…But …this is something that I feel is extremely
important…and all therapists should… have the opportunity to participate in this.
This excerpt highlights the powerful psychological impact on this provider of having received paid training in an evidence-based modality at the agency. She refers to what she “admires about the agency,” feels the Initiative “is extremely important,” feels lucky that her agency has been chosen to participate, and expresses greater loyalty and gratitude to the agency. She even mentions that she conveyed her appreciation to the CEO as a result of being included in this initiative.

Nevertheless, the provider in the excerpt above draws attention to the meager financial resources of the agency and the priorities of systems involved in funding community mental health services that impact the way that services are provided. In the case of this training in cognitive therapy, Penn received grant funding from the Department of Behavioral Health (DBH) to provide the training and supervision, so the agency really did not have to do much more than agree to participate. When a training institute is done its work and has left, what happens to the organizational climate? Are the gains made with respect to organizational climate sustained? Do those trained in the therapy train others at the agency? Do initial gains fall prey to other powerful forces within the organizational social context.

**Clinical supervision.** Another aspect of employment that speaks to organizational climate is clinical supervision, which offers the potential for a provider to form a close relationship with a more seasoned professional, who may be able to be a critical resource for them, practically- and emotionally-speaking, as they navigate the many challenges of working at a CMHO. The potential for growth in a healthy supervisory relationship can be tremendous. Additionally, providers at the highest level of licensure can be incredible resources as supervisors to those providers seeking to move to the next level in their
licenses, particularly since this permits them to advance in their field. Providers in the sample are split as to whether they get supervision at their agencies. Generally, providers feel valued when they get good clinical supervision, as this FFS provider succinctly illustrates: “I can get all the supervision I need which I really appreciate. Um, so I think that that’s pretty solid for me.” Another FFS provider speaks to the lack of supervision:

People are…really scheduled to see clients and…so there’s not a chance to really talk about…I’m not given any opportunity for any kind of a formal supervision...There’s no group either…maybe just a chance for people to come together and discuss cases or something…[A]gain, I’m not very informed unfortunately. I come in, and I see my clients, and that’s it. [Laughs] But I don’t know why they don’t do a supervision, but when I came in and applied to work for them they told me that there was no supervision.

The provider feels strongly that supervision would be helpful, and seems to point to being FFS as the cause for her lack of it. While she recognizes that providers are there to see clients, she points to the lack of access to supervision.

The provider’s laughter in the excerpt above, perhaps, speaks to her recognition that, as a FFS provider, she may be asking too much of the agency, or may not want to sound “entitled.” This dynamic may point to personal, and/or structural constraints, that impinge on FFS providers’ ability to feel worthy of access to agency resources. On the other hand, she is unhappy about lack of supervision – “a policy I’m not too happy about” – especially since it was something that was promised when she applied to work there. These types of responses speak directly to organizational climate.
One full-time provider is more adamant about clinical supervision that is provided by an outside source, and she reflects on her positive experiences with strong clinical supervisors: “[G]ood clinicians, very good clinicians that I would respect that I could get supervision from…I at one time had a student intern…and she was a natural for this field…she was excellent.” She also expresses frustration at having to pay for private supervision outside the agency, and how she feels about not receiving any supervision from the start: “…in the past when I did go to the [supervisor, her] response would [be]…for example, [if] there’s a problem with a client, well we’ll give that client to a different therapist.” This provider offers more depth to this issue in discussing the type of clinical supervision she would like to have and the financial burden of going outside the agency. She also speaks to the downside of poor supervision, in the previous excerpt – in this case, having a client reassigned because the supervisor may have thought he/she was too challenging. While she does not make clear the direct impact of the supervisor’s response, one would suppose that she felt betrayed by the supervisor’s decision to transfer the client. This leads to deeper questions that go beyond the scope of this study regarding the role and impact of the quality of supervision – positive, negative, or mixed – on organizational climate at CMHOs.

Another full-time provider receives supervision, but is not too happy with the way that her supervisor carries it out: “I also just think um, more, more…feedback of a positive nature. Like you, you tend to get the feedback when there’s problems…but you don’t really get the positive reinforcement of good feedback.” Perhaps, this provider is speaking about supervision in general, but her comments seem reflective of her
relationship with a supervisor whose only comments to her about her work are negative, and who does not recognize her for her positive contributions.

Interview excerpts regarding supervision speak to providers’ feeling a strong need for a strong clinical resource person with all of the benefits that come with having such a staff member. In most of the cases studied here, when providers have received good supervision, they have felt valued by the agency, and this speaks to the power of the supervisory relationship with respect to organizational climate. The agency makes a commitment to appreciating providers for the central feature of their work – helping clients – by offering supervision. Supervisory relationships that do not work out, for any reason, can leave a bad taste in providers’ mouths, and may cause CMHOs’ managerial staff to reduce and/or devalue clinical supervision, especially if it is not leading to gains in productivity. Given the scope of this study, this would be an area for further examination.

Another sub-theme with respect to clinical supervision that seems implied in these excerpts is the presence at the agency, or absence, of providers at the highest level of licensure in their field. How many of these providers work at CMHOs (either as providers or in leadership positions)? Do they have time to carry-out clinical supervision? Presumably, if these licensed providers can get better compensation elsewhere – either in a private practice or other private setting – they would be more likely to fill these kinds of jobs, leaving CMHOs without this type of supervisor. Minus the salary for fully-licensed providers, and with the financial strains placed on providers in community mental health, not to mention the widespread move towards increased professionalization and licensure, the community mental health system may be keeping providers from advancing.
Among the provider interviews, there is one with a provider who is also the clinic director at the same CMHO. Speaking from her experience with both roles, she offers a unique perspective regarding the needs and challenges of providers:

They need fewer clients…better pay…more supervision, they need, honestly, I’m not available to them as much as they need it, especially because they are [green???]… And they need more training. I mean they need some type of, not necessarily tons, but I think something coming from within the agency, or something that’s clinically based, or even good, solid training, documentation, if coming, I think especially from the agency, they are requiring documentation.

She relates directly to the providers’ concerns: compensation, professional development, and clinical supervision. At the same time, she recognizes the importance of training on documentation and other compliance-directed trainings. This provider/administrator also feels that trainers should come from the outside versus having a small staff of in-house trainers do most of it:

It’s ideal to think that we can start training ourselves, but…the training goes through one or two people, and I can tell you the staff is sick of that…And we have too much of that going on in this agency, and so there are some trainings but, (chuckle), it’s not really trainings, it’s clinicians…

She makes a clear statement that on-site training has not been effective and expresses her frustration on behalf of the clinic when she states, “the staff is sick of that.” She seems to have experienced this personally, as her dual role would confer. Her commitment to the providers becomes evident, as well, in her statement, “it’s not really trainings, it’s
clinicians,” reflecting that just having trainings is not enough; they need to be trainings that are valuable to providers.

Despite attempts to bring evidence-based training to CMHOs with a built-in clinical supervision component, and the seemingly altogether positive impact this has on climate, structural elements may be a strong counterweight to “Cadillac” trainings. What emerges is a picture of agencies that seek to keep costs to a bare minimum, while keeping concessions or alternative treatments, like group therapy, perks for staff – like trainings – and development of new funding models, to a bare minimum, unless another stakeholder is willing to cover the expenses of bringing in their own trainers and supervisors, such as the Penn/DBH training program. This points to parallel processes that may serve to maintain structural barriers, while keeping themselves hidden to providers and other stakeholder who seek to change the way things are done. Perhaps, as Kai Erikson’s (1962) deviance theory suggests, these implacable and substandard structural barriers serve a function for those in power by preserving the deviance of those with mental illness.

**Day-to-Day Experience of Working at the Agency**

Providers’ everyday experiences of working at their agencies with respect to climate include their feelings about frequent staff turnover, their sense of collegiality with peers, the autonomy and flexibility they feel they have, as well as their interactions with clients. These experiences are discussed in response to the research question about providers’ perceptions of the organizational climate.

**Turnover of staff.** As noted above with respect to lack of adequate compensation, providers spoke about their frustrations with frequent staff turnover. A
majority of the provider sample spoke about the problem of staff turnover, indicating its relevance and significance, although it was often as part of a larger list of concerns or related to other issues, hence, extensive excerpts are absent, relatively speaking, in this sub-section.

As one FFS provider above indicated, not enough providers stay at the agency because, she surmised, they do not get raises even after being at the agency for a while. She has also frequently seen support staff leaving the agency. The end result is that clinical and support staff members may not stay long enough to learn about agency processes or become proficient in day to day tasks, which can have an effect on agency processes, communication, and, thus, providers’ perceptions of the organizational climate.

At one of the agencies in particular, turnover of providers is a very large problem, and this may account for a lack of any interaction with peers that would look like collegiality. As the provider at this agency states:

Provider: [T]here’s just a lot of turnover and…because of that, sort of a low morale, I would guess, I would say.

Interviewer: Alright…what would you say you enjoy the most about working at [Agency]?

Provider: Definitely just the direct contact with my clients.

One wonders whether this provider’s focus is mainly on her clients because of the high turnover and low morale at the agency. With frequent turnover, therefore, collegial relationships may suffer from the sheer lack of time providers stay at the agency, not to mention relationships with supervisors and support staff. A sense of transiency in the
working relationships seems to pervade the language of the providers, and this may fuel some of the frustration that they feel with the agency as a whole. Not only do their peer social relationships seem to suffer but their feelings about the day to day aspects of the work suffer, as well.

**Collegiality.** In two out of four agencies, providers spoke about the interactions with colleagues as one of the positive elements of working at the agency. The omission of reference to collegiality in the other two agencies may be related to the small number of interviewees from the other two agencies, or other possible reasons. Looking at an agency in which providers feel positively about the sense of collegiality, one full-time provider states:

I really do enjoy it and…the relationship between coworkers is good…I enjoy the support from my coworkers…because we as an agency do have…kind of support set up in places for peer review when we get together and talk about our difficult cases...

The provider feels a strong sense of collegiality and cohesion with her peers at the agency, particularly as it is related to clinical peer support, and sees this support as a valuable part of her experience.

A new provider at the same agency also has positive things to say about staff: “Well, it’s the first time I’ve ever worked in community mental health…it’s the people…some of the staff are really lovely, great, so the atmosphere’s really nice.” Being new to community mental health, her perspective offers a glimpse of what it is like for a provider to come into a CMHO for the first time. Her statements highlight a sense of friendliness among staff, and the competence of her colleagues which, again, speaks to
peer support. Having competent peers can make a significant difference for providers, especially for ones new to the field, because many issues come up that they may not know how to handle on their own, whether these are moments of crisis with a client, safety concerns, or when cases are being discussed during a moment of calm between sessions.

At a second agency, the same themes of friendliness and support emerge in this interview with a FFS provider who is at the agency two days a week: “I like my colleagues. I don’t get to spend that much time with them but people they are generally very friendly and warm and open to, you know, to support each other...” Perhaps, she lacks time to devote to collegial relationships, but “friendly nice environment” speaks to a positive climate. The openness and warmth of providers that she speaks about reflect additional affective elements.

Another provider at this agency highlights her respect and admiration for other staff, including her supervisor: “…I think I have a really great supervisor and staff overall I’ve been impressed with…just professionally and also personally, I think there’s just a lot of really good people there.” As an aspect of climate, collegiality gives providers a sense of confidence that they are not alone at the agency, and that they have supports to rely on when needed; the few provider interviews excerpted here give the sense that collegial support is readily available.

**Autonomy.** Providers at three out of the four agencies also speak positively regarding the autonomy they experience in providing therapy. As this FFS provider indicates, “…I’ve been able to be rather autonomous. I feel like I’m recognized for my expertise and, you know, for actually providing therapy treatment I really have not felt
This provider connects the idea of autonomy with her expertise and her abilities as a therapist. She seems to imply that there would be less freedom if it was discovered that she really did not have the skills. In the last part of the excerpt, the word “stymied” seems to imply that she is able to provide the kind of therapy she feels comfortable with. One might say, then, that the idea of autonomy reflects a mental state – that is, having the freedom to think and practice independently.

A full-time provider at this agency makes the same connection between her autonomy and abilities as a therapist: “I do have pretty good latitude in regard to therapeutic approaches…I don’t have anybody closely monitoring me…If I have enough training experience, I’m able to be reasonably self-sufficient.” As before, this provider exhibits this mental autonomy in that she feels able to provide the service that she feels comfortable with. By the same token, autonomy as a physical state emerges from her statement about “monitoring.” In both cases, the autonomy is related to work with clients.

Both conceptualizations of autonomy emerge in this excerpt with a FFS provider at another CMHO:

I don’t feel…a lot of interference or that somebody’s over my shoulder all the time…I think that people who might work here full-time might feel that or the administrators, but I don’t…because I kind of work here one day a week and so I don’t really get too uptight about certain things, but maybe they do…

The terms “interference” and “over my shoulder” reflect both the mental and physical qualities of autonomy. In this case, the provider appears to be expanding the theme of autonomy include general interactions with administrators, not just those related to providing therapy. The provider seems happy with not being controlled. Being at the
agency only one day a week, perhaps, adds to the sense of independence.

In one of the interviews, the term “laissez faire” is used, and this gives a pretty good sense of what providers mean with the idea of autonomy – that is, administrators allow providers to choose what they will therapeutically. As the provider above notes, however, this dynamic may be different for full-time providers:

I particularly like the opportunity to do the therapy with the clients that I have…and do it in any method that I choose and…I’m basically free, I have no supervision. Nobody knows what I do all day long (laughs) and that’s ok, I mean, that’s fine with me. I don’t have anybody on my back until it comes time for audits and then, everybody gets all upset around here and anxious.

This provider works full-time in the agency’s partial program and, while she works autonomously in her clinical capacity, her administrative work receives a lot of attention from all sides – “everybody gets all upset around here and anxious.” She appears to be swinging between the two poles of autonomy and constraint. The sense is that the agency becomes very reactive to oversight from auditing bodies, directly impinging on this provider’s work. Providers in general have to meet documentation requirements, audit their charts, and at times provide examples of their work to auditing bodies, but the responsibility for these mandates would seem to be more strongly felt by full-time and administrative/clerical staff.

The provider above also returns to the theme of lack of clinical supervision. So that while autonomy may appear like a very positive aspect of agency climate, it also has some negative qualities, particularly a sense of benign neglect, that speak to the tensions providers must feel with respect to clinical supervision, audit requirements, or
documentation in general. In agencies where communication and relationships between administrators and providers is poor, the tensions may be felt even more. In this sense, administrators must feel the strain of having providers with so much autonomy (an autonomy for which they are partially responsible), particularly in cases where there is almost total clinical autonomy, no clinical supervision, a top-down management style, and so little positive communication that providers may become resistant to administrators’ requests.

On a basic level, the dynamics within the agency with respect to audits, other documentation requirements, or other demands of the workplace, come down to expectations (or perhaps, lack thereof), and both providers and administrators play a role in negotiating them. Not generally seen as an aspect of organizational climate, I argue that expectations that appear in patterns of behavior (those of clients, communities, providers, and administrators, and the overarching system) are in many cases the unconscious and/or unseen elements of climate (doxa) that have a tremendous overall impact on CMHOs. It is through expected behaviors with patterns of relationships that clients, providers, and administrators, among others, relate to each other. Underlying these patterns are values, beliefs, and norms that inhere in multiple and diverse cultures.

The statements of this provider from Agency D reflects the complexity of these ideas:

There are many unwritten rules and it’s just the politics of the agency. [S]ome of them are confusing too. But I think that’s too complicated at this point to go into…I can’t think of what they are, on a daily basis they just slip by. …How the administration… expects things to go…It’s all administration, you know.

Expectations are often tied to larger context issues – that is, audits, system-wide policies
– so that external demands or constraints can impact what happens between staff at different levels. With respect to the experiences of providers, when they do not respond appropriately to expectations, or when expectations are unclear or unstated, a “do it or else” mentality may develop on the part of administrators with respect to audits and other agency requirements.

Since language structures meanings, expectations of providers (and clients, too, for that matter) may be seen as “complaints” or “grumbling,” but may be more positively be referred to as “feedback,” and this speaks to providers caring enough to have expectations of the system within which they work. Administrators may experience providers’ feedback as negative and, in not recognizing the importance of and value in their feedback, administrators may become frustrated and feel squeezed between competing expectations from all sides. In the same vein, providers care about the services they and other members of the organization provide because, basic to all helping professions, is the desire to see individuals make positive changes in their lives; one would assume that this is one fundamental reason why providers and other staff at the agency are in the field in the first place. Another fundamental aspect of the codes of ethics in helping professions is the belief in the dignity and worth of every individual, and this is perhaps is felt even more acutely in organizations that have the potential to infringe on these basic rights, if systemic pressures are not somehow mitigated by members of the staff.

**Flexibility.** Related to expectations, an FFS provider who was interviewed discusses flexibility, an element of organizational climate which, though loosely related to the theme of autonomy, is different, particularly in terms of what it references; in this
case, the provider’s schedule and documentation requirements. This excerpt is a response to a question about system-wide policies that make it easier for the provider to do her job:

[W]e all have flexibility in our schedules, we make our own schedules, our own hours...we can stay late if we have, we have so-called regular hours but we don’t have to stick to them...so there’s a lot of independence in that way. There’s not really that much checking up...except with a particular supervisor...He may check your charts however often, but...there’s not really continuous checking up.

The provider enjoys the freedom of being able to choose her hours, even when they do not adhere to the original schedule. There is some question here about what impact this might have on the way providers are perceived by their supervisor and vice versa.

The selection above states that the supervisor does examine her work, but she does not feel overly concerned or constrained by it. She goes a bit further in saying that the supervisor may be a bit lax in his oversight on charts – that is, “not really continuous checking up.” This statement reveals a tension for providers between flexibility around aspects of the work and an administrator’s arbitrary expectations. The providers may wonder at times with this administrator what they can “get away with.” The administrator may experience this tension as: expecting providers to be compliant with the scheduling and documentation requirements, versus empathizing with all the challenges, financial and other, of being a provider. If providers can get things done in a timely and satisfactory manner, then the administrator may allow them to flex their own schedule as they see fit without question.

In whatever ways these dynamics occur, it speaks to how providers and administrators cope with the stresses of working within the community mental health
system and attempt to make it work for them. The positive elements of autonomy and flexibility relate to providers choosing their own approach to therapy, not having supervisors micro-managing the clinical aspects of the work, and being able to create a schedule that works for them individually.

**Perception of administration.** To understand the tensions that providers and administrators experience with respect to organizational climate, the perspectives of providers on agency leadership and decision-making provide a valuable frame. This excerpt from a FFS provider, illustrates this perspective:

I just think having…some leadership…[T]here’s an administrative building some distance away…and there’s very little…connection, communication. That’s where…I guess, you see, I don’t even know who these folks really are, like the CEO.

She experiences leadership as distant and removed, both physically (at a separate administrative building) and emotionally, and she points to a lack of communication and engagement by leaders at the agency, expressing a need for greater collaboration. The sense is that she wants to be able to see and understand where and how the decisions are being made, and that the way leadership operates and positions itself feels like lack of concern for the unit.

A full-time provider at this agency reflects on the top-down way decisions about day to day work processes are made and interactions with colleagues occur at the agency:

[T]he bosses say we have to do this so we have to do it… I would like to see…the direct care of workers…with the decisions that have to be made…about, it could
be anything from paperwork or how we deal with a specific situation or things like that. I would like them to take into account our views.

Her perception of leadership and decision-making at this agency is that it is undemocratic. Like the previous provider, she would like to see how decisions related to the work are made and have more of a role in the process. While this excerpt speaks to the agency culture – that is, the way things are done – the provider uses terms like “the direct care of workers,” and states that she “would like them to take into account our views,” which speaks to the affective experience of management decision-making. In this vein, she does not feel cared for and feels that she does not have a voice. Lastly, she does not feel valued for her potential to contribute something worthwhile to agency decisions that impact her work.

The same provider also speaks to the interaction between upper management and clinic directors, and how this impacts the work: “[I]t’s often present in a way that’s…our bosses will come to us and be like, well this is coming from the administration…and you know, I fought for you, but this is just something we have to do.” She offers some insights about the tensions that clinic directors/middle management experience, who seem to be fighting on both sides, and how this trickles down to the providers. Their communication in this provider’s eyes reflects that there may be some advocacy by middle managers on behalf of the providers, but that the administration’s decisions are not up for discussion. In this sense, the provider seems frustrated by upper management and disappointed by middle managers. One wonders whether a good portion of their affective experience in this regard is not the decision-making itself but the way in which the decisions are communicated and how feedback is handled. There is a strong sense,
here, that middle managers’ voices are not being heard and they have limited opportunity for feedback, which may parallel providers’ experiences.

The account of one final provider at this agency points to the clinic director’s “authoritative” and “micromanaging” style, which may be reflective of the frustration just mentioned:

[H]er ability to relate well is very minimal… this is her personality…it’s only dependent upon the mood…[Y]ou’ll be more of a colleague and an equal, but for the most part you get the feeling you’re quite subordinate…[T]hey’re very thankful to have us, they need a lot of therapists and they really want to have therapists…but she doesn’t treat you like she really wants you to stay.

This excerpt contains many themes with respect to climate, and the provider seems particularly harsh, stressing that the negative management style seems like a personality issue and/or an inability to relate interpersonally to others. Apparently, she has had this discussion or has witnessed this manager’s style in interactions with other providers there, even though other providers in this sample have not spoken about these issues. Either way, her feelings of being “quite subordinate” speak to the same sense of not being valued that others at the agency get. While she attributes the supervisor’s issues to an intra-psychic problem, her experiences may also speak to a parallel process that has to do with a conflict occurring between the direct supervisor and upper management.

In thinking about conflicts administrators may be experiencing, the clinic director at another agency, who is also a provider, refers to one of the changes she would like to see: “And I would like to see the administration have a less hierarchical structure of, um, uh, system in place…..communication needs to improve.” She sees the hierarchical
structure as a barrier to communication, pointing to a tension she must feel when she has
to bring issues or concerns to upper management. If providers are only looking to the
one-on-one interaction with management in isolation, they may very well miss the overall
context of it, and may be unable to differentiate their own experience from the conflicts
occurring elsewhere.

Similar themes regarding providers’ perceptions of administration were found at
all four agencies. One full-time provider at another CMHO states, “I would definitely like
to see better leadership as far as…my specific unit,” and later refers to an unwritten rule
that “certain…people who are in authority positions can’t really be questioned.” This
provider also spoke earlier about not getting positive feedback when speaking about her
supervisor. At another CMHO, a full-time provider sees leadership as honest and ethical,
and this is the reason she stays at the agency:

[People have asked me to do things for example, because I have a license. I was
asked by individuals if I would sign supervision papers for [licensure]…I said I
would be more than happy to sign the papers for them as long as I also did the
supervision...[T]he intention was that somebody else was going to be doing
that…I refused to do so and administration said I had a perfect right to do
that…They weren’t going to budge…they just don’t ask me to do anything illegal
or that would jeopardize my license.

This provider has had other experiences at agencies in which decisions were not always
handled honestly and ethically – that is, she was asked to write notes and bill for services
that did not occur, and ran into problems with Medicare, as a result – and she feels
respected and supported by the administration for standing up for herself.
The statement of the above provider regarding the reason she stays at the agency may be an overstatement. On the other hand, she feels strongly about this important issue and, whatever other issues she may have, this one piece of her work allows her to feel a connection with the administration, to feel recognized by them, on a topic of shared concern. Whereas many of the providers have talked about not feeling valued by the agency and have highlighted the negative impact, feeling valued for something important to the provider, in this instance, seems to have had a powerful and positive effect on her experience of working at the agency. Perhaps, this offers a way for CMHOs to help providers feel more respected by including them in discussions of certain types of issues, like ethics. The importance of being given individual attention and input in the organization, as well as the impact of positive social interaction (this speaks to the theme of collegiality mentioned earlier), have been shown to increase productivity (Etzioni, 1965; Pugh, Hickson, & Hinings, 1985). This dynamic is fundamental to human relations thinking with respect to organizational behavior, and is known as the *Hawthorne effect*.

**Agency process.** Connected to the theme of how providers perceive the agency administration, all of the elements just discussed relate to processes occurring at the CMHOs with respect to organizational climate. Another way to look at this element is to examine communication, but the more general term, *process*, is used to convey something more complex than communication. Each time there is an interaction between a provider and a supervisor, a process has occurred, and the way the provider responds speaks to the way they experience the process, as well as the content. This section examines several agency processes detailed by providers that attempt to offer a sense of the ways in which they occur and how providers experience them. At one agency,
providers are asked to do intakes by the clinic director, and this “asking” speaks to a clear expectation by the clinical supervisor. Ultimately, however, providers are not required to take on the client with whom they have done an intake, and providers feel respected in making an independent choice. So providers are asked to do intakes.

The agency’s intake process, above, seems to work for providers. One provider juxtaposes it with an experience at another agency of having to take on any client that she saw for intake. The intake is obviously a different kind of clinical process than completing documentation, or interacting with a supervisor, for example, and it would be important to look at a process like completing documentation further. Some might argue that completing documentation or interactions with other staff are not clinical, and this offers an interesting area for exploration, but the point here is not to debate what is clinical and what is not. Of note is that a process that directly relates to contact with clients, and perhaps one that is related to a service covered by a fee, is privileged with respect to the supervisor’s expectations. As a clinical process, the intake may be seen as an area where providers have felt a sense of autonomy.

A full-time provider at this agency puts a different spin on intake as an agency process. When asked about unwritten rules, the provider states:

[B]asically…if the boss comes and asks you to do an intake for a person and they’re not really your person, you kind of have to, I mean you don’t get into trouble for it or whatnot, but…you pretty much have to do it.

When clients are referred to a CMHO, they are usually given an appointment with a specific provider for the intake. An intake might go to another provider if a particular provider is double-booked with intakes, if the provider runs over time in providing other
services, if the client has come at the wrong time (too early or too late), or for other possible reasons. Perhaps, this excerpt is reflective of the top-down management style with respect to unwritten rules, which loosely refers to something that is not seen as an expressed policy or procedure of the agency. The unwritten rule with respect to this work process is something that is simply taken for granted by providers, similar to the notion of doxa spoken about earlier. The previous provider glosses over this aspect of the process. Whereas expectations may be lacking or arbitrary in other areas, they do not seem to be with respect to intakes and, again, this may speak more about the process of being assigned an intake itself, as a clinical part of the work. Because the provider in this excerpt is a full-time, the question of being paid for the service may not be as much of a factor.

The same provider also discusses an issue that gets into the clinical process of intakes, but that reflects a change in the process itself. Here, she discusses a change in which providers had to begin discussing mental health advance directives with clients without a full explanation of how they should be integrated into the intake, or a discussion about the implications of them for clients:

[S]ome of us had concerns about, well if you’re talking to a suicidal person about them finding a form or creating a form that says they can say what kind of treatment they want to receive and what kind of treatment they don’t want to receive…that’s not really the best situation, because then they could just go ahead and go through with things and rush you through treatment.

The provider explores the tensions inherent in being told to complete a clinical process without, perhaps, a well-thought-out plan of how the process should be implemented, and
she points to the challenges of carrying out a directive when certain client issues may otherwise complicate the completion of an advance directive form. Of note is the description of how the decision was brought to providers’ attention: “…it was kind of presented…this is something that the state says we have to do, and the administration says we have to do, so just go over it with your clients...” The language this provider uses makes no bones about the top-down chain of command with respect to this change, reflecting both the affective and bureaucratic features of the interaction. The excerpt speaks directly to the systems-related features of the agency process, particularly with respect to power and the way in which power is wielded as an expedient means to an end.

In the last section of this provider’s statements on mental health advance directives, she reflects on the “general annoyance” and the lack of support generated by the interaction:

[W]e kind of took it as one more thing that we have to do, especially because when you’re already in an intake…you have to go through like forty five minutes of administrative paperwork before you actually get to see the person and figure out why they’re there and interact with them and try to develop a relationship…but it wasn’t really clear to us so it wasn’t clear to people.

Accounts of this process from members of other systems and sub-systems would have to be recorded in order to draw a thread that shows how this change in process developed, and what occurred in these interactions that led to the way it was presented to providers. Figure 4.2 provides a pictorial representation of what the process may have looked like with arrows representing communication channels that speak to the affective content of the different stakeholders. In whatever ways these systems and sub-systems interfaced
with each other, the negative effects on providers are clear, reflecting a parallel process that mirrors the conflict at the clinic between providers and administration. Another key component would be to look at whether and how clients may have experienced this change during the intake, and also how their particular presentation or stated reasons for treatment may impact the way the provider approached the topic (another potential parallel process). While the provider mentions the state, above, one wonders what role the state actually plays in this dynamic, as indicated by the gray box and arrow.

Figure 4.2. Parallel Process with Agency Process: MH Advance Directives

A FFS provider at another agency discusses how lack of process, or at least lack of a clear and effective process, to address an area of critical importance with respect to providers and clients leads to negative feelings: “…there isn’t a sense that people are always listening or taking care of safety issues…they don’t seem to be prepared here for safety issues of people going off or getting agitated.” The provider uses the general term “people,” which gives the sense that no one is paying enough attention to safety issues, or may be a reflection of what he sees as more of a agency-wide problem, and he attributes this to “their” lack of preparedness and disorganization.

How does this provider face this lack of process? Affective qualities of this provider’s experience emerge more vividly in this statement regarding a conversation he had had with another provider who raised concerns about safety issues: “And she says that nobody really listens. So I kind of get the sense of, like, there’s just this sort of
helplessness…like it’s the way it’s always been, and you just have to deal with the fact.”

Parsing the language the provider uses – “Like I kind of get the sense, like” – perhaps, reflects a felt, yet amorphous, element of the organizational climate, which is a feeling, according to him, shared by another provider. The provider suggests that feelings of “nobody really listens” and “That’s just the way it’s always been,” lead to a sense of “helplessness.”

A different provider at this CMHO raises another unaddressed process issue – that of interruptions in the middle of sessions – which may be a policy or procedural issue, but the concern for this provider seems to be about professional boundaries:

I have a huge pet peeve about that, but people don’t think much about, like, if they need a chart they’ll come into the session, which is incredibly distracting, it all has to be processed, it’s really annoying, and I can’t seem to make it stop completely…that drives me crazy…so I think that anything that sort of interferes in the time becomes…an obstacle for me.

This selection suggests an aspect of the agency culture, pointing to how boundaries are not respected while the provider is in the middle of therapy session. It is unclear whether this is an issue at the agency in general, or if the provider is, perhaps, not doing a good job of returning charts when he is done with them. The provider is clearly irritated about the disruptions, however, referring to the lack of courtesy and invasiveness about the situation. He takes some of the responsibility upon himself, stating, “that’s just a pet peeve of mine,” but a tension seems to lie at the heart of what he is saying – that is, “I can’t seem to make it stop completely” – which may point to how difficult it is to change the way things are done. Without a clear sense of why these interruptions occur, this
discussion is still open to further exploration.

A full-time provider at another CMHO discusses how decisions are passed down without any warning or apparent process:

[W]hen people feel that they’re a part of the decision making in the change…they’re more open to it, but sometimes when things are just handed down, if you don’t understanding where it’s coming from, people are not always open to things.

The sense, here, is more of a general feeling that providers do not have a role in the way decisions that directly impact them are handled at the agency. The provider indicates that having an understanding of where decisions are coming from would allow staff to be more open to changes. A counterargument could be made that having more knowledge about the decision-making process might cause staff to attempt to block changes, although there are certainly ways to strike a healthier balance between complete transparency and complete secrecy. Equally important, as noted above with respect to advance directives and other challenges, is the lack of a deliberative process before decisions are made that directly impact providers and staff, and poor communication of decisions. Given that so few of the providers said anything positive about agency processes, it is difficult to know exactly what providers’ responses might be to a “good” process.

**Responses to change.** A question from the provider interview guide that yields insights with respect to agency process and organizational climate is: How do people within this agency react to change? Like many of the attributes of climate discussed, providers in general report that responses to change depend very much on how the
changes are presented. Here is an example from a full-time provider regarding how staff react to change:

Like some people, with some resistance…when the (system?) comes down at a staff meeting say’s we’re going to do something…we’ll groan…[I]t depends on the way it’s presented…[W]e had a new supervisor come in and she…was sort of dictatorial… She came in, said all right you gotta do this that and the other and, she made some mistakes, and..she told us well I’ve been doing it this way for the fifteen years I’ve been here and we looked at her and said…this is the first we heard of it.

The provider’s initial statement regarding “resistance” reflects, perhaps, a relatively balanced view of staff responses to change. At issue in the provider’s description of a particular process seems to be the way it has been carried out by providers at the CMHO versus the supervisor’s approach to it. The statement, “we’ll groan,” perhaps illustrates the initial resistance to change, as well as the way the change is presented. From the standpoint of climate, this provider calls attention the notion mentioned earlier of needing to feel valued and respected; in this case, it is through communication about changes in processes and procedures. Her indignation is emphasized in calling the supervisor’s approach “dictatorial.”

A full-time therapist at this agency reflects on the issue of staff responses to change with respect to the hiring of a new outpatient director:

[N]aturally, I think as we all do to change, there’s some anxiety and some concerns at times…But I think people, for the most part, are pretty good at adapting to change and you know, kind of rolling with the punches.
Later in this statement, she speaks directly to the change to a new director as something that people adapted to “because they realized as I did, that they had no say in the matter, and so we might as well make the best of it, you know.” The first part of this selection conveys staff’s realistic response to change – that is, “some anxiety and some concerns at times” – although the tone changes when she mentions “rolling with the punches” to something more indicative of a lack of voice in changes that are made. The end of the passage clarifies this point with respect to the hiring process. While hiring processes, particularly for supervisory staff may not be an area for providers to be involved, one gets the sense that many of the decisions and changes at this agency are handled this way. So providers adapt to a change, “make the best of it,” about which at first they may be deeply unhappy.

Similarly, another CMHO experienced changes brought about by having a new supervisor, and this full-time provider speaks more directly to the types of changes this brought on with respect to climate:

[T]here were just a lot of…things about like handing in all of your progress notes to them…letting I mean these are all sort of stupid examples, but… letting them know when you left the building, even if you were just like walking outside for just a few minutes, things like that that felt sort of micromanaging.

The hiring of a new supervisor brought on changes in everyday aspects of agency life, and the provider’s response to the tensions she feels between adapting to or resisting the change. She downplays the importance of the example – “I mean these are all sort of stupid examples” – which, perhaps, signifies the way administrators feel that changes in the more mundane aspects of the work should be taken. This dynamic potentially points
to another example for the examination of a parallel process; supervisors seem to expect providers to simply accept change *carte blanche*, and this may very well be indicative of a tension they are experiencing in response to upper management.

The statements of the aforementioned provider/administrator at Agency D serve to clarify the dynamics related to how staff members respond to change. She feels that staff respond “very well” to change and that “they are cooperative about it,” but that change is not handled well by the administration “because they jump too quickly”:

[T]hey expect the line workers, everyone in the front line to suddenly know how to make these changes with very little training, with very little information, and sometimes with absolutely no communication…[E]very time that CBH comes in and tells us that we need to be doing something differently on our treatment plans, when I go to my staff and say, ‘This needs to change,’ they’re cooperative about it. They don’t necessarily do it, (chuckle), but they’re cooperative about it. I mean, they try their best.

At least at this agency, the supervisor is sympathetic to the tensions providers experience (probably because she is a provider, as well), and she offers a clear picture of the expectations of administration regarding change. As surmised, administration seeks immediate action at the clinic level when changes are handed down; in this case, a new requirement from Community Behavioral Health (CBH). The supervisor experiences the stress and tension from the unrealistic expectations, and, in response, demands change from the providers, who seem to “cooperate” but really find ways to adapt and/or resist. The dynamics she describes are highly complex, and what her statements point to is that all levels of the organization are complicit; multiple triangulations between CBH,
administration, supervisors, and providers serve to create this pattern.

A full-time provider at Agency D offers a different picture of staff responses to change at the agency that seems to relate to staff who have been at the agency for a while:

Oh, they hate it (laughs)…they don’t react to change very well at all. All you have to do is initiate a new…billing system or a new payer in billing and you can identify how they react to change…I think sometimes perhaps the employees don’t have a great deal of faith in the fact that…the change is going to be permanent or better…Because they’ve had negative experiences with that in the past.

She points to staff hatred of and discomfort with change because they are afraid they will lose their jobs, and that this is elemental to human nature. One wonders what kind of change she is referring to, whether she has experienced this herself, and/or what kinds of messages staff have been getting from administration regarding. Additionally, she indicates that changes have come about, seemingly positive ones, but that they have not lasted. When changes are not sustained, staff become upset and, perhaps, cynical – that is, “employees don’t have a great deal of faith.”
Quantitative Findings

Incorporating quantitative data from the ORC scale from the sample of a combined total of 17 providers and outpatient directors at the four CMHOs offers an additional context for the qualitative data. While other subscales included on the charts below offer important data, the last six subscales relate to organizational climate – mission, cohesion, autonomy, communication, stress, openness to change. The final “subscale,” climate, is an aggregate score of all the climate subscales. Graph A provides a combined picture of the ORC data across the four CMHOs included in this study.
The 25<sup>th</sup> and 75<sup>th</sup> percentile scores (or norms) for the subscales are included for comparison and interpretation, and are based on more than 2,000 similar surveys conducted at other organizations (Simpson & Dansereau, 2007). Comparative percentile data was only available for 18 of 28 subscales, and is only included in Chart A due to the amount of data and the small sample size of each individual CMHO in Chart B. The neutral point of 30 is indicated on both charts so as to allow “organizations [to] evaluate their staff’s responses…in terms of how far they fall above or below 30 – the neutral point of neither agreement nor disagreement with the content of the scale” (p. 23).

Combined CMHO scores for cohesion (“work group trust and cooperation”) were rated considerably higher than the 25<sup>th</sup> percentile, while mission (“staff awareness of agency mission and clarity of it goals”), autonomy (“the freedom and latitude staff members have in doing their jobs”), and stress (“perceived strain, stress, and role overload” (Simpson et al., 2007, p. 22) were only slightly higher. Communication (“the adequacy of information networks to keep staff informed and the presence of bidirectional interactions with leadership”), and openness to change (“attitudes about agency openness and efforts in keeping up with changes that are needed”) (Simpson et al., 2007, p. 22) were ranked poor as indicated by their proximity to the 25<sup>th</sup> percentile.

While there are some high points in the data (cohesion), the indicators suggest problems for all of the CMHOs in the area of organizational climate. As stated earlier, the combined sample size is quite small, which poses some limitations, but the results seem to indicate some important parallels with the qualitative data.
Graph B examines the scores for each CMHO across all the ORC scales and, to reiterate, the last seven sub-scales in the line chart above are reflective of organizational climate. All of the respondents ranked the first three aspects of climate above the neutral point of agreement: mission, cohesion, and autonomy. While the qualitative data did not explicitly reflect mission as a theme, cohesion as a positive aspect of providers’ experience of working at the agencies became a theme with respect to collegiality. As well, all of the providers felt that autonomy was one of the positive aspects of the work.
Comparing scores of mission, cohesion, and autonomy with national norms, mission was only slightly above the 25\textsuperscript{th} percentile norms, reflecting a comparatively poor score, while cohesion and autonomy were ranked higher as they were closer to the 75\textsuperscript{th} percentile.

Whereas Agencies A, B, and D rated mission, cohesion, and autonomy higher than Agency C, the sample is too small to draw a true comparison between the agencies. Notably, two out of the five providers who completed the ORC scale at Agency C have been at the agency for one year and none of the providers have been there for more than four years, which may impact the sense of mission and cohesion at the agency. As well, a full-time provider at this agency reported low morale, high caseloads, little to no collaboration with other programs and/or psychiatrists, a lack of support, lack of resources, and a high rate of turnover, which perhaps conveys a stronger sense of dissatisfaction with the agency than the responses of other providers.

As for the lower score regarding autonomy at Agency C, this may be reflective of having more full-time providers who experience the problem of high caseloads. On the other hand, the autonomy sub-scale had a lower coefficient alpha reliability than the other sub-scales, at .56. As well, the challenge of such a small sample size is that one respondent’s scores can have a very strong effect on the aggregate, as was the case with autonomy, as well as the stress sub-scale.

Communication fell below 30 for three out of the four organizations. However, for Agency D, communication was above the 30 mark, which may be due to the engagement by the clinic director, who is also a provider, with the agency’s providers, and her understanding of and involvement in, as noted in the qualitative interviews,
improving agency processes. Whereas communication in Agencies A, B, and C were closer to the 25th percentile, Agency D’s communication score was right in the middle with respect to national percentiles, reflecting better, but still problematic, communication.

A strong explanation for why Agency C has such a high score for stress is the increased presence of full-time providers in the sample. As noted, full-time providers experience high caseloads, and have less flexibility schedule-wise, and so they experience a heavier burden of the workload. Agency C’s score was above the 75th percentile, indicating very high stress levels. The sample at Agency A also had a larger number of full-time providers, and so the score is reflective of this element, but it is still well below Agency C’s score and the 75th percentile.

All of the results for openness to change hovered around the 30 mark, and these scores were comparatively poor as indicated by their proximity to the 25th percentile of surveys conducted at similar organizations. In all, while the agencies registered a greater sense of cohesion and autonomy, other indicators suggest problems in the area of organizational climate. While these results are inconclusive, given the size of the sample at each agency, the scores agree what much of what was presented in the qualitative data, and they offer a promising beginning point to conduct further study.
Chapter V

Clients’ Perceptions of Climate and Services

Given providers’ mixed impressions and experiences, how do clients experience the organizational climate? Can a relationship be drawn between providers’ and clients’ experiences? The findings presented in this chapter paint a picture of clients’ impressions of the CMHOs and the services they receive. The first half of the chapter, on clients’ perception of the organizational climate, is divided into clients’ impressions of the agency, staff turnover, and the internal systems and physical spaces of the CMHOs. Clients’ perceptions of services are broken down into general impressions, helpful and unhelpful aspects of the services, and perceptions of medications, followed by a summary, as depicted in Figure 5.1.

Clients’ Perceptions of the Organizational Climate

While the concept of climate refers to an aggregate of affective experiences, usually those of the workers in an organization, clients’ views on organizational climate...
offer one way of examining whether tensions and conflicts among the staff of the agency trickle down to those receiving services. There is some difficulty in separating out the features of organizational climate and those of agency services because the service undergirds the agency’s purpose which is derived from community sanction. This purpose inheres in all aspects of an agency’s organization and activity. In a sense, there is a false dichotomy between these and other elements being discussed here. Like the systems concept of *holon*, the elements are both a part and a whole at the same time; separating the elements in this manner offers one way of looking at a highly complex picture.

**Impressions of the agency.** Clients were asked to respond to what it is like to receive mental health services at their respective CMHOs. While that question speaks both to climate and services, many clients responded more generally about the agencies themselves, which offers a sense of their overall feelings about the agencies. Their responses convey other experiences they have had at other agencies or in other types of therapeutic services, their level of loyalty and comfort, as well as their experiences with agency processes, like intake or interactions with front desk staff. Clients also spoke about how their experiences often changed to the positive after negative first impressions.

Client responses offer a variety of positive impressions with some mixed ones, as well. An African American female client in her mid-twenties at Agency A, who has been at the CMHO for 2-3 years for a serious mental health issue, responds to the way it compares to others where she’s received treatment: “I love it, it's great. It…came a long way…over the years. The buildin' is nice…the people are nice, yeah.. .I like it here
overall. I like it here.” The client’s general feeling about the agency is that, while it has not always been this way, it is a positive and pleasant to come for services.

At Agency B, a Caucasian male client in his late 50s suffering from chronic depression, who had previously been seeing therapists in private practice, offers a comparison of his experiences in his first year of treatment at the CMHO:

[I]t's institutional to be sure, as I said it's been a difficult transition fer me...I would say as an organization, this place is doing very well...for the most part I've seen it would be very helpful to the clients…Functional…Being in an institutional setting is something I'm not used to…y' have to go to the front desk, y' talk to the receptionist, and get a card…

While the “institutional” feel he gets seems to speak more to the nature of public community mental health services in general than this particular CMHO, he does provide a fascinating counterpoint to what clients experience in private practice. He indicates the difficulty of coming into an “impersonal” environment and the frustration he felt at first at the seemingly bureaucratic processes. This speaks to the sense of individual attention, perhaps, feeling valued for his uniqueness, that he was experiencing in private practice. Despite the adjustment to a public setting and to the need to have different expectations, he seems pleased with the agency, and interestingly, steers away from the word “institutional” to a more positive one, “functional,” seeing treatment at this CMHO as something that fulfills a current need.

Another Caucasian male in his late 20s, who has been coming to Agency B for just under a year with issues related to depression and recovery from alcohol dependence, discusses his positive feelings toward the agency and one of its staff member’s
(presumably, business office staff) proficient ability to handle an issue related to his insurance:

[I] have nothing bad to say about it…Well...'cause I can't remember what her position is, but [Name] I think it is...She was very helpful 'cause I had if I'm on Medicaid and like I made the appointment, and they cut it off without tellin' me for some reason, and she was really helpful with... like kinda encouragin' me to stick with it and follow through and I think she had the doctor fill out like medical necessity…paperwork.

At the end of this statement, he comments on his experience with his initial intake that left a different impression on him: “…the young woman that did it seemed very nice and it went fine but then at my first therapy session, my therapist had this information that was incorrect…but we were able…to clear that up.” So the client feels supported by the agency and encouraged to not give up on treatment, despite a frustrating challenge, like having his insurance cut off by public welfare. On another note, he seemed to feel discouraged at first by a mix-up at intake, which involved being misdiagnosed for alcohol dependence when he had already been in recovery for some time. Notwithstanding these difficulties with flawed processes in his initial encounters at the agency, he states later that he looks forward to coming to weekly therapy.

In all three of these cases, clients’ initial experiences with the organization were challenges that they overcame. The female client at Agency A referred to the fact that it had “come a long way.” At Agency B, the Caucasian male client in his late 50s indicated a struggle with the “institutional” quality of the agency and the need to adjust his expectations. The younger male client at Agency B referred to the obstacles he faced at
the outset. All of them stuck with the services, however, and found that they were able to
get past the problems. Initial impressions seem quite important, particularly in cases
where clients may be resistant to coming to treatment for a variety of reasons.

Other positive impressions are offered at Agency C and Agency D. An African
American male client in his 50s at Agency C, who has been coming for over five years
for issues related to a chronic serious mental illness, discusses his experiences of
receiving mental health services at the agency: “I have a good discussion, and it’s
like…you’re talkin’ to a family member…it’s very enlightening and…you get to
understand your…mental illness better, and…you…have a sense of you belong to
something because you come here.” These reflections convey the client’s feelings about
the services and the organizational climate. In both cases, he indicates a feeling of being
welcomed by the agency. This client also spoke at length about his feelings of loneliness,
so his sense of belonging is a powerful one for him. Other clients speak equally positively
regarding their experiences at Agency C. One African American woman in her early 40s
states: “Well this agency, I wouldn't trade it for nothin' in the world. I love these people
in here. They really helpful.”

Clients’ responses to questions about Agency D reflect equally positive reviews.
One Caucasian woman in her mid-50s with serious mental illness related to grief and loss
issues, who is also homeless, offers this statement: “I don' think it could improve any
gooder than what it is…But then…this is the first in my whole life…If you got a
problem, they'll bend over backwards tryin' t' help you solve it…” Although she has not
had the opportunity to see other CMHOs, her impressions are altogether positive.
Another interesting aspect of this client’s account is that her children have repeatedly tried to get her to go to the CMHO where they go, but she feels very loyal to Agency D: “But I don' wanu...I figure I'm not gonna transfer. I got [name of therapist]. I'm not transf'n her, I'm not leavin'. I know when I got a good thing.” So in spite of her children’s insistence, she feels comfortable, safe, and secure at Agency D. She also feels very connected to the staff of the agency, as she states: “I know the guard downstairs. I met 'im every.. I meet 'im every week when I'm s'posed to at the appointments.” What this client and the other clients point to is the importance of feeling a connection to the agency, especially for those who may lack other supports (family, social, service-related) in their communities.

An African American male client in his 20s, who has had a history or child abuse and has been in drug and alcohol recovery, offers his impressions of Agency D:

It's helpful…it's a pleasure when you can come and…to talk about what'chou…these people here have yer best interest.. what's goin' on wit'chou. E'rybody don't ha' yer bes' interest….I feel comf'table comin' here and talkin' to 'em cause I ain't go'a worry about it goin’.. outside this room. So it's very helpful to my recovery.

The client has had problems in the past (perhaps, at other CMHOs and elsewhere) of people not having his best interests in mind, so the sense of respect that he has from the staff is a critical point. Equally important is his sense that things are kept confidential at the agency, and this helps him feel comfortable and able to open up, particularly in regard to his recovery.
An African American female client in her mid-40s, who has been at Agency C for a number of years, points to her experiences of being judged based on staff and client attitudes related to having a diagnosed mental illness:

[When I first came here I was a mess. I had no voice, no desire to talk, and I didn’t want to be here so I didn’t apply myself. And so because of the way I presented myself in the beginning as I started to grow and develop, some of the staff members…kinda frowned upon it because they I think they felt that I was…Maybe they were so used to people comin’ in here actin’ a certain way just to get outta the program…but really maskin’ their feelins and the way they really felt. So I was…different and new to them because…I grasped my recovery and realized my potential really fast…

While she currently has positive impressions of the agency, she calls attention to the importance of staff attitudes towards clients and how this may impact clients’ affective experience of the agency. Not feeling like she had a voice, not feeling accepted, and having the sense that perhaps staff and clients were not really being honest about their true feelings, this statement speaks broadly about the stigma of mental illness, the ways in which a social problem like stigmatization can be replicated in a CMHO, and whether/how clients in general can sense it.

**Turnover of staff.** Another climate issue with which clients struggle that strongly parallels that of providers is turnover. Providers expressed their concerns with respect to turnover as a frustrating aspect of their employment. While clients in general are unhappy about having to change providers, unless it is one with whom they do not connect, one Caucasian male client in his 60s, who is homeless and struggles with symptoms of
bipolar disorder, describes in detail his negative feelings about having to change therapists at Agency D:

[T]o start to go back to childhood and then discuss very emotional issues with a new person to so to speak get up to speed on a continuing basis for like a year, in other words a new therapist once a year, once every 14 months is uh the least…is my biggest problem.

The frequency of change to a new therapist, as well as the issue of opening up and sharing his problems with therapists who turn over almost yearly, bother him greatly. Later in the interview, he discusses the tremendous impact of the therapeutic relationship, and how turnover “exacerbates” his anxiety problems and “neutralizes” the progress he has made. The sample size of providers at this agency was too small to get a true sense of whether providers see turnover as a major problem at this agency. Given the rate of turnover he has experienced, will this client ever have a sustained relationship and process with a therapist in which he is able to work through his issues? Again, one can see one of the many challenges clients face in attaining their goals.

An African American female client in her mid-40s, who receives her services at Agency A, discusses her experience of not having seen a psychiatrist a long time:

It's kinda hard. Cause you need someone to see who you know…giving you medicine and stuff….Sometimes I can talk to the doctuh bettu than I can talk to my therapist…the last doctuh I had…me and her use t' talk f' hours…but I don't know nutin' 'bout this one cause I ain't nevuh seen 'er.

Despite that the client has not see her psychiatrist, he or she still writes the client a script for medications, which raises a host of issues related to ethics and liability. While it is
unclear exactly why she has not seen the psychiatrist and why she is still receiving medications, the situation points to questions related to the role of psychiatry in the broader mental health system.

**Internal systems and physical space.** Client impressions of the internal systems and the physical space – public and work spaces – offer another window into organizational climate. While general statements may be made about all of the agencies, data from Agencies A and B comprise this section as they offer the richest material. To offer a fuller picture of these two elements of climate and to give client perceptions a broader context, provider perspectives and this researcher’s impressions are included.

Two FFS providers at Agency A express their dismay over problems occurring at the reception desk. The first provider identifies communication with the front desk staff as a major issue, particularly around not being notified by them that a client has arrived for their appointment: “…we’ve had some bumps at the reception desk. You know, setting appointments and greeting clients….And that’s not always consistent. Sometimes you have to come out and search for your client.” The provider sees the frustration of the front desk staff and recognizes that they are overwhelmed by virtue of the physical space and the clients: “…they’re the front line, so people are coming off the elevator and they’re being bombarded.” She eventually expresses the wish that whoever is supervising the staff would come up with a better system.

The other FFS provider at Agency A turns the problem at the front desk into an issue of client services: “…the support staff…is not as good at the front desk…So, that produces some anxiety for me for my clients, because they’re not treated that well, when they come in, you know, and there’s a lack of advocacy…so that stresses me.” Her
statement has multiple implications, highlighting the way in which the front desk fits into the broader organization as a client serving system. Speaking of front desk staff as “support staff” versus “receptionist” or even “front desk staff” conveys the idea that they are responsible for an aspect of the service; that of greeting, welcoming, and attending to client needs. Her use of the word “advocacy” emphasizes this notion of front desk staff as service providers. While there are aspects of front desk work that are related to advocacy, one might question whether advocacy is the correct term, or whether the provider is framing it this way as a suggestion to the staff in those positions and their supervisor. Is this an unrealistic expectation, or might it offer a reasonable first step as to how to help front desk staff (support staff) see their jobs as integral to the agency’s services.

At all of the agencies, clients spoke positively about the waiting area and interactions with reception staff, at two of the agencies. On the other hand, a small number of clients at Agencies A and B gave mixed reviews. In this excerpt, a Hispanic woman in her 60s who suffers from chronic depression at Agency A, discusses a problem with the television in the waiting area:

[A] lotta people...that come here, they don't complain...they sit there, and watch Dr. Phil and then they're gonna hear to you know their real their therapist...If they're comin' here to see their therapist, why would you watch Dr. Phil and create more problems?

The waiting room in this particular agency has a large screen TV installed in a top corner, and it was loud and distracting at times. The TV was tuned to Dr. Phil, Maury Povich, Judge Mathis, and others, and there is some question about the appropriateness of these shows, much less any TV. If a show has the potential to be offensive to, upsetting, or
irritating, to clients, it may be an area that CMHOs have to look at closely. The client’s impression is that others at the agency do not complain about the problem, but she has the feeling that others share in her irritation.

The waiting area in Agency A is somewhat narrow, and there is no barrier except a high desk separating the waiting area from the front desk area. As in all of the agencies, front desk staff hold many responsibilities, including responding to and directing clients who come in for their appointments, fielding and making phone calls, paging staff, handling client paperwork, being a resource for information, and other tasks. With competition from the TV at Agency A and with, at times, loud conversations in the waiting area, the staff would often get loud and the talk would sometimes veer toward personal conversations. An African American female client at Agency A spoke about the “loud talking” and “private conversations,” and the need for greater “professionalism” on the part of front desk staff. At times, client names and client issues – related to medications or other issues – were audible to others in the waiting area. Without any partition between the front desk and the clients, one has to wonder what front desk staff can do to protect confidentiality. On the other hand, this same client and a variety of other clients indicate that staff are helpful in directing calls, rescheduling appointments, and managing other tasks.

Another concern at Agency A experienced first-hand by this researcher was the disruptiveness of the overhead paging system. While conducting client interviews, there were frequent and loud interruptions from the overhead paging system that is connected to the phone system. While there may have been a way to shut off the sound of the
paging system, clients and providers both mentioned this issue, so it may be a training issue and/or a question of what people get used to at the agency.

At Agency B, a glass partition separates the front desk/reception area from the waiting area, which keeps things quieter and more private. However, there seem to be fewer numbers of clients coming in and sitting in the waiting area, so the potential for noise is considerably less. While there is no TV, there was a radio, which at times seems a bit loud, and the reception staff tune it to the station of their choosing. While not unpleasant, one wonders about differing musical tastes and the sometimes evocative nature of music. Clients from Agency B who were interviewed like the sense of privacy afforded them by the partition, but one client felt the staff there was a bit “standoffish” and unpleasant and relates this behavior to staff’s response to challenging clients. As the Caucasian male client in his 60s mentioned earlier states:

[S]ometimes people walk in the door drunk outta their fuckin' minds…or just hangin' out and they're ill. It's a partial hospital in the lobby out there. I kinda been catchin' on…it's kinda hard fer him to differentiate... At least, fer the most part, they're really pleasant…

What emerges in this excerpt is a tension related to the client’s expectation that front desk staff be a bit warmer and personable with the challenges the staff face in meeting the needs of clients who may present challenges at times.

This researcher also experienced the abruptness of the reception staff, and it led to questions with respect to the front desk in general and whether this was how clients were greeted as well. The obvious question here is whether the reception staff can find a better balance so that clients feel welcomed, as well as know their boundaries.
Clients’ Perceptions of Services

Having a sense of what the organizational climates of the four CMHOs look like from the clients’ perspective, this section of the study examines the way clients perceive the services they are receiving at the CMHOs. It begins with clients’ general impressions and then addresses helpful and unhelpful aspects of the services and medication, and ends with a summary. As one study (Morris et al., 2007) that looked at the impact of organizational factors on client outcomes at 14 CMHOs in Colorado found, organizational factors were associated with improvements in clients’ perceptions of their physical and mental health status, but not with improvements in quality of life. There is some question as to the importance and validity (in a general sense) of perceptions with regard to services. Do positive and/or negative perceptions of services reflect something about outcomes, as well? What do providers’ perceptions of the service say about their expectations, and are organizations responding appropriately and effectively to those expectations?

General impressions. Clients were initially asked in general what is it like to receive mental health services at the CMHO where they are getting services. The responses are mainly positive and offer some interesting insights, as this African American female client in her mid-30s, who has been coming to Agency A for three months, reveals:

I'm starting to feel it out because…I'm not really here enough…I can see me gettin’ …some good help...I have a better feel…than I've had at other places…from what I get so far whenever I come in here I feel a good vibe…I feel
cleansingness and I don't feel like they treat you like…they don't care, or they just doin' their job.

Perhaps, this excerpt reveals something both about the service and about the organizational climate. The client has a good feeling about the agency and the services and feels hopeful about her treatment. Clients can, of course, have different views of the services based on a number of factors, and in this case, the client has only been at the agency a short time and has seemingly had positive initial experiences.

On the other hand, the client above has not seen her psychiatrist, yet, and she feels like her problems have been deteriorating. Her sense is that she has not had a psychiatry appointment because the agency is too busy and that other clients have problems that need to be addressed, seemingly feeling guilty for wanting the service. The sense is that the “neglectful” response from the agency is resulting in her taking responsibility on herself for an agency process. This client may not be telling the whole story, but her expectations for the service seem quite low and they may be based on neglectful and/or negative experiences she has had at other agencies.

Another client (African American female in her mid-20s), who has been coming to Agency A for two-and-a-half years, refers to the relationship she has with her therapist and doctor: “It's great…I had to change therapists since I been here...so we have a very very close relationship, and…she's good to talk to and…the doctor I see he's very good.” The client highlights her relationship with the therapist and the closeness she feels with him/her, which speaks compellingly about the power of the therapeutic alliance. Looking at the factor of length of treatment, it is unclear how long she has been with this particular therapist, but one would guess that it is a connection developed over a time.
Clients at Agency B have more mixed reviews of the services. In this interview with a Caucasian male in his mid-30s, who has been attending services for close to 10 years, he expresses a positive view of the services: “It's...a nice atmosphere...The people are very friendly. Very professional, and...I enjoy comin' here...It's a pleasant experience.” The connection between climate and services emerges, again, in these statements. While positive, his response seems somewhat unremarkable, particularly his use of the words “nice,” “friendly,” “pleasant.” Another client at Agency B (a Caucasian male in his late 50s mentioned earlier) who has been coming for approximately three months, compares his experience at the CMHO with private practice:

[I]t's been a difficult transition...My private therapists...all of them were therapeutic... The person I see here now is a good therapist.. but I really need to be self-directive otherwise I'm doin' the therapy...But he's good for me in another way because he's older he has a strong personality...I'm stayin' with this guy.

The client expresses the tensions he has felt in his expectations of the services since coming to the agency: private versus public, therapeutic versus unknown, and therapist directed versus self-directed. Initially, he seems to indicate that he is not deriving benefits from the treatment, but speaks positively at the end of the statement regarding his provider’s personality and, perhaps, the relationship he is forming.

Another client (Caucasian female in her early 40s), who has been coming to Agency B for about two-and-a-half years, speaks to her experience:

It's really good. I don't feel weird or like I'm...labeled as...a crazy person... I know when I come here it's confidential and I...sign in, it's a closed book...you just have that sheet that has yer name on it and there's nobody else like there like
there's none of the names on there so y' don't get..think y'know who else is comin'…[I]t's very private and… it just helps me…comprehend…things when I come in.

The client has a very positive take on the agency, which is particularly interesting, given the problems a client and this researcher were having with the somewhat off-putting behavior of front desk staff. Her feeling about the interface with the front desk is one of safety and security. Critically important, as well, is her feeling that she does not feel labeled by the agency, which goes against the sense of this researcher that front desk staff were ambivalent towards clients with mental illness and/or related disorders.

Clients at Agency C express positive feelings towards services there. As this African American female in her mid-40s, who has been in outpatient services for approximately a year, attests:

[This] has been positive/rewarding experience for me because I’m a person that for years was ashamed, embarrassed and stigmatized by the fact that I am a person with mental illness, and…I have learned very valuable things about mental illness and that has changed my perspective on life.

As mentioned earlier, this client spoke strongly about her negative experiences with staff and other clients regarding stigma in the partial program at this agency, so her perceptions have undergone a complete turnaround. The “transformation” within herself occurred over many years (approximately 15), and one wonders whether her earlier experiences held her back from making changes, whether her length of treatment could have been considerably shorter. Nonetheless, her statements indicate a very positive outcome that she attributes partially to the agency. Other clients at Agency C seem to
have similarly upbeat comments to make about the helpfulness of the services: “It's pretty good. The people are nice and down to earth. Give you good advice…I like it here…You get a lotta help.”

Clients at Agency D have equally positive things to say about the agency services. A Caucasian male in his 60s, who has been coming to Agency D for about seven years, feels the outpatient program is “very accommodating.” For one homeless, Caucasian woman in her mid-50s, who has been coming to the agency for around two years (her first experience with any therapy), the services have been particularly helpful following the death of her husband:

[W]idout [husband’s name] like I was like devastated. I didn't know where to turn. But when I come in, I sit down and I talk to [name]. And like she helps me figure things out so I c’n understand what I'm doin' and how to go about doin' things.

This client’s experience is indicative of the helpfulness of the agency’s service in meeting the needs of a someone experiencing tremendous grief and loss issues. Her day to day needs appear to be met by the therapist, as well, which seems of particular importance given the chaos she experiences following the loss of her spouse.

Many of the clients mentioned above have been receiving services for considerable periods of time, and a smaller number have been coming for only a few months. The sense so far is that clients in the interview sample feel a connection to the CMHOs where they are receiving services and feel they have strong and promising relationships with their therapists. This statement raises the point, again, about the experiences of clients who have chosen to leave the agencies, and what led to that
decision. While some clients spoke about the experiences at other agencies and with other therapists that caused them to leave, the sample is not representative enough, nor is it necessarily reflective of clients who leave services, to truly make any kind of general statement. Some reasons that clients mentioned for leaving services elsewhere are as follows: feeling frustrated with agencies’ processes with respect to how calls were handled by the front desk, scheduling issues, having difficulties with providers around styles or approaches to therapy, and having conflicts with psychiatrists or other staff; life situations changed – they decided to return to school, they found work, they moved or became homeless; they went into the hospital for psychiatric and/or physical problems; they got involved with drugs and/or alcohol; and many other possible scenarios.

Nevertheless, the clients interviewed for this research were generally those who are motivated to come to therapy and, perhaps, trust (to varying degrees) themselves and their therapists to at least begin to open up about potentially painful issues.

The discussion above raises a number of critical points, as well, about specific clinical issues, with respect to clients’ motivation and hopefulness, their ability to feel worthy of forming a trusting and healthy relationship, their ability to sustain a relationship, their comfort level at the agency, and a variety of other factors that may be reflective of where clients are in their respective processes. Looking at this from another angle, one might argue that some clients who have been coming for a certain length of time have developed an unhealthy dependency on, or loyalty to, the agency and/or provider. In either case, the clients in this research generally have positive feelings towards the agencies where they are now receiving services.
Helpful and unhelpful aspects of services. Now that some of the clients’ general feelings about the agency services have been spelled out, the next step is to look at clients’ perceptions of helpful and/or unhelpful aspects of the agencies services. Helpful aspects are considered first.

An African American female in her 40s at Agency A, who has been coming to services for approximately one year, reflects on what has been helpful to her in her interaction with the therapist: “Talking. To have somebody to talk to.” Later in the interview she explains further: “ Cause they talk back… like when I ask them something, they respond. Instead of lookin' at me and my face… When somebody else here give feedback about what I'm talkin' about.” The client appreciates her provider’s therapeutic style because he/she seems to be actively responding during session. This client spoke about a previous experience with a therapist who just sat there and did not respond, and the irritation this caused her. So the active verbal style of her current therapist seems to really work for her.

Another client (African American female in her mid-30s at Agency A), who has been at the agency for about three months, appreciates the way her therapist is structuring her treatment: “They work out… a plan... a regimen... to see… what we can come up with that would help me stabilize my situation. And come up wit tools to help me whenever I go through my mood swings or to balance.” This client discussed having bipolar disorder, a history of “nervous breakdowns,” and a series of accidents that seem to have triggered fears of going outside and being in crowds. While she has not yet felt stabilized, she is pleased with her therapist’s approach to her situation.
A Caucasian male client in his 30s at Agency B, who was mentioned earlier, came to work on problems related to social phobia, obsessive compulsive behaviors, and panic attacks. He reflects on the “interaction with my therapist” and “the insight” he gains from the therapy: “I really don't have a lot of people to talk to in my life about…my issues or…whatever's happening with me. I mean therapy should be about goals, change, things like that…they tell you that here.” Later in the interview, he discusses more detailed aspects of his treatment:

I've seen...many therapists here…They're good listeners…They try t' problem solve... I'm not big on goals, or goal-setting, or problem solving…[S]ometimes coping techniques…how to deal with the anxiety….breathe deep…deep breaths. In addition to those already mentioned, the client is able to identify some of the main elements of his therapy: goal setting, listening, problem solving, and coping strategies to reduce stress and anxiety. The different aspects of his treatment seem to be a hodgepodge of different therapeutic modalities (what seems like insight-oriented, problem solving, and cognitive behavioral approaches). Since this is only a one-time interview, the client’s presenting problems may be just the tip of the iceberg, but given that he has been coming for services for around ten years, it is interesting to hear that he is “not big on goals…or problem solving.” One gets the sense that he has become complacent after having tried and failed to make changes.

One might look at whether this client’s treatment reflects an unhealthy dependency on the organization, and examine what roles he and the agency play in creating this problem, especially because he expressed motivation to get better. Another possibility may be that he has had so many different therapists that he has never really
been able to fully address his problems, which may also explain why he is “not big on goals” and why he does not convey a clear sense of the therapeutic modality his provider is using. For a client who has tremendous difficulty negotiating social relationships, one has to wonder about the possibly fragmenting impact of provider turnover on the overall course of his treatment and his psyche.

The Caucasian male client in his late 50s at Agency B who struggles with chronic depression and issues related to the aging process mentioned earlier as having had prior treatment in private practice, describes his view of the services he receives: “[H]aving a structured time to come and talk to somebody weekly is a good deal... It's a safe environment...I do feel heard…although... and I almost quit this particular guy over this.. it's a bit…matter-of-fact.” The client feels able to advocate for himself if he needs to, but he does feel the style of the therapist is “real casual” and “anything but therapeutic.” On the other hand, he seems to have come to terms with the therapist’s style, recognizing that he is stabilized and that the sessions may actually be benefitting him. He also enjoys being able to consistently come every week, the structure of having a time for sessions, the feelings of safety he experiences, and reflects on the therapist’s sense of humor and unpretentiousness.

Again, the perceptions of the client above indicate some of the tensions he is experiencing at the agency, especially given the “personalized” services he was getting with private practitioners. He describes his experiences with the psychiatrist, whom he sees for “eight minutes” at a time, as “perfunctory”: “He's like…'So how you doin'. Oh that's good that's good. Okay, let's go. Here's your script.'” The tension are present, again, because of conflicting expectations about norms of treatment: he wants more time, but
recognizes that “I don’t really need it to be any more than that.” One wonders about the effects on the client’s psyche of the stress caused by these competing expectations, and how this impacts the overall service. This appears to be an important issue to work through with his therapist. In looking at whether this client has noticed any changes in his problems, he reports that he has gained greater acceptance of the aging process. Perhaps, his strongest statement of this positive transition is as follows: “I'm tryin' to get active…tryin' different ways, tryin'a live the open hand way, as the Buddha would say.” So despite all of his struggles with the shift from private practice, he has found value in the service.

Perhaps, the Caucasian female client in her 40s, who has been coming to Agency B for over two years to get help with anger and mania issues associated with bipolar disorder, offers the clearest picture at this agency of what her therapist does that is helpful:

[C]oming every week fer me is very helpful…[My therapist has] looked at every situation as an outsider, so she can say, 'Well…have y' thought about this?' Or 'Have y' thought about that?' And she actually…has opened up my own thinkin' to…a broader perspective to understand there's other…outcomes…that maybe I just don't have one outcome she can think of 2 and 3 and 4 outcomes, and she helps me figure out things in my daily life.

The therapist is providing the client some form of cognitive and/or cognitive behavioral strategies to assist her in managing every day issues that can easily agitate the client. Helping her to begin to think differently seems to be having a strong effect on the client, although one wonders whether the therapist is offering the client alternative explanations.
or perspectives on her problems, and/or whether she is helping the client to develop the ability to consider other possibilities on her own. On another note, this client has had the advantage of finding both a therapist and psychiatrist with whom she has been able to stay for the entire length of treatment, which she clearly states has been one of the most positive aspects of her treatment.

Another client at the agency (Caucasian male in his late 20s) who has been coming to Agency B for close to a year for depression and issues related to recovery from drug and alcohol dependence has found that the services have been effective for him, despite an initial problem with his intake. He seems to enjoy his therapy sessions in which he has found useful strategies through cognitive techniques to identify and recognize triggers and develop different reactions to them. He offers a particularly clear statement of his therapist’s cognitive approach:

To identify…if I do catch myself in that mood or if I'm sorta not wanting to deal with anything just wantin' to be left alone...Y'know she's asked me to just really be aware 'a that, and write down what may be going on or what may have happened that day that could trigger it…She's talked about um.. developing some ways to..sort of identify…a trigger so that if I see a situation arising, I'd be able to…change my thought pattern…I think identification of moods and feelings has been really helpful.

He has also found that regular appointments with the psychiatrist and a medication regimen have been particularly useful: “I see a psychiatrist every 5 weeks or 6 weeks, which through experience I've learned that I need to be on anti-depressants er else sooner er later I'll have a bad episode.”
An African American client in his 50s at Agency C who is receiving long-term help at the CMHO for a severe and persistent mental illness offers a glimpse of what his provider in a recovery-oriented program at the agency does that is helpful. They discuss what the client does in his “spare time”: “I read and I…paint… artist’s paintings…I discuss them with the…therapist…We talk about my family and friends…my support systems.” The client feels that the support and understanding he gets in the interaction with his therapist gives him the motivation he needs and allows him to better negotiate his relationships with his sources of support. He seems to speak generally about the services, not getting into what his therapist does that is helpful, except in a passive way.

Later in the interview, the client above discusses his provider, “He can correct mistakes in your thinking,” which expresses, again, the passivity in the relationship and in the work of therapy. This client states that the things he would like to accomplish in treatment are, “to be a recuperated citizen,” “to be a better citizen,” which offers a fascinating of looking at the service in general. Framing his goals and expectations in these terms gives goals of treatment new meaning, and the services seem to be geared toward helping him see his problems differently so that he can meet these goals.

An African American female in her mid-40s with trauma-related issues mentioned earlier, a client at Agency C, provides another clear picture of a cognitive behavioral approach her therapist is providing that is helpful to her in her marriage:

I was havin’ problems…with my husband, and…I was ready to end my marriage…[S]he gave me some suggestions such as…not bein’ too hard on my husband for his beliefs and for his way of thinkin,’ but to realize that we’re two separate individuals and relationships take a lot of work.
She describes how her therapist had her make list of pros and cons and examine these together, and that this was an effective means of addressing the issue. So the therapist has been helpful to her in identifying and examining her automatic thoughts and core beliefs, and in finding creative ways to cope better with her relationships and other areas of her life. As a result of the positive changes that have come about through treatment and education, this client has achieved her goals of getting married and working part-time while attending college. The educational component speaks to the need for learning to occur with respect to mental health diagnosis and, perhaps, recovery. Whether clients are ready for different types of learning is a critical aspect to consider.

An African American woman in her mid-40s who has been coming to Agency D for four years following the loss of her grandmother several years prior reflects on the aspects of her experience that have been helpful to her. She said, “[T]alking…over with my therapist about my problems openly and not holdin' everything in. Bein' open.” The client recognizes the importance of her role in the therapy and the need for her to open up. Later, she discusses what the therapist does that is helpful:

Encouragement and prayer. Those are the most two that are healthy with me with [therapist's name]…She… talks to me about the positive…things like…try not to worry and to hold things in and… just give it to God and leave it there about my problems and situations…Don't keep dwelling back on what happened in the past and present just pray about it and leave it there cause if I don't it'll stir up my anxiety.

The client’s provider seems to be helping her tap into spiritual aspects of herself that aid her in transcending her problems, and she feels the service has helped with her anxiety,
particularly with panic attacks, although this could be related to medication. What started off as an interview with a client who generally likes her treatment, however, concluded with a more mixed impression. She particularly misses her previous therapist who seems to have offered her something more concrete, but an insurance issue prevented her from being able to continue with him. This client expressed a desire for more supports from her provider outside of sessions, and to be involved with group therapy, so there is some question about whether her current therapist is helping her enough with respect to how to manage her struggles outside of the sessions.

An African American male client in his 20s, who has a history of child abuse, drug and alcohol issues, and a diagnosis of bipolar disorder, offers this impression of what his provider does that helps him the most: “Comfort. [I]t helps me to understand my sickness and what I'm goin' through… medication they give me. Just teachin' me a lot about my you know my mental…A lotta stuff I ain't know I'n understand 'til I got'ere.” The client sees the value in the service in learning about his mental health issues and in taking the medication. Looking over the rest of the interview, the client is pleased with his treatment and seems confident in the skills and abilities of his treatment providers to help him “get well.” He sees self-motivation and a desire to improve as major components of his treatment.

**Medication.** Another related topic with respect to services is that of medication. Many clients in the interviews spoke about the effectiveness of medication, while a very small number spoke about negative responses. A Caucasian client in his 60s mentioned earlier, who has been coming to Agency D for about seven years for reasons related to an accident, loss of insurance, homelessness, anxiety, and bipolar disorder, was initially
averse to medications, but found that getting on the right medications, followed by the experience of being diagnosed initially by another system, has been an very helpful aspect of his treatment, although it took some convincing. The medications have given him the ability “to function” with other people and be more accepting of living in a fast-paced urban environment. He attributes this change mainly to the medications.

The client above has also found the combination of medications and therapy to be helpful, despite having been through several therapists: “…whether their style and my personality enabled me to…speak openly…the medication and a good…therapist that I seem to meld with… is what helps.” Along with having the right “fit” with a therapist, he goes on to reflect on what his treatment providers have done that has helped him the most:

Well, the people that I have…are kind. They're…caring...they're...sincere, they're hardworking, and they're they give me a feeling that they...that they care about my well-being…I feel that they really sincerely have my best interest and my well-being at heart.

The client’s focus is not on anything that speaks to a therapeutic modality (maybe, support and understanding), but his statements express fundamental attributes of interactions with any helping professional: wanting to feel that providers are caring and compassionate. Interestingly, and while reflective of a different type of relationship, his views on the services parallel providers’ desires to feel valued by administrators.

Summary of client responses. Reviewing the various responses to what has been the most helpful to them in their treatment, clients did not necessarily direct their comments to a particular therapeutic modality, although in some cases they did point to
elements of cognitive and/or cognitive behavioral, behavioral, supportive, and psychodynamic approaches. Rather, the responses range from providers helping clients with more practical issues to helping them address underlying and/or intrapsychic problems. Often it seems that providers are helping the client to work on both elements at the same time, while remaining focused on a particular area.

Interviews with providers convey their understanding of the multiple challenges and the seemingly insurmountable obstacles that clients face in accessing basic needs. All of the clients seem to express a need to work on problems in their social relationships and in their interactions with other social institutions. While some speak about wanting to address a particular diagnostic issue, such as bipolar disorder, or about an underlying trauma, all of the clients speak to these problems with respect to how they are affecting their interactions in the social environment. Given the critical significance of their social interactions, the implications for the kinds of relationships they have with their providers and CMHOs, as a model for their interactions with others, are tremendous, and this brings the discussion back to attributes of the organization, particularly organizational climate.
Chapter VI

Discussion and Conclusions

This chapter offers an integration of the findings as they relate to the research questions and theories provided in Chapter I and II, and a final synthesis of the overall study. Discussions of the first and second research questions are provided in succession, whereas discussion of the final research question regarding parallel processes occurring on the levels of providers and clients with respect to climate and services will be woven throughout, as part of an overall synthesizing concept. Because it is abstract and has broad applicability, the concept of parallel process is used in an interpretive manner.

As this study reflects, a number of themes were developed with respect to the research questions. Themes related to the organizational climate, described as the affective impact of the work environment on an individual employee’s well-being that is agreed upon by employees, were developed through the interviews with providers. While this study cannot confirm the statement that Glisson (2000) and many other researchers (Glisson & Durrick, 1988; Glisson & Hemmelgarn, 1998; Hemmelgarn, Glisson & Dukes, 2001) suggest, that providers who are demoralized are unlikely to develop and sustain effective relationships with clients and other stakeholders that are essential to integrated service delivery and quality care, the findings provided here on providers and clients may offer some clues to those dynamics at the four CMHOs.

Providers’ and Clients’ Perceptions of the Organizational Climate

Providers generally feel undervalued by the CMHOs in which they work as a function of aspects of their employment, their experiences of working at the agencies, their perceptions of administration, and their responses to agency processes and to change.
within the agency. These themes reveal provider dissatisfaction over inadequate compensation, differences in work status (FFS versus full-time), lack of clinical supervision, inadequate professional development, frequent staff turnover, and lack of deliberative processes in decision-making. What seems to be implied by the FFS/high no-show rate tie-in is that FFS providers may feel more responsible for whether or not a client shows up than they would if they were not directly affected financially. One wonders whether this creates an incentive for providers to step out of their role in sustaining a therapeutic process to one of being more focused on productivity and income. Given the implications of “unproductive” time, the FFS provider and providers in general must find ways to negotiate this difficult balance.

In either case, there seems to be confusion regarding the possibilities around FFS all around, and this may be because in a Bourdieusian sense, the FFS model is part of the doxa of CMHOs - an accepted and taken for granted "subtext" that is an integral, yet obscure, part of their everyday existence (Fram, 2004). Staff and agencies have a difficult time challenging it and/or seeing through its presumed complexity; as one provider states, “there’s no way that makes sense for them,” and, “they haven’t figured it out.”

Bourdieu also introduced the term, heterodoxy, to represent a “disagreement” with mainstream assumptions about the way things in society should be (Fram, 2004, p. 566). Domination as doxa involves a framework where domination is practiced “so subtly that it cannot be questioned” (p. 566). When domination is questioned, “generally through crisis,” the result is heterodoxy. In a sense, providers’ responses to these negative experiences at the CMHOs were marked by a heterodoxic pattern noted in a study (Ware et al., 2000) of clinicians’ responses to managed care: adaptation and resistance. What
emerged, here, was a combined response; that providers seemed to adapt or “cooperate” as one administrator/provider indicated, but really this pattern reflected a sense of passive resistance, not full cooperation. This suggests that providers either do not feel free to fully express their concerns to their supervisors, and/or that they are just finding a way to cope with a bad situation by knuckling under. The concern is that these behaviors may result in burnout.

At the same time, providers felt supported by healthy collegial relationships, autonomy in their relationships with managers, and flexibility (for FFS providers) in their work schedules. While this second set of themes speaks to positive aspects of the work environment, the negative aspects were notable as well. This was particularly true when the problem of turnover marred healthy collegial connections, when autonomy led to feelings of neglect, or when flexibility in work schedule expressed ambivalence on the part of managers toward underpaid and underappreciated staff. Perhaps because providers generally do not receive the kind of clinical supervision they would like, they rely largely on each other for clinical and/or other unmet needs.

When collegiality is a positive attribute of the CMHO, providers find it both helpful and available. One has to wonder whether peer support is also beneficial to providers in ways that are not as appreciated, or not acknowledged, as intensive and/or one-on-one types of supervision. When effective, one-on-one supervision with an experienced clinician offers a qualitatively different type of relationship that allows for more in-depth exploration than peer-to-peer support normally would. In agencies where communication with supervisors or administrators is poor or lacking, one would imagine that peer-to-peer interaction could become an outlet for providers to vent their
frustrations, as well, and there may be positive and/or negative consequences to this. In agencies that experience serious problems with turnover and/or negative, or lack of, interactions with supervisors, the paucity of interactions with any peers or staff could lead to stress and/or possible burn-out.

In many respects, there seems to be a tacit acceptance by both providers and administrators of these aspects of providers’ work experiences. The tradeoff is that providers more often than not do not get clinical supervision, and they may be faced with what seems like a passive-aggressive, or arbitrary, communication style on the part of administrators when it comes time for them to meet certain requirements for audit purposes, or otherwise. Administrators, as noted earlier, seem to empathize with the stressors that providers experience – inadequate compensation, lack of training/supervision, poor communication, and so forth – and yet, they seem squeezed by tremendous pressures from elsewhere – whether they are from upper levels of management or from external entities such as Community Behavioral Health. Ultimately, providers and administrators must find ways of navigating these tensions in order to best address the needs of clients. Feminist theory and systems theory both speak to these tensions in their focus on the interactions between personal and political realms of social operation. The feminist view of personal struggles as being situated in a larger social context is similar to the systems theory approach of analyzing personal struggles and interactions in the context of different systems.

Providers’ abilities to handle client crises and agitation is a key component of the issue of clinical training. The lack of process and vagueness around a fundamental issue like client and provider safety, perhaps, suggest a deeper systemic ambivalence about
unchecked client emotions and crises. A critical element of this discussion is whether providers know what procedures to follow and/or have access to crisis response resources. The issue of crisis response blurs the line between clinical process and procedural matters, and one cannot help but wonder whether the agency mandated trainings cover this topic and allow providers to process their concerns. Helping providers not just with procedural matters (emergency contacts numbers, alerting key staff members, filling out paper work) and techniques, such as de-escalation and emotional containment, but with processing their feelings and experiences, would be critical to this process. As well, one cannot rule out the potential impact of the client issues themselves (e.g., agitation, anger, psychosis, suicidality, physical threat, or severe biopsychosocial concerns, exposure to which can produce vicarious traumatization), and in what ways the emotions generated by these psychological states or biopsychosocial problems filter through a clinic and the systems.

Quantitative data regarding organizational climate from the ORC scale of 17 providers at the four CMHOs, despite the small sample size, offered support for much of what was found in the qualitative data. Graphs A and B provided a overview of aggregate responses from the four CMHOs to the ORC with 25th and 75th percentile data based on 2,000 similar organizations, as well as a disaggregated view of the CMHOs. Focusing specifically on climate sub-scales, cohesion, related conceptually to this study’s theme of collegiality, registered the highest across all four organizations. Mission (provider’s clarity regarding agency mission and goals), and autonomy and stress, which are self-explanatory, were ranked only slightly higher than 25th percentile national norms. In the disaggregated chart, stress was rated higher in organizations where a greater number of
full-time providers were employed. Communication and openness to change ranked the lowest of all the sub-scales. These data suggest providers’ general dissatisfaction with the organizational climates at the CMHOs.

While organizational climate is an attribute of employees, this study veered into uncharted territory in examining organizational climate, relevant to the first research question, through the perceptions of clients at the agencies. There is some question as to whether this would require a revision of the original concept of climate, particularly in agencies where clients receive services on site. One might say that clients make up a community of individuals who have their own affective responses to different facets of the agencies where they are receiving services and are, therefore, the primary stakeholders in this environment. While their responses to individual service providers may be quite diverse, based on a wide array of factors, the climate of the agency impacts their affective, and other, experiences there. Climate as a feature of both providers’ and clients’ experiences at the agencies was examined through the findings on clients’ general experiences of the agency, their responses to staff turnover, and their experiences, along with those of providers, of the agencies’ physical environments.

In general, despite some bumps and false starts at the agencies, clients felt positively towards the CMHOs where they receive services. Ostensibly, there was only one negative case example of a client who had previously been receiving therapy in private practice. His struggle with the “institutional” feel of the agency and the tensions he experienced between the intimacy of the interaction with the private practitioners and the “impersonal” quality of the CMHO was the exception. It is difficult to know whether his viewpoint expressed something felt but not expressed, or identified, by other clients.
because they did not have private practice experiences for comparison. This relates back to Bourdieu's concept of *doxa*, and given this client's experiences in private practice, he is in a position to provide a clear contrast of the accepted norms between public and private.

Clients by and large seemed to feel welcomed at their agencies, they knew members of the support staff, and conveyed a positive sense of familiarity and comfort with the CMHOs. They also noted when something was not quite right, such as the client who spoke about her sense, when she was in the partial program, that staff and clients were not sensitive and compassionate toward people with mental illness. This raised questions as to whether the social problems of *stigma* and *deviance* were being replicated in the CMHOs. Other questions were posed about clients who had left the agency, particularly given the high rate of attrition in Philadelphia CMHOs, and whether the clients in this study were particularly motivated to receive the help and/or willing to look past negative experiences with the agencies. Client motivation and the ability to tolerate tensions and stresses at the CMHOs are critical areas for further study.

Notably, many of the clients had weathered the frequent turnover of therapists in order to stay at the CMHOs, although there is some question about the transience, or permanence, at the agencies, of those clients in the study who had been coming for a few months or, perhaps, less than a year’s time. The issue of turnover cannot be underestimated as a function of climate in terms of clients’ experiences. It directly parallels providers’ frustrations at the agency. For providers who face inadequate compensation, supervision, and training, and who feel undervalued in a variety of ways, other therapists are their source of support and collegiality, which are critical elements of their work relationships. Peer social relationships at the CMHOs supply the extrinsic
value to the work that the providers are doing. As well, because turnover impacts clients in such a powerful way, other providers represent the linkages to the community that may become severed if/when providers leave, leading to potential for atomization and disaffection on the part of providers and clients alike.

For clients, turnover represents another kind of break in the relationship in that they come to the agency concerned about whether they will be able to trust themselves enough to open up to their provider. In particular, one long-term client spoke poignantly about his experience of having a new therapist every 14 months, and his thwarted attempts to cope with underlying relationship issues. Another client, who had been coming to one of the CMHOs for ten years or more, spoke about having a number of therapists, and seemingly not ever truly addressing his anxieties regarding social relationships. The system, therefore, appears misaligned with clients who require sustained therapeutic relationships to address the underlying concern that is obstructed by the issue of frequent turnover: *relationship*. Several researchers have investigated the importance of the therapeutic relationship, or alliance, to clients with serious mental illness (e.g., Martin & Garske, 2000; McCabe & Priebe, 2004; Ware, Tugenberg, & Dickey, 2004). This also speaks to what Colapinto (1995) calls “diluting effects” of public social services agencies.

In the analysis of staff turnover, one has to wonder whether the agency policies and structure destabilize the very issues they seek to address, pointing to a parallel process. With clients who have experienced multiple traumas and a host of other biopsychosocial challenges, finding a therapist with whom they can sustain a long-term relationship to the end is key, but it seems to be a rarity in community mental health.
Clients’ affective responses about each agency with respect to the physical space of the agency and interactions with and processes of front desk staff were generally in agreement, but two of the agencies seemed to struggle more with these issues. The ways in which front desk staff at these agencies handled issues with scheduling and paging were frustrating for providers and clients. One client spoke about the atmosphere of the waiting room at one of the CMHOs and what was playing on the TV, highlighting the importance of client impressions of the physical environment, not just when they are working one-on-one with their provider. This researcher was also keenly aware at this agency in particular of the lack of division between the front desk and the waiting room so that all of the processes that are meant for private discussion become public knowledge. This may have the effect of “collectivizing” clients’ experiences, and perhaps, in a positive sense, help them to feel that they are not alone in their struggles. Clearly, however, the waiting room is not the appropriate venue for such an experience, which may further stigmatize and render deviant the “community” of mental health clients at the agency.

In everyday life, we interact with a variety of front desk staff persons that represent “the face” of the particular agency or business. Sometimes it may be a private business. Other times it may be a hospital, doctor’s office, law firm, post office, educational institution, or other type of organization. We all have a sense of what staff at the front of these organizations are like, and how we feel about it – “welcoming,” “unfriendly,” “accommodating,” “intimidating,” “organized,” “chaotic,” “clean,” and others. The front desk at CMHOs is no different.
Front desk staff at each agency had a different approach to handling the multifarious responsibilities these positions usually require, not to mention the tensions and pressures that each faces, that led to several questions with respect to the critical importance of this agency function. One provider interview aptly pointed out that front desk staff/receptionists really are support staff, which reflects their connection with the service provided by the agency; in other words, while staff at the front desk do not provide therapy or one easily identifiable “service,” they represent the agency service as much as any other employee. In framing a question of how the front desk can be better organized at CMHOs, perhaps, looking at how front desk staff are “service providers” offers a beginning approach to what is often a perpetual challenge at many agencies.

The issues of front desk staff appeared, again, at another agency, where the presence a glass divider seemed to provide a healthy separation for the private tasks occurring there; however, clients were met with an overly stern and unwelcoming approach of the front desk staff. So that while this staff member seemed to take care of certain responsibilities very proficiently and efficiently, the result was off-putting and confusing because the boundaries were too rigid. Clearly, a wide variety of clients come into the waiting room, some with issues that may arouse discomfort for front desk staff and others, and healthy limits and boundaries need to be set for all clients, but done in a balanced and service-oriented way.

The issue at this agency may speak to the New Mexico study (2005) of mental health services under managed care in which it was found that “managed care accountability models can subvert the very phenomena that they claim to enforce, including the allocation of responsibility for delivering, monitoring, and improving health
services…reinforce[ing] preexisting blame ideologies…” (p. 85-86). From a systems perspective, one would have to examine the style of supervision that occurs with front desk staff, and how this connects with the processes along the chain of command, so that this behavior can be looked at outside the domain of the individual staff members.

**Clients’ Perceptions of the Services**

In examining responses to the second research question – *how do clients perceive the services they receive at the CMHOs?* – a link was drawn between services and organizational climate in recognition of these two elements as inseparable attributes of agency life. Initially, clients seemed generally pleased with services. However, the overall picture became more complex, particularly with one client who spoke about her initial experiences and difficulty in seeing a psychiatrist within the first three months of her treatment. Figure 6.1, below, offers a visual depiction of how this client’s experience may be an example of a parallel process at the agency, looking at how expectations and other values, beliefs, and norms at the agency may impact the way that this client felt about her lack of an appointment with the psychiatrist. The process may also be looked at in reverse to see how the client’s and the client community’s ambivalent expectations may result in a lackadaisical reaction from the organization so that the status quo is preserved.
This visual representation, which offers a ground level look at the issue, as contrasted with Figure 2.1 that offered more of a bird’s eye view, attempts to offer a quick depiction of the parallel processes, and does not list implicit elements, such as the powerful effects of the agency administration and overarching systemic concerns, like local and state policies, pressures from pharmaceutical companies, and the powerful forces of oppression and marginalization. Nor does it capture the non-linear, or multi-linear, aspects of parallel processes, which speak to the potential for the stakeholders in the system to impact each other in direct and/or indirect ways. Providers are included in Figure 6.1 but only in gray scale because the interaction relates to a client’s experience with front desk staff; however, it does seem that providers would find a way to advocate
on behalf of clients in scheduling appointments if clients are unable to do so themselves, unless they too are struggling with front desk interactions.

While elements, such as expectations and the like, are typically thought of as organizational culture, this study looks at their "felt" aspects. The arrows in Figure 6.1 depict multiple parallel processes and serve to illustrate the emotional content communicated through expectations, values, beliefs, and norms of the different stakeholders. From a systems perspective, Figure 6.1 suggests an agency parallel process in which support staff feel their needs regarding the process of scheduling appointments are neglected, or are addressed arbitrarily, and this trickles down to the clients; the clients' low expectations, on the other hand, which may be reflective of general community expectations (community of mental health clients served by the agency, or client’s home community), are communicated to the staff at the agency, who then respond ineffectually and/or arbitrarily. The overall dynamic speaks to the systems concept of "non-summativity" in which interactions between parts of a system over time result in the emergence of new properties (Forte, 2007).

Reviewing clients’ statements regarding what the provider did that was most helpful, their mixed reactions suggested that initial positive responses in many cases were more about the strength of their therapeutic alliance with the provider, as well as their loyalty to the provider and CMHO, than to the concrete aspects of the service. Several clients, however, spoke about their positive experiences, particularly with respect to cognitive techniques – identification of automatic thoughts, development of alternate thoughts, use of journaling and other constructive methods – and this seemed to speak to
the power of cognitive therapy, specifically the importance of helping clients develop concrete ways to address their everyday challenges.

There is some question about whether cognitive therapy techniques were being used appropriately, given that a couple of clients spoke about their therapist giving them ways to think about difficult situations, possible alternative interpretations, as opposed to helping the clients come up with their own. While this might be helpful for clients who have challenges with certain types of reasoning, the concern is that clients may not develop their own capacity to come up with alternate thoughts – e.g., when not in therapy – and they become dependent on the therapist for the work. Of course, this is a major challenge with any therapy, but homework is built into cognitive therapy, so the question becomes how the therapist and client are negotiating the homework and using it to its greatest effect.

In most of the other cases, the actual “help” was more vague, although clients felt the powerful effects of the therapeutic alliance – the emotional charge derived from the encounter, the unconditional regard, the power of being in a one-on-one relationship with someone who is compassionate and able to empathize – and the less-well-defined supports derived from problem solving methods and case management-related help with accessing other social institutions. In these cases, one client discussed “encouragement and prayer” as two very helpful aspects of her treatment. Others spoke about the positive effects of their therapists having their best interests in mind, feeling cared for, having someone to talk to, receiving feedback, getting a different perspective and many other aspects of the treatment that seemed to speak about the effectiveness of their therapy.
While each client offered his or her own unique way of discussing their mental health issues, several clients provided examples of a medical discourse with respect to the mental health issues. Use of the terms “my sickness” and “get well” leads to a much broader discussion about these different discourses that seem to permeate the provider and client interviews. While this topic would require an entire paper in itself, the different discourses – medical (or disease) model versus person in environment, or a combination of the two – speak to different and conflicting expectations, values, beliefs, and norms that filter circularly through the mental health system in general. Particularly important in this discussion is how diagnosis almost becomes like a currency at CMHOs and other mental health settings because it is what defines medical necessity for receiving treatment under managed care policies.

The societal effects of having a diagnosis can be devastating, which is significant given that the discourse of the medical model and diagnosis permeates the language of therapists and clients. After speaking initially about diagnosis (during interviews and, from this researcher’s personal experience, during the intake process), clients began to delve more into their underlying issues. So there is a possible tension that providers and clients experience in understanding mental health problems and all of the possible sources of those problems. Another parallel process might be reflected in the tensions between the discourses themselves – that is, in mental health policies, the language of recovery, initiatives pushed by states/counties, the impact of the media, the influence of pharmaceutical companies, and the role of psychiatry and other helping disciplines that work with mental health issues.
Almost all of the clients interviewed, particularly those who had been at the agency for close to a year or more, were motivated for treatment, felt their therapist was a good fit for them, and that they were taking on at least some of the responsibility for the work. In many cases, clients had developed a personal sense of *agency* with their treatment providers, feeling like they could talk to their providers about things they want to see happen differently at the agency or in their treatment. On the other hand, there were a few clients who exhibited a passivity in their approach to the treatment and to the agency, seemingly wanting the providers to take on the responsibility for the work. This passivity also came through in the interviews, and, in fact, a couple of clients seemed to be surprised by the nature of the questions, as if it had never occurred to them to examine the agency or its services.

**Conclusions**

Bourdieu’s notion of *doxa* refers to taken for granted notions/patterns that are produced and reproduced in society (Fram, 2004; Munch, 1994), and this study began as a way to examine how the problems in CMHOs are part of a broader societal pattern that is played out in the organizational social context – in this case, the climate and services of CMHOs. Feminist theory and, by extension, institutional ethnography, provide a frame for how everyday practices – that is, agency processes – reflect power relationships (DeVault & McCoy, 2002; Smith, 1987, 1999; Townsend, 1996). This study has examined several agency processes that speak to “the socially accepted subtext” of everyday life, and it has done so through the concept of *parallel process* in which “conflicts belonging at one location are often displaced and enacted elsewhere” (Bloom, 2006, p. 37).
As in systems theory, parallel processes, perhaps, operate on positive and negative feedback loops that speak to the affective qualities of expectations, values, beliefs, and behavioral norms operating between systems, suprasystems, and subsystems.

From the point of view of institutional ethnography, this study has sought to take the concept of parallel process to examine providers' and clients' experiences through “the empirical investigation of linkages among local settings of everyday life, organizations, and the translocal processes of administration and governance” (DeVault & McCoy, 2002, p. 751). These linkages create a dynamic field of coordination and control identified as "the ruling relations," or "the forms in which power is generated and held in contemporary societies" (DeVault & McCoy, 2002, p.751; Smith, 1999).

Policies, legislation, and other parts of the “ruling apparatus” may be seen as creating “an invisible and subconscious web of forces that sustain the subordinate location” of clinicians in CMHOs (Townsend, 2003, p. 25). These ideas are aligned with feminist and systems theories and Bourdieu's theory. Institutional ethnography begins with the experiences of "individuals whose everyday activities are in some way hooked into, shaped by, and constituent of the institutional relations under exploration” (DeVault & McCoy, 2002, p.753) to investigate the ruling relations in organizational and institutional processes.

Despite the difficulty of examining how parallel processes “travel” through the interactions within the entire system, as this would require the testimony of key witnesses and the ability to follow an agency process from start to finish and on all levels, this study has attempted to examine through interpretive means how certain processes are
implemented at the everyday process level reflect upon all levels of the organization. Provider responses to adding mental health advance directives to the intake process were used as a prime example. Provider, client, and community responses to the way a process is carried out can filter back into the system with implications for management and administration, as well as perhaps, for policy-makers.

What this study points to is the contrast between the conflict-laden, parallel process-oriented, interactions between providers, managers, administrators, as well as front desk staff, and the often rich relationships providers experience with their colleagues and clients experience in their therapy sessions. The relationships between clients and their providers, however, are greatly impacted by the organizational climate with respect to what causes providers to leave and what effect this may have on client treatment over the long-term, particularly when clients desperately require the positive influences of steady and consistent relationships.

Staff turnover – which is likely the result of from a combination of inadequate compensation, lack of supervision and paid professional development, and other factors – is the main sticking point for clients in regard to the one-on-one relationship with the provider. The relationship between the client and the organization is marked by ambivalence, and, as in the case with the female client who was unable to get a psychiatry appointment in the first three months of her treatment, clients and communities may end up taking the agency’s responsibilities upon themselves, reinforcing blame and other oppressive forces that clients already experience. Feminist theory offers one particularly useful way of exploring this dynamic through the concept of “internalization of subordination” (Forte, 2007). Vulnerable groups are influenced by
internal factors as well as external threats that replicate their subordinate status in relation to people in positions of dominance. As in the case of the female client, explicit oppression is not always necessary in order to continue the hierarchical structure of society, due to other oppressed groups’ internalized cues of inferiority and subjugation.

The CMHO represents a community sanctioned need set up to address clients’ complex mental health and related problems. As such, it bears a heavy responsibility for the stewardship of public and private funds devoted to this purpose. The CMHO, in a sense, is a living entity. It is a crucible of society’s many conflicts and expectations with respect to perceptions of American mental health, medicine, health insurance, corporate management, and social norms, values and beliefs. This study offers an approach to examining organizational and other context factors that impact client services at CMHOs, and points to some practical ways in which CMHOs can improve services to clients.

It is easy to project our deficits onto organizations and to see community mental health and CMHOs only in negative ways. As Kai Erikson (1962) and Michel Foucault (1977) stated, society needs deviancy/deviants (in this case client with serious mental illness) so that citizens have clear ideas between right and wrong behavior in society. Institutions where deviants are grouped (where deviant group behaviors/responses are learned from others and carried out) are underfunded, or neglected, in order for society to preserve a sense of what is deviant. In extending these theories, the healthcare system with respect to community mental health seems to thrive on deviancy, particularly when mental illness and related problems are framed as a medical illness, diagnosis, and/or disease.
The community mental health system in the managed care era has strengths upon which to develop organizations and services that are more deliberative and responsive to the needs of clients. As providers have discovered, working in community mental health requires strong and committed individuals who are clear about themselves and their roles, and who are able to navigate through and not become the object of negative societal projections related to mental health. The system should look to these providers, and their knowledge regarding process and relationship, as their strongest assets in mitigating the powerful negative effects of an ambivalent society.

**Next Steps: Implications for Social Work and Organizational Change**

While the literature on organizational context factors in community mental health continues to grow and develop, this study points to their significance with respect to CMHOs. Social work providers in CMHOs function at the hub of changing social and organizational forces that impact their perceptions of everyday work experiences. The pressures social workers face at CMHOs that can lead to demoralization and burnout must be met, not just with knowledge of clinical skills and theories of individual development, but with acknowledgment and understanding of the systems within which they are working. An understanding of organizational theories and, perhaps, theories of broader social phenomena - theories of deviance and stigma, power relationships, and difference - would aid in this process. Knowledge regarding policies at all levels, how they are implemented and what impact they may have for themselves and clients, is critically important. As well, education, mentoring, and/or supervision in systemic and organizational aspects of community mental health is essential for the development of social workers who seek work at CMHOs or related organizations.
Similarly, administrators (social workers or otherwise) at CMHOs must be aware of the organizational context and its influence on providers, support staff, and clients. From the findings presented in this study, administrators must pay closer attention to the ways in which climate factors, like conditions of employment and the day to day experiences of working at CMHOs, can have trickle-down effects on clients. Administrators should find ways to be creative about providing better compensation for providers, as well as opportunities for top notch professional development in evidence-based practices and clinical supervision. In-service trainings for administrators, providers, and support staff should clearly and adequately address procedures as well as providers' emotional needs regarding clinical matters, such as client emergencies, and how every aspect of the day to day work at the agency is connected with the services to clients, including interactions with front desk and business office staff.

Administrators must examine how they are positioned within the hierarchical structure of the agency carefully and reflect upon how they might better negotiate the pressures they face from higher level administrators and providers. In a similar vein, they must address issues inherent in agency processes, as well as how changes are communicated and decisions are made so that there is empathy for the role and responses of providers. Otherwise, administrators and providers may feel pitted against one other, a conflict that ultimately impacts the services to clients, whether through turnover, or other negative outcomes.

This study also has implications for assessment and intervention with CMHOs. The Sanctuary Model® offers one compelling approach to organizations that emphasizes the creation of a trauma-informed organizational culture, with the understanding that
“[u]nfavorable financial, regulatory, social, and political environments can adversely impact organizational functioning” (Bloom, 2007, p. 13). Organizations can begin to exhibit signs and symptoms of trauma themselves, reenacting violence, adversity, and chronic stress, and leading to a devaluation of the culture as a whole. The model is “based on the active creation and maintenance of a nonviolent, democratic, therapeutic community in which staff and clients are empowered as key decision-makers to build a socially responsive, emotionally intelligent community that fosters growth and change” (p. 12). While this is only one example of a program that seeks to bring about healthy organizational change, it fits with many of the theoretical constructs offered in this study. Another promising organizational intervention developed by Glisson and Schoenwald (2005) is designed to build organizational social contexts that support mental health services and relies on change agents, or "boundary spanners," who are trained to bridge social and technical gaps within and between organizations.

Lastly, continued quantitative and qualitative research on organizational context factors in community mental health must be conducted to examine their impact on providers and clients. The perspectives of key informants, administrators, and support staff must be studied, as well, to gain a deeper understanding and show linkages in parallel processes that are detrimental to CMHOs. Perceptions of clients and client communities are critical to this discussion, as client voices can have an impact on CMHOs in "unseen" ways relative to parallel processes. Institutional ethnography offers one way of investigating how organizational context "invisibly" shapes the interactions between various stakeholders through examination of day-to-day processes that point to power relations across systems.
References


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APPENDIX A

Interview questions (THERAPIST):

Are you fee for service?

What proportion (approximately) of the clients at this agency receive services through publicly funded insurance like CBH?

How would you describe your role/goals as a therapist? (probe: what do you do as a therapist in working with your clients?)

What do you believe produces change in therapy? (probe: can you give me an example of what you mean?)

Can you give me 3 or 4 words that describe your agency, at it’s essence?

What is it like to work here? What do you enjoy the most about it? The least? How does it compare to other agencies in which you have worked?

What would you like to see change?

Are there any unwritten rules at this agency?

What would make you more able to do your job? What do you feel you need to develop further professionally?

In what areas would it be helpful for you to receive further training in this job? (probe: why these areas?)

What are the most challenging client-related issues that you work with?

What client issues do you feel most confident about working with?

What system-wide policies (such as reimbursement policies, DBH policies) make it challenging to do your job? What policies make it easier to do your job? (probe: how do these policies impact your ability to work with your clients? Do you see these policies having an impact on your clients? What impact do they have on you, personally?)

Would you like to see this agency participate in training in cognitive therapy? Why or why not? What concerns would you have about it? What might get in the way of the treatment being implemented if you or your therapists were trained? Would your answer be different of another type of therapy training were being offered? What therapies are you interested in learning more about?
How do people within this agency react to change? Can you give me some examples? If there’s time:

What do you think of the recovery movement? How is it working here in your agency? In what ways might it improve services to your clients?
APPENDIX B

If you are interested in participating in research study in which you participate in a one-on-one interview about your experiences receiving mental health services. This interview should last about 30-45 minutes.

Please see the University of Pennsylvania research staff in the waiting room.

As a participant, you will be given a $40 gift card for completing the interview, which will be recorded.

If you are not able to participate today but would like to schedule a time to participate, you may contact Katherine Toder at 215-746-7337. Tell her you are interested in the “client interview study”.
APPENDIX C

CLIENT CONSENT FORM
UNIVERSITY OF PENNSYLVANIA, DEPARTMENT OF PSYCHIATRY  
Psychopathology Research Unit and Center for Cognitive Therapy

Principal Investigator: Aaron T. Beck, M.D.  
Psychopathology Research Unit  
3535 Market Street, Room 2032  
Philadelphia, PA 19104-3309  
(215) 898-4102

Co-Principal Investigator: Shannon Wiltsey Stirman, PhD  
Psychopathology Research Unit  
3535 Market Street, Room 2055  
Philadelphia, PA 19104-3309  
(215) 573-0209

Emergency Phone Number (24 hours)  Ask for the Psychiatry Resident on Call  
(215) 662-2121

CONSENT FORM FOR CLIENTS

NEEDS ASSESSMENT AND READINESS ANALYSIS OF COMMUNITY MENTAL HEALTH CENTERS  
IN PHILADELPHIA: INTERVIEW OR FOCUS GROUPS

INVITATION TO PARTICIPATE AND PURPOSE OF STUDY

We are inviting you to participate in this research study because you are receiving treatment at your community mental health agency and you indicated an interest in participating in an interview or a focus group.

In the present study, we are examining factors that are associated with your satisfaction with treatment. We would like to learn your opinions about these issues. Although this research may not benefit you directly, your participation may lead to a better understanding of organizational and individual factors that are barriers or facilitators of change.

PROCEDURES

If you choose to participate, you will be asked to talk with the researchers about what it is like to receive treatment in the agency, and what you believe could improve service delivery. The interview will last 20-30 minutes, and a focus group will last 1-2 hours. The session will be recorded, but no names will be used during the recording. The recording will be transcribed and then destroyed to protect your privacy. If you do not wish to be recorded, you may choose not to participate in this research.

Your treatment providers will not have access to any information you disclose. Your participation in this research is completely voluntary. You can choose not to participate. Your participation, or decision not to participate, does not affect your care or treatment in any way.

Date of last revision: 4/2/10
participate, will remain confidential and will not be disclosed to your treatment provider.

POTENTIAL RISKS
A potential risk is that your responses would be disclosed to other parties such as your treatment provider. However, the researchers will not share individual responses or participation information with your treatment provider, and will ask the other participants to keep all discussion during the group confidential. You may also experience some discomfort during the discussion of your treatment.

BENEFITS
Although there are no direct benefits to you for participating in this study, you will be contributing to the existing knowledge of the factors associated with successful change, job satisfaction, and turnover. This knowledge may be used to develop or refine strategies to improve the organizational context of community mental health agencies.

COMPENSATION
You will be paid $40 for your participation. If the agency at which you receive your mental health services has a policy against cash compensation for research participation, you will be given a $40 gift card instead. You will be notified of this policy in advance.

______(participant initials) I understand that I may receive a gift card instead of cash.

ADDITIONAL INFORMATION
Any significant new findings developed during the course of this study that may affect your willingness to continue participation will be provided to you.

WITHDRAWAL/PREMATURE COMPLETION
If you wish to withdraw your consent to participate in this study, you can do so at any time. You may also choose to stop talking or to leave the room at any point during the interview or group, and can ask that your responses not be transcribed.

CONFIDENTIALITY
The information that we obtain in this study will be kept confidential except in situations in which disclosure is required by law, such as in the event of a disclosure regarding child abuse or intent to harm self or others. The researchers will not link your name to your responses in any way and will not share any individual data with your employer or with any other outside parties. The name of the agency will not be disclosed in any reports of this research, and only aggregate data will be reported.
Needs assessment and readiness analysis of CMH centers

P.I.: Aaron T. Beck, N.D.
   215-898-4102
Shannon Stirman, Ph.D.
   215-973-0209
Co-P.I.s:
Emergency 24-hour Number
   215-652-2321

Authorized representatives of the University of Pennsylvania Institutional Review Board (IRB) and the Philadelphia Department of Public Health Institutional Review Board (IRB), committees charged with protecting the rights and welfare of research subjects, may be provided access to research records.

SUBJECT RIGHTS

You should understand fully that you are free to decide whether or not you wish to participate in this research study. Should you decide not to participate your decision will in no way prejudice your eligibility for future participation in any treatment or services at the University of Pennsylvania. In addition, your participation, or your decision not to participate in this research study will not have an effect on your status at the agency in which you receive treatment.

If you wish further information regarding your rights as a research participant, you may contact the Director in the Office of Regulatory Affairs at the University of Pennsylvania by telephoning (215) 898-2614, or you may contact Judith Samans-Dunn, Administrator, Philadelphia Department of Public Health Institutional Review Board, 215-685-2411.

You should ask any questions you have concerning this research study before you sign this consent form. Additional questions or concerns about the study can be addressed to Dr. Shannon Stirman at (215) 573-0209.
CONSENT
I have read and understand the consent form. I agree to participate in this research study and will allow my responses to be audiotaped or digitally recorded. Upon signing below, I will receive a copy of the consent form.

___ I consent to participate in an interview

___ I consent to participate in a focus group

___ I understand that due to the policy of the agency at which I receive my mental health services, I will receive a $40 gift card for my participation (check if applicable)

(Name) (Printed)        (Date)

(Name) (Signature)      (Date)

Name of Person Obtaining Consent (Printed)  (Date)

Name of Person Obtaining Consent (Signature)  (Date)
APPENDIX D

Client Interview Guide

1. How old are you?

2. How long have you been receiving therapy at the agency?

3. What brought you into treatment?

4. What are the most important things you want to get out of treatment?

5. What is it like to receive mental health services here?

6. What parts of your experience here do you think are the most helpful?

7. What parts of your experience here do you think are the least helpful?

8. Have you noticed any changes in your problems in the last few months? (If yes), would you describe those changes? Are things getting better or worse?

9. What does your treatment provider do that helps you the most?

10. What does your treatment provider do that is the least helpful, or not helpful?

11. What part of your treatment, if anything, would you like to see happen differently?

12. What do you think about (what is your opinion of?) therapy that focuses on helping you to understand your past experiences and how they connect with your current experience?
   Some therapies focus on the past. What do you think about that?

13. What do you think about therapy that focuses on giving you support and understanding?

14. What do you think about therapy that helps you find solutions to your problems?

15. What do you think about therapy that helps you change your behavior?

16. What do you think about therapy that helps you examine (look at) how your thinking influences (affects) your feelings and behavior?

17. How does [agency] compare to other agencies in which you have received treatment?

18. What, if any, are some changes you recommend in order for [agency] to improve services?
19. Is there anything, at the agency or otherwise, that would make it easier for you to get the help you need?