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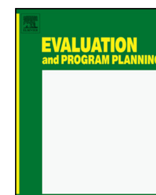

Organizational structure, leadership and readiness for change and the implementation of organizational cultural competence in addiction health services

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ABSTRACT

Increasing representation of racial and ethnic minorities in the health care system and on-going concerns about existing health disparities have pressured addiction health services programs to enhance their cultural competence. This study examines the extent to which organizational factors, such as structure, leadership and readiness for change contribute to the implementation of community, policy and staffing domains representing organizational cultural competence. Analysis of a randomly selected sample of 122 organizations located in primarily Latino and African American communities showed that programs with public funding and Medicaid reimbursement were positively associated with implementing policies and procedures, while leadership was associated with staff having greater knowledge of minority communities and developing a diverse workforce. Moreover, program climate was positively associated with staff knowledge of communities and having supportive policies and procedures, while programs with graduate staff and parent organizations were negatively associated with knowledge of and involvement in these communities. By investing in funding, leadership skills and a strategic climate, addiction health services programs may develop greater understanding and responsiveness of the service needs of minority communities. Implications for future research and program planning in an era of health care reform in the United States are discussed.

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1. Introduction

Leaders of behavioral health organizations face significant challenges to implementing culturally competent practices to respond to the increasing diversity of clients in the United States (Mallow, 2010; Office of Minority Health, 2001; Osborn, Hinkle, Hanlon, & Rosenthal, 2011). Current funding initiatives emerging from health care reform present an opportunity for these leaders to foster the implementation of culturally responsive practices and consequently improve standards of care for underserved racial and ethnic minority populations (Andrulis, Siddiqui, Purtle, & Duchon, 2010; Hyde, 2011; Osborn et al., 2011). Cultural competence—the recognition and responsiveness of organizations to the service needs of culturally and linguistically diverse populations—has become a widely supported service innovation that requires investment in administrative, policy, and service delivery components to improve quality of care (Guerrero, 2013; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Howard, 2003). This work is highly important for reducing well-established health disparities in the United States among racial and ethnic minorities, as well as timely in terms of determining the current state of culturally responsive care available in ethnic minority communities prior to changes resulting from health care reform legislation, which will require providers to deliver evidence-based culturally responsive care.

The emergent literature on implementation of evidence-based practices in behavioral health has highlighted the role of organizational structure, leadership, and readiness for change in the implementation of innovative program and service delivery practices (Aarons, Wells, Zagursky, Fettes, & Palinkas, 2009; Guerrero, 2013; Fixsen et al., 2005; Howard, 2003). Few studies, however, have empirically examined the extent to which organizational structure, leadership, and readiness for change enable addiction health services (AHS) organizations to implement a diverse set of community, policy, and workforce practices believed to increase their competence to respond to the cultural and linguistic service needs of racial and ethnic minority populations.

Prior studies that have attempted to operationalize cultural competence have identified organizational practices, attitudes,

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and services that can be adapted to enhance the cultural sensitivity and responsiveness of health care organizations (Brach & Fraser, 2000; Chow & Austin, 2008; Fisher, Burnet, Huang, Chin, & Cagney, 2007; Harper et al., 2009; Lewin Group, 2002; Mallow, 2010; Inniss, Nesman, Mowery, Callejas, & Hernandez, 2009; Weech-Maldonado, 2002). Specifically, these studies have outlined several organizational domains in which culturally competent practices can be developed, including providers' knowledge of, outreach to, and personal involvement in racial and ethnic minority communities; development of resources, linkages, and policies to effectively respond to the service needs of minority clients; and hiring and retention of employees who reflect the racial and ethnic minority backgrounds of clients (Brach & Fraser, 2000; Harper et al., 2009; Mason, 1995). Although much work has focused on defining and conceptualizing organizational cultural competence, standardized and empirically validated scales designed to measure cultural competence in health services have been limited (Guerrero & Andrews, 2011; Cross, Bazron, Dennis, & Isaacs, 1989; Harper et al., 2009; Lewin Group, 2002). In addition, although cultural competence has become a common approach to serve minorities, limited research has relied on theoretically informed approaches to implementation (Guerrero & Andrews, 2011; Harper et al., 2009; Weech-Maldonado et al., 2012). This exploratory study examined the relationship between conceptually informed organizational leverage points (structure, leadership, and readiness for change) and the response of AHS programs to health care reform in terms of improving their knowledge, connections, linkages, and resources in racial and ethnic minority communities, as well as culturally responsive policies, procedures, and staffing practices.

2. Conceptual framework

2.1. Organizational structure

Consistent with neoinstitutional theory—which posits that by complying with institutional demands and endorsing macrocultural ideals with public cachet, organizations obtain necessary resources and professional support (DiMaggio & Powell, 1983; Scott, 2001)—studies have identified public funding, regulation, and professional accreditation as structural factors associated with provision of culturally responsive service delivery practices in AHS programs. Specifically, these studies highlighted the role of public funding, Medicaid insurance provision, and regulation through state licenses as factors positively associated with client–provider matching based on race, ethnicity, and language, as well as training of staff in cross-cultural issues (Guerrero, 2010; Guerrero & Andrews, 2011; Campbell & Alexander, 2002; Howard, 2003). To develop a greater degree of organizational cultural competence, experts have suggested that providers should develop an inclusive approach in which their setting, staff, policies, and connections with the community are responsive to the treatment needs of the client population (Guerrero, 2012; Brach & Fraser, 2000; Cross et al., 1989; Harper et al., 2009; Weech-Maldonado, 2002). Publicly funded programs located in Los Angeles County, California, are pressured by funders, regulators, and other stakeholders to respond to health care reform legislation, which urges programs to provide services in clients' native language, by professionals trained in cross-cultural issues, and by programs with organizational supports to respond to the service needs of minority clients (Guerrero, 2013; Andrulis et al., 2010; Brach & Fraser, 2000). Hence, Hypothesis 1 posited that funding and regulation would be positively associated with the development of knowledge, connection, linkages, and resources in racial and ethnic minority communities, as well as culturally responsive policies, procedures, and staffing practices.

2.2. Leadership

Leadership is an emerging focal point in efforts to identify actors responsible for initiating, implementing, and evaluating the process of change. Recent studies in behavioral health highlighted the role of leadership in the implementation of evidence-based practices and improvement of client treatment outcomes (Aarons, 2006; Guerrero, 2010; Guerrero & Andrews, 2011; Broome, Flynn, Knight, & Simpson, 2007; Edwards, Knight, Broome, & Flynn, 2010). Well-established leadership styles—such as a transactional orientation, which involves guiding performance, and a transformational approach, which involves leading by example and motivating self-growth—are essential components of leadership associated with fostering organizational change (Avolio, Bass, & Jung, 1999). In particular, recent research suggested that through the use of individualized consideration, intellectual stimulation, inspirational motivation, and idealized influence, transformational leaders promote a culture of inclusivity associated with improved performance by culturally diverse staff (Kearney & Gebert, 2009). Promoting inclusivity can involve developing connections with surrounding minority communities. Program leaders who spend significant time in the community are more likely to build bridges with minority communities and tailor practices to respond to their service needs (Guerrero, 2012, 2013). In this context, Hypothesis 2 posited that leadership among program directors would be positively associated with development of knowledge, connection, linkages, and resources in racial and ethnic minority communities, as well as culturally responsive policies, procedures, and staffing practices.

2.3. Readiness for change

The organizational readiness-for-change model represents a comprehensive approach to developing capacity to implement new technologies or knowledge to successfully engage clients in behavioral health services (Edwards et al., 2010; Fuller et al., 2007; Gotham, 2004). This model highlights staff motivation and attributes, as well as organizational resources and climate, as key analytic constructs in the process of exposing, adopting, implementing, and routinizing new practices (Lehman, Greener, & Simpson, 2002; Simpson & Flynn, 2007). Attributes such as positive peer influence, opportunities for professional growth, and a strong sense of organizational mission have been associated with higher implementation of cognitive behavioral treatment approaches (Broome et al., 2007; Lehman et al., 2002), whereas staff training and greater external pressures have been associated with implementing mental health treatment in AHS organizations (Gotham, Claus, Selig, & Homer, 2010). Training and positive climate also have been linked with greater client retention in treatment (Greener, Joe, Simpson, Rowan-Szal, & Lehman, 2007; Simpson, Joe, & Rowan-Szal, 2007). In sum, the readiness-for-change framework highlights critical areas associated with organizational capacity to implement innovative policies and practices. In light of the diverse Latino and African American communities in Los Angeles County, the six components of cultural competence can be viewed as strategies expected by health reform legislation to better respond to this client population. Thus, Hypothesis 3 posited that programs' readiness for change (supervisors' perceptions of their staff's motivation for change and attributes, as well as program resources and climate) would be positively associated with development of knowledge, connection, linkages, and resources in racial and ethnic minority communities, as well as culturally responsive policies, procedures, and staffing practices.

Considering the paucity of research on drivers of implementation of cultural competence, we proposed a general conceptual

framework of program capacity that explores the extent to which organizational implementation of cultural competence relies on pressure from funding and regulation, perceived leadership, and readiness for change. These components have become critical to improving standards of care in ethnic minority communities.

3. Methods

3.1. Sampling frame and data collection

The sampling frame considered all 408 addiction health services programs funded by the Department of Public Health in Los Angeles County, California. A program was defined as a treatment unit in which substance abuse treatment constituted at least 75% of services. The sampling procedure involved a random selection of 147 outpatient programs drawn from the 350 programs located in communities with a population composition of 40% or more Latino and/or African American residents in Los Angeles County. Latino residents represent more than 56% of the county's population (U.S. Census Bureau, 2010). More than 89% of clinical supervisors responded to the online survey. Follow-up site visits were completed with 91% percent of the sample to validate measures.

Data collection involved four steps to increase the validity of measures: (1) online survey responses from supervisors; (2) a review of program characteristics and service delivery information reported to the funding organization (L.A. County Department of Public Health); (3) qualitative interviews with one counselor per program; and (4) a review of printed material available at each provider site (e.g., brochures, group activities, posted signs). Consistent information on our measures of interest from at least three of the four sources of data was necessary to include data for each program in the analytic sample. We excluded 14 programs that had inconsistent data and 11 programs that had recently closed. Thus, the final analytic sample consisted of 122 eligible programs with full and verified information.

3.2. Sample

Data were gathered in 2010–2011 from a random sample of program managers who were mainly clinical supervisors. Consistent with nationally representative organizational studies in AHS, we relied on clinical supervisors as key informant of program structure and practices (see D'Aunno, 2006; Knudsen, Ducharme, & Roman, 2006; Roman, Abraham, & Knudsen, 2011). Our power analysis using program level data suggested that data from at least 99 programs featuring 15 variables would have 80% power to detect a standardized effect size of $\delta = .24$ (Cohen, 1988). Although our exclusionary criteria resulted in a reduction in sample size, our final sample of 122 supervisors was deemed adequate for our modeling framework. The average age of our sampled supervisors was 46 years and the racial/ethnic composition was 39% Latino, 25% Asian, 22% Black, 6% White, and 8% mixed race or other. Missing data comprised approximately 4% of all survey measures.

3.3. Dependent variable

Organizational cultural competence. The Cultural Competence Self-Assessment Questionnaire is composed of six subscales with 9, 8, 3, 15, 10 and 12 items each, representing various culturally competent practices (Mason, 1995). These subscales measure (1) knowledge of, (2) outreach to, and (3) personal involvement in racial and ethnic minority communities, (4) development of resources and linkages to serve racial and ethnic minorities, (5) development of policies and procedures to effectively respond to the service needs of racial and ethnic minority patients, and (6) hiring and retention of employees with racial and ethnic minority backgrounds. Sample items for each scale are presented in Table 1 (for a full description of items, please refer to http://www.racialequitytools.org/resourcefiles/mason.pdf). Reliabilities of the six subscales ranged from .69 to .85. Responses were rated on a 4-point Likert scale (1 = *not at all* to 4 = *often*) and averaged to create

Table 1
Organizational, director, and supervisor characteristics of addiction treatment programs ($N = 122$).

Variables	*M* (*SD*) or %	Response format
Cultural competence[a]		
Knowledge of communities	2.98 (0.45)	9 items, e.g., How well can you describe Latino social problems in your service area?
Outreach to communities	2.75 (0.68)	8 items, e.g., Does your agency reach out to organizations in communities of color?
Involvement with communities	2.68 (0.77)	3 items, e.g., How much do you interact with Latino communities in your service area?
Resources and linkages	2.80 (0.59)	15 items, e.g., Do you collaborate with programs that provide mental health psychiatric services?
Policies and procedures	2.32 (0.75)	10 items, e.g., Does your agency use Latino-specific assessment instruments for diagnosis?
Diverse staffing	2.61 (0.68)	12 items, e.g., Does your agency staff discuss barriers to working across cultures?
Structure		
Regulation by state	95.1	Program is licensed by the state = 1
Accreditation by TJC	16.7	Program is certified by TJC = 1
Medi-Cal	70.8	Program accepts Medi-Cal reimbursement = 1
Private insurance	48.3	Program accepts private insurance reimbursement = 1
Public funding	0.67 (0.38)	Percentage of public funding received during prior fiscal year
Parent organization	35.3	Program is managed by a parent organization = 1
Graduate-level staff	28.88 (35.80)	Percentage of treatment staff with graduate degree
Readiness for change[b]		
Motivation for change	3.11 (0.61)	24 items, e.g., Your program needs more training for effective implementation of EBPs
Resources	3.76 (0.56)	12 items, e.g., Clinical management decisions for your program are well planned
Staff attributes	4.16 (0.43)	8 items, e.g., You are able to adapt quickly when you have to make changes
Organizational climate	3.50 (0.56)	16 items, e.g., You feel encouraged to try new and different techniques
Directorial leadership	3.90 (0.69)	9 items,[b] e.g., Your director inspires others with plans for facility's future
Supervisor characteristics		
Latino	37.7	Self-identified as Latino = 1
Licensed	32.8	Supervisor has a certification as addiction specialist = 1
Field tenure	12.99 (9.43)	Years of experience in drug abuse counseling
Graduate degree	31.4	Supervisor has a graduate degree = 1

Note. EBP: evidence-based practice and TJC: The Joint Commission.
[a] Ranges from 1 = *not at all* to 4 = *often*.
[b] Ranges from 1 = *strongly disagree* to 5 = *strongly agree*.

scores for each scale. Higher scores indicated perceptions among supervisors that their program had higher levels of cultural competence in each subdomain.

3.4. Independent variables

Structure. Organizational measures included regulation, public funding, and insurance capacity. Regulation measures included two items: whether the program had a state license and accreditation by The Joint Commission. We also included measures of percentage of any type of public funding (block grants, special programs for vulnerable populations, etc.) in each program's budget and whether the program accepted Medicaid (Medi-Cal in California) and/or private insurance.

Leadership. Nine items validated by Broome, Knight, Edwards, and Flynn (2009) that represent transformational and transactional leadership styles were used to measure supervisors' perceptions of the leadership abilities of program directors. Clinical supervisors rated leadership on a 5-point scale (1 = *strongly disagree* to 5 = *strongly agree*), and scores were averaged to create a total scale score. Higher scores represented higher levels of leadership among directors as perceived by clinical supervisors. Cronbach's alpha of leadership capacity was .96.

Organizational readiness for change. Organizational readiness for change was measured with the treatment director version (TCU-ORC-D), which was developed for managers to report on their programs' level of readiness. This measure has 67 items divided into four domains with 18 subscales: motivation for change (three subscales: program needs, training needs, and pressure for change), resources (five subscales: offices, staffing, training, equipment, and Internet access), staff attributes (five subscales: growth, efficacy, influence, orientation, and adaptability), and organizational climate (six subscales; mission, cohesion, autonomy, communication, stress, and change; Lehman et al., 2002; Simpson & Flynn, 2007). All items were rated by supervisors on a 5-point Likert scale (1 = *strongly disagree* to 5 = *strongly agree*). Items from subscales were added and averaged to create scores for each of the four domains. Prior research used this approach to validate scales for these four domains (Greener et al., 2007; Saldana, Chapman, Henggeler, & Rowland, 2007). Cronbach's alphas of readiness for change ranged from .74 to .86 (the full scale is available at http://www.ibr.tcu.edu/pubs/datacoll/Forms/ShortForms/09%28SF%29ORC-D4.pdf). Higher scores represented supervisors' perceptions of increased program readiness for change.

3.5. Control variables

Control variables included two organizational structure factors: whether the program operated within a larger parent organization and the percentage of graduate-level staff members in the program. Supervisor demographic and work characteristics, such as Latino ethnicity, level of education, field tenure, and license status, were included in the analytic models because those characteristics have been found to be associated with adoption of culturally responsive practices (Guerrero, 2012; Guerrero, Campos, Urada, & Yang, 2012). See Table 1 for the response format of all variables.

3.6. Statistical analysis

Bivariate Pearson pairwise correlations were conducted to identify main relationships among our variables of interest and inform the regression models. Maximum likelihood estimation in multivariate regressions was used to effectively respond to missing data (the average rate was 4%). Maximum likelihood is considered the most adequate way to obtain unbiased estimation parameters, particularly when relying on robust standard errors (Allison, 2002). This procedure was conducted in STATA/SE Version 12, which was also used to conduct six multivariate regression analyses, one per outcome. Because the conceptual framework described a relationship between organizational factors and six subdimensions of organizational cultural competence, Table 2 includes a model for each dimension using standardized regression coefficients and explained variance estimates (R^2) to inform comparisons. Model 1

Table 2
Multivariate regression models on components of cultural competence ($N = 122$).

Independent variables	Knowledge of communities β (*SE*) Model 1	Outreach to communities β (*SE*) Model 2	Involvement with communities β (*SE*) Model 3	Resources and linkages β (*SE*) Model 4	Policies and procedures β (*SE*) Model 5	Staffing diversity β (*SE*) Model 6
Structure						
State regulation	.13 (.07)	.06 (.09)	−.04 (.08)	.09 (.09)	.13 (.09)	.10 (.08)
TJC accreditation	.07 (.07)	.11 (.11)	−.11 (.10)	.06 (.09)	−.07 (.11)	.09 (.09)
Medi-Cal	−.07 (.09)	.01 (.10)	.00 (.10)	.05 (.09)	.20 (.09)*	−.04 (.10)
Private insurance	.00 (.08)	.18 (.10)†	−.06 (.09)	.10 (.11)	.09 (.10)	.18 (.11)†
Public funding	−.10 (.09)	.05 (.12)	−.10 (.10)	−.17 (.10)†	.19 (.09)*	.12 (.10)
Parent organization	−.25 (.08)**	.15 (.12)	−.03 (.10)	.10 (.10)	.14 (.08)†	.03 (.12)
Ratio of graduate-level staff	−.21 (.10)*	−.03 (.11)	−.18 (.08)*	−.14 (.11)	−.15 (.09)	−.03 (.10)
Readiness for change						
Motivation for change	−.01 (.11)	.06 (.11)	.14 (.09)	.02 (.11)	.05 (.13)	.07 (.12)
Resources	−.12 (.16)	−.16 (.18)	.13 (14)	−.11 (.16)	−.07 (.16)	.29 (.12)
Staff attributes	−.10 (.09)	−.06 (.11)	.08 (.10)	.10 (.11)	−.01 (.11)	−.15 (.10)
Organizational climate	.40 (.14)**	−.09 (.16)	.24 (.14)	.22 (.17)	.29 (.14)*	.08 (.16)
Directorial leadership	−.15 (.11)	.33 (.13)*	−.04 (.12)	.02 (.14)	.03 (.11)	.33 (.13)*
Supervisor characteristics						
Latino	.29 (.07)***	−.05 (.11)	.17(.09)†	−.15 (.11)	−.13 (.10)	−.07 (.10)
Licensed	−.12 (.09)	−.02 (.10)	−.02 (.08)	.18 (.09)*	.06 (.10)	−.05 (.10)
Field tenure	.01 (.09)	−.06 (.10)	.09 (.10)	.09 (.10)	.01 (.10)	−.05 (.11)
Education	.09 (.10)	.09 (.12)	.16 (.10)	.10 (.12)	.19 (.09)*	.16 (.11)
R^2	.28***	.16*	.21**	.19**	.22**	.16*

Note. Standardized parameter estimates with robust standard errors in parentheses from two-tailed tests; TJC = The Joint Commission.
† $p < .10$.
* $p < .05$.
** $p < .01$.
*** $p < .001$.

tested knowledge of communities, Model 2 tested reaching out to communities, Model 3 tested personal involvement in communities, Model 4 tested having resources and linkages to serve racial and ethnic minority clients, Model 5 tested having policies and procedures to respond to the needs of racial and ethnic minority clients, and Model 6 tested having diverse staffing policies.

4. Results

The bivariate correlational analysis showed relationships among some of the main variables of interest. A correlation matrix is not included here, but is available upon request. No statistically significant correlation was found between outcomes, such as linkages and resources and reaching out to communities, and independent variables of interest. However, other cultural competence variables, such as knowledge of the community ($r = .21$, $p < .05$) and policies and procedures ($r = .17$, $p < .05$), were related to organizational climate. Personal involvement in communities was positively associated with leadership ($r = .24$, $p < .01$), resources for change ($r = .32$, $p < .01$), staff attributes ($r = .16$, $p < .05$), and organizational climate ($r = .25$, $p < .01$). In addition, having diverse staffing policies was positively associated with Medi-Cal ($r = .21$, $p < .05$). Variables reporting non-significant bivariate relationships (e.g., licensing and accreditation) were included in the regression analysis only when multicollinearity was not an issue and when variables were directly supported by our theoretical model and empirical evidence.

Findings from the multivariate regression analysis partially supported Hypothesis 1, which posited that public funding and regulation would be positively associated with greater implementation of all six components of cultural competence. Accepting Medi-Cal ($\beta = .20$, $SE = .09$, $p < .05$) and receiving more public funding ($\beta = .19$, $SE = .09$, $p < .05$) were positively associated with policies and procedures that better serve minority communities. See Table 2 for results.

Findings partially supported Hypothesis 2, which suggested that supervisors' perceptions of directorial leadership would be positively associated with greater implementation of all six components of cultural competence. Leadership capacity was positively associated with outreach to minority communities ($\beta = .33$, $SE = .13$, $p < .05$) and development of diverse staff ($\beta = .33$, $SE = .13$, $p < .05$).

Findings partially supported Hypothesis 3, which posited that supervisors' report of program readiness for change would be positively associated with greater implementation of all six components of cultural competence. Of the four subscales of readiness for change, only organizational climate was positively associated with knowledge of minority communities ($\beta = .40$, $SE = .14$, $p < .01$) and development of policies and procedures to serve minority communities ($\beta = .29$, $SE = .14$, $p < .05$).

Finally, other nonhypothesized relationships were statistically significant. Consistent with other studies (Guerrero, 2012; Guerrero et al., 2012), programs with more graduate staff and those with parent organizations were negatively associated with knowledge of minority communities ($\beta = -.21$, $SE = .10$, $p < .05$ and $\beta = -.25$, $SE = .08$, $p < .01$, respectively). Programs with more graduate staff were also associated with less involvement with communities, as reported by supervisors ($\beta = -.18$, $SE = .08$, $p < .05$). Programs with a higher proportion of Latino supervisors were positively correlated with staff knowledge of predominantly Latino communities, reported by supervisors ($\beta = .29$, $SE = .07$, $p < .001$). Supervisors with a clinical license or addictions certification were positively associated with resources and linkages pertaining to cultural competence ($\beta = .18$, $SE = .09$, $p < .05$). Lastly, programs with graduate-level supervisors were associated with more culturally responsive policies and procedures than programs with supervisors with no graduate degree ($\beta = .18$, $SE = .09$, $p < .05$).

The component of organizational cultural competence that was most associated with variables of interest in this study was knowledge of communities. This outcome, presented in Model 1, had the highest explained variance ($R^2 = .28$). In contrast, the least-predicted components were outreach to minority communities and development of diverse staff ($R^2 = .16$ each), both of which were explained primarily by directorial leadership.

5. Discussion

These findings indicated that organizational factors, such as public funding, leadership, and climate for change, are associated with the degree of implementation of several administrative and service delivery components related to cultural competence among addiction health services programs. Important differences were identified in terms of organizational characteristics (structure, leadership, and readiness for change) and different dimensions of organizational cultural competence. Yet, there were some relationships that were not expected. For instance, it is not clear how variables such as organizational climate were related to knowledge of communities but not to outreach or involvement with communities, or alternatively, how leadership was related to outreach but not involvement with communities. This study uncovered some of these empirical relationships, but new theoretical models are needed to explain subtle differences in organizational practices.

However, other relationships found in this study were consistent with neoinstitutional theory and empirical studies in health care. The significant influence of public funding and Medicaid imply that these public resources may pressure community-based programs to develop policies and procedures that comply with institutional expectations for culturally responsive care (Guerrero, 2012; Guerrero et al., 2012; Campbell & Alexander, 2002; D'Aunno, 2006; Howard, 2003; Weech-Maldonado et al., 2012). However, there is limited evidence of the role of these pressures in the implementation of practices in service delivery on a day-to-day basis (Campbell & Alexander, 2002; Stork, Scholle, Greeno, Copeland, & Kelleher, 2001).

Leadership has been regarded as an emerging focal point in efforts to support the implementation of evidence-based practices in behavioral health (Guerrero, 2012, 2013; Guerrero et al., 2012; Aarons, 2006; Aarons et al., 2009; Edwards et al., 2010). Although results only showed directorial leadership as a significant factor in increasing outreach to minority communities and the diversity of program staff, the effect of leadership on these two practices ($\beta = .33$) was greater than all other significant factors in the six-model framework, except for the relationship between climate and knowledge of communities ($\beta = .40$). Previous research has highlighted the influence of leaders' characteristics (e.g., Latino, licensed, graduate degree, and cultural sensitivity) on the implementation of services in Spanish, cross-cultural training of staff, and hiring and retention of minority staff in outpatient AHS programs in the United States (Guerrero, 2010).

Training and encouraging employees to view situations in new ways are important aspects of the transformational leadership style measured in this study. Directors perceived as invested in training and performance may be more encouraging of staff to try new approaches with minority clients than poorly engaged leaders. As small treatment programs in minority communities seek to cope with changes precipitated by health care reform legislation that mandates cultural competence in service delivery to reduce health disparities (Andrulis et al., 2010; Osborn et al., 2011), leadership efforts to promote staff development (transformational) or incentivize performance (transactional) will serve a

pivotal role in tailoring administrative and service delivery practices to the needs of minority communities.

Somewhat surprisingly, except for climate, indicators of the readiness-for-change framework (motivation for change, resources and staff attributes) were not associated with components of cultural competence. Program climate was positively associated with knowledge of minority communities and having policies and procedures to serve racial and ethnic minorities. The relationship between climate and knowledge of communities was the strongest in this study, highlighting the importance of this factor for developing a climate of inclusion. Although these concepts may seem intractable and require more refinement to capture program norms that deliberately promote a climate of inclusion, results suggested that significant factors such as leadership style and perceived climate for change are critical to the implementation of cultural competence.

Finally, although we sought to determine which organizational factors foster implementation of components of cultural competence, our results highlighted other factors, such as parent organizations and percentage of staff with graduate degrees, as inhibitive of the implementation of knowledge and involvement with minority communities. Our sample represented programs located in minority communities. Yet, it is conceivable that programs embedded in parent organizations or with professionalized staff, compared to small programs with less professionalized staff, may be more likely to follow standard service and billing procedures instead of adapting to local situations, which requires establishing and investing in community relations. This finding is consistent with emerging evidence that the least community-oriented and most professionalized programs also report lower racial/ethnic diversity in staff composition and fewer policies to match clients based on race/ethnicity, language, and community background (Guerrero & Andrews, 2011; Guerrero, 2012; Guerrero et al., 2012).

As health care reform seeks to develop population health through client-centered care that reduces health disparities in minority communities, diversification of the workforce and development of organizational policies and practices that respond to the cultural and linguistic service needs of ethnic minority communities will be critical. As highlighted by findings from this study, building capacity to serve the cultural and linguistic service needs of ethnic minorities requires investment in public funding, regulation, leadership, and program climate in community-based addiction health services programs.

5.1. Study limitations

Several issues, including methodological challenges, complicated the relationships between organizational factors and the implementation of culturally competent practices, and should be considered when interpreting these findings. The structure of the survey data did not allow for establishing causality, directionality, or implementation of practices over time. These are cross-sectional data, and explored factors may be bidirectional; e.g., addiction health organizations with greater minority outreach in communities and diverse staff may attract directors with greater leadership capacity. Also, the cross-sectional data and the dependent measure did not allow for longitudinal and sequential assessment of implementation. There are only a few longitudinal studies on implementation of culturally responsive practices (e.g., Guerrero et al., 2012) whose panel design can inform future studies. We also acknowledge that our sample was relatively small and drawn from one county, limiting generalizability. However, the randomly selected sample represented a service area featuring more than 7 million residents from urban and highly diverse backgrounds. Finally, we relied on a key informant model with cross-validation to collect data. Some studies have suggested relying on multiple informants to identify the significant variability among staff members on organizational climate variables (Courtney, Joe, Rowan-Szal, & Simpson, 2007) or reduce response bias from managers when asked to rate implementation of evidence-based practices (e.g., Adams, Soumerai, Lomas, & Ross-Degnan, 1999; Lee & Cameron, 2009). However, other studies have found that the organizational readiness-for-change scales did not discriminate between responses of staff and supervisors, using aggregates in the final analysis (Saldana et al., 2007). Our single key informant model with cross-validation checks allowed us to collect system data from a larger number of programs. Although not optimal, we attempted to reduce response bias by completing validity checks (using funding data, counselor interviews, and printed materials at program sites) with 91% of the sample during site visits, allowing us to dismiss 14 programs with inconsistent responses. Despite these methodological challenges, analysis of this random sample of programs located in minority communities and the largest AHS system in the United States provided preliminary evidence of promising organizational factors that may enable programs to build administrative and service delivery capacity to serve racial and ethnic minority communities.

6. Conclusion and implications

Findings underscore the role of resources, leadership, and program climate to build capacity to implement different components of cultural competence. In this context, leadership plays a pivotal role in building capacity, particularly in terms of "leading by example." When organizational leaders invest in communities of color, they potentially gain the buy-in, motivation, and practical knowledge that management training requires to effectively implement cultural competence—for instance, developing networks to enhance efforts to recruit and retain employees with racial and ethnic minority backgrounds (Guerrero et al., 2012).

This study provides preliminary evidence for the addiction health services research literature by identifying the role of program climate for change in the implementation of cultural competence. As such, it opens up areas for further inquiry. For instance, these findings can inform future research to identify the loci and mechanisms of leadership styles to enhance organizational climate for cultural responsiveness by building connections with minority communities. Implications for evaluation and program planning include preparing AHS programs to effectively respond to health care reform incentives and regulation to increase workforce diversity, cross-cultural training, and cultural competence education (Andrulis et al., 2010). More specifically, it provides guidance for program managers to develop organizational strategies that promote understanding of the cultural layers that exist for client, counselors, and the organization (Mallow, 2010) and that may ultimately enhance treatment engagement and reduce health disparities among racial and ethnic minority clients struggling with addiction.

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