Transforming Administrative and Clinical Practice in a Public Behavioral Health System: An Ethnographic Assessment of the Context of Change

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Abstract: In July 2005, New Mexico placed all publicly funded behavioral health services under the management of one private corporation. This reform emphasized the provision of evidence-based, culturally competent services. **Methods**. Participant observation and semi-structured interviews with 189 administrators, staff, and providers were carried out in 14 behavioral health safety-net institutions (SNIs) during the transition period. **Results**. New administrative requirements led to substantial paperwork demands, payment problems, and financial stress within SNIs. Personnel at the SNIs often lacked knowledge about and training in evidence-based practices and culturally competent care, and viewed the costs of delivering such services as prohibitive. **Discussion**. Policymakers must account for the challenges that SNIs face as the reform continues to unfold. The financial stability of SNIs is of critical importance. Efforts are needed to increase training and development opportunities in evidence-based care and cultural competency; SNIs typically lack resources to pursue these opportunities on their own.

Key words: Behavioral health, cultural competency, evidence-based practices, rural, safety-net institutions.

In July 2005, New Mexico became the first state to place all publicly funded behavioral health services under the management of a single for-profit private corporation, ValueOptions® (VO), referred to locally as the "statewide entity." This reform promoted conventional managed care principles, such as efficient use of limited resources, cost-effectiveness, and performance, and emphasized the provision of evidence-based, culturally competent services within a state system. During the first year of this massive restructuring, state officials and VO administrators largely focused on immediate "nuts

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and bolts" issues rather than clinical practice innovations: (1) ensuring that services continued with as little disruption as possible; (2) introducing new processes for enrollment, billing, and governance; and (3) creating comprehensive quality improvement and information management systems.[1]

Here, we draw upon a multi-site ethnographic study to document the initial implementation of this unprecedented reform in selected counties of the predominantly poor and rural state of New Mexico. We examine how administrators, providers, and staff members of behavioral health safety-net institutions (SNIs) experienced the implementation before the onset of major changes in the direct service delivery system, and explore agency-level factors that affect the capacity of SNIs to deliver evidence-based, culturally competent care. Safety-net institutions are agencies that have historically served low-income populations, including those on Medicaid or uninsured and at serious risk for behavioral health problems.[2–4] These institutions are vital to the care of the socially disadvantaged, functioning as important providers for individuals who may not otherwise have access to needed services.[5–7] National[8–12] and local[2,3,13,14] research on privatization and state-mandated managed care reform has raised concern over the trajectory of SNIs within rapidly changing health care environments. Our study of SNIs thus has wide implications, as other states closely monitor developments in New Mexico in efforts to reform their own publicly financed behavioral health systems.

Systems change in New Mexico. Safety-net institutions experienced the first of two dramatic reforms of behavioral health services in 1997, when the state instituted Medicaid managed care (MMC). ValueOptions® was one of three managed care companies tasked specifically with administration of mental health services under MMC. The hurried transition to MMC led to problems for SNIs specializing in mental health care. These SNIs experienced the transition as chaotic and stressful. They did not receive operational manuals until weeks after implementation, and telephone systems intended to supply information about the program's rules were often inoperable or busy. Workloads changed significantly as a result of frequently changing policies under MMC. This first reform led to substantial administrative burdens, payment problems, and high turnover among clinicians, contributing to the closing of mental health programs throughout the state.

Although the first reform did not focus on evidence-based care, MMC did emphasize the importance of culturally competent services. However, previous ethnographic research on MMC in rural New Mexico suggested that the reform did little to reduce service barriers or improve quality of care for either Hispanics or Native Americans,[15] two ethnic groups that constitute about 52% of the state's population and bear the brunt of behavioral health disparities.[16,17]

The move to MMC compromised an already fragile and severely underfunded mental health care delivery system,[2,14,15] but effected minimal impact on SNIs that largely provided substance abuse treatment to people ineligible for Medicaid. Such treatment was typically funded through state-administered federal block grants. Thus, MMC reinforced the traditional separation of mental health and substance abuse treatment services in New Mexico.

In 2003, The President's New Freedom Commission on Mental Health, a group of policymakers, practitioners, and administrators, put forth a wide-ranging study of

behavioral health care in the U.S. The Commission challenged states across the nation to initiate comprehensive strategies in order to enhance use of existing funds and improve quality in their delivery systems by ensuring the availability of evidence-based, culturally competent services. Evidence-based services or practices include manualized interventions for which scientific evidence has consistently demonstrated that they improve patient outcomes. These interventions consist of specific guidelines, usually outlined in a manual, which are implemented in a structured manner.[18] Cultural competence in behavioral health encompasses ". . . a general approach to delivering services that recognizes, incorporates, practices, and values cultural diversity."[19, p. 52] The combination of evidence-based, culturally competent services was intended to facilitate delivery of the highest quality of care and contribute to the reduction of behavioral health disparities in ethnic minority and rural and frontier populations.

Inspired by the Commission's ambitious vision of a transformed system[1] and influential documents published by the U.S. Surgeon General[20,21] and the American College of Mental Health Administrators,[22] state officials in New Mexico began planning the overhaul of all publicly funded behavioral health care in October 2003. A central feature of the revamped system included the braiding and blending of service funds from 15 state agencies to manage these funds better and to leverage them in new ways.[22] Ideally, the consolidation of funding streams would contribute to the development of a unified set of administrative practices, and thus decrease duplicative and costly paperwork requirements for providers who traditionally contracted with multiple state agencies.[1]

After a competitive bidding process, the state established a contract with VO to collaborate with state officials in order to create the infrastructure for a cost-efficient, seamless system of care that would maximize use of limited funding in July 2005. The new statewide entity was also entrusted to oversee the incorporation of evidence-based practices (EBPs) and culturally competent services into the public sector.[23] In spite of the negative experience that marked the behavioral health system's transition to MMC, SNI personnel remained guardedly optimistic that this latest reform might lead to better working conditions and long-term improvements within an otherwise beleaguered system.

Through an ethnographic lens, we shed light on the work environment of SNIs during the initial restructuring phase, conceptualized as a period of do-no-harm by state officials and VO administrators. Their goals for this period were to develop and introduce streamlined administrative processes and to make sure patients received needed services while providers, in turn, were duly compensated. No substantive improvements were planned for the benefit package of patients in public insurance programs. Expansion of the patient population received minimal attention. Finally, no new money was added to the overall behavioral health system.[1]

We aim to identify several dimensions of clinic "noise," i.e., contextual factors within the workplace that can affect the transition of SNIs to New Mexico's still-developing system of service delivery.[24] Such factors include preexisting stressors both on the workforce and the organizations themselves—stressors that reform efforts may exacerbate in the short term or eventually alleviate. We also elucidate the range of contextual factors likely to influence achievement of the long-term goal of evidence-based, culturally

competent services, focusing on provider perceptions, pragmatic issues, and resistance to the adoption and implementation of innovations in clinical practice. Close attention to these factors by state policymakers and other relevant stakeholders can enrich ongoing planning processes related to the reform.

Methods

As part of a long-term study of reform implementation and effects on access and quality of care for low-income adults with serious mental illness, our ethnography team carried out participant observation and semi-structured interviews with 189 administrators, providers, and staff members in 14 behavioral health SNIs between April and December 2006, prior to the onset of major changes in the service delivery system. The ethnography team comprised six anthropologists (including the first author), one psychiatrist, and one counselor. All team members held advanced degrees. The SNIs were located in three urban and three rural areas, carefully selected for study on the basis of their racial/ethnic demographics. Six SNIs were community mental health centers, three were substance abuse treatment centers that delivered residential and outpatient services, two agencies specialized in outpatient services for homeless adults with co-occurring disorders, and three agencies represented small group practices.

We implemented a purposive sampling approach to recruit participants at each SNI. The aim of samples in qualitative research is to represent the range of views and values related to the study issues, such as local experiences under the statewide reform. Such samples include individuals who can discuss most issues under investigation.[25] We first interviewed a lead administrator who then referred direct service providers (e.g., psychiatrists, psychologists, social workers, case managers, and psychosocial rehabilitation coordinators) and support staff members for participation. We selected participants specifically involved in the delivery of services to adult patients for interviews. Close to 73% of these participants were female; 36% were Hispanic; 17% were Native American; 44% were White; and 3% were classified as Other. Approximately 11% of participants reported having a high school education or less; 30% had completed some college; 16% had completed college; 39% had at least some graduate school education; and 4% reported other types of education.

Three complementary interview protocols elicited responses from each participant group (administrators, providers, and staff). The protocols covered multiple domains: job duties, workplace, and workday; EBPs; culturally competent services, with a special emphasis on Hispanic, Native American, and White or Anglo populations; organizational financial issues; and benefits, drawbacks, and implementation issues associated with the reform.

We also observed participants in various settings. This component augmented the interview material, enhancing our insight into the work lives of providers. In particular, we took part in psychosocial rehabilitation programs, attended therapeutic support groups, observed daily operations in SNI reception areas and offices, and accompanied case managers as they helped patients navigate health and human service systems. To track relevant policy changes, we also observed public forums pertinent to the New Mexico reform. For each observation, the ethnographers took special care to document

the setting, the individuals in attendance and the nature of their interactions, and all discussion pertinent to the New Mexico reform. The resulting data consisted of descriptive and inferential information, as the ethnographers were encouraged to record their overall perception and interpretation of the people and events observed.

Observation and interview notes were handwritten and transcribed into an electronic database. Interviews, which lasted approximately 45 to 60 minutes, were digitally recorded, transcribed, and coded.

Data analysis proceeded according to a plan that differed somewhat for semi-structured interviews vs. observations. To analyze the interviews, we developed a descriptive coding scheme from transcripts based on the specific questions and broader domains that made up the interviews. We used the widely respected qualitative data analysis software NVivo 7[26] to organize and index data and to identify emergent categories and themes.[27] We analyzed data from observations first by using *open coding* to locate themes. We then used *focused coding* to determine which themes emerged frequently and which represented unusual or particular concerns.[28] Coding proceeded in an iterative fashion; our ethnography team coded sets of transcripts and observation fieldnotes, created detailed memos linking codes to emergent themes, and then passed their work to the three authors for review. Discrepancies in coding and analysis were identified during this review and resolved during regular team meetings.

We strengthened the credibility of our qualitative inquiry through triangulation of the interview and observation data.[27,29] Comparison of data from different sources and participant groups contributed to a coherent account of cross-cutting themes relevant to changing state policies and their effects on New Mexico's behavioral health safety net. Through this comparative approach, we also identified important variations in how SNIs were poised to respond to such policies. The results below represent the main themes generated by our data and analysis. Quotations that underscore the perspectives of study participants and examples of commonly shared experiences are presented to illuminate these themes.

Results

Initial transition issues. At the start of the reform, a common issue pervading SNIs concerned the "stressed out" workforce. Several sources of stress—time constraints, challenges of caring for persons in mental health crisis, and practitioner shortages—preceded the reform. However, an examination of these sources lends insight into contextual factors that can influence reform implementation in practice settings. The enrollment, billing, and reimbursement requirements introduced under the reform created new sources of stress, including heightened paperwork demands, payment problems, and financial insecurity for SNIs.

"Stressed out" workforce. Time constraints were the most widely cited stressor before and after the reform among all groups of respondents. Echoing a common sentiment, one provider stated, "Too much to do, not enough time." Regardless of their positions within an agency, SNI personnel attributed the experience of "not having enough time in the day" to overwhelming paperwork, organizational understaffing, and overall workload burden.

Providers observed that paperwork related to intake, progress notes, treatment plans, and diagnostic reviews had become more onerous, as they now had to familiarize themselves with new VO forms and assessment requirements. Providers contended that completion of these requirements cut into time spent with patients.

Personnel of SNIs, specifically providers and support staff, also focused on the stress of helping patients who were suicidal and/or otherwise in serious crisis, including the work of intervening with police assistance or ensuring that an inpatient bed could be secured. They characterized the sheer volume of patients and their demands for immediate service and satisfaction as stressful. In most settings studied, SNI personnel felt ill-prepared to contend with the complex problems presented by patients and underappreciated by SNI leadership.

Recruitment and retention were viewed as a cause and consequence of such workplace stressors. Most SNIs, particularly those in rural areas, struggled with the problems of filling all available positions and retaining qualified personnel, especially providers who were bilingual and/or licensed to deliver mental health and substance abuse services. Chronic provider and staff shortages meant more work for individual employees and compromised the overall service delivery capability of SNIs. One administrator observed, "Having a full staff would be wonderful. . . . Having enough staff for people to take time off without overloading the existing staff [would be great]. . . . We don't have enough staff to run at capacity."

Impact of new billing, reimbursement, and enrollment requirements. To the extent that direct service provision remained unaffected, SNI personnel were largely indifferent to the reform. As the transition period ended and VO became more aggressive in monitoring adherence to new administrative procedures, SNI personnel grew more critical of the reform.

While all SNIs participating in our study experienced difficulties adapting to the initial changes in billing and enrollment procedures under the reform, some fared better than others. The state's earlier transition to MMC primarily affected SNIs that specialized in physical and mental health services delivery, and not SNIs specializing in substance abuse treatment. Because they never developed the infrastructure to operate effectively under managed care arrangements, these SNIs reported problems developing internal billing systems and complying with electronic enrollment requirements, discussed below. In addition, larger SNIs with more established corporate infrastructures tended to adapt quickly to the new requirements, while smaller, less formally organized agencies lacking staff members with solid training in business and accounting practices and use of computer technology struggled.

Safety-net personnel frequently complained of "bureaucratic frustration" resulting from inadequate technical assistance from VO, particularly in billing and enrollment procedures. This frustration was acute during the early months of transition. One administrator noted, "I never really know what VO expects. They kind of think it's a self-service thing, where if you want to know what we've changed or what we're doing, go to our website and find it for yourself." A second administrator stated, "When this first started coming in . . . I had a log of the places to call when I needed technical assistance. My log was like 12 to 15 numbers. . . . Chances were if I called one of them, I would get shunted around between three or four of them before I'd finally—if I did—get

a hold of anyone who knew what they were talking about." Concerns about inadequate technical assistance were not unique to the reform in question; SNI personnel expressed similar complaints during the state's transition to MMC in 1997.[2,13]

Before SNI personnel could bill for services, they had to enter patient information into a Web-based data management system developed and maintained by VO (a process called *enrollment*). Providers typically entered patient data into this system, including demographic and diagnostic information, during the patient intake or soon after. Adherence to shifting enrollment requirements emerged as one of the most notable stressors in SNIs during the transition period, contributing to significant tension within these organizations.

In July 2005, when the first fiscal year of the reform commenced, SNI personnel were asked to enter demographic information for each patient whose care was financed through public means. As of January 2006, SNI personnel began entering detailed diagnostic information into the enrollment system. In June 2006, one month prior to the close of the fiscal year, SNI personnel reported that they had been blindsided by a new directive requiring the input of demographic and diagnostic information for all patients seen between July 2005 and December 2005. If SNIs did not complete this requirement within two weeks, they were told, then the agencies would experience payment delays and/or denials for services already rendered. This unanticipated requirement entailed pulling hundreds of charts and then combing through them to locate needed information. Safety-net administrators were faced with the decision to cancel appointments with patients in order to free providers to finish the enrollment paperwork. Some providers threatened to quit due to this push. Support staff members who otherwise were not involved in enrollment processing were also trained to undertake this task. Several SNIs accrued substantial overtime charges and some hired temporary staff members. These expenses were absorbed into the existing administrative budgets of the SNIs.

Financial insecurity. The majority of SNIs, especially those in rural areas, were under financial pressure prior to the reform.[15] However, financial pressures intensified for some SNIs during the transition period, reportedly owing to reduced payment rates. Under the previous Medicaid reform, the state's corporate managed care partners negotiated reimbursement rates with individual provider organizations. Several organizations that cared for populations in rural and frontier settings—where the overall costs of service delivery exceeded those in urban settings—also benefited from higher reimbursement rates for delivering select services. In addition, multiple state agencies responsible for purchasing behavioral health care frequently funded the same services according to their specific and thus disparate fee schedules; some agencies funded these services at higher rates than others. In pursuit of a uniform system of service rates, the state government and VO began to equalize payments for Medicaid funded services across provider organizations, regardless of geographical considerations. Some SNIs subsequently experienced reduced revenues. One administrator explained, "I'm struggling with trying to find money to cover payroll this Thursday. . . . Rather than getting the full amount [for services], we get less because it's going to go through ValueOptions®." A second administrator observed, "The stressful part of billing is that the rates aren't what they used to be."

Safety-net personnel also complained of payment delays and service denials. One provider stated, "We can't get payments on time even if we send our billing in on time." Administrative and support staff commonly stated that VO tended to deny claims without adequate explanation, which contributed to lags in reimbursement. We observed these same staff reviewing stacks of denials for services already rendered to determine the cause and then revise and resubmit claims. The amount and nature of these administrative demands led to higher overhead costs and contributed to financial problems for several SNIs.

A handful of SNIs assumed the costs of caring for some low-income clientele simply because they lacked the technical expertise and equipment needed to enroll patients and bill. Having never had to operate in a managed care environment prior to the reform, those SNIs specializing in substance abuse treatment were most likely to be in this position. Other SNIs considered cutting unprofitable and/or logistically expensive programs from their scope of services. These organizations were often in "crisis mode"—unable to put forth long-term plans for future viability, let alone act on new ideas for service expansion and improvement.

Safety-net personnel consistently identified finances as the "biggest stress" affecting the workplace. As awareness of financial troubles associated with the reform deepened among SNI personnel, so did their anxieties regarding long-term employment prospects. One administrator explained, "Staff [begin to think], 'Oh, my gosh! The last time we had financial problems, [the agency] laid people off. . . . What's going to stop the CEO from letting me go if things really get bad?'" Fear about job security on the individual level and fiscal solvency on the agency level weakened employee morale within SNIs toward the close of the transition period.

Perceptions of evidence-based care. As SNIs attempted to adjust to new administrative processes, maintain existing services, and resolve their financial difficulties during the transition period, concern for provision of EBPs remained low. Our research uncovered numerous factors influencing their capacity at the start of the reform to implement new EBPs: variation in awareness and knowledge of EBPs; practical difficulties associated with training, cost, and application; and provider resistance within SNIs.

Awareness and knowledge of EBPs. Awareness of EBPs varied widely among SNI personnel. The majority of direct service providers showed poor knowledge of EBPs in the fields of mental health and substance abuse treatment. The least experienced of the providers and/or those who were not in licensed positions (e.g., case managers and other paraprofessionals) were the least knowledgeable. The few SNIs in which knowledge was high and EBPs were already integrated into the work setting had track records of establishing these initiatives through funding sources other than the state government or VO. The leaders within these SNIs were expressly committed to EBPs and had sought the resources needed to incorporate EBPs into the workplace.

Across all SNIs, Motivational Interviewing, a patient-centered, directive method for encouraging change in substance use behavior, emerged as the most readily identifiable and widely implemented EBP in the care of adults,[30] followed by the Matrix Model, an intensive outpatient treatment approach for people with drug addition.[31] In a small number of agencies, SNI personnel had become enthusiastic practitioners of Community Reinforcement and Family Training Intervention, which assists people

providing social support (e.g., family and friends) in engaging substance-using loved ones in treatment while addressing environmental factors that also affect their problems with alcohol and drugs.[32,33]

Unless given specific prompts, few direct service providers could discuss specific EBPs for adults in depth. When asked to describe the components of these EBPs, they generally offered superficial overviews. One provider admitted that she was unfamiliar with the concept: "Evidence-based practices? What is that? I mean I might know it as a different thing, or I might. . . . What is it? What is it exactly?" Another provider reluctantly inquired, "You mean like Freud? It has a theory . . . ." Despite their inability to provide a coherent definition, most providers believed that their agencies implemented EBPs beyond Motivational Interviewing, Matrix Model, and Community Reinforcement and Family Training Intervention. However, interviews with SNI leadership revealed that EBPs focused on adult patients were not commonly implemented and were rarely implemented with standard fidelity protocols.

Practical difficulties. Safety-net personnel questioned the feasibility of applying EBPs in New Mexico practice settings. One provider said, "When you research evidence-based design, [EBPs] usually come from a research model with many dollars behind [them]. . . . We're asked to basically implement [EBPs] without any tools." Inadequate supervision and a lack of qualified professionals needed to implement EBPs in SNIs exacerbated the feasibility problem. Financially strapped SNIs had difficulty attracting such professionals. One administrator noted, "We don't really have the funding to hire people with Master's level degrees that can implement these things." He added, "The most we offer is $16 an hour to anybody except me. . . . It's hard to get people who want to work for that much money if they have a Master's degree or are licensed."

Safety-net personnel, particularly administrators, also observed that it could be costly to train available staff in EBPs. Administrators agreed that staff could not be expected to use EBPs proficiently after a workshop or two (the most common way in which information regarding EBPs was disseminated statewide). Participation in training also detracted from revenue generation. One administrator explained, "Training pulls staff out of what they're doing, and we have productivity requirements." Even if staff received training, implementation of EBPs would entail long-term commitment to the practices under consideration by SNI leadership, as well as a stable workforce to operate them. Implementation also necessitated adherence to monitoring and fidelity requirements, the latter of which potentially cut billable service hours.

The leaders of participating SNIs consistently argued that it would be difficult to implement new EBPs within the current public sector funding climate. One administrator put it this way: "I think there's not time to really do that right now, because of the financial worries and scares. You know, when you're worried if you're gonna stay open, you're not worried about starting some new program." Given this economic context, few SNIs planned to move forward with EBPs in succeeding years. Administrators also voiced concern that neither the state government nor VO had clearly specified which EBPs would be encouraged and reimbursed in the new system.

Resistance to EBPs. Some SNI personnel resisted the concept of EBPs. Therapists, in particular, questioned the appropriateness of EBPs as a way of making treatment decisions for individual patients, expressing preference for clinical practices they knew

and associated with positive outcomes, including some practices without validation by formal research. These providers also expressed the view that EBPs impose a "one size fits all" approach that stymies "creativity" in clinical work and diminishes if not ignores the role of professional expertise. One provider explained, "I go with the flow of the client and what they need. . . . I kind of look at what the patient needs first instead of putting them in a little box saying, 'You have depression and this works best for you.'" A second provider asserted, "Not one ideal program will work for every family or every person." A third provider questioned the authority of scientists to determine whether a given EBP should be viewed as efficacious or effective. She asked, "Who's to say what's right or wrong? If [a clinical practice] works for somebody, so be it." This concern about who has the power to define effectiveness emerged as a source of resistance to EBPs within SNI settings.

Nevertheless, while many SNI personnel lacked a solid footing in EBP delivery (and effective strategies for implementing them within agencies), they generally recognized the value of using practices linked to "evidence" that has demonstrated positive outcomes for patients. It was important for them to see "models that work" not only from personal and clinical perspectives, but from scientific perspectives as well. However, the providers often qualified their support for EBPs with statements emphasizing the need to adapt them for their specific patient populations. The paucity of EBPs that have been adequately tested or shown to be effective among Hispanic and Native American populations was commonly cited as a problem likely to affect the uptake of EBPs, particularly by providers employed in SNIs that served large ethnic minority clienteles.

Perceptions of culturally competent care. As in their discussions of EBPs, SNI personnel expressed varying levels of support for and understanding of the concept of cultural competence and its relationship to clinical work, with the majority in favor of enhancements in culturally competent care delivery. They also highlighted the financial costs that delivery of culturally competent services would entail.

Varying levels of support. As in the case of EBPs, a range of perspectives emerged regarding the reform's emphasis on cultural competence. Most SNI personnel agreed that cultural competence "sounds great" and counts as "a good idea." One provider affirmed, "It's positive because [cultural competency is] accepting of everyone, without discrepancies because so-and-so's this or that or believes in that. . . ." "Culture should be respected. . . . Traditions and all that should be honored," stated another. Yet, some providers expressed ambivalence, one stating "[The emphasis is] great just as long as they don't overdo it and forget the regular person."

Other providers were critical of their agencies. One provider observed, "We're not culturally sensitive here. . . . When Hispanic and Native American people come in, it's more or less . . . a White agency." For these providers, recruitment and retention of mental health and substance abuse treatment professionals from underserved minority backgrounds was a centrally important avenue for ensuring culturally competent services.

It was not uncommon for respondents simultaneously to express support for cultural competence and to minimize the need for enhanced cultural competency in their own work. One provider explained, "I haven't heard or haven't seen any problems with [cultural competence]." A second provider noted, "There's not that much need for it

here. . . . None of the Mexican American consumers have approached me and said anything about needing more Hispanic or Mexican American teachings or anything like that. They all seem to speak fluent English and don't really have a problem getting along with the *gringos* [Anglos]."

While the vast majority of direct service providers expressed positive attitudes toward improved cultural competency, a minority of them did not particularly support the concept. One provider asserted, "This cultural crap is crap." Those who tended to make negative comments regarding the reform's emphasis on cultural competency typically claimed to be unsatisfied with dominant discourses in the mental health field that promoted perspectives on "culture" and "cultural issues" that, in some cases, reinforced stereotyping of ethnic groups, whereas others (a very small group) simply said they did not "buy into" the concept.

Understanding of cultural competency. Safety-net personnel faulted the state government and VO for failing to clarify the meaning of cultural competency within the reform context. One provider, for example, longed for a "tangible" definition of cultural competency tailored to New Mexico. Another expressed frustration with varying definitions circulating nationally, describing herself as always unsure about what the term connoted, despite two decades of experience working with state and federal programs that emphasized cultural competency.

Regardless of whether or not SNI personnel supported the state government's interest in promoting cultural competency, the concept itself was often discussed in relatively simplistic terms. As documented elsewhere,[15,34] cultural competency was typically associated with the capacity to serve non-English speakers, and the possession of knowledge of a social group outside of one's own. "You cannot understand people until you understand their culture," observed one provider.

Some SNI personnel conflated cultural competency with a form of "political correctness" intended to combat "discrimination," readily asserting that they were not "prejudiced" and that they "treat all [patients] the same." The providers in our study commonly espoused a "color-blind" approach to service delivery. One provider commented on the fundamentals of this approach by saying, "We serve everyone that comes in here. . . . We don't look at culture. We don't look at ethnicity. What we look at is the person and everybody's treated equally here. We bring people in and it doesn't matter what race they are, what religion, what anything else."

In most SNIs, personnel had not received training in culturally competent care delivery in either the year leading up to reform implementation or the first year of the reform. Safety-net personnel suggested that the state government and VO should take greater initiative to ensure that training opportunities were available to SNI personnel if, as one provider noted, they were going to "recommend that we be more culturally sensitive." The majority of SNI personnel also expressed a genuine interest in participating in cultural competency training.

Safety-net personnel further suggested that Anglo providers were least likely to be culturally competent and most in need of training. They clarified that such providers were among the most likely to have emigrated from regions outside of New Mexico and were thus most likely to be unfamiliar with local populations. One provider observed, "They haven't really been educated or trained to work with people of different cultures

and backgrounds." The assumption was also widespread that Hispanic and Native American SNI personnel were more culturally competent because they were more likely to possess a first-hand understanding of culturally based views of mental illness and treatment, and they knew how to interact in a socially appropriate manner with members of their ethnic group. Such individuals were thought to be in less need of such training by virtue of their ethnic backgrounds and experiences.

Costs of cultural competency. Safety-net personnel implicitly argued that cultural competency was difficult to attain and would not come cheaply. Cultural competency was not an easily taught value or skill, nor would sporadic lectures or brief trainings achieve the goal. Resources were needed not only to provide ongoing training, but also to translate written materials, pay for interpretation services, and adapt and evaluate behavioral health interventions to ensure appropriateness for ethnic and rural populations. Without access to such resources, SNI personnel were skeptical that the goal of enhanced cultural competency would be achieved.

Overall, SNI personnel viewed the promotion of cultural competence within the behavioral health system as an unfunded mandate, much as they had suggested in their discussions of EBPs. Summing up the views of his colleagues, one provider explained,

> I would love to have the time to provide culturally competent care. I would love to be able to practice in the setting where I had an hour each visit with every one of my patients so that not only could I be doing med management, but I could also be getting to really know the patient and listen to them talk a lot about themselves. . . . I'm all for it, but the question is how? How does that happen and who pays for it?

Those SNI personnel who strove to provide culturally competent services tended to feel that lack of adequate funding would hamper their accomplishing this goal. They remained uncertain about how to make cultural competency a central objective of their practice and a driving force of interactions with patients because the system would not pay for lengthier visits and imposed limitations on duration of treatment.

Discussion

Our ethnographic research offers insight into actual practice settings affected by major state policy reform from the specific vantage points of administrators, providers, and staff. Onerous paperwork demands, the surging tide of patients with very complex needs, and practitioner shortages had contributed to stressful work environments within SNIs prior to this most recent reform. Initial implementation processes exacerbated this stress. In particular, changes in administrative processes related to billing, reimbursement, and enrollment adversely affected worker morale as well as SNI capacity to deliver evidence-based, culturally competent care, a widely publicized, long-term aim of the New Mexico reform.[1]

Safety-net administrators identified delayed payments and lower reimbursement rates under the reform as factors contributing to financial problems within agencies. Not all SNIs had the necessary administrative apparatus in place to adhere to the new billing

and reimbursement requirements established by VO. These SNIs typically lacked the financial resources necessary to purchase technology—including computers, software, and consistent access to Internet—in order to submit required materials to VO online. Safety-net institutions also cited lack of technical assistance from VO as one reason they were unable to build this apparatus or comply with the new requirements. Employees of VO, many of whom had worked in New Mexico's behavioral health system prior to the reform, were not yet prepared to provide technical assistance to these sites. Under pressure to design and implement a novel administrative structure intended to consolidate the management of all state-funded behavioral health services in a short period of time (12 months), VO lost sight of the need to ensure the availability of appropriate personnel and guidelines for assisting SNIs during the critical period of transition.

It is important to note that, from a health policy perspective, not all SNIs are likely to be effective users of scarce public dollars for service delivery. That such SNIs may be unable to adjust to new ways of doing business within the restructured system might simply reflect pre-existing problems specific to these organizations. For example, poor leadership and demoralizing organizational climates may undermine receptivity toward new policies that seek to promote substantive changes in either administrative or clinical practice.[35–37] In contrast, strong leadership may enhance receptivity by actively eliciting and engaging staff concerns regarding changes, cultivating clinic-based support and resources for eventual practice innovations, and inspiring a positive vision for the future.[38] State officials and VO personnel acknowledge that some SNIs may not survive under the reform unless agencies address factors related to internal agency leadership, climate, and infrastructure. In addition, a state-sponsored *provider readiness assessment* conducted prior to the transition confirmed that a significant number of behavioral health agencies in New Mexico: (1) lacked management information systems to provide data for billing and site-specific planning and operational purposes; (2) possessed inadequate capacity for electronic connectivity to VO; and (3) suffered from serious cash flow problems that could hinder implementation of administrative and clinical change.[39]

Regardless of whether a given SNI possessed the infrastructure and resources needed to operate effectively in a managed care environment, the New Mexico reform increased workload and decreased morale for SNI personnel. Nevertheless, it is to be expected that a mammoth system overhaul will generate more work for SNI personnel in the short run, as administrators, providers, and staff members acquaint themselves with unfamiliar and evolving procedures. Other studies have documented that organizational change is often unsettling to employees, particularly those with entrenched work habits. New duties and responsibilities can also contribute to "feelings of uncertainty and ambiguity" for staff.[38] In our study, SNI personnel suggested the new administrative procedures diverted their time and energy away from direct service provision, threatened the financial stability of agencies, and potentially jeopardized the employees' job security. Over time, however, it is possible that mechanisms to promote administrative efficiency will actually decrease their workload and strengthen the service delivery capacity of agencies, especially if the state government and the statewide entity provide appropriate technical assistance and infrastructure development support to SNIs.[40]

While no new practice innovations were introduced during the rollout of the reform,

neither the state government nor VO focused on preparing SNIs to provide EBPs or enhancing their capacity to deliver culturally competent services. Indeed, EBPs were not a high priority within SNIs during this initial period. Administrators who set the agenda for SNIs were more concerned with being paid for services that agencies were already delivering than with promoting awareness, acceptance, and use of EBPs. Rather than risk creating anxiety about future practice innovations, many administrators played down the issue of EBPs. At the same time, given the pervasive lack of supervision and specialty providers, particularly within agencies serving rural and frontier areas, providers questioned their own ability to render "basic services" in an effective manner.

Safety-net personnel also underscored the difficulties of ensuring that EBPs were culturally appropriate for their service populations. While the political desire to introduce EBPs was unmistakable,[1,40] the empirical evidence regarding the suitability of available EBPs for the state's particular cultural groups was minimal, as SNI personnel consistently argued. Only a very small number of empirically validated treatments provided information on efficacy and effectiveness for Hispanic and Native American people.[41,42] Our research has revealed ways in which the perception of insufficient evidence to support a given practice might contribute to provider resistance and thus complicate efforts to implement future EBP guidelines for culturally diverse populations.[43] If efforts to promote EBPs on a statewide basis are to succeed, then such perceptions and other clinic-based contextual factors must be carefully considered by reformers.

Our research allows for insight into what SNI personnel thought about cultural competency and EBPs. Cultural competency emerged as an ideal that most SNI personnel appreciated, even if only on a superficial level. At the same time, SNI personnel were unsure of their own capacity to implement this ideal. In many instances, SNI personnel downplayed the issue of cultural difference within clinical practice, often asserting that all clients were treated the same, regardless of race or ethnicity, while they criticized EBPs for neglecting cultural differences and promoting a universal approach to service provision.

For state policymakers interested in furthering the goal of evidence-based, culturally competent service provision, these insights should underscore the need for practitioner-level interventions. Such interventions could target attitudes and beliefs, and advance knowledge and skill development in EBPs and cultural competency. While this focus is clearly important, a more pressing need may be to address structures within SNIs (e.g., leadership, clinical supervision, practice expectations, and incentives) that may support service innovations agency-wide. Annual organizational self-assessments of cultural competency, for example, may be helpful. Such assessments are a critical first step in undertaking agency-wide initiatives to improve cultural competency.[44] Self-assessments could educate SNI leadership, providers, and staff about cultural competency capacity and gain their support for the implementation of a comprehensive action plan.[45] A similar approach could be used to address agency-level issues surrounding utilization of EBPs in SNIs.

For the initial transition period, state officials and VO had concentrated on the creation of a single administrative infrastructure for New Mexico's fragmented behavioral health system. Ethnographic work conducted during this period indicates that SNI personnel may require substantial support from both parties if they are to move forward

with implementing evidence-based, culturally competent care. The state government and its corporate partner must exert greater leadership in identifying and operationally defining relevant EBPs and cultural competent services, and clarifying how national standards for EBPs and cultural competency could be modified to produce positive behavioral health outcomes for New Mexico's diverse populations. In lieu of adequate resources within SNIs, these entities must pave the way for technical assistance and cost-effective training opportunities for SNI personnel. The recent development of a statewide cultural competency plan[46] and establishment of The New Mexico Consortium for Behavioral Health Training and Research, a state-university partnership focused on improving service quality through workforce development and training in EBPs,[47] are notable steps in this direction. A four-day inaugural behavioral health conference offered training opportunities in EBPs and cultural competency to behavioral health providers, many of whom were awarded scholarships to attend. The state government and its corporate partner are also funding community-based demonstration projects to facilitate implementation and cultural adaptation of EBPs.[48]

Limitations. While this ethnographic work helps clarify relationships between policy change and SNIs, we recognize certain limitations. This work focuses only on a subset of adult-serving SNIs affected by reform. It does not document the experiences and perceptions of independent practitioners and primary care providers who deliver a limited set of behavioral health services (typically, medication management and individual therapy). The reform reflects a ten-year process; in this paper, we report only on SNI capacity for EBPs and culturally competent services during the early transition period. This paper does not assess the perspectives of state and VO personnel and other key shareholders nor investigate SNI capacity in relation to other reform goals (e.g., promotion of recovery-oriented services, cultivation of consumer and family-driven services, development of community-based systems of care).

Conclusion

This ethnographic study offers needed contextual information about the challenges that can affect the integration of EBPs and enhancement of culturally competent services within behavioral health systems where underserved racial/ethnic minorities and rural and frontier populations predominate. While this research focused on 14 behavioral health SNIs in selected counties during the initial transition period, the experiences we recount may not be unique to these institutions. Participant observation in public forums pertinent to the reform suggests that other agencies in New Mexico have grappled with similar workplace and financial stressors as well as service capacity problems. Ongoing ethnographic research, which we are undertaking, will illustrate the long-range effects of a reform intended to foster patient care innovations in the service delivery system. Safety-net institutions typically lack resources to pursue the challenges of putting policy into practice on their own. For this reform to meet its stated goals and objectives, emphasis must be placed on increasing ongoing and cost-effective training and development opportunities in EBPs and cultural competency for SNIs. It is also vitally important for policymakers to make a concerted effort to address

the administrative and financial difficulties that SNIs face as this reform continues to unfold, and as similar reforms are introduced in other states.

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