Mental Health Service Access in Arizona: A Qualitative Examination of Ecological Impacts for the Latinx Population

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Abstract

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Latinx persons experience mental health needs at rates similar to White individuals; however, they do not have the same utilization rates as their White counterparts. Research has indicated that multiple logistical factors go into this underutilization, such as lack of insurance coverage, transportation, or English-language skill proficiency; however, structural realities like culturally relevant components, provider biases, or a clinic's atmosphere are not discussed within the context of the workers and the organization in which they practice. The three papers in this dissertation seek to understand the influence of external forces onto- and -within mental health organizations that deliver services to the Latinx community in Arizona. The primary aim of this qualitative study is to understand what factors influence access, how power is practiced through the delivery of access, and how the workers within mental health

organizations interpret their function within that system and how they interact with their Latinx clients.

Semi-structured interviews with 18 administrators (n=10) and direct service workers (n=8) were conducted throughout 2020 during the COVID-19 pandemic through online meetings or via telephone. Using the theoretical framework as a guide—a combination of ecological theory, critical race theory, and the power relation perspective--transcripts were coded with a focus on the relationships of power and environment within the organization. In navigating internal organizational policy, administrators more than direct service workers spoke of the limitations of funding, community collaboration, and the reputation of their organization within the large environment. In terms of navigating access that is culturally relevant for the Latinx population, the majority of participants identified Spanish language resources, while only a few (primarily administrators) spoke of how to create access through implementing broader cultural components. Results also indicate that individuals felt supported to make decisions within their organizations in how they work with the Latinx community, with descriptions of empowerment and power-sharing. Recommendations for policy, practice, and community partnerships are discussed.

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ACKNOWLEDGMENTS

There are multiple people that have supported and guided me throughout this process. First among these is my husband, Matt, who has been there through every moment of doubt, success, failure, and hope. Without him and the support of peers in the doctoral program, I never would have been able to succeed in achieving this dream. As a first-generation college student and Mexican American woman, I would also like to acknowledge all the family that came before me to have this dream but who were never allowed the same opportunities as I have had.

I have so many words for my committee, but I must begin by praising all of them for their inexhaustible knowledge, their dedication, and their patience. Throughout this process I have had to take some breaks and have had to step back more than once. Fortunately, my committee never failed to stand by my goal to achieve the doctoral degree. I would like to thank Eugene (Gino) Aisenberg, PhD, MSW, for working with me since my first day in the program and for never failing to push my thinking, to encourage my inquiry, and show compassion for me as a person. Cynthia F Pearson, PhD, has been the backbone of my writing process. Never in my life will I be able to write anything again without hearing her voice, guiding how I formulate my argument, how I support my findings with evidence, and above all, to strengthen my methods. Lastly, to Drs. Kara Jackson and Amanda Swarr, I would like to extend my gratitude for their ability to support a social work dissertation through keeping an open mind to learn the intricacies of the field while helping me navigate the doctoral process and teaching me so much about method, theory, and application.

DEDICATION

This dissertation is dedicated to all persons of Latinx heritage who ever needed to talk to somebody, or who were afraid to seek out mental health services when they were needed. This is also dedicated to mental health workers who may get frustrated with the "status quo:" you have allies in the community and in research who want to see equity in mental health care and who will not stop seeking justice.

INTRODUCTION

Throughout the past few decades as the Latinx population has increased in the United States, mental health researchers have investigated what contributes to their participation in services. It is through these studies that we have learned about some elements that contribute to participation in treatment, such as client satisfaction or religiosity (Villatoro et al., 2016) but we still are not certain what contributes to the lack of access for this large racial/ethnic minority population. Although research indicates that the mental health needs of the Latinx community are comparable to their White counterparts (Alegria et al., 2008), it remains less likely that they choose to access services (Valdez & Langellier, 2015); 27% versus 40%, respectively (LeCook, Zuvekas, Carson, Wayne, Vesper, & McGuire, 2013). Several factors have contributed to this issue, such as language barriers, lack of cultural relevance in provided programming, transportation issues, and less reported satisfaction with healthcare providers (Alegria et al., 2002; Alegria et al., 2008, Guarnaccia et al., 2005). Similarly, mental health organizations have struggled to provide access to the ever-changing dynamic of the Latinx population, who utilize both formal (e.g., therapists, psychiatrists) and informal (e.g., priests, traditional healers) services (Alegria et al., 2014).

The multiple facets of mental health organizations that contribute to access issues have been understudied. Few mental health researchers have examined the role played by organizations that work with the Latinx population (Guarnaccia et al., 2005). Fewer have investigated the role of the worker in every facet of organizational operations that serves underrepresented communities (Garrow, 2012), but, in particular, the Latinx community. Much of the work that studies the practice and function of mental health organizations comes from outside the field of social work and is primarily focused on the

processes and functionality of the organization as opposed to power dynamics internal and external to the organization, environmental influences, or the interpretation of policies or practices by the worker themselves. Each of these factors will be explored later in this study.

Understanding power dynamics both within and external to- the organization is crucial in understanding how to serve a historically marginalized community. For example, a new Latinx immigrant may be able to go into a clinic as a walk-in and fill out paperwork; however, the process after that differs from clinic to clinic, and even from site to site within any organizational network. The moment the individual client walks into an organization they must be able to navigate the structure of managed care, which typically means that a person may not be able to just walk-in and sign-up for services. Intakes usually functions through a referral system, which is processed through insurance, which then decides which clinics you can and cannot go to for your diagnosis. If you are low-income and are insured through a state Medicaid program, you may not be able to get into a clinic unless they can take another client on Medicaid. This often translates to long waits for consultation unless you have an emergent need. Also, if Spanish is your preferred language, translated forms and bilingual staff may not be available.

In Arizona, where this study takes place, an additional major contributing factor to access issues is the power of funding and environmental influences. In 1981, a class action lawsuit was filed in Arizona state called Arnold v. Sarn. It claimed that the state did not offer comprehensive mental health services as required by state law. Ultimately, it was decided that the state did not uphold its duty. Unfortunately, it was not until 2014 that the Arizona Department of Health Services, Maricopa County, and the

Governor came to an agreement on which community services will be afforded to mental health service recipients. This 2014 decision finally concluded the litigation:

> "The agreement includes an increase in services in four areas: Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, and Peer and Family Services. The agreement also provides for the use of several tools by the parties to evaluate services provided in Maricopa County, including a quality service review, network capacity analysis, and SAMHSA fidelity tools (Arizona Health Care Cost Containment System, 2018)"

In response to the ruling, the state aids those living with a mental illness through multiple areas, which include housing, medication, peer support, therapy and alternative therapies, vocational rehabilitation, and much more (Arizona Health Care Cost Containment System, 2018). Thus, the Regional Behavioral Health Authority was created and divided into three major regions of the state. The purpose of the RBHA was to provide a centralized system wherein behavioral health services were made accessible, were managed, and were delivered. The RBHA served both Medicaid and non-Medicaid clients until mental health services were mostly transitioned to the state Medicaid service, known as Arizona Health Care Cost Containment System (AHCCCS). Transition from the RBHA to AHCCCS has been occurring since the settlement of the litigation; however, services pertaining to individuals with a serious mental illness has remained within its scope (Arizona Health Care Cost Containment Services, 2021).

To qualify as an individual that lives with a serious mental illness, you must be given a diagnosis that severely impacts daily functioning (e.g., bipolar, schizophrenia, major depression). With a qualifying diagnosis, you are then able to receive services,

even without qualifying for Medicaid. In fact, the client could have a job that offers them medical insurance, but they may also have difficulty with daily living skills significant enough that it impairs functioning (Arizona Disability Law Center, 2021). As of 2021, the number of persons served by the RBHA in the greater Phoenix Metropolitan area was 25,784 (Arizona Health Care Cost Containment System, 2021).

The monumental impact of Arnold v. Sarn changed the environmental landscape for the functioning of mental health organizations. With Arnold v. Sarn came an increase in key services offered through organizations, such as Assertive Community Treatment (ACT) and Peer and Family Services (Arizona Health Care Cost Containment System, 2021b). Implemented changes also required that services undergo quality reviews and utilize program fidelity tools created through the Substance Abuse Mental Health Services Administration (Arizona Health Care Cost Containment System, 2021b).

The environment in Arizona has historically been wrought with inequities for the Latinx community, most active during the mid-2000s through the mid-2010s with legislation that was enacted against service provisions and supportive services for undocumented persons. The details of that will be discussed below in the third paper. Through this introduction, we must look at the scope of this work through a blending of theoretical and organizational perspectives.

Theoretical Foundation

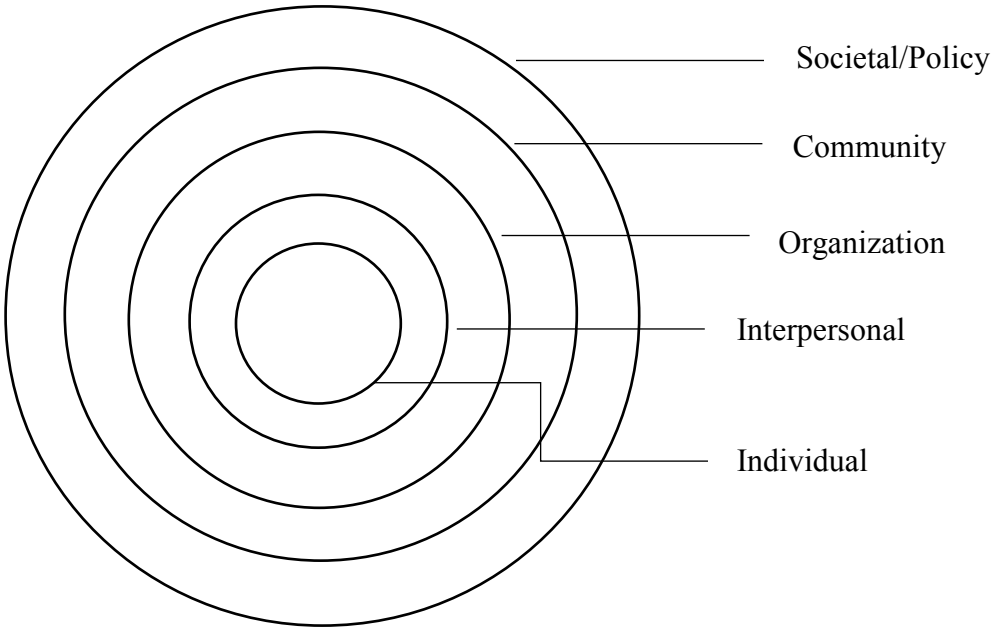
Ecological Theory. The ecological perspective (Bronfenbrenner, 1979) is utilized throughout the rest of the study as the cornerstone of understanding the contextualization of mental health access for the Latinx community (Figure 1). In the political aspect, we can then examine the legislation that changes the flow of public

funding, the policies that work to include – or exclude – persons of undocumented status, or even internal organizational policies that are built as a response to the external forces acting upon the organization. Bronfenbrenner's theory (1979) describes how an individual moves within and through the various levels of ecology: macrosystems, exosystems, mesosystems, and microsystems. Working through each of these systems, we can begin to see how the organization may experience dysfunction starting at the macro level and moving in toward the micro—hierarchical management, restricted innovation, and organizational culture that limits group collaboration and individual decision-making among the frontline workers and administrators, for example.

Ecological systems theory posits that a person's environment influences their actions and behaviors. According to Ecological systems model, organizations, such as health providing organizations, as part of a patient's environment, influence the person's actions and behaviors. In addition, the organization, like the individual, is embedded in a context of policy and funding that influences its mission and scope of services. These external influences, or external actors (e.g., stakeholders like policymakers and funding sources) exert their power and influence onto—and into—the functioning of the organization that is ultimately either accessible or inaccessible for the Latinx client. For the organization, this macro environment can also influence their functioning by limiting their community support, the populations they serve, the funding and the resources they receive (or are allocated to them, such as in public systems like Medicaid). Thus, an overall impact carries from the macro political sphere into the individual's experiences in trying to access mental health services.

Figure 1

Ecological Systems as Applied to the Conceptual Framework



Note: A translation of mental health ecology, based on work by Urie Bronfenbrenner

Critical Race Theory. Using critical race theory, we will examine the elements of the environment. As previously mentioned, we can look at racial/ethnic biases and stereotyping, understanding how those attitudes can be present in mental health organizations. The assumption, for example, that all persons of Latinx identity speak Spanish and have no other cultural considerations is a shallow understanding of a heterogeneous culture that includes diverse indigenous practices and languages, and a collectivistic framework. Critical Race Theory (CRT) acts as a mechanism toward combatting the oppressive structures Latinx clients face, particularly as they navigate managed care systems. Its origins can be traced back to in the mid-1970s as advocates and activists sought to find a way to combat the racism that people of color were encountering beyond the active civil rights movements of the 1960s. CRT combats, head on, issues of power, much like those seen within our healthcare system.

CRT asserts that racism is deeply ingrained into our cultural conscience and explicitly built into our institutions. Additionally, the benefit of racism to the dominant White group is the psychic and tangible advantages of oppression, wherein resources, collaborations, and access are reserved for their prioritized needs. This allows organizations that operate under the assumption to act out what they (stakeholders with power and access to resources) believe is best for this historically oppressed community. From an ecological perspective, informed by CRT, we can better understand the fluctuations and tributaries of power that can impact mental healthcare access. A benefit of utilizing CRT is the examination of power that coincides with the biases of providers or the larger system in providing or allocating resources to organizations that attempt to increase access to the Latinx population.

Critical race theory examines our institutions by looking through a lens of power that contributes to inequity. Formed through legal studies and education, critical race theory has been vastly underutilized in social services research, despite some scholars in social services writing on how CRT applies to ethical practice (Abrams & Moio, 2009). CRT provides a framework to analyze the pathways through which the Latinx community experiences a devaluing of their mental health needs in institutions that react to an environment that holds biases against them.

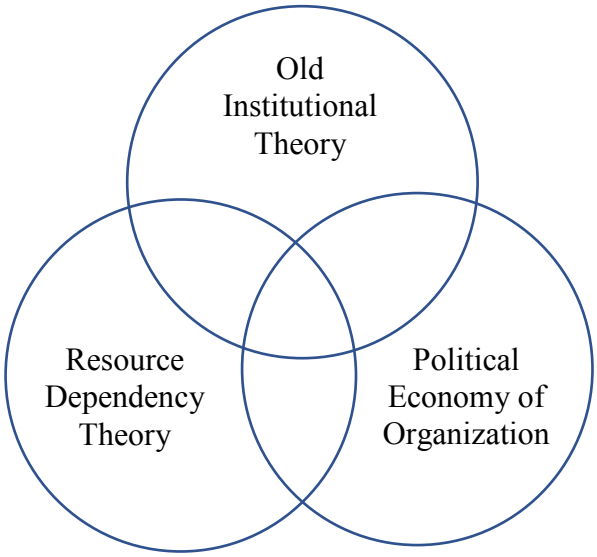
In this dissertation, CRT is discussed as it relates to the ecology of the study location's community. This specifically pertains to the furthermost rings (see Figure 1) of public policy (such as through Medicaid or governmental mental health programs), communities (the larger statewide community, which is majority White), and institutions/organizations (mental health organizations that receive public funding).

Power Relations Perspective. Combining old institutional theory (Selznick, 1957), political economy of organizations (Zald, 1970), and resource dependence theory (Pfeffer & Salancik, 1978), this study utilizes a formed power relations perspective (Garrow & Hasenfeld, 2016) to frame the external influences on internal organizational functioning. Each of these elements speaks to the ability of this perspective to look at the functioning and practices or organizations that are influenced, to any degree, by external agents. While these three theories have been minimally used in social service research, they are applied here to understand internal structure and functioning of service providing organizations (Hasenfeld, 2010).

Using critical theory as a guide, we will look at the external factors in the area of mental health service access: 1) policies both external to, and within, organizations that may impede access creation for the Latinx community; 2) the influence of policies that constrain collaborative efforts toward increasing access; and 3) how organizational culture impacts access creation through an examination of hierarchy, the power the organization holds, and how that power is wielded to create opportunities for access.

Figure 2

Power Relations Perspective in the Conceptual Framework



ARC Model

Hemmelgarn and Glisson, (2018) in their Availability, Responsiveness, and Continuity (ARC) model, discuss several types of organizational social contexts (OSC)—these contexts drive the functionality of the organization. There are multiple components to this perspective that are discussed in subsequent sections, but the primary point is the acronym itself: availability (clients are ensured prompt and efficient access); responsiveness (clients believe their needs are being addressed); and continuity (providers are consistent in their care and services; Hemmelgarn and Glisson, 2018).

The ARC nests within five principles of organizational context: 1) mission-driven vs rule-driven, 2) results-oriented vs process-oriented, 3) improvement-directed vs status quo-directed, 4) participatory-based vs authority-based, and 5) relationship-centered vs individual-centered. For the purposes of this research, the focus is on improvement-directed vs status quo directed human service organizations to illuminate positive responsiveness to persistent disparities. Organizations that are reluctant to

change and operate within established protocols, regardless of their efficacy, are known as status quo-directed human service organizations (Hemmelgarn and Glisson, 2018); organizations that do not settle with the status quo and consistently seek out effective actions are known as improvement-directed organizations.

The focus of the Accountability, Responsiveness, and Continuity (ARC) model (Hemmelgarn and Glisson, 2018) is primarily discussed in the third paper, but it is useful for the examination of *how* the organization's structure and functioning contribute to a lack of access.

Proceeding Chapters Overview

This dissertation focuses on 1) organizational practices such as how internal and external policies coexist and are intermingled; 2) how organizations resist "business as usual" in their access efforts and support the Latinx population; and 3) how organizations grapple with issues of power within the community and their organizational culture to improve access via the rejection of the powerlessness that is present in how organizations create and provide access. This cross-sectional, qualitative study investigated into the above areas by asking questions on policy, collaboration, power and reputation in the community, and hierarchy, beginning with a couple of broader questions on access (see Table 1).

Paper one focuses on the back-and-forth between internal mental health organizational policies and how the workers then practice access creation for the Latinx community. In short, what are workers doing to understand their organization's internal policies in multiple areas (e.g., intake, funding) to perform their primary function: helping clients get into services, stay in services, and eventually practice their

recovery. It sets the stage for the broader scope of the problem of access to mental health services by Latinx individuals.

The second paper examines the ways that service organizations navigate internal and external power and how that influences their service access pathways for the Latinx population. We explore how funding limitations, internal conflict, unclear priorities, social stereotypes, about the Latinx population impact access. The second paper takes a deeper dive into the power dynamics of what happens in an organization when there are insufficient resources to create access.

The third paper examines the functioning of the organization in relationship to the larger community. The focus is on where the power lies, who wields the power, and the impact of the organization's reputation in the community. In other words, it examines the ability of an organization to make their own decisions, potentially removed from the external actors (e.g., funders, policymakers) that we discussed in the section on the power relations perspective.

All questions in the interview guide were derived from a reading of the literature across the contributors to the conceptual framework (ecological theory, critical race theory, power relations perspective, and the ARC Model). The interconnectedness of these respective pieces creates the lens through which we can begin to piece together the many moving parts of a mental health organization's involvement in access creation for the Latinx community. The questions, though they are primarily exploratory given the mostly unexplored topic area, are meant to ascertain paths that can be taken to improve mental health service access for the Latinx population and ultimately decrease disparity.

Table 1

Interview Guide Questions Excerpt

Please describe for me how clients begin to access mental health services in your organization? In Arizona?
From your perspective, how culturally focused is mental health service access for Latinx individuals in your organization? In Arizona?

Potential Impact for Mental Health Services Research

The examination of power dynamics through an ecological lens contributes to understanding the bidirectional relationship of interactions among public policy, community, and institutions, for example, as illustrated in the ecological model (see Figure 1). Standard models of understanding client engagement into healthcare, in any form, focuses on the thoughts, behaviors, choices, and actions of the client (e.g., Andersen's Behavioral Health Model). The onus is placed upon the person needing help and the responsibility of their healing is contingent upon their abilities to navigate the healthcare system successfully enough to get their needs met. In this study, the view of choice and behavior are dependent upon the system in which the individual finds themself. In Arizona, this is particularly relevant given the unique structure of mental healthcare services due to the Arnold v. Sarn lawsuit. The idea that an individual is free to behave and make their own choices, without coercion, in a managed care system that will only help them if they can prove lawful status and need is challenged in this work through that analysis of power.

The use of Critical Race Theory and the Power Relations Perspective to examine power imbalances within the organization that can filter onto the client has rarely been done in mental health practice and their application to the Latinx population, specifically, is woefully limited. Much of the work in this area uses ecological theory, which can only begin to gauge the magnitude of power imbalances that can shift the decision-making power and access of the individual to treatment. The examination of power and the imbalance of control is essential to advancing our knowledge and understanding of how internal organizational functioning is influenced by a social and political environment that may or may not support its mission. .

The population is understudied due to a number of reasons: 1) diversity within the group which makes service access difficult to traverse; 2) mobility among communities due to financial or housing instability for those whom may be of undocumented status or living in poverty (25% of the Latinx population in Arizona lives under the FPL; Valdez et al., 2014); 3) difficulty in reaching all segments of the population due to language barriers or issues with provider/client congruence, and; 4) barriers to access to mental health services within the Latinx community to mental health services due to stigma, transportation issues, and organizational lack of capacity with regards to linguistic and culturally competent practitioners. Using the ARC Model, this study will understand how the status quo and organizational dysfunction contribute to ineffective measures aimed toward improving access.

Findings from this study can be used to inform training, policy, and future research. In the first paper, for example, we examined policy as it relates to the inner functioning of the organization—what entry into services looks like, how workers understand policy, and how the organization implements and works with (or around)

policies. In the second paper we explore worker perceptions of the Latinx community within the larger environment and how that contributes to mental health service access; in the third paper we investigate innovation and breaking away from traditional hierarchy. Although the implications for this work are summarized more in-depth in the concluding chapter, recommendations include extensive cultural training to stakeholders and organizational leaders, improvements in Arizona's re-evaluation of their criteria for cultural competence, and ongoing dialogue on power and privilege across the ecological model and their bidirectional relationships.

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CHAPTER 1: NAVIGATING ORGANIZATIONAL POLICIES AS A MENTAL HEALTH WORKER: THE IMPACTS ON CREATING ACCESS FOR THE LATINX POPULATION

Social environment, federal, state, and organizational policies, and funder agendas influence the internal functioning of mental health organizations in the United States (Garrow & Hasenfeld, 2016). These factors influence access to care through a complex system that determines eligibility, what services are available, and what resources are allocated to whom. Andersen et al. (1983) define healthcare access as "the potential and actual entry of a given population to the health care system" (p. 51). Latinx preferences for mental health access and service requires several things, including but not limited to a family-like environment (Gonzalez, Barrera, & Applewhite, 2015), language resources, a similar lens between client and provider on health and well-being, and a sense of confidentiality (Villalobos et al., 2016). In short: culture matters. However, the push of funding agendas, private or public, influenced by the larger social and political environment (i.e., the immigration debate, stakeholder biases) impact how organizations provide access, which may not allow for the resources necessary to implement these culturally-relevant necessities.

Organizational policies are often influenced by societal priorities at the time (Hasenfeld, 2010). An examination of all factors related to organizational culture and functioning is beyond the scope of this research, but it is acknowledged that external forces can implement prescribed policies that meet the needs of those actors. Political and institutional environments in which organizations are embedded have changed drastically from a system that seeks out avenues for social safety nets to an environment that promotes self-sufficiency and personal responsibility (Hasenfeld, 2010). This approach places the onus upon clients to seek their own services and maintain their

participation in their own treatment. Collectivist cultures, such as Latin American, tend to focus on context of communication, close relationships, and interdependence (Heine, 2012). Policies and practices that are grounded in notions of self-sufficiency are in sharp contrast to the values and norms of the collectivist Latinx population.

Power Relations Perspective

For the purposes of this study, stakeholders are any agency, institution, or individual with decision-making power on organizational policies, funding, or functioning; this does not include clients, although it is acknowledged that clients may be part of peer-run organizations or advisory boards. We use a formed power relations perspective (Garrow & Hasenfeld, 2016) to frame the external influences on internal organizational functioning. This perspective emphasizes that varying forms of power dynamics exist that constrain an organization's work—contributing to this are the stakeholders' resources (funders, policymakers), which are governed by the agenda of multiple external forces at varying levels (macro, meso, micro). Social forces that impact the Latinx population include anti-immigrant sentiment, discrimination, and institutions that decrease funding toward low-income communities. These factors also contribute to stakeholder perceptions that have the power and ability to create opportunities for organizations to receive resources. Thus, "priorities of the stakeholders are based on political, social, and economic stimuli, which then contribute to how the organization is structured and how it conducts its business (Hasenfeld, 1980, p.510)."

The discussion is not whether or not power is at play, but how that power contributes to access or acts as a barrier. Stakeholders hold power that influences and supports processes within an organization. For example, let us consider referral

processes. Referral processes are ever-present in mental health organizations for the purposes of managed care payor systems; however, the onus is ultimately on the individual to first seek out services through a general practitioner or other health authority to perform an intake or examination that will give them a qualifying diagnosis for the referral. Qualifying diagnoses are required for the payor (i.e., insurance provider) to compensate the clinic or doctor that made the diagnosis. If an individual does not have a qualifying diagnosis, they may not receive the referral, or, their insurance may turn down the service and the individual will be forced to pay out-of-pocket.

The stakeholders on the organizational level, such as CEOs and providers, are beholden to the insurance provider who wields power as the payor. As an example, in the study location, behavioral health incentives are dependent upon service units, established milestones attained within different resources, and the milestone rate to determine payouts, which is all pre-determined by Medicaid and governmental leadership (Arizona Health Care Cost Containment System, 2021b).

Stakeholders and External Interest

As relayed through the Power Relations Perspective, shareholder and external actors influence the internal functioning of organizations. It is through this influence that we see the inequities of access offerings in the Latinx community. The anti-immigrant sentiment present in the broader Arizona community impacts practices, priorities, and policies in organizations (e.g., deciding funding priorities). Funding goes toward crisis responses instead of sustained service access and delivery and training consistent with the needs of the Latinx culture falls by the wayside. Bilingual skill (English/Spanish) compensation for workers, for example, is not always provided by

organizations despite monolingual speakers being assigned to their caseloads. For some, the lack of compensation, or insufficient compensation, may be a deterrent for bilingual speakers to work in mental health, which can cause disparities for monolingual Spanish-speakers seeking access to treatment and services. Moreover, insufficient language services contribute to lower satisfaction rates for clients and providers, in addition to creating delays in provider and client communication (Al Shamsi et al., 2020).

Collaborations and Agency

With the push and pull for resources in constant flux and sociopolitical support for the documentation status diversity of the Latinx community only minimally provided (Documet et al., 2018) workers within mental health organizations may feel constrained to advocate for changes in access. Oftentimes, in an organization reluctant to change, the hierarchy is strictly maintained and power in decision-making rigidly maintained as collaborations within the organization and with the larger community are stifled (Hemmelgarn & Glisson, 2018). Hierarchy and reporting processes are not inherently bad, but instead it is the strict adherence to hierarchy that can limit change and collaboration within an organization. Hierarchical organizations that limit engagement with community and focus on the organization's funding priorities are often at odds with the needs of those requesting services. Restricted by social factors, personnel's autonomy is limited to acting within the norms, policies, and procedures laid out by the organization. A healthcare worker's autonomy can have lasting impacts on their engagement in their work, their ability to lead, and absenteeism or premature exit; thus, research has suggested that increasing autonomy and support can increase motivation (van Dorssen-Boog et al., 2020). Social policies that influence funding

priorities and organizational agendas may shift the power from the organization to the funding sources that keep the lights on.

In this article, which is part of a larger study that examines power differentials in mental health organizations and the impact on service access, we will focus on how organizations navigate the interplay of internal and external policies. This connects to powerlessness and a lack of autonomy for personnel, but it ultimately impacts the limitations we see in service access. This study takes place in the greater Phoenix metropolitan area in Arizona.

Conceptual Framework

Bronfenbrenner's Ecological Model explains the impact of the sociopolitical environment on policy at the national, local, and organizational level. The social and political environment create the backdrop in which organizations are embedded. Mental health organizations are influenced by social priorities and funder agendas, which are dictated by available resources and the decision-making processes in policy. In response to the sociopolitical, these organizations are constrained in how they provide access and to whom they can provide access. The individual is then left with limited options in how they can seek out and receive services. The individual is not autonomous within the system of care. In short, each piece impacts the next and they are connected within the larger environmental setting. Each aspect of mental health organizations, from referral to treatment and peer recovery services, all relate to the competing priorities of the sociopolitical environment. Funding will often go to "hot button" topics, not always to the marginalized, which, in the case of Latinx mental health, these individuals are stigmatized not only by their identity but by their diagnoses.

Social Environment. There is a paucity of empirical research about mental health and healthcare organizations among Arizona's Latinx population (Valdez & Langellier, 2015); however, there are general population statistics on mental health. Among the population, of those living with any mental illness, 59.9% do not receive treatment or services (SAMHSA, 2015). Within the state, overall, mental health consumers who received treatment from public institutions reported a lower improved functionality rate (66%) when compared to the national average (70%; SAMHSA, 2015). For the Latinx population, the stress of anti-immigration policies contributes to the perceived discrimination of this group and the possibility of poor mental health and well-being of U.S born Latinos (Ayón, 2010).

In addition, fear of deportation contributes to decreased help-seeking. The anti-immigrant policies in the state and in the Southwest at-large, "can accelerate the stress and fear experienced by immigrant populations, thus potentially impacting the Latino community's mental health… (Ayón, et al., 2010, p. 742)." Although high psychological distress exists within the Latinx population (Valdez & Langellier, 2015), such as depression, it does not translate to seeking out services (see Barrio et al., 2008; Ojeda et al., 2006; and Guerrero et al., 2013). This may be due to the way mental health services have historically been made accessible and the stigma associated with seeking treatment within the larger community and within the Latinx culture.

Political Environment. The sociocultural environment can impact internal functioning of organizations and on the practitioners therein (Guerrero et al., 2010). In turn, practitioners may or may not be receptive toward expanding access for the Latinx population if there is insufficient support in the sociopolitical community. A concrete way this is experienced is through decision-making regarding public funding of services.

In Arizona, public funding is minimal (see Arizona Health Care Cost Containment System, 2021; Langellier et al., 2014) for persons with legal residency within 5 years, DACA, immigrant visa status recipients, or those that are undocumented. Although insufficient, some organizations survive through the financial support of private donations or partnering organizations. Bias in the larger sociopolitical environment toward undocumented persons can result in sparse access and discriminatory practices. Provider bias, for example, is well-documented with the Latinx community, ranging from working with immigrants to working with adults. Bias, in this form, often takes the form of stereotyping or a misconstruing of cultural norms (Olcón & Gulbas, 2018) that can be detrimental to creating meaningful access to this community. In nearly a decade of anti-Latinx work, starting in the year 2000,

> the Arizona legislature enacted 65 bills related to immigration or targeted at immigrants. Among these bills were changes in state statutes that required individuals applying for driver licenses to provide proof of citizenship or legal residency, expanded the definition of human trafficking, increased the power of law enforcement agencies to ascertain the citizenship status of detainees, empowered the National Guard to enforce immigration laws, created penalties for employers that hire undocumented workers, and prohibited cities from establishing day labor centers that assist undocumented immigrants (Powers and Williams, 2012, p. 15; Zatz & Rodriguez, 2009)

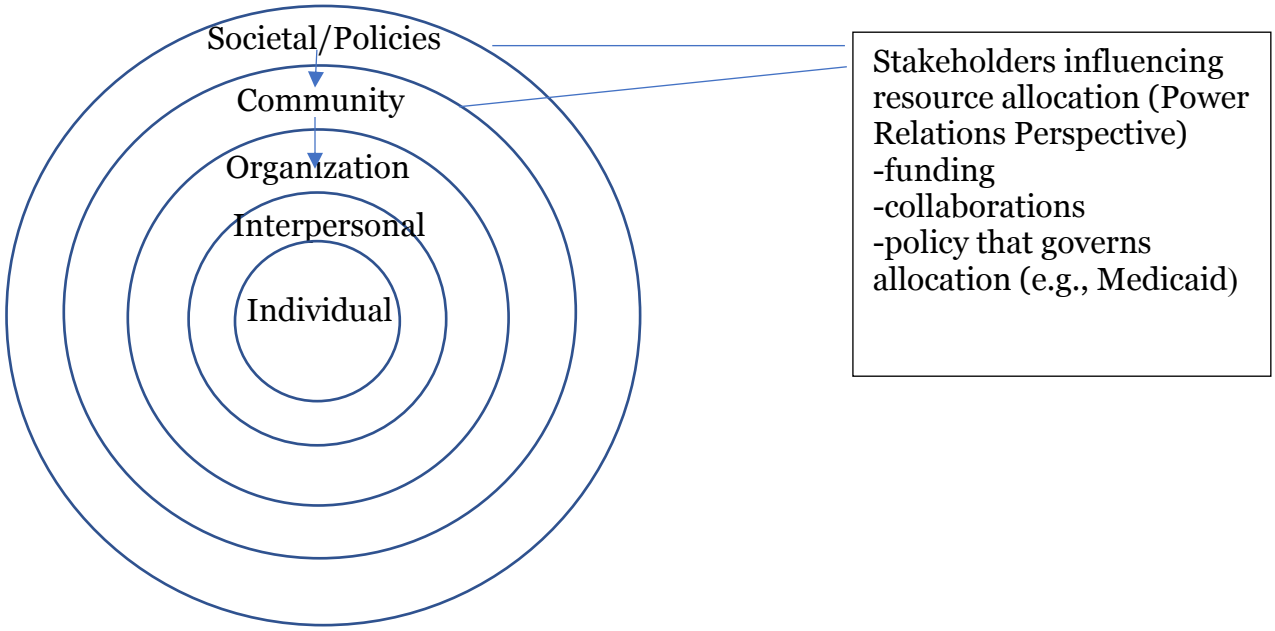
Although these policies are primarily targeted at immigrants, they also impact the daily functioning of US-born Latinos who are similar in appearance, culture, and language to their foreign-born counterparts.

We use qualitative methods to describe how administrators and direct service staff provide access to the Latinx population, within their ecological position and the social environment. Our aim is to understand "how do key stakeholders (practitioners, frontline workers, administrators) and their organizations utilize their current internal policies and navigate the interplay with external social policies to foster mental health service access for the Latinx population?"

Based on our conceptual framework and use of ecological systems and the power relations perspective (see Figure 3), we posit that the larger political environment can have an impact on internal functioning of organizations and on the practitioners therein (Guerrero et al., 2010). In turn, practitioners may or may not be receptive toward expanding access for the Latinx population if there is insufficient support in the sociopolitical community. In the figure below, the illustration shows the levels of influence from the power relations perspective and the directional flow of that influence from the political to community and onto the organization.

Figure 3

Diagram of Relationship Between Ecological Systems Theory and Power Relations Perspective



Methods

Positionality

Growing up in Phoenix, Arizona, I knew that there were disparities in my community that had to do with health and mental health. I was aware that my family had little means to get the care they needed and vowed to be a doctor that would help everyone, regardless of their ability to pay. I am Mexican American, cisgender female, and queer. I was raised in a multigenerational household, below federal poverty level, that was largely supported by social services. As a social worker, I was primarily assigned clients who were monolingual Spanish-speaking persons who had minimal financial resources, no health insurance other than perhaps Emergency Medicaid, and were struggling with understanding their own diagnoses, let alone working with their

family members to understand their diagnosis. To the work of this study, I bring with me multiple identities that align with the typical behavioral health client.

Participants and Setting

This qualitative, cross-sectional study takes place in Phoenix, Arizona, where the Latinx population is 42.6% (United States Census, 2020) and the white non-Hispanic population is 42.5%. The Latinx community in Phoenix is heterogeneous, composed of multiple ethnicities from the 33 Latin American countries. In Phoenix, 87% of the Latinx population identifies as Mexican or Mexican American (United States Census, 2018). In the city, 19% of the population identifies as foreign-born as compared to the national average of 13% (United States Census, 2019). In-depth interviews were collected among 18 participants from Spring through Fall 2020. Participants were frontline workers and practitioners (n=8; work roles such as "specialist" or "case manager"), and administrators (n=10; roles such as "managers" or "executive officer") across 8 mental health organizations throughout the great Phoenix metropolitan community. Self-reported demographic information indicates that the sample was primarily White, and several (n=4) identified as recipients of mental health services, otherwise known as peers.

The majority of these organizations were mid-size to large with over five locations (n=6), though there was one with less than five. Except for two organizations, the remaining four have been established in the community for more than 10 years. Participants were recruited from organizations that required residency documentation for services and only a few (n=3) from organizations that did not require documentation status. All participants had at least two years of relevant experience (range 2-31 years) in the mental health community and were over the age of 18.

Data Collection

Participants were recruited via word-of-mouth and connections through personal and professional networks. Recruitment occurred during the COVID-19 pandemic, thus all interviews were conducted via phone or video chat. Interviews lasted an average of 60-75 minutes (range 38-126 minutes) and were digitally recorded in addition to notetaking. At the start of all interviews, the primary author reviewed the informed consent with all participants and consent was submitted through signature as well as verbally before commencing the interview questions. Memoing was conducted at the end of each interview for the purposes of immediate reflection and to capture additional details of the individual interviews.

Interview Guide. The first author conducted all interviews and is English/Spanish fluent. Participants were asked questions (see Table 1.1) to ascertain whether there is collaborative communication across the organization or if all units act in isolation of each other. Semi-structured interviews consisted of 13 open-ended questions with nine prompts. Questions were focused on four main content areas: client services, accessibility, organizational policies, and power or powerlessness or the organization within the community.

Table 1.1

Organizational Policy Impact, Focused Interview Questions

In your tenure working in the mental health field, in what ways do social policies (like the famous SB1070) influence how an organization functions and gets funding?
a. How do social policies and social climate "mesh" with your internal policies?
b.
In your efforts, how well do you feel supported by your organization leadership when you or others approach them with new ideas that could support better mental health service access?
c. How does your organization get support for change efforts through external funding or internal policies?
d. How have social policies and the social climate influenced your efforts?
Walk me through what collaborations look like within your organization—or among other organizations—that have promoted mental health service access in Arizona.
a. What are the policies for staff, practitioners, and administrators (trainings, attendance at conferences, participating in the community, etc.) within your organization that promote culturally relevant approaches to creating mental health service access?
Thinking of your organization, tell me about the barriers or promoters to mental health service access.
e. How do you navigate the barriers and promoters? How does your organization navigate them?

Data Analysis

Digitally recorded interviews were transcribed and verified for accuracy prior to commencement of coding by the first author. All data were analyzed via an inductive process of thematic coding using the Dedoose online coding program. Through an

iterative process of inductive and deductive coding to develop the codebook, the major themes and subthemes were identified. We used the conceptual framework to determine major theoretical components: power relations perspective and ecological theory. Oftentimes, participants referred to previous points or jump off ideas, so these moments were included as they generated other categories, inductively. Additionally, patterns and discrepancies were examined as they presented from workers within different roles. Preliminary results were distributed to a subset of participants as a form of member-checking to confirm the interpretation of data and to capture missed meanings.

Results

In each of the main content areas we covered during the interviews, regardless of their role within the organizations, participants had similar responses. Organizational policies were primarily spoken about in terms of their inclusivity and non-discrimination efforts. Similarly, the conversation on power and powerlessness were focused on equitable relationships within each participant's respective organization. On client services and accessibility, providers were more apt to discuss the mechanics of their role; administrators mostly spoke to current and future developments and improvements they are hoping to implement. The four main themes that emerged are: 1) policy impacts on the work (how mental health personnel navigate policies within and external to the organization); 2) decision-making and training (policies surrounding training in areas like cultural competency); 3) organizational collaborations (the ability to navigate policies and procedures that influence the ability to create partnerships or coalitions that may influence power or resources); and 4) promising policy practices

(policy or guidelines that reflect culturally-focused practice, access, or service delivery that reflects the needs of the Latinx population).

Policy Impacts on the Work

Administrators indicated that a frontline worker may not know the pathways to getting support for their ideas to improve services or access (I think the perspectives may be different depending on who you speak to…if I made a decision that was not so great, I would be supported in that sense. I think that others who don't necessarily develop that type of relationship are going to feel more of that, "I have to get permission in order to do," Chief Integration Officer), whereas frontline workers stated that they feel supported in going to their peers, leads, or supervisors with their ideas; those who were not as successful had difficulty navigating channels for access or resources. This was particularly true for creating, changing, or improving policies in creating access. This was attributed to the strictures of hierarchy and procedure within organizations and leadership:

> *Case Manager:* I think anything that I may present or discuss or open up for discussion, I don't think they're prepared to handle it. It's a fear factor. You could see cliques… Everybody wanted to hire me, but when I got in there and I started making changes or rocking the boat, —I remember one board person told the director, 'He's a loose cannon.'

Several participants felt their organization's policies were aimed at making positive changes. This was not specific to the Latinx population. participants felt their organizations supported culturally relevant practice, but few discussed how that plays out for the Latinx community.

Most of the discussion on culturally relevant policies and programs were focused on language acquisition and translation services. None of the participants indicated that there are policies other than non-discrimination and language translation to serve the needs for the Latinx population For example, some responded to questions on cultural relevancy of services with generalities:

> *Family Support Partner:* Specifically, when working with—you mentioned the Latinx population, it's been pretty straightforward. We don't look at any one aspect of an individual. We look at the entirety of them and their cultural—whether it be their cultural background, their current economic status, or their well-being, basically, to assess their overall wellness, and see which areas we can provide support in. I know when working with—I've had some experiences with working alongside those who there might be a language barrier, and so what we've been able to do is use a translator, and even had some staff certify to translate, so that we can still provide the services that we do to those who we might have had a language barrier with before. We can get past that and still work with them.

This incident of focusing on broader cultural competency and the focus on Spanish-language translation was common across direct service providers and administrators:

> *Moderator:* From your perspective, how culturally focused is mental health service access for Latinx individuals within your organization or within Arizona?"
>
> *Clinical Manager:* "With the organization that I'm with, they offer interpretation. Also, if we do have anyone that is bilingual, we do assign that individual to the family just so they could assist better if there's that

> language barrier or to explain the process or program. We pretty much get very educated--especially now, they'll send out alerts, or stuff from the American Counseling Association or APA, and they'll let us know a lot of tips to help certain cultures -- we have a lot of resources.

Some participants described the need to apply "all hands on deck" (*Family Support Partner*) when it comes to working with Latinx individuals who may not have access to services. Several individuals, primarily those from a direct service background, discussed the need to sometimes go around policies to make sure clients could get their needs met.

> *Chief Executive Officer*: Yeah, I can tell you that my goal has always been to find the grey area with any policy and walk it extremely hard… I hear words like "should" and "may" and "have to" completely different. So when I see "can" or "may," I'm like, 'Oh, but that doesn't mean I *have* to.' I feel very strongly that I'm going to look at any policy, and I'm going to bend it as far as I can to the best interest of the young people we're working for. I would rather err on the side of asking for forgiveness than to deny someone access to something that they absolutely need.

In terms of access, most respondents described a referral process when discussing how clients gain access:

> *Community Outreach Manager:* They call. We have a referral and information line. They call to schedule an intake. We have different referral sources from the community, so not necessarily all the time they call, but referral sources come from DCS, juvenile probation, hospitals, sometimes schools…

Two of the participants were unsure about the exact mechanisms of how individuals get access to services and were unsure as to how all Latinx subgroups could gain access (i.e., undocumented persons).

> *Rehabilitation Specialist:* I'm not sure we treat undocumented people. I would have to ask my clinical coordinator how they get into services.

Other organizations operate through multiple channels to get clients through the door and into services. This could involve an extensive multi-step process of going through referral, then evaluation.

> *Case Manager:* The way they initially get started with us is they first would have to have previously been given an SMI diagnosis in the past like a recent diagnosis by a psychiatrist or through the court system… We start from that beginning intake process where we do the full psych evaluation assessment, have them meet with our treatment providers…then they would meet with me as their case manager to go through their psych assessment and treatment plan based on the recommendations of the clinical team

Or, further, there are processes and guidelines for how recruiting is done for employment that may not be equitable to providers that can culturally meet the needs of their clients:

> Chief Integration Officer: Well, I think leadership needs to be—how do I word this? Accordance to being open to a different way of doing things. Oftentimes we get stuck in, 'This is our recruiting process, and so this is how we're gonna do things, and this'—and we get stuck in that

Many respondents discussed their ability to make decisions on their own; however, they also noted that there are processes laid out by the organization around which they have to navigate.

Decision-Making and Training

Participants discussed their ability to work with clients but also noted that some of that autonomy is limited by funding or local priorities. In essence, their autonomy in making decisions with their clients was impacted most greatly by the type of support they received from funders and from the community.

> *Housing Specialist*: My role is the only role [in the agency] that is not a medically covered service. Housing is not a covered service under Medicaid. ...They provided some dollars to try to create a program to get subsidies, a housing subsidy, to create them for the most vulnerable without resources, but you're talkin' 26,000 people. Who's the most vulnerable without resources if they're all living below poverty? They're all struggling to manage with the rental-rate increase 'cause there's never any regulation with it...There's a lot of using vulnerability index, coordinated entry. There's a lotta halfway housing. None of those are medically covered services

Some responses focused on the training of staff that comes into their agencies and what that means for how they make decisions and provide services in working with the Latinx population. Further, they discussed how certain materials that might be distributed throughout the organization from management may not be sufficient in making the right decision and practicing with Latinx clients.

> *Executive Clinical Manager:* I don't think there's enough training, to be honest. I think it's more what people know because, as therapists, we're supposed to be culturally diverse. We're supposed to have an open mind and set that tone because of the trainings that we get when we work through our masters, and when we get licensed, you take the test on cultural. I think after that, it kind of gets depleted. I don't think there's enough to have that much training on the cultural side…I had to research. What's their culture like? What do they do? I had some [Latinx clients] that came from gangs and just out of prison, or women that--they just experienced trauma, but they didn't believe in therapy or talking to someone because that's not within their culture…I just don't think there's enough training. I think when you've provided something just to read, it's a little bit different than actually implementing the tools to actually assist with that culture

Although there was minimal discussion about resources other than language preference, there were some participants that discussed their cultural competence training with all populations, but not specifically those that identify as Latinx. In these discussions, they describe the internal functioning of the organization in terms of initial training upon hire, then ongoing training that continued throughout their tenure.

> *Peer Support Training Manager:* I teach peer support and training and one of the classes I teach is cultural competency. I teach our clients how to go to work as peer supports and how to look at different cultures and class standards and requirements of the state…we have a lot of Spanish speakers. We don't just wanna pop you on the line with somebody who can

> translate, but really get a team member who can understand you and your language…We teach that in new employee orientation

Largely, participants noted that training is important, but were split on what that looks like within their agencies. Approximately half of respondents, mostly direct service providers, spoke toward cultural competency training but also expressed that they felt prepared to work with the Latinx population; however, administrators and those in leadership positions were more apt to describe ways they work around policies or systems to get more training, more development, and more decision-making power in accessing training.

Organizational Collaborations

While some participants were optimistic about their ability to create access opportunities for their clients, others spoke about how their ability to create collaboration within the community was limited by policies, funding, their own identity, or their role within the organization. In short, collaborations to create access opportunities were restricted by the larger environment.

> *Chief Executive Officer:* The funder says, 'Oh, I'm going to give it [funding] to this big White agency 'cause I know they can handle this 'cause this other one was going under.' They don't say 'Well, X agency is real capable right now, why don't we consider them?' Funders will do that. They'll do it with someone that's not much of a risk. Latinos, then, are ticked off that people don't come to them if they're working really hard. Then, they just do their own thing inside and not make enough of an outreach to community… When there were committees and stuff in the community, I would volunteer…I, as a Latina woman, never have been

> asked… They don't think of us. It's not that they think we run a bad program. Some may. Some may not. They just don't think of us

Few respondents noted competition among organizations instead of collaboration. For example, policies or external funding may create a shortage of resources to smaller community-led organizations.

> *Community Outreach Manager*: I think that collaboration at the end of the day is not the true collaboration because everybody wants a piece of the pie, as far as funding goes. Writing grants, and like, if I wanna go to another organization, to say, 'Hey, let's work together, let's write a grant together, I don't think that really happens…grant funders, not state funders

Practitioners, on the other hand, felt that collaboration was a part of their job requirements to help serve the Latinx population, and they relied heavily on administrators or clinical leads to reach out to other organizations.

> *Case Manager:* More on a micro-level, my own supervisor and clinical director are very supportive…If we are having struggles collaborating with other agencies, they're very involved in that process so that we can continue to move forward. For the most part, agencies are responsive and they're doing the same thing.

Promising Policy Practices

Practitioners and administrators alike discussed promising efforts in diversity, equity, and inclusion for their clients. In one such effort, the members of an organization discussed affinity groups that were designed to contribute to diversity, equity, and inclusion efforts that would filter into client services. In another effort,

members of the organization discussed a dedicated team that focused on diversity. It must be noted, however, that no study participants spoke directly to the cultural or diversity needs of the Latinx population other than testing and compensation for bilingual ability:

> *Clinical Lead:* We encourage and we foster empowerment in our employees…some of the things that we've done more recently are standing up those culturally--the committees. Those are called [omitted] agency employee resource groups, and so we have one around the Latinx population, we have one for the LGBTQ, we have one for African-American/Black/people of color and allies, so allies an join any of those groups as well…The idea is that not only did the employees who identify in those areas or the allies can join together and discuss whatever they want, they have a voice to be able to influence what we do in an organization.

Some policies focus on meeting the needs of the client in multiple platforms. For example, if a client is assigned to a clinic on the west side of the city but works on the east side of the city, all the clinics have a reciprocal relationship with one another.

> *Peer Support Trainer:* The cool thing about [agency] that I will say is that you can go to any [agency] site and work with somebody. If you're an [agency] client, our doors are open. I've seen that happen as a case manager at one of the clinics. I would wanna meet with somebody who's a translator, and then they lived over there, but their provider was a Spanish speaker, so they were coming to me over here. I could just go and meet with them at the other location…my badge worked and everything. It was like walking into just an extension of my desk.

One last promising policy within the state is a resource line that can be used by practitioners, administrators, other even clients, that can direct them to community resources. This is not a practice specific to an agency, but it is specific to the needs of any individual who works with a client. One peer specialist highlighted how some Latinx clients research resources on their own if they feel they are unable to speak with a formal practitioner.

Discussion

Results highlight many barriers to facilitating access to mental health services for the Latinx population. Minimal resources, lack of collaboration across agencies, and equating language translation as cultural competency contribute to behavioral health disparity. Research highlights that Latinx individuals prefer a provider that can speak their language (Villalobos et al, 2018) as well as a family-like environment that can support their needs (Gonzales et al., 2013).

Seminal work from Alegria and Takeuchi on the National Latino and Asian American Study (2002-2003) indicates that while Latinx persons do utilize social services, more generally, they also seek out informal services at similar percentages (Chang et al., 2014). Combining this knowledge with the organizational experiences of practitioners and administrators in this study, we may be able to understand the barriers that contribute to behavioral health disparity. The low utilization of formal services has historically contributed to behavioral health disparity; however, from the findings of this study we can ascertain that formal services may be restrictive in how they provide access and the barriers to the creation of access that is relevant to the Latinx population. Issues concerning lengthy referral processes and insufficient cultural

training may alienate Latinx persons that are more collectivistic or that do not adhere to the stereotype of minimal English language competency. Despite working with one of the highest Latinx populations in the country, organizational processes described in this study did not translate into the practice of culturally relevant access. On the contrary, cultural training appears to be limited to translation services, bilingual differentials for workers, and an understanding that the Latinx population is a high-risk group that does not seek out services due to cultural stigma.

All participants in this study discussed the need for services within the Latinx population, but they focused on the need for Latinx persons to approach the agency as opposed to conducting community outreach. This is in line with previous behavioral health models that place the onus of help-seeking on the potential client (see Andersen's Behavioral Health Model, 1983; 1995). This could be due to the training - or lack of training - practitioners and administrators receive through their organizations, regardless of their role within the organization.

In this study, there are several limitations. There was no question or discussion on immigration policy other than uncertainty as to how undocumented persons enter services or commentary on the lack of funding for programs that serve undocumented or DACA status clients. Mental health need as it is associated with documentation status or discrimination was not the focus of this study; however, even in adolescents, there are negative outcomes (higher blood pressure, obesity, increased maternal stress) due to these factors (Eskenazi et al., 2019). Further, components of this study that require deeper examination, such as the how organizations walk the line of policies, or how providers personally interpreted policies outside of their job function, were not explored. To fully capture the personal biases of both administrators and direct service

workers, future research is warranted to explore this at different levels of the organization and across years of experience and location.

Implications for Policy and Practice

Organizational policies that incorporate deeper cultural training (i.e., focus on closeness of relationships, open communication, interdependence within families) may be successful to increase access to services for the Latinx population. Processes that incorporate Latinx cultural components, such as trust and family involvement, as opposed to multi-step practices that could dissuade social services participation, may improve access. Additionally, as described through conversations with the participants, promising policies that incorporate the perspectives of affinity groups may give administrators insight into the needs of various groups (U.S.-born clients, undocumented persons, undocuqueer, etc). The greatest benefit of the affinity groups could be understanding how to create outreach within the Latinx community, or further, encouraging clients to seek out services that meet their needs. The impact of resource and referral phone numbers is understudied with the Latinx population, although they could act as a primary resource for individuals who are not ready to seek out formal services like case management or therapeutic treatment.

In reflection of the conceptual framework, possible interventions could include the development of policies that reflect the need for equitable resource allocation (funding, collaboration opportunities, policy that governs allocation) that responds to the needs of the Latinx population. Further, organizational policies that create opportunities for additional training may serve to extend the knowledge of working with Latinx persons, which may prove applicable to working with similarly underrepresented populations in mental healthcare.

Conclusion

Mental health services for the Latinx population are best when catered to the cultural and social needs of the community. As we previously explored through the literature, this could mean the creation of a family-like environment, the building of trust (confianza), and considering context within communication. Although funding, agency collaboration, and worker standing within the organization may act as barriers to creating access opportunities for Latinx clients, policies that can circumnavigate those issues may decrease behavioral health disparity. Examining how the role of the worker creates an organizational environment conducive to Latinx persons seeking treatment and services may promote help-seeking. Speaking in both the literal and metaphorical language of the population could be a benefit to this population and to the larger community in central Phoenix, Arizona, which is on the verge of minority-majority status.

Declaration of Conflicting Interests

The author(s) declare that there is no conflict of interest in the publishing or funding of this study.

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CHAPTER 2: INFLUENCES AND POWER IN MENTAL HEALTH ORGANIZATIONS' CREATION OF SERVICE ACCESS FOR THE LATINX POPULATION

Research has indicated that Latinx persons face multiple barriers to mental health service access, such as lack of insurance, provider bias, cultural stigma, and language translation (Cabassa et al., 2012; Rastogi et al., 2012). Minimal emphasis is placed on the power and privilege held by mental health organizations that contribute to behavioral health disparity. For organizations to develop successful access pathways and target culturally responsive community outreach multiple factors must be considered. This includes examining the influence of the social and political environment to gain an understanding of internal organizational functioning (an ecological perspective). At the organization level is the power to secure funding, conduct hiring for minority representation, or to implement evidence-based training. At the staffing level, administrators and direct service workers navigate hierarchy in their organizations to make culturally relevant change. And lastly, at the service level, organizations are responding to the needs of the Latinx community: is there representation in decision-making, are outreach efforts tailored to the Latinx community, and are methods through which that "tailoring" is accomplished culturally meaningful?

Stereotypes, racist messaging, and discrimination often contribute to negative mental health outcomes in the Latinx population (see Arbona et al., 2010; Caplan et al., 2007; Williams, 2001). Organizations that use stereotyping in offering services and ignore the heterogeneity of this population add an additional barrier to creating an environment conducive to seeking services (Furman et al., 2010). As of 2019 a little over one-third of Latino households spoke a primary language other than English in the home (United States Census, 2019) and only half report they can speak English "very

well" (Valdez et al., 2015). An example of racial/ethnic stereotyping is language preference. Many organizations use Spanish language translation services and materials as a proxy for cultural competency (Guarnaccia & Rodriguez, 1996). The failure in this approach is that not all Latinx-identified persons speak Spanish, such as the large Indigenous populations in Central and South America, or even the next-door neighbor with a Spanish last name but minimal Spanish language competency. In fact, by the second or third generation of Latinx families living in the U.S., fewer persons can read or speak Spanish proficiently (71% versus 47%, respectively; Pew Research Center, 2012).

While language use is important, needs assessments indicate that the Latinx community needs other representations of culture present to engage in therapeutic support (American Psychiatric Association, 2021). This includes a family-like environment (Gonzalez et al., 2015), provider representation, and communication in a shared cultural language (Aguilar-Gaxiola, 2012; Heine, 2012). Mental health research has also indicated that the average Latinx client experience is complicated: most prefer to seek mental health treatment from a family provider as opposed to a specialist (Jimenez et al., 2013), younger Latinx adults experience suicidal ideation at higher rates than their non-Latinx peers (Brown et al., 2015; DeLuca et al., 2012), while older adults are the least likely among the population to seek out any help at all.

As of 2019, the U.S. Department of Health and Human Services Office of Minority Health reports that Hispanics were 50 percent less likely to have received mental health services than non-Hispanic Whites (2020), while in Arizona, Latinxs utilize services at a lower percentage (31% versus 86%, respectively; Substance Abuse and Mental Health Services Administration, 2017). For the Latinx client, identifying a

need and using available resources to seek treatment is not the norm, despite population health models (see Andersen's Behavioral Model, 1983). Indeed, the Latinx client lives in a social and political environment that restricts their autonomy based on their identity.

This study aims to understand how issues of power are present within mental health organizations and how those issues contribute to unequal power balances in organizational hierarchy, and racial or ethnic stereotyping of needs. We explore power relations as the come from the community to the organization, and from within the organization to the individual functions of the worker in their role. More specifically, the effort is to understand the ability of organization personnel to respond to the cultural needs of the Latinx population through power sharing within the organization.

Power Structures within Organizations

The examination of power differentials in social service organizations has historically focused on client empowerment or power-sharing among administrators and direct service staff (Salzer, 1997) but has not explored the impact of external actors' power within the organization. Societal biases are reflected in our healthcare organizations that have historically pushed people of color to the margins and maintained White dominance (Williams, 2001). For decades, the accessibility of services has been filtered through multiple streams that maintain the imbalance of power, ranging from staffing decisions and leadership development to how resources like funding and training are allocated (Williams, 2001).

Potential funding sources have the power to dictate which organizations would be the best "fit" for their goals, which organizations meet their goals and align with their image and vision. While adapting services to meet funders' goals holds true across most

non-profit organizations, in mental health the landscape has changed drastically. In the mid-1980s, most payments made to hospitals for mental health services came from private insurers; however, within the last decade Medicaid has been one of the biggest payors for behavioral health services (Levit et al., 2013). As such, larger organizations with community presence may receive greater funding support due to their recognition in the community as well as their average reimbursement from payors with whom they create contracts. The more well-known an organization, the greater likelihood of their community support that helps them sustain operations; smaller organizations cannot survive on low yield from reimbursements. Oftentimes, this translates to organizations chasing funding to maintain their organization's mission and provide services. In practice, this often results in programs within organizations that may meet the financial needs of the organization, but not the social or therapeutic needs of the population. Funding stakeholders may have a different mission (e.g., private donors and grants) than organizations that aim to serve the Latinx population.

For the Latinx population, the structure of the U.S. healthcare system may require a considerable overhaul. Services would have to decrease provider turnover and increase the number of Latinx mental health professionals and allow time for relationship building. In Arizona, where this study takes place, there are less mental health providers per 100,000 in the population than there are nationally: 148 providers versus 268, respectively (United Health Foundation, 2020). Providers are often accountable to 100+ productivity units a week (Bennett, 2010), updated documentation every 30 days, and an arduous intake that requires the creation of a service plan, safety plan, cultural intake, medical history, medication history, etc., within the first meeting (Social Worker Resource, 2013). Taken in tandem with the low number of providers

available to the population, we can see begin to understand the scope of provider access to the general population, let alone the availability to Latinx persons who prefer to work with providers who can speak both a literal and metaphorical language (Aguilar-Gaxiola, 2012; Heine, 2012). Although an investigation into the experiences of Latinx clients during the mental health services intake process is beyond the scope of this paper, it must be noted that such an overwhelming introduction for a high needs population may create new barriers as opposed to fostering a therapeutic environment.

Environmental Discrimination

Bronfenbrenner's Ecological Model (1979) allows us to explore organizational functioning as a response to the broader landscape of mental health access. Although organizations can make decisions about how and why they create service access, they are not fully autonomous. Like the Latinx client, mental health organizations are limited by their acquisition of resources and the level of support they receive from their political and social community. Support for mental health access creation for the Latinx community may be limited due to their organizational biases concerning this population. In critical race theory (CRT), we learn this is due to the White dominant group maintaining their psychic and physical control of institutions—institutions that support omnipresent racist tactics to maintain power.

Political sentiments influence state and local healthcare funding for persons in the Latinx community who may have a documentation status other than "citizen" or "legal permanent resident." Approximately 65 bills related to immigration were created in Arizona between 2000 to 2009 (Powers and Williams, 2012). Many of these were focused on increasing power of law enforcement and other militarized entities to remove undocumented persons' liberties (driver's licenses, increasing power to agencies to

ascertain citizenship of civilians, creating harsher penalties for businesses that hired undocumented persons, etc.). These policies may have resulted in poor access for the Latinx population. U.S. data reports that population, Mexicans are least likely to seek out mental health services (Aguilar-Gaxiola, 2012) and in large metropolitan areas like Phoenix, most Latinx individuals with mental illness do not receive treatment or services (59.9%; SAMHSA, 2015) and many mental health consumers have more difficulty functioning than the general population (SAMHSA, 2015).

Further, there is minimal guidance from the state on cultural competency measures. For example, for contractors in Arizona's state Medicaid program, the Arizona Healthcare Cost Containment Service (AHCCCS), the expectations of cultural competency primarily focus on Spanish-language materials and resources. In fact, as of public documents in 2019, 9 out of 28 contractor requirements focus specifically on language translation, interpretation, or written communication of services (see Table 2). In this chapter, we utilize elements of critical race theory, ecological systems, and the power relations perspective to understand what is occurring at the governmental and policy level to influence the internal functioning of the organization and how personnel then exert their influence on interpersonal and individual experiences of the Latinx client that attempts to engage with services.

Table 2

Examples from AHCCCS Contractor Operations Manual, Policy 405, Attachment A

A description of the Contractor's method for evaluating the cultural diversity of its membership to assess needs and priorities in order to provide culturally competent care to its membership (languages spoken and ethnicity of membership).
A description of how the Contractor evaluates its network, outreach services, and other programs to improve accessibility and quality of care for its membership. It shall also describe the provision and coordination needed for linguistic and disability-related services**.**
A description of how the Contractor makes the member, at the point of contact, aware that Translation/Interpretation services are available. This includes access to oral interpretation, translation, sign language, disability-related services, and provision of auxiliary aids and alternative formats on request.
How written materials critical to obtaining services (also known as vital materials) are made available in the prevalent non-English language spoken for each LEP population in the Contractor's service area. [42 CFR 438.10(d)(3)]. This includes the requirement for provision of all written materials for members to be translated into Spanish whether or not they are considered vital. Refer to ACOM Policy 404 for additional requirements.

Source: AHCCCS Contractor Operations Manual, Policy 405, Attachment A – Cultural Competency Plan, Assessment, Language Access Plan, and Family-Member Centered Care Reporting Checklist

Social Power and Resource Competition

Mental health organizations are not isolated from the influence of social agendas, dictated by power differentials. The Power Relations Perspective (Garrow & Hasenfeld, 2016) allows us to examine organizational power through resource dependence, institutional theory, and political economy. This perspective allows us to do three

things: 1) create connections between shifting power dynamics and funding stakeholder interests; 2) understand how this dynamic can constrict the full potential of an organization's ability to provide their services; and 3) examine how the competition of resources within a community that may hinder the progress of smaller non-profits. Looking through the lens of resource competition and the idea that internal actors try to resist external agents, we can then examine about how an organization's power influences—and is influenced by—the external political and social community.

When thinking of power differentials, we often think of those that exist between administration and direct service workers, or those that exist between provider and client; however, limited exploration has been done on power negotiation and organizational standing in the community as a means of organizational survival. Utilizing Bronfenbrenner's ecological perspective, we can then examine the influence of social stereotypes of the Latinx community, the impact of organizational hierarchy, and an organization's power within the constraints of external involvement (i.e., funding, prioritizing of programs). In essence, the exploration here is if an organization's power within the community (related to their reputation in the community) has any bearing on their ability to improve or create service access.

This cross-sectional qualitative research examines the impacts of power upon and within the organization and how that improves or hinders mental health service access. Guiding this study, the research question asked: "How do administrators and direct service workers within mental health organizations address issues of power and external influence to better provide mental health service access to Latinx persons?" We tried to understand that nature of acting as an individual in concert with others in the organization, how individuals contribute to the creation of access, and how an

individual's understanding of their organization's power and privilege contribute to behavioral health disparity in the Latinx population. In summary, like the previous chapter, the ecological theory coupled with the power relations perspective can provide insight into what is occurring in hierarchy

Methods

Researcher characteristics and reflexivity

The principal investigator is a Mexican American cisgender queer woman who was born and raised in a low-income community in Phoenix, Arizona. As a social worker, the author worked and volunteered in a range of areas including, but not limited to, homelessness, child mental health, and domestic violence. She primarily focused her studies and research on mental health in both the Latinx and Indigenous communities, coming from a perspective of decolonizing healthcare treatment for non-dominant persons and examining the role of power in mental health organizations and how they create relevant access pathways.

Context

This study takes place in greater Phoenix, Arizona, which is the largest city in Maricopa County, and has a Latinx population of 42.6%,the majority of which identify as Mexican or Mexican American (87%; U.S. Census, 2020); 19% of the population identifies as foreign-born as opposed to the national average of 13% (United States Census, 2019).

Sampling strategy and Participants

In selecting outreach sites, the following was considered: standing in the community, size, and location. Initial outreach was conducted through online interaction due to data collection occurring during the COVID-19 pandemic. This outreach occurred through community connections at local mental health organizations that serve the general and SMI populations. A snowball technique was applied throughout the data collection process after the initial outreach by the primary researcher to professional networks across mental health organizations.

Administrators (n=10) and frontline workers/practitioners (n=8) were recruited from 7 mental health organizations throughout the great Phoenix metropolitan community. Among them were three well-known and wide-reaching organizations, three mid-size organizations, and one small organization, all of them were in major cities within Maricopa County with large Latinx populations.

Inclusion criteria asked that participants had at least two years of relevant experience (range 2-31 years) working with Latinx persons in the mental health community, lived in the community they served, and were at least 18 years of age. The substantial number of participants (n=8) worked within organizations that served the seriously mentally ill (SMI) population; others were in mental health organizations that are not limited to that population.

Data collection

Interviews were semi-structured and took place via video chat on the preferred platform of the participant or via phone call. The principal investigator conducted all interviews and, although Spanish/English fluent, only certain words or phrases were spoken in Spanish in four of the interviews. In-depth interviews were collected among

all participants from Spring through Fall 2020 and lasted in a range from 38-126 minutes.

Data collection instruments

Interview guide questions (see Table 2.1) originated from the study's theoretical approach. informed by the ecological perspective, critical race theory, and the power relations perspective. The focus on how power is practiced is woven throughout the questions as well as a focus on the role of the worker in how they create access within the means of their position. More specifically, questions are asked to target who decides processes and agendas, how power of the dominant group is maintained (either through institutionally enforced biases or through biases fed from social perceptions of the Latinx population), and how organizations perform their power within the community based on factors like reputation or community presence.

Table 2.1

Influences and power in mental health organizations, Focused Interview Questions

Question 5:
Walk me through what collaborations among administrators and staff look like within your organization—or among other organizations—that have promoted Latinx mental health service access.
Question 6:
Taking a deeper dive, how effectively do you think your organization takes efforts toward anti-racism and negative stereotyping in working with the Latinx population?
Question 7:
Thinking of your experiences, can you share with me an example where there was a clear power difference between you and the administrators or other staff?
Question 8:
Now let's think of the organization. Can you describe for me an example where the organization lost or gained power and standing in the community or with funders?
a. How are the priorities of the organization determined; by the staff, the community, by funding, or all of the above?
b. In your opinion, how well do the organizational priorities meet the needs of the Latinx community when it comes to mental health service access?
c. What about with the needs of external funding priorities?

Data processing

All interview recordings were transcribed and verified for accuracy through comparison to the original audio prior to deletion. Data were secured in a password protected computer and through encrypted file saving. Participant data was deidentified from the moment of recording, assigned the digital code for the recording

and, when possible, personal information in the recordings is omitted in the presentation of the findings.

Data analysis

Themes were identified through an iterative process of examination and code creation. After several initial reads to grasp the content, a second read occurred to pull together main ideas and concepts before a third read in which initial codes were sketched out to create the preliminary codebook. Further iterations required this process of reading and re-reading the transcripts to look for meaning and understanding the transferability of terms and service approaches within each organization. Using both an inductive and deductive approach, analysis occurred through the lens of an ecological perspective, looking at the flow of power through each level of the ecological framework (e.g., policy, institutions, community).

Techniques to enhance trustworthiness

At the end of participant interviews, a subgroup was asked to provide feedback via member checking. The process of member checking was explained to all interested during the time of the initial interview. A total of 6 outreach attempts went out (three administrators, three direct service providers) and 2 replied with feedback. Through this member checking process, this subgroup was provided a brief report on the major themes, the interpretation of those themes, and the focus of the results. Six individuals were accessible through their contact information (three administrators, three direct service providers) and were delivered a brief report and an opportunity to speak about the findings via virtual meeting or through written response. Member checking participants were provided two weeks to return any feedback with a point of contact after the first week and after the second. Also offered to these participants and their

organizations were formal presentations of any research findings that could be of use to their needs. At the time of this writing, no participants asked for a formal delivery of the report to their organization.

Ethical issues pertaining to human subjects

This study was approved as exempt by the University of Washington Institutional Review Board. There was no funding conflict for this study among the organizations, the authors, or the institution.

Results

Three main themes emerged from the data analysis: 1) power and standing in the community; 2) differing hierarchy interpretations; and 3) contextual issues in racial/ethnic stereotyping. In "power and standing in the community" the focus was on the reputation of the organization and whether it created opportunities for exerting power or the cause of a loss of power— "power" in this context was whether an organization had recognition, prestige, or had the ability to have their pick of organizational partnerships or collaborations. In the second theme, "differing hierarchy interpretations," the focus was on who has the power to create priorities for the organization and how that can contribute to access. The final theme, "contextual issues in racial/ethnic stereotyping," homed in on the ability of the organizations to be culturally responsive to the needs of the Latinx population.

Each of these themes are examined and summarized across both administrators and direct service providers (see Table 2.2). In this study, administrators are individuals that gave their titles as "coordinator," "director," "manager," or "administrator." This was done to assure representation across all organizations

involved in this study since many organizations have different titles for the same function. Similarly, a direct service provider was any participant that was a "coach," "behavioral health technician," "case manager (not manager of a unit)," "support/peer specialist."

All participants perceived there were social and cultural barriers to the Latinx community receiving services, but they did not attribute these to power, instead they focused on prospective clients choosing not to engage in services due to societal and cultural stigma. Approximately half of the participants had difficulty identifying their organization's standing within the mental health community and the power they carried yet were able to discuss missteps with great clarity. Administrators were more likely to discuss the limitations of their current work and how those contributed to what they are striving toward—these efforts were primarily focused on diversity, equity, and inclusion for all populations as opposed to just the Latinx population. The discussion of power and the influences of the larger environment focused on social stigma of seeking mental health treatment among the Latinx population as well as the lack of resources for this high needs population.

Discussions on power were more focused on the individual's power within the organization: who can make decisions, who they must report to, and how those relationships impact their ability to perform functions related to access. Three participants were vocal about the state of mental health care throughout Arizona in terms of funding and allocation – despite frustrations, they indicated that the current Medicaid system is difficult to navigate for persons that may not speak English or that do not have experience navigating managed healthcare.

All participants perceived there were social and cultural barriers to the Latinx community receiving services, but they did not attribute these to power, instead focusing on prospective clients choosing not to engage in services due to societal stigma.

Power and Standing in the Community

Participant conversation on organizational power covered a wide array of issues that narrowed in on funding, collaborations, and the need for outreach. Most participants were initially unable to identify and describe the power their organization had within the community when asked about how their organizations use that power to make decisions, gain resources, or provide culturally relevant services through collaboration; however, throughout the conversation many used the word "reputation" when talking about how they gain or lose external support.

Two of the organizations that participated in this study are in the process of overhauling processes, staff, and leadership. The participants from these organizations provided examples of what these changes look like in relation to Latinx access: creating staff constituency groups, implementing diversity teams, and creating policies that "improve the clinics and the situation" (Peer Support Specialist). This was always attributed to new leadership that was either brought in or that were given power and opportunity to bring in novel resources for clients and staff, create coalitions, and partner on community grants: "We have partnerships with many organizations across the county and state…If there's a service that we don't provide, we try to partner with organizations that can" (Chief Integration Officer)

Although most participants acknowledged that client needs come first, they also noted their inability to always meet those client needs with their current organizational structure, regardless of new leadership. Recognition as a reputable organization with

clout was important. Issues of local presence included lack of Latinx personnel representation, advertisement, and knowledge about mental health services in the population ("We don't get on TV, and we don't advertise and all that…," Peer Support Specialist). Largely, respondents noted that funding was a major motivator of reaching out for grants, federal programs, and developing connections with private funders. Although every clinic in this study received federal or state dollars, there were issues in making sure clients were getting the right resources in the right way due to eligibility requirements:

> I know there's federal dollars that are attached to coordinated entry, which have been super helpful, but then we have to look at their eligibility requirements. Not all people meet them (Housing Specialist)

One participant indicated frustration that not all organizations were aware of resources for funding or support. This was viewed as unintentional, but a reality of changing leadership in the organization:

> My own agency, a year ago, I kept saying, 'why don't we solicit federal moneys, look in the federal register? These [omitted] didn't even know what a federal register were! (Case Manager)

The frustration felt by this individual came from their decades of experience in working for federal programs. Their interpretation of the status of mental health services in Arizona was that the ability of leadership to secure funding or create new opportunities was lacking.

Differing Hierarchy Perceptions in the Organization

This theme was centered on a singular focus: hierarchy. This could mean hierarchy among administrators, or among staff, in decision-making on how the

organization creates access. This section focused primarily on power within the organization – who has the power to make decisions, initiate opportunities, and create change. While both groups indicated that their ideas are fully supported by administration, they also indicated that not all individuals are heard or represented. This was seen as a contributing factor to the lack of access to mental health services. Some administrators spoke about hiring practices and recruitment by organization decision-makers, which ultimately dictated who served the community and who did not, while also emphasizing macro factors in bringing in trained Latinx providers as opposed to relying on support staff:

> …how are the colleges targeting the students that they're bringing into their programming? We're not seeing them coming into our workforce…what we are seeing are our customer-service representatives. We do have quite a few behavioral health technician-level staff but it's still a low percentage compared to the overall population that we serve of people who need that service. (Chief Integration Officer)

This statement is reflective of the larger conversation in this interview on educational opportunities for non-dominant groups entry into social service professions. This was a larger environmental concern that contributed to a lack of representation in the organization.

Participants both agreed and disagreed about how their roles had, or did not have, decision-making power within the organization. While most agreed that administrators were at the top of hierarchy, direct support staff stated they felt comfortable sharing ideas in a group or even disagreeing with their supervisors. In

several conversations, individuals reported that their Chief Executive Officers were open to dissenting opinions, or were more invested in the staff and client needs being met:

> The Chief Operating Officer sat me down, and she goes, 'If you talk to me about dollar signs again, we're gonna end this conversation. How is this going to impact the clients? That can be by means of the employees, but what good is this going to do to our clients? Share with me that…I would say the only barriers to that [to professional development] are my nervousness…the only barrier I have is self-doubt (Peer Training Manager)

Across all participants, training and development seemed highly supported in their organizations and most responses indicate positive experience in asking for those experiences. While there were no participants that reported a negative experience in asking for training, the overall perception was that it was the higher-ups that made decisions on what trainings were accessible to them.

Contextual Issues on Racial/Ethnic Stereotyping

Several of the identified issues were training/education, hiring, racial/ethnic stereotypes, and assessment. Sixteen out of the 18 total participants reported they felt their organizations were doing "okay" when it comes to avoiding racism, stereotyping, or discrimination of any kind toward the Latinx community. The consensus seemed to be that participants felt their organizations were meeting the cultural needs of the community and avoided stereotyping by treating every client the same. Some felt they were doing well because of the representation they have on staff:

> There's three of us [out of 11] that are Latin people. The rest is white…the representation of the population is okay, I think (Clinical Outreach Coordinator)

Others pointed out several issues in providing culturally relevant access and services to the Latinx population when there is not a shared identity with providers:

> I think one of the biggest challenges that we see is particularly with the behavioral health medical practitioners that there is not a lot of them that identify as Latinx…it's difficult to be culturally fully competent unless you can really identify. Simply providing someone with language services is not being culturally responsive… (Chief Integration Officer)

Beyond representation, direct service participants reported that they took part in diversity training that was required by their organizations. On the other side of this were the administrators that often spoke of creating and improving cultural training opportunities. This was meant to break free from social stereotypes of the Latinx population. Training, in this area, differed widely. Some individuals reported a one-day training upon hire while others reported half day workshops or even striving toward ongoing training. The reality of this theme is that many participants spoke of the generalities of diversity, equity, and inclusion, with little mention of the realities of discrimination against Latinx persons. For example, an administrator at one of the three largest organizations that participated in this study noted that they have a document that asks persons their cultural needs. This respondent focused more on inclusive versus exclusionary practice:

> …because during that tool you can ask them, 'do you speak more than one language, which do you prefer… you need to pretty much ask them to everybody…not exclude someone because of their race or ethnicity or something like that (Clinical Manager)

Similar documents described by participants included asking clients their faith/spiritual preference or asking them how they would like personal practices involved in their treatment. This sentiment was almost always connected to cultural responsiveness and what that looks like within each participant's role within the organization and within the organization itself.

In efforts to avoid racial or stereotyping approaches to working with this population, some identified a need for greater resources that are sought out in a more nuanced way. More broadly, participants were unable to identify aspects of the Latinx community other than the well-documented cultural stigma of mental health help-seeking. Discussions in nearly half of the transcripts led toward the conclusion that Latinx individuals do not seek out services because they do not want to "air their dirty laundry" (Chief Executive Officer) and that any stereotyping in mental health organizations is not deliberate ("I don't think they do it intentionally," Case Manager).

Some responses in this category focused on the lack of community support due to expense. Participants spoke of funding sources as vital to the continuation of their efforts; however, they also noted that finding resources was difficult to manage given the high needs of the population:

> We serve predominantly around 70% Hispanic in our organization. They have that high tendency to live in poverty, to have higher dropout rates…When it comes to funding there's always a dwindling amount of money available. It's always like they're [Latinx clients] the first ones to lose funding because the needs are higher… (Peer Training Manager)

This individual did not suggest that you are at risk of having funding cut or lost if your population is high needs; they, in fact, were focusing on the lack of funding that is

available to meet all of the population's needs. This respondent felt that Latinx persons had higher needs than the average client they served.

In summary, respondents spoke of a myriad of contextual considerations when examining mental health service access for the Latinx population. The focus of this sample, however, centered on representation in the workforce, in staffing, in cultural similarity, and in training and development.

Table 2.2

Summary of Themes and Content Among Administrators and Direct Service Staff

Theme	Administrators	Direct Service Workers
Power and Standing in the Community	a) Describing positive leadership changes	a) Describing positive leadership changes
	b) Community organization collaborations needed for survival	b) Unsure of the mechanisms of funding for undocumented persons; lack of resources for undocumented
	c) Ongoing need for funding and partnerships; typically goes to more recognized organizations	
Differing Hierarchy Perspectives	a) Identified need for greater cultural and diversity training in the organization	a) Identified need for greater cultural and diversity training in the organization
	b) Organizational leadership encourages diversity trainings, conference attendance, interdepartmental collaboration	b) Organizational leadership encourages diversity trainings, conference attendance, interdepartmental collaboration
	c) Indicated difference in power structure; hierarchy is clear	c) Felt supported by supervisors to propose change
	d) Open door policies for direct reports	
Contextual Issues on Racial/Ethnic Stereotyping of the Latinx Community	a) Focused on diversity training and developing cultural competence	a) Primarily identified language proficiency as needed to work with Latinx community
	b) Spoke about need for cultural relevancy of services more than language proficiency	c) Emphasized treating all clients equally
	d) Primarily identified language proficiency as needed to work with Latinx community	b) Latinx clients not accessing services primarily due to cultural stigma

Note: Boxes highlighted in grey represent commonalities across both groups

Discussion

Mental health organizations operate under the social and political priorities that may or may not benefit the Latinx community. Based on the results in this study, mental health organizations in Arizona experience shortages in funding and support due to the stigma of help-seeking, insufficient funding for a high needs group, and issues in finding workforce representation. The scant representation of Latinx mental health workers is well-established in the literature (see American Psychological Association, Demographics of the U.S. Psychology Workforce, 2019); this study reflects that shortage and the perception that the lack of representation is "okay." This could be due to several factors, such as the acceptance of the norm in social services where white persons are the majority and Latinx persons are a minority (68.8% vs 11%, respectively; Council on Social Work Education, 2017), or a lack of awareness regarding research that indicates Latinx individuals feel more comfortable working with a provider that shares their literal and metaphorical language (Aguilar-Gaxiola, 2012; Heine, 2012).

Taking things further, this may also reflect the social environment in Arizona, where anti-immigrant sentiment has prevailed until recent elections (the political element) have turned the tide in voting and representation. Future mental health research may seek to investigate the interpretation of racial/ethnic-related power dynamics within organizations.

Conversations on power almost always came down to who was making the decisions in the organization, which often are not persons of Latinx identity. Literature on Latinx representation in the mental health workforce tend to focus on the low educational attainment within the population (59% <high school as compared to 39% across the United States; see Pew Research Center Tabulations of 2017 American

Community Surveys, 2017) and a greater likelihood that degree-seeking Latinx students will major in business or engineering (U.S. Census Bureau, American Community Survey, 2009-2013). The minimal Latinx representation we see in the mental healthcare profession may also have linkages to insufficient mental health literacy (Benuto et al., 2019; DeSilva et al., 2020) within the community. Further, social work higher education often overlooks the Latinx population, which is reflected by the paucity of graduate program content focused on this population (Rosales et al., 2018). Future research may examine pathways for targeted Latinx recruitment in programs that focus on mental health and social services.

Training, education, and development were discussed at length in most interviews, though participants had mixed reports of what they felt was sufficient or insufficient. Some indicated their understanding of the complexity of culture and how it needs to be further explored within their organizations, while others felt that their organizations were making great strides in equity and inclusion. These differences of perspective may stem from a variety of reasons that include provider bias and the approach to competency training (Cuevas et al., 2017), though in this study, it could also be attributed to the resources the different organizations had to deliver evidence-based training. This harkens back to the larger examination in this study on power relations: who is controlling the allocation of resources, who is making decisions about the types of funding that will be acquired by the organization, and the degree of "fit" between stakeholder funding and the needs of the population. Or, as in the comments of the case manager frustrated by their leadership's lack of knowledge of available resources, training may also reflect a larger concern of who is encouraged to thrive in leadership

positions, with or without training needed to focus on the acquisition of resources to support underrepresented populations.

Limitations. In this study, there was no cross-referencing of all services offered through each of the participating organizations that are specific to the Latinx community. Gathering logic models, program design documents, or even documents on funding receipts and allocation, then comparing them to the responses of the participants would have been useful in this endeavor. Understanding each organization's hierarchy could potentially provide insight into some measure of the power wielded by individuals in a concrete way, as opposed to their individual interpretations of their own power to make decisions or influence processes. This information could have allowed deeper insight into how interpretations of an individual's role are reflected in the functioning of the organization.

Additionally, richer data could have been obtained had interviews not been limited to phone calls, emails, and video chat services during the COVID-19 pandemic. In-person conversations in research often contribute to building rapport, maintaining intimacy, and creating a space where participants can speak more openly about their experiences (Novick, 2008; Seitz, 2015). Although not generalizable, qualitative research can be transferrable to similar contexts, thus, sample size in this view is not a limitation; however, future research in this area may benefit from the utilization of a quantitative strand that could provide an overview of interactions between prospective Latinx clients and mental health staff.

Implications

Although the impacts of the social and political environment on organizations is hard to control and would require an intensive overhaul in our institutions, policies can

be implemented within organizations to ensure that representation is included in decision-making. These policies can take several paths: 1) the enforcement of ongoing specialized cultural education as opposed to generalized training that speaks toward equity in broad strokes; 2) creation of internal policies around funding that focus on established population need; and 3) policies that guide the creation of partnerships that are mutually sustainable and will allow for equitable mental healthcare practices. Though time-consuming, some of these efforts may prove fruitful and could create present change. Cultural training, for example, is often met with resistance, but with deliberate long-term planning and garnering personnel buy-in, organizations can improve their standard of care (Chun, 2010). Practice implications include the creation of embedded staff senate or advocacy groups that can develop ongoing practices that contribute to power-sharing within the organization, which has seen some success in employee empowerment studies (Berraies et al., 2014; Garcia-Juan et al., 2019).

Conclusion

Mental health organizations have numerous responsibilities in creating greater mental health service access for the Latinx population. They must address the needs of the population while being held accountable to funders, collaborative community partners, and the empowerment of their personnel to make decisions and gain support in the organization. Though understudied, the perspectives of mental health workers – in any capacity—can help us better understand where the breakdown in access stems from, whether it be due to external environmental factors or internal culture and training. The results of this study support future research within mental health organizations that address three domains: internal hierarchy, avoidance of embedding

societal stereotyping into access creation, and improving standing in the community through culturally relevant outreach and building agency reputation.

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CHAPTER 3: BEYOND "BUSINESS AS USUAL": THE ROLE OF MENTAL HEALTH WORKERS IN CREATING ACCESS FOR THE LATINX CLIENT

A preference for maintaining organizational hierarchies and conducting "business as usual" can impact innovative efforts that could potentially improve access to mental health services for the Latinx population. Innovative practices can improve disparities we see in access for populations that may not traditionally utilize formal mental health services. This is true, particularly, for the Latinx population that requires a more community-focused environment where providers can speak a literal and metaphorical language to which clients can connect (Aguilar-Gaxiola, 2012; Heine, 2012). E-therapy, a recent example of innovative practices with the Latinx community, has been conducive to shrinking behavioral health disparities (Dwight-Johnson et al., 2011); however, reluctance toward implementing new and innovative practices may not be successful if they do not meet the needs of the population an organization serves (Payne et al., 2020).

Factors that are barriers for seeking out mental health services by the Latinx community include costs and lack of insurance (Alegria et al., 2002) and cultural incongruence (Villatoro et al., 2014). Whether an organization accepts clients with undocumented status (Bucay-Harari et al., 2020) or if the organization offers a family-like (Villatoro et al., 2014) or religious environment (Villatoro et al., 2016), can impact likelihood of the Latinx community reaching out for services. These factors are important to consider when examining the function of the organization: by examining how administration responds to these needs by providing the worker the space to incorporate those changes into their organizations. Using Hemmelgarn and Glisson's (2018) Availability, Responsiveness, and Continuity (ARC) Model, we elucidate the

environment of mental health organizations that contribute to hierarchy and support the stagnation or innovation of mental health services.

Status Quo vs Innovation

The ARC Model abides by five principles of organizational context that all focus on the functioning of the organization, ranging from adherence to mission to the centering of relationships (see Hemmelgarn and Glisson, 2018). Organizations that are reluctant to change and operate within established protocols, regardless of their efficacy, are known as status quo-directed human service organizations (Hemmelgarn and Glisson, 2018). Organizations that do not settle with the status quo and consistently seek out effective actions are known as improvement-directed organizations. In conversation with the ARC Model, the ecological perspective informs us on the access mental health organizations provide through their interaction with the larger social and political environment.

Ecological Context of Power and Powerlessness

Of specific importance to the ecological perspective is the amount of influence transmitted from stakeholders into the practices of the organization. A vital piece in understanding how we can improve mental health access to the Latinx population is examining the internalization of power that is expressed upon the organization. An imbalance of power within the organization may create a feeling of powerlessness among the organization's personnel as opposed to agency and empowerment. While administrators and practitioners in organizations often work tirelessly on their craft, research has noted that "the time it takes to learn something new" is also a barrier to innovation (Leathers and Strand, 2012; Stewart et al., 2012) Focusing on the innovative efforts in mental health practice, this study examines how mental health organizations

operate internally to create innovative efforts in mental health access and the acceptance of those efforts by administrative decision-makers.

Power Relations and Critical Race Theory. Hasenfeld and Gallow's Power Relations Perspective (2018) helps us understand the structure and functioning of social service organizations (see Garrow & Hasenfeld, 2017; Van Den Berk-Clark, 2019). In short, it looks at what external factors influence internal functioning by examining resources and the decision-making of how those resources are allocated, focusing on the power of stakeholders and decision-makers have in directing the functioning of the organization. We supplement the power relations perspective with critical race theory (CRT), which argues that many of the issues the Latinx community faces may have come from our institutions—in this case, healthcare (Williams, 2001): discrimination, stigma against health beliefs, or the lack of support for innovative ideas that are responsive to the needs of the Latinx population. CRT combats, head on, issues of power, much like those seen within our healthcare system (Williams, 2001). CRT can be used in social service practices as a framework for ethical care (Abrams & Moio, 2009). From an ecological perspective, we can then understand the fluctuations and tributaries of power that can impact mental healthcare access.

Abiding by the ARC Model (Hemmelgarn and Glisson, 2018) this paper will focus on the innovating efforts taken by the organization, operating internally and within the larger community of Latinx serving mental health organizations. In other words, the approach taken is to analyze the organizational environment and how it contributes to access creation. This includes an examination of how the organization and its frontline workers navigate the needs of the Latinx population to effectively create access, or, perhaps not so effectively. This paper centers on the supposition that breaking away

from business as usual can then create better opportunities in the organization for service access. The research question posed is: How are the efforts of mental health service providing organizations resisting "business as usual" in fostering mental health access for the diverse Latinx population?

State of Mental Health in Arizona

Latinx Mental Health Need

Forty-four percent of Latinos living in Arizona are foreign-born and 49% report they can speak English "very well" (Valdez et al., 2015). The largest ethnic identification is Mexican (87%; United States Census, 2010). In Maricopa County (Phoenix and the greater metropolitan area), Latinx persons comprise 30% of the total population (Pew Research Center, 2019). In Phoenix, specifically, 41.8% identify as Hispanic or Latino (United States Census Bureau, 2018). Further, a barometer report from the Substance Abuse and Mental Health Services Administration (SAMHSA; 2015) highlights that Latinx persons in Arizona have higher percentages than other large minority groups that identify as living with a serious mental illness but still participate in services at a lower percentage than their White counterparts (31% versus 86%; Substance Abuse and Mental Health Services Administration, 2017). Overall, Latinx persons in Arizona are less likely to report lower psychological distress than Whites (69% versus 76%; Valdez et al., 2015)

Although Latinos have reported significant psychological distress on the Kessler K6 measure, which asks about recent anxiety and depression (Valdez & Langellier, 2015), it does not translate to high service utilization or access to services (see Barrio et al., 2008; Ojeda et al., 2006; and Guerrero et al., 2013). This may be due to the way

mental health services have historically been made accessible and the stigma associated with seeking treatment. In Arizona, U.S.-born Latinx persons report less social support than Latinx immigrants, which contributes to the higher need for mental health services within this population (Valdez et al, 2015).

Social and Political Context

Numerous social stigma issues arise for the Latinx client, namely, the inability of services to meet their needs in an environment that is rife with anti-immigrant sentiment. Within one decade alone, dozens of bills were pushed through the Arizona legislature to limit everything from which schools undocumented students could attend to stop-and-frisk protocols due to "reasonable suspicion." This "reasonable suspicion" could often be as simple as looking as though you had an unlawful presence in the country (American Civil Liberties Union, 2010). A fortunate consequence of that bill being signed into law was the activation of many Latinx groups around the state to push for police reform, equitable practices in law enforcement, and the support for representatives that focused on strengthening social services to transform historical injustices (Murguía, 2020). These political changes spurred transformations in the local dialogue on health and well-being for the Latinx client, which included affinity groups that focus on the political identity of Arizona Latinxs.

Organizational Context

Healthcare access has been ranked as a priority within the state that needs to be addressed (Medicaid, 2020); however, this focus has not incorporated the unique needs of undocumented residents. Within the last few years, services have transferred from the Regional Behavioral Health Authority (RBHA) to the state Medicaid official. Payouts, clinic options, and inpatient/outpatient services are now dictated by this body.

Contractors interested in working with the Medicaid body must comply with culturally competent practices; however, they focus primarily on language translation and interpretation services and offer support through manuals and guides for contractors to determine what practices they initiate to meet the needs of the population (Arizona Health Care Cost Containment Services, 2019). Although these services promote "access to care," there is minimal direct focus on mental health service access that is culturally relevant for the Latinx population.

Litigation as a Precursor for Systemic Change. The creation of access and state service delivery have arisen since a pivotal lawsuit from 1981 known as Arnold v. Sarn. In this class action lawsuit, it was claimed that the state did not offer comprehensive mental health service as required by state law. In 2014 the state conceded to a wide array of services for the mentally ill (case management, peer support, family support, counseling, alternative therapies, medication), thus ending the litigation (Arizona Health Care Cost Containment Services, 2019). While the focus of provisions is on those with Medicaid eligibility, there is an extension of funding that supports individuals with private insurance living with serious mental illness (SMI); however, there are limitations for service access for those individuals. With these limitations of funds, there is minimal support for innovative culturally specific access that can impact mental health clients.

Materials and Methods

Recruitment and Sample

Recruitment occurred throughout 2020 as the COVID-19 pandemic arose throughout the United States. Thus, the recruitment process occurred primarily through

email communications, newsletter releases, and word-of-mouth and referrals throughout each organization contacted for participation. Eight organizations responded to initial contacts through recruitment, although only seven organizations had respondents that were interested. A total of 18 participants with an average of 15 years work (range 2-31 years) experience in the mental health field participated. Of the total participants, 10 identified as administrators (e.g., chief executive officers, training managers) and 8 identified as direct service workers (e.g., peer support specialists, case managers). Self-reported demographic information indicates that the sample was primarily White, and several (n=4) identified as recipients of mental health services, otherwise known as peers.

The majority of these organizations (n=5) served seriously mentally ill clients whereas the rest catered to general mental health; eight of the total participants came from the clinics that served the seriously mentally ill (SMI). All participants were asked to consent prior to their participation, which was completed through both written and verbal communication and confirmation prior to the beginning of the interview. For a participant to be involved, they had to have at least two years' experience working with Latinx persons in the mental health field, live in the community they serve, and had to be at least 18 years of age.

Data Collection

Data was collected via in-depth semi-structured interviews (see Table 3) that lasted approximately 38-126 minutes. Interviews were recorded digitally recorded and uploaded through a secure connection to a password-locked computer.

Data Analysis

Participant interviews were transcribed, and the recordings were verified for accuracy. The identifying of themes began with an open-coding process where main ideas were identified through an inductive-deductive process wherein I read through the transcripts through the lens of critical race theory, the power relations perspective, and the ecological perspective. Through this process, the analysis was conducted by analyzing transcripts through the lens of an ecological perspective as it impacts the functioning within organizations as they pertained to the conceptual framework. Once main ideas were identified, coding began with an initial in-depth read for specificity, followed by a second read for creating major codes and organizing any subthemes. A third read was conducted to solidify codes before finalization for the codebook.

Table 3

Beyond "Business as Usual," Focused Interview Questions

In what ways do you consider the work of the organization as innovative or "breaking the mold"?
Walk me through how your organization strives to work effectively (such as adapting programs, Spanish language materials, etc.) with the diverse Latinx population.
How has your organization sustained innovative efforts in providing better mental health service access to the Latinx population, while also meeting the needs of funding requirements?
How would you describe the culture of your organization? By "culture," I mean how your organization promotes change or does things pretty much stay the same, or sticking strictly to policies and protocols.
Lastly, how do you feel your organization's culture contributes to promoting mental health access for Latinx persons?

Ethics

This study was approved as exempt by the University of Washington Institutional Review Board. There was no funding conflict for this study among the organizations, the authors, or the institution.

Results

Three main themes emerged: 1) hierarchy and empowerment; 2) innovation and "business as usual"; and 3) combatting the status quo. Each code is anchored by an understanding of the larger contextual factors associated with organizational processes and operations that could be seen as innovative or as a hindrance to fostering mental health service access. The theme of "hierarchy and empowerment" describes the hierarchy that exists within organizations but that is transcended due to an internal cultural shift that focuses on empowerment and personnel support. The second code, "innovation and 'business as usual'" explored what occurs when an organization dismantles a top-down approach to management and inclusion of the workforce. The final code, "combatting the status quo" was defined to mean any practice that is not pre-defined by standard practice, which could mean a one-stop facility or constituency groups that provide staff with a sense of belonging or ownership.

The identified themes indicate that most of the participants felt supported in their roles by their supervisors or agency directors. When presenting new ideas or considering their priorities, respondents noted that they felt they could meet their clients' needs without interference from those above them in organizational hierarchy. Only a few participants highlighted difficulty in describing any processes they felt were breaking away from the status quo or in creating efforts that were innovative. Most

respondents discussed seemingly "open door policies" within their organizations that allowed them to present new ideas. Three participants from two organizations discussed how they could even contribute to creating constituency groups that catered to employee affiliation, either by identity or interest. In fact, several participants noted that they feel empowered to make decisions for themselves and for their clients when it came to access or meeting their needs.

Hierarchy And Empowerment

Approximately one-third of the respondents mentioned feelings that could be described as "empowerment." Several stated that they felt their decisions were trusted or that they were not afraid of asking for clarification, support, or for their needs to be met, either for their job role or personally. This was particularly true of workers that also identified as peers—"peers" are individuals who also identify as having a serious mental illness. Peers worked in a variety of roles ranging from direct service to administrative. Peers were quite vocal about their experiences in creating opportunities for others to participate in treatment and did not feel their identities as peers were a barrier, nor did they feel their voices were any less heard. The power differentials in their organizations, for the most part, were not as palpable as they could be, in essence, these participants felt they were trusted to make decisions on their own. Often, this sense of empowerment came from the way supervisors and other administrators supported them or responded to them in various forms of communication

> …we feel like we matter…I feel like an equal… I don't know of very many places that work that way…when they send out letters, emails, whatever, you can always tell that it is like, 'I am this position, but you are more than welcome to reach out to me (Peer Support Specialist)

Some noted a sense of empowerment when they were able to actively see the results of their recommendations play out without hesitation or push-back from their supervisors. Although one mental health worker discussed a negative experience working in another organization, they described their near disbelief at the positive responses they received for being vocal.

> I saw an issue that was coming up with our billing reports, and I took it to my boss. I'm like, 'I don't feel comfortable being the loudmouth on this, but this is broken.' It was fixed the next weekend…and that's cool. I like that (Peer Training Manager)

Individuals identified their organizational hierarchy through a lens of acceptance and, in some cases, pride that their leadership was communicative and receptive to their ideas. The only reported feelings of hierarchy or a fear of sharing ideas about access or service was due to insecurity of personal attributes like race, field experience, or issues with confidence.

Describing themselves as a "chicken," this individual described the context of that feeling as stemming from their lack of experience in their department as compared to the rest of their team, despite having accumulated 17 years of experience.

> I think it has to come from within me. Just kinda voice myself a little bit more. Educate myself a little bit more in certain things that I don't know…I think because they're [colleagues] older me…it's a big age difference. We're very different. I feel like there are parts of me where I can say, okay, this is how I feel…whether it's acknowledged or whether it's unspoken, I see it because I feel it at times (Community Outreach Manager)

This statement expressed a dissenting voice from most other respondents and was the only one seemingly indicating discomfort with voicing themselves based on their personal characteristics or attributes. This individual expressed insecurity in the face of several factors: age, experience, and seniority. This feeling the manager had to hold back or withhold ideas based on their own experience of power and hierarchy based on those attributes.

Innovation and "Business as Usual"

There was minimal conversation on practices within organizations that supported the hierarchy other than the occasional mention of the "higher ups." In fact, in multiple discussions respondents reported that they felt the freedom to provide their input or create innovation in their roles. Participants noted that "business as usual" in their organization typically amounted to open communication and collaboration, which was not always in-keeping with the expected hierarchy. In fact, several respondents indicated that they had freedom in creating their job roles and that their organization was innovative in structure.

> …we are rapidly growing the organization, the whole organization…the organization as a whole provides a whole array of services to the mental health organization…more like a one-stop-shop. One of the services we have are multiple SMI clinics…Their therapist, their psychiatrist, their primary care physician are all in the same building and can easily collaborate with each other. So that's an interest in support to people. The bottom line is offering so much within one organization…we're pretty unique and pretty cutting edge around here (Recovery Specialist)

The idea of a "one-stop-shop" was innovative in the context of this community and was brought up as a means of supporting access—the participant felt their organization was doing well in creating access for persons who may have difficulty with transportation or who would otherwise experience delays in receiving care.

Further, participants highlighted the innovative efforts as systemic throughout the organization. This was most common in interviews with direct service workers and among a few mid-level administrators. Top-level administrators primarily spoke toward the limitations of creating new programs to respond to ideas that are presented to them due to funding and external priorities in the environment. One CEO clearly outlined the issues with the transition from the RBHA oversight to the oversight of Medicaid health plans:

> I think that, when the RBHA was funding service translation and that kind of stuff, there was more opportunity [for organizations] to move the bar. Now that the health plans are doing that—I mean, somebody's gotta pay for it. As a nonprofit, you have to make a profit, or you're dying. If you're not making some profit, it's a problem (Chief Executive Officer)

This CEO's comment hangs on the notion that the changing of institutional oversight and supports for funding organizations limited innovation and access due to the payor structure.

Breaking away from traditional standards and practices was not the norm across all aspects of functioning in the organization. This was seen in the context of peers in recovery (those who still live with severe mental illness but have had minimal functional limitations due to their symptoms) that seek employment as direct service workers. In discussing the image of the organization to gain social and political community support,

an executive spoke about how some employees may be removed from the limelight due to their appearance or expression. This was seen as a way of minimizing social stigma of mental illness as opposed to promoting stigma by reflecting a subsection of the population

> We are very careful and understanding of the stigma that is out in the community with mental illness, so we will be careful with who we hire to make sure – like if they have a bunch of gang tattoos across the face, or if their hair is very unnaturally colored – we're a little more careful about hiring the person…it's shocking to people in the community and we don't want to add reinforcement to the stigma…we may not have them be as public in the community so that we can keep the relationships positive and slowly get those community members' understanding
>
> (Chief Executive Officer)

The above participant discussed how a person looking different, threatening, or unnatural may be damaging to the stigma already seen in the community about mental illness. A peer workforce with a neutral appearance seemed to be desirable to create the image of a population that can be relatable to the public.

Combatting the Status Quo

Part of the discussions on innovation, "breaking the mold," or navigating hierarchy, focused on how to get things done for clients in a way that may not be expected from the organization. As far as protocol within the organization, most participants did not speak toward the daily ins-and-outs of program functioning like intake and referral. Instead, this group of participants highlighted how they work around the formal chain of command.

> It's weird, there's no question that I fight with staff and superiors. If something's not right, I don't seem to be happy. I have a supervisor, my supervisor has a supervisor, etc. But I go to the CEO. I go to whoever I need to, it's not abnormal for me to communicate with other CEOs or whatever…I don't advertise how good a relationship I have with my CEO, one reason is that I don't want to get people jealous. Right now, my supervisor…Does she know I have the relationship with my CEO that I have? No, no. She doesn't need to know that…my bigger interest is my job (Recovery Specialist)

Contrary to maintaining the status quo of operations, most participants discussed their willingness to advocate for their clients or to create opportunities for clients to advocate for themselves. In one such instance, a CEO discussed how they have implemented a program that trains employees to handle conflict with each other and with clients. This training is also available for clients. This was developed to create change in the community and to promote empowerment among their SMI clients

> We go over what the behavioral expectations are with members and staff and we enforce it…all of our staff are trained in crisis intervention and we focus real specifically to see, and hear, and feel tensions that are starting to agitate another person and how to deescalate it…and then we allow our members to also attend the same training so they can learn themselves. A lot of them have challenging relationships with their loved ones, their friends, their employers…it teaches them another way of soothing and not demonizing another person
>
> (Chief Executive Officer)

This practice is used to create empowerment among mental health clients to disrupt the traditional power hierarchy in what we see in organizations providing services. In essence, it was discussed as an effort to join or rejoin members into active members of their communities instead of maintaining passive roles as service recipients.

Discussion

Most participants felt they could create their role how they wanted to within the organization, which included bringing innovative ideas to the table with their leadership. Even for those who felt they had to circumnavigate the traditional chain of command, they at minimum had an outlet for expressing their ideas or concerns to the highest level of administrator. This break with a strict top-down approach in leadership may be reflective of a norm within the mental health service community that embraces power-sharing; however, it may also be reflective of the populations served by these organizations that make such a practice beneficial to fostering mental health access. As mentioned, there were several peers that worked throughout different levels of each mental health organization that is presented here; a reality that may be unique to healthcare, in general, as much of the literature on the topic speaks to the benefits toward clients (particularly minority or hard-to-reach populations) when peers are part of offered services (Solomon, 2004).

Contrary to previous literature that spoke toward the powerlessness a worker may feel within the organization due to environmental factors, this sample seemed to find their own way of coping with constraints typical of managed care systems. Looking at this from the power relations perspective, the influence of external decision-makers on the internal functioning of the organization seemed minimal when it came to making

access decisions. The only exceptions spoke to power differentials for an already minoritized group: those living with mental illness who may not present in culturally normative ways. In the instance with the administrator that felt certain appearances were not welcomed by the general public, there may have been some supporting of biases toward subcultures that have non-traditional appearance or affect. The administrative approach that enforces conformity may be an indicator that further work is needed in equity for persons living with mental illness. In the realities of surviving as a mental health organization, however, the perspective of the administrator is that they were trying to garner community support for their organization. Although there is minimal if any research on the impact of peer appearance on organizations that employ them, future research may want to examine the role of incorporating peers into mental health organizations as they reflect the population they serve in both their experiences and their attributes as a way of understanding access.

Two takeaways emerged related to creating mental health service access for the Latinx community: 1) there were no considerations for the social power dynamics when exploring the reach of innovation in mental health access; and 2) respondents focused primarily on funding or the chain of command. Critical race theory, combined with the ARC model, tells us that institutions wield power that is founded in discriminatory acts and actors; however, when applied to mental health organizations this translates to power that is still held at the top but can be shared to create innovation for the sake of improving services. In the case of Arizona, the unique circumstance of the Arnold v Sarn lawsuit may influence the functioning of organizations—such an exploration is beyond the scope of this paper.

Implications

Future research may want to analyze the historical aspects of serve delivery to Latinx persons prior to the implementation of the statewide changes that came after 1981. Further implications of this research indicate that despite the empowerment that workers may have reported experiencing in their organizations, it does not seem to trickle down to the client. This is evident in the issues that were raised about how a client's appearance may deter support for an organization, or in conversations where the worker stated they felt they had to circumnavigate their direct supervisors in order to get things done for their community. This is an interesting point that warrants investigation into understanding how the priorities of the direct service worker may be different than the priorities of the administrator. Rather, this study suggests that in the case of Arizona, larger social systems may be at play regarding the constraints of policies, regulations, and litigation.

Limitations

There are two limitations to this study. First, to fully understand the depth of status quo maintenance, an analysis of the reporting structure of each participant could have shed light on how direct service workers and administrators choose to present their ideas, to whom they present those ideas, and whether there is follow-up on those communications. Secondly, although the strength in this research is examining multiple voices from within multiple organizations, recruitment targeted at specific organizations with varied funding sources may have helped to ascertain the full scope of environmental influence.

Conclusion

Seeking services in Arizona as a Latinx client can be difficult to navigate given the social and political barriers to acquiring treatment. This study revealed thtat while workers feel empowered to serve the community in their organizational roles, they also have some gaps in understanding how that can translate to better access for Latinx persons. The goal of this research was to understand how external factors contribute to a lack of innovation, powerlessness, or maintaining the status quo within organizations that can hinder access. On the contrary, this sample seemed comfortable in navigating the system through which they have dedicated their skills. Research in this area will benefit from continuing this conversation into larger studies that also consider the perceptions of clients that access services through the organizations that are examined.

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Declaration of Interest

The authors declare no competing interest in the development, execution, or writing of this article.

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CONCLUSION

Broadly, this dissertation examined the power relationships between the organization and the larger social and political environment that impact the creation of mental health service access for the Latinx population in Arizona. More specifically, the aim was to ascertain the ability to create an inroad for further access creation that is more relevant to the Latinx population's cultural (e.g., communication in literal and metaphorical language), social (e.g., a family-like environment), and political needs (e.g., lack of insurance/ability to pay). The body of work presented here is relevant for two reasons: 1) it contributes to the conversation on what, exactly, organizations and the workers therein experience when trying to create opportunities for access; and 2) it allows for a qualitative perspective on mental health services access that does not focus on the client's behavior and attitudes, but instead on the actions, choices, and practices within organizations.

Examination of Results

The results of this study tell us that mental health organizations in Arizona are influenced greatly by funding, a lack of information on the specific cultural needs of the Latinx population other than language, and issues related to training; some felt cultural training was inconsistent or insufficient, while others accepted it as adequate. Despite these factors acting as barriers, there are also promising practices, such as the collaborative approach within the majority of these organizations. Participants reported that hierarchy was present in issues like decision-making, hiring, and assigning training, which could be explained as typical administrative functions.

Fortunately, participants also said they felt they could approach their supervisors, directors, or managers with new ideas and could create constituency groups that

represented their experiences as individuals, based on their identities or interests. In addition, several participants reported that they saw improvements to their organization's reputation and functioning, particularly after leadership changes. The strengths in these promising approaches may be reflective of the types of organizations that participated, which tended to be larger and possibly had more flexibility or freedom in the creation of processes or access. In fact, some research has indicated that the more open communication from management that is present within organizations, the greater the implications for overall staff performance (Neves and Eisenberger, 2012).

In Paper 1, we discussed how the workers within these organizations navigated policy and practice. In this paper we saw that, although they abide by the hierarchy within their organizations, they try to find grey areas of internal and broader public policy to get things done; similarly, in Paper 3, we saw that another component to this "grey area" is working around the higher-ups. Both findings speak to different things: Paper 1 speaks directly to policy, which may not be in the worker's control, whereas Paper 3 speaks to successfully working through the organization to get needs met in an almost subversive way through circumnavigating policy that did not meet their needs or hierarchy. As one respondent noted, they did not tell their direct supervisor of their closeness to the CEO of their organization. This was to ensure that they could continue to provide services to their community in a way that resonated with the CEO but that may not have been acceptable to their direct supervisor. The experience of this respondent was not unique to them. As we read throughout each chapter, there was a clear delineation between policy and practice. Almost as if to say, "here's what the policy does, but here's where I find grey areas that will let me do what I need to do for my clients."

Of particular interest, relating to culturally relevant practice, were several ideas presented about clients, in general, as well as Latinx clients. In each paper, but particularly in Papers 2 and 3, participants discussed the high needs of the Latinx community as well as the cultural stigma surrounding seeking out services for mental health treatment. This was emblematic of most conversations with these participants as they described their experiences in working with the Latinx population. These viewpoints speak to stereotyping and racism that is present in aspects of CRT, but also in biases that could be influenced by the social and political environment that has bred attempts at legislation that would decrease the size of the Latinx community in the greater metropolitan area. A further exploration into the applicability of the theoretical framework as it applies to institutional power and racial/ethnic biases is in the proceeding section.

Relationship Back to Theoretical Frameworks. Looking at this from our theoretical frameworks, we begin to see the relationships between the environmental influences, power dynamics, and the internal functioning of these organizations—hierarchy, maintenance of the status quo, empowerment, and innovation—as they relate to mental health service access. Several participants were very vocal about their hardships in administering services, citing policy and organizational hierarchy, yet they persevered and found ways to overcome those barriers for their clients. Unfortunately, one thing that is also evident is the political structure that restricts their freedoms in making decisions for their clients.

For example, in Papers 1 and 2 participants were asked about within organization collaboration and across organization collaboration. It seemed participants were more able to make decisions about within organization collaboration with their peers or even

their superiors. In terms of across organization collaboration, it was mostly administrators that said they felt there was "no true collaboration" because of issues like funding and stronger partnerships going toward organizations with a better reputation in the community, which could be due to leadership. These papers primarily spoke to ecological theory, the power relations perspective (PRP), and to critical race theory (CRT). Using these lenses in creation of the study created an alignment through which we could examine power dynamics.

The examination of power was essential to this dissertation in Paper 3 as well. For Paper 3, I used Hemmelgarn and Glisson's ARC Model (2018) in combination with the PRP and CRT to examine how external influences in concert with institutional racism and stereotyping changed, contributed to, or manipulated functioning. There were mixed results: in one aspect, administrators and direct service workers both felt empowered and on the same level with their organization's decision-makers, but in another aspect, they reported having to play politics within their organizations to get things done. The disconnect could be explained by a deeper analysis into participant interpretations of power in their function within the organization.

The combination of the theoretical frameworks in this dissertation allows us to get a broader picture of mental health access for the Latinx population in Arizona. This is present in the formation of the larger conclusion as follows: the dynamics of institutional power and racial/ethnic biases are present to an unknown extent within Arizona's mental health organizations; partly due to legislation, funding, and the cultural competency priorities of the state's Medicaid service. As we saw in Table 2, AHCCCS contractors are required to provide non-specific services in a way that is "delivered in a culturally competent, family/member centered manner to diverse

cultural and ethnic backgrounds, including those with Limited English Proficiency (LEP), disabilities, and regardless of gender, sexual orientation, or gender identity (AHCCCS Contractor Operations Manual, 2019)." The outcomes of these dynamics have seemingly created organizational culture across multiple organizational systems that considers language translation as a proxy for cultural competency. An additional outcome is the lack of training that would breakaway from those stereotypes and assumptions about the Latinx community.

Implications for Future Research. The implications for future research are twofold: 1) greater efforts must be made to conduct research in a similar setting to understand if the phenomena we have encountered here speak to the larger experience of similar communities working with Latinx persons, particularly along the Mexican-U.S. border were the Latinx population is typically higher than the national average; and 2) in practice research, education and training on culturally relevant pathways for access can be explored utilizing an approach that examines power and privilege within mental health organizations. Examining power and privilege in the functioning of the organization has not fully made its way into social work research; however, this dissertation may inform future research in how perspectives like critical race theory can be utilized to examine inequities in mental health.

This dissertation aimed to address the gaps in the research related to mental health organizations' contribution to behavioral health disparity, though future research may also want to consider the ability of the individual to influence and exert their own power within organizations with a focus on empowerment. Although empowerment has been studied, a mixed methods approach that surveys perceived influence on professional relationships coupled with a qualitative strand that explores meaning of

those perceptions may enhance future work on behavioral health disparities we see in underrepresented communities. Moreover, supporting research that explores the reach of mental health service access creation for the Latinx community may begin to include perspectives on systemic structures that contribute to behavioral health disparity for marginalized populations.

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