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The Impact of State Behavioral Health Reform on Native American Individuals, Families, and Communities

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Abstract

In 2005, the State of New Mexico undertook a sweeping transformation of all publicly funded behavioral health services. The reform was intended to enhance the cultural responsiveness and appropriateness of these services. To examine achievement of this objective, we conducted a qualitative study of the involvement of Native Americans in reform efforts and the subsequent impacts of reform on services for Native Americans. We found that the reform was relatively unsuccessful at creating mechanisms for genuine community input or improving behavioral health care for this population. These shortcomings were related to limited understandings of administrators concerning how tribal governments and health care systems operate, and the structural limitations of a managed care system that does not allow flexibility for culturally appropriate utilization review, screening, or treatment. However, interaction between the State and tribes increased, and we conclude that aspects of the reform could be strengthened to achieve more meaningful involvement and service improvements.

Keywords

Aboriginal people; North America; evidence-based practice; health care disparities; health care; access to; health care; remote / rural; health policy / policy analysis; mental health and illness

Historically, Native American communities have been excluded from decision-making processes pertaining to state-funded behavioral health services. In July 2005, the State of New Mexico undertook a unique reform in managed care, entrusting a single for-profit corporation to administer these services to its vulnerable populations, including individuals from economically challenged rural areas and those with serious mental illness or substance abuse problems (Hyde, 2004; Willging & Semansky, 2004).¹ The reform's architects emphasized that the reform would facilitate delivery of evidence-based treatment, encourage development of a seamless system of care that is accessible and continuously available, and

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¹Managed care refers to "health-care services under the administrative control of large, private organizations, with prepaid, 'capitated' payment" (Waitzkin, 2011, p. 100).

address issues specific to Native Americans as well as other marginalized groups (Hyde). To help ensure that behavioral health services would be responsive to the particular needs of Native Americans, State officials also created community input mechanisms to facilitate involvement of this population in decision-making processes related to the reform. In this article, we utilize a multimethod qualitative approach that combines semistructured interviews with participant observation to elucidate the relative success of the reform in engaging Native American communities and improving services for a population that disproportionately suffers from behavioral health disparities.

Background

Native Americans suffer from greater behavioral health disparities than any other ethnic population in the United States (U.S.). For example, Native American youth have the highest rate of suicide among 15 to 24 year olds (National Center for Health Statistics, 2010); higher prevalence of mental disorders and the potential for subsequent behavioral health problems (Whitbeck, Hoyt, Johnson, & Chen, 2006); greater substance abuse risks, such as drinking at a younger age, drinking more heavily, using drugs in combination with alcohol, and experiencing negative life consequences from drinking (Beauvais, 1992; Beauvais, 1996); and higher prevalence of comorbid alcohol use and psychiatric disorders (Beals, Novins, Mitchell, Shore, & Manson, 2002; Beals et al., 1997). A large epidemiological study conducted among youth and adults in two major tribes found that 15 to 54 year olds had significantly higher rates of alcohol dependence and posttraumatic stress disorder than among the nation's overall population (Beals, Manson, et al., 2005).

Health care is a legal right guaranteed to members of federally recognized Native American tribes. The federal government pledged some form of health care in many of the 371 treaties it forged with tribes. Congressional investment in health services for tribes was formally declared in the Snyder Act of 1921, which vaguely proclaimed that under the Secretary of the Interior, the Bureau of Indian Affairs (BIA) would "direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians throughout the United States" (p. 1). The BIA was ineffective in obtaining funds and recruiting doctors for reservation health services (Pevar, 2004). The 1928 Meriam Report (Meriam et al., 1928), which relied on data collected on the Navajo Reservation in New Mexico, offered a damning but holistic appraisal of the BIA system for delivering health care, asserting the need for higher paid, better trained professionals, and calling for the collection of new statistics on Native American health (Berkhofer, 1978). Both workforce development and the collection and use of data to drive health care planning remain as pressing today as in the 1920s (Gone, 2003, 2004).

The Transfer Act of 1954 shifted responsibility for Native American health care from the BIA to the Public Health Service of the Department of Health, Education, and Welfare (currently the Department of Health and Human Services), and led to the establishment of the Indian Health Service (IHS). Since its inception in 1955, the IHS has been a tightly budgeted agency that, despite severe fiscal limitations, now operates an extensive nationwide network of hospitals and clinics that serve 2 million American Indians and Alaska Natives who belong to 565 federally recognized tribes. For the IHS user population, the per capita personal health care expenditure is \$2,741, vs. \$6,909 for the general U.S. population (Indian Health Service, 2011a).

For the first 10 years after it was founded, the HIS concentrated its efforts on elevating the physical health status of Native Americans, providing mental health services only on a sporadic basis. The IHS established its Office of Mental Health in 1965, characterized as a "fledgling national program," funded with an annual budget of \$500,000 (Nelson, McCoy,

Stetter, & Vanderwagen, 1992). Since then, the IHS has distinguished itself by setting up community-oriented clinics in tribal communities throughout the country. Its continued efforts to administer mental health care remain insufficiently funded (Gone, 2003, 2004).

The Indian Self-Determination and Education Assistance Act of 1975 provided tribes with mechanisms to participate in the planning, conduct, and administration of federal programs and services provided by the BIA and the IHS. With passage of the Act, approximately 332 tribes and tribal organizations entered into agreements with the federal government that enable them to assume responsibility from the IHS for administering health care services. The annual IHS budget appropriation provides the main source of financing for these services (Indian Health Service, 2011b). Uninsured Native Americans are also eligible, on the same basis as other U.S. citizens, for state-funded health care services (Pevar, 2004).

Those Native Americans who do not reside on or near a reservation generally lack access to the IHS or to tribally operated facilities (Brown, Ojeda, Wyn, & Levan, 2000). However, Native Americans have long been denied access to state-funded services because it has been commonly and erroneously assumed that the IHS (which is a payer of last resort) will absorb the cost or otherwise provide for all their health needs, rather than third-party insurance or public health coverage administered by states, such as Medicaid. Several barriers prevent Native Americans from obtaining this coverage, including reluctance to participate in public programs because of stigma, burdensome enrollment processes, fluctuating eligibility requirements, and the belief that participation might lead to the abolishment of the IHS (U.S. Commission on Civil Rights, 2004; Willging, Waitzkin, & Nicdao, 2008). In the case of Medicaid, the largest purchaser of behavioral health care throughout the nation, the federal government reimburses the IHS and tribally operated facilities at 100% for eligible individuals they service. Whereas an estimated 20% of the IHS clinical services budget derives from Medicaid, less than 0.5% of all Medicaid expenditures go to Native Americans (Urban Institute, 2005). In general, states have had little incentive to enroll or encourage Native Americans to obtain care in other types of facilities, because this then requires them to pay a portion of the Medicaid costs incurred by these service users (U.S. Commission on Civil Rights). Conversely, IHS funded facilities themselves have not been consistently aggressive in seeking reimbursement for Native Americans eligible for Medicaid (U.S. Government Accountability Office, 2008).

Within the past decade, the federal government has urged states “to work as closely as possible” with tribes on issues involving Medicaid and similar public programs, asserting that provision of services must be on par for eligible Native American and nontribal members (Thompson, 2001, p. 1). The federal government considers access to state-level decision-making processes to be critical to tribes for “cultural, treaty, and statutory reasons,” and has directed states to establish mechanisms to ensure ongoing consultation with tribal governments (Thompson, p. 1). States must provide evidence of such consultation when reviewing and approving plans for Medicaid and other federally sponsored programs. Regarding Medicaid, the federal government provides substantial leeway to states to determine the nature and scope of tribal participation. At minimum, states with sizeable Native American populations must (a) ensure that tribal governments receive written notification prior to the submission of plans, including a description of purpose and impacts, within a specified time frame; (b) allow tribal representatives to provide a written response to these plans; and (c) offer opportunities for in-person meetings with these representatives if so requested by tribes (Thompson, p. 2).

There are no published examples of collaboration between tribes and state governments in designing and implementing public behavioral health systems. The New Mexico reform, which involved the revamping of Medicaid and all state-funded behavioral health care,

provides a unique opportunity to examine the challenges of engaging tribes and tribal members in state-level decision-making processes. To our knowledge, this qualitative study is among the first to provide a longitudinal perspective on factors that can affect such collaboration. This study is also the first to generate insight into how varying groups of Native American stakeholders—community leaders, direct service providers, service users, and their families—experience the implementation of state-mandated behavioral health reform.

The New Mexico Context

New Mexico presents a challenging context in which to plan and deliver behavioral health care for State residents in general and Native American people in particular. New Mexico is a poor and sparsely populated state, with an estimated 2,009,671 people currently spread across 121,356 square miles (U.S. Census Bureau, 2010). Thirty-two of 33 counties are federally designated as Mental Health Professional Shortage Areas (U.S. Health Resources and Services Administration, 2010). Workforce shortages are concentrated in McKinley and San Juan Counties, which are home to the greatest number of Native Americans (Hough, Willging, Altschul, & Adelsheim, 2011). The State is diverse, with 45.6% of the population being Hispanic, 40.9% White, non-Hispanic, and 9.7% Native American (U.S. Census Bureau).

New Mexico has the second largest Native American population in the nation, which includes 22 tribes and pueblos, and sizeable communities of off-reservation Indians.² Each tribe and pueblo is a sovereign nation with its own government. Elected officials, such as the presidents of the Navajo Nation and Jicarilla Apache Nation, remain in office for 4-year terms, whereas the preponderance of pueblos within the State are led by governors who are appointed for 1- to 2-year terms, which can result in frequent changes in leadership and new political and administrative priorities. The majority of tribes and pueblos operate their own substance abuse services under the Indian Self-Determination and Education Assistance Act of 1975. Only a handful of tribes and pueblos presently administer mental health services on their own.

Within New Mexico and across the nation, the unmet mental health and substance-abuse treatment needs of Native Americans remain high (Beals, Novins, et al., 2005; Beals et al., 2003; Brown et al., 2000; Gone, 2003, 2004; Goodkind et al., 2010; Manson & Altschul, 2004; Manson, Beals, Klein, Croy, & the American Indian Service Utilization, Psychiatric Epidemiology, Risk and Protective Factors Project Team, 2005; U.S. Commission on Civil Rights, 2004). The majority of behavioral health care for low-income Native Americans in New Mexico is provided through the IHS, tribally operated programs, and off-reservation facilities financed by a mixture of local, federal, and tribal funds. As citizens of New Mexico, Native Americans are also eligible for Medicaid and other state-funded services. Between 1997 and 2004, the IHS and various tribally operated and off-reservation facilities functioned as critical safety-net providers for New Mexico's Native American population by caring for Medicaid-eligible individuals without collecting reimbursements from either the State or the three managed-care organizations responsible for administering Medicaid services (Willging et al., 2008). In this article, we examine the degree to which the State's most recent reform has supported these providers and improved care for Native American service users and their families.

²All pueblos are tribes (as in a community that shares kinship, language, and sovereignty), but not all tribes are pueblos. Dutton (2011, p. 9) wrote that in the 16th Century, the Spaniards encountered people living in "compact, many-chambered, flat-roofed structures built around plazas, or squares, and from one to several stories in height." Reminiscent of villages in Spain, *pueblo* was used to describe both the settlements and their residents. The Apache and Navajo were seminomadic people of Athabascan descent who migrated to the southwest in the 1400s.

Structure of the New Mexico Reform

The key groups that structure the current New Mexico reform include (a) the Behavioral Health Purchasing Collaborative (a partnership of 15 State agencies responsible for oversight of the public behavioral health system); (b) the Statewide Entity (SE; the single managed-care company entrusted to disburse federal and State behavioral health funds); (c) the Behavioral Health Planning Council (a governor-appointed advisory body that assists the Purchasing Collaborative with planning and counseling on system change); and (d) the local collaboratives (LCs; State initiated community stakeholder groups that provide recommendations on behavioral health needs to the Purchasing Collaborative via the Planning Council).

The creation of mechanisms to foster community input and participation was in keeping with national trends to include the public, particularly service users and families, in the development and evaluation of health services (Jacobson, 2004; Kano, Willging, & Rylko-Bauer, 2009).³ As noted previously, the federal government had also encouraged states to create mechanisms to involve tribes (Thompson, 2001). To this end, State officials in New Mexico instituted specific positions and structures to facilitate the inclusion of Native American perspectives into State-level decision-making processes related to the reform. First, the Cabinet Secretary of the Indian Affairs Department served as a member of the Purchasing Collaborative with full voting privileges. Second, two Native American LCs, intended to represent the State's sovereign tribes and pueblos, were created in the first year of the reform—one for the Navajo Nation and a second for the remaining tribes, pueblos, and off-reservation communities. Third, State officials convened the Native American Subcommittee, comprised of members of the Behavioral Health Planning Council, co-chaired by the Indian Affairs Department, to provide input into cultural issues and improving services. Fourth, the Purchasing Collaborative established a formal tribal consultation protocol to dialogue with the political leadership of tribes and pueblos on reform-related matters. Finally, the SE included an in-house unit that employed Native American liaisons who were to work with tribes and pueblos on developing service delivery infrastructure.

Methods

Our research design was informed by Hohmann and Shear (2002), who pressed mental health services researchers to utilize qualitative methods to understand populations impacted by interventions (in this case, a new statewide policy), including their particular ideas and experiences related to those interventions, in addition to the broader sociocultural context of implementation, and both intended and unintended consequences of implementation. Our work was also influenced by the constructivist tradition in evaluation research. In this tradition, evaluators oppose positivism, allow for critical inquiry to unfold over time, privilege iterative processes of data collection and analysis, examine diverse participant perspectives in relation to intervention objectives, provide for rich and deep description, and value consensus (and contestation) when arriving at conclusions predicated on study findings (Stufflebeam & Shinkfield, 2007).

³Our critique of community input and participation draws from anthropological research that highlights the importance of involving community members in policies and programs that impact issues of local concern, based on notions of justice, acknowledgement of their expertise, and recognition that engaged communities are more likely to support initiatives they help shape (Greenwood & Levin, 1998; Schensul & Schensul, 1992). The public health literature also points to factors affecting community involvement, including political support; access to funding and resources; awareness of cultural differences, biases, and the sociohistorical context of collaboration; critical reflection on the collaborative process; and fostering respect, understanding, and compromise (Butterfoss, 2007; Christopher, Watts, McCormick, & Young, 2008; Minkler & Wallerstein, 2008). The development literature shows that the potential exists for cooptation of local needs and values to promote external agendas if processes of community involvement are not truly collaborative and democratic (Cooke & Kothari, 2001).

This article is based on 5 years of fieldwork carried out between November 2005 and May 2010. The fieldwork consisted of several components: (a) ongoing observation of monthly Purchasing Collaborative meetings and other public forums concerning the reform; (b) ethnographic work in two community-based agencies specializing in treatment for Native Americans at 9 months after the onset of reform, and 18 and 36 months later; and (c) semistructured interviews with Native American community leaders at the 9- and 36-month intervals. For the analysis presented here, we drew on 800 hours of observation (600 at public forums and 200 in clinical settings) and 320 interviews conducted with 169 Native American participants, including 12 community leaders, 42 providers, 67 service users, and 48 social supports (e.g., families and friends). For all observations carried out at public events or in agency settings, we documented the setting, the individuals involved and the nature of their interactions, and all discussion relevant to Native American populations under the New Mexico reform. We also recorded direct quotes whenever possible and collected and inventoried written materials that were distributed.

We implemented reputational case selection to recruit participants for the semistructured interviews (Schensul, Schensul, & Le Compte, 1999). Within agencies, we first interviewed a lead administrator, who referred us to providers and staff. Similarly, service users were identified with help from agency personnel; they, in turn, recommended family members, friends, and others instrumental in their recovery process for semistructured interviews. Recommendations from Purchasing Collaborative officials, providers, county-based health council members, and local advocates helped identify Native American community leaders involved in the new reform.

Four complementary interview guides were created; one for each stakeholder group. Pertinent to this article, we solicited from each participant knowledge and perceptions of how Native Americans had fared under the reform. Our questions concerned the extent of the participant's involvement in reform-related activities, the role of community input from Native Americans in the broader behavioral health system, the relative effectiveness of the State-initiated input mechanisms in representing diverse stakeholder interests, and overall impacts. We also asked each participant if he or she was aware of special initiatives for Native Americans, and we posed additional questions to those who answered affirmatively. All data collection protocols and informed-consent procedures were approved by the Pacific Institute for Research and Evaluation Institutional Review Board and the Navajo Nation Human Research Review Board.

Data Preparation and Analysis

Observation and interview notes were handwritten, transcribed, and uploaded into an electronic database. Interviews were digitally recorded and professionally transcribed. We employed an iterative process to review the textual data from observations and interviews. Data were first analyzed by open coding to discover themes and issues, followed by focused coding to determine which of these were repeated or represented particular concerns (Emerson, Fretz, & Shaw, 1995). Discrepancies in coding and analysis were identified and resolved during team meetings. We strengthened our qualitative inquiry through triangulation of observation and interview data (Patton, 2002), which contributed to a coherent account of cross-cutting themes and issues relevant to the impact of the reform on Native Americans in New Mexico. We subsequently consolidated and organized the major themes and issues under eight subheadings: positive initial impressions and experiences; perceived successes; insufficient knowledge; adjusting to managed care; uniform screening procedures; evidence-based practices; community input mechanisms; and effects on service users and families. A panel of Native American advocates reviewed the findings and performed a final accuracy check.

Results

As we describe below, participants were hopeful about the prospect of reform for underserved Native American communities, recognizing the potential value of collaborating with the Purchasing Collaborative and SE to build local service delivery infrastructure. Some tribes and pueblos experienced tangible benefits provided by new sources of program funding, especially in the area of prevention services. However, enthusiasm dwindled over time, as participants found that officials from the Purchasing Collaborative and the SE lacked critical knowledge of how tribal governments and health care systems operate. Community leaders and providers pointed to difficulties related to managed care, including provider contracting, client enrollment and billing, and use of culturally inappropriate utilization review mechanisms. They were also suspicious of the Purchasing Collaborative's emphasis on introducing standardized screening instruments and evidence-based practices to Native American communities. In general, they suggested that the community input mechanisms put in place by the Purchasing Collaborative to elicit Native American voices fell short in meeting this goal. The reform did little to discernibly expand or sustain services or to improve the lives of low-income Native American individuals struggling with mental health or substance-abuse issues, or those of their families.

Positive Initial Impressions and Experiences

Participants underscored that Native Americans were typically marginalized from policy-making decisions at all levels, and forced to accept what resources and services were made available by federal and State governments. The Purchasing Collaborative's invitation to Native American community leaders, behavioral health professionals, service users, and families to come together to identify the most relevant challenges in behavioral health care and to put forth ideas to improve services was widely perceived as a key step in rectifying this situation. Several participants suggested that the reform presented new opportunities for learning during the early years of implementation. One community leader commented,

[The reform represented] a learning situation for me. I had to hear what the State was trying to do. I had to assess what the impact would be on tribes and tribal services, and then take that information and put it into a form I could bring back to tribes.... That was exciting in terms of learning a whole new way of thinking, learning about how this new system was going to evolve, and then providing that information and education to tribes.

Participants considered personal growth as a potential outcome of involvement in the reform, and also highlighted how system transformation might empower their communities. A second community leader stated,

Part of what [the SE] is supposed to do is create the infrastructure and the capacity [for tribes and pueblos] to build their own self-sustaining, revenue generating programs to meet the needs of their community and of every Indian community.... That's real sovereignty and real self-determination, and that's real community.

In terms of both infrastructure and capacity building, participants were hopeful that resources afforded through the reform would make it possible to address persistent workforce shortages within Native American communities, and to improve quality by increasing training opportunities for the current provider system. Support for the reform was bolstered by the unprecedented attention that the Purchasing Collaborative had accorded to traditional healing modalities in Native American communities. Indeed, participants were heartened by overtures from the Purchasing Collaborative and the SE to include traditional healing services as part of the benefit package for those receiving public coverage from the

State, especially given the extensive history of government policies that prohibited use of them, disregarded them, and questioned their credibility and validity (Goodkind et al., 2010). Language to this effect was included in several State-issued documents concerning the reform and in the annual SE contracts.

Perceived Successes

Over the years, participants identified several positive effects of reform. Above all, they appreciated the increased attention to behavioral health issues specific to Native Americans at the State level. For instance, the Purchasing Collaborative lent its support to several projects to identify needs specific to Native Americans, including a university-administered survey of service users and families within seven tribes and pueblos. The Purchasing Collaborative also secured funding to establish a Native American tribal epidemiological workgroup, which drafted guidelines for the culturally responsive, ethical conduct of behavioral health-related data collection and evaluation practice. Under the reform, a “single point of contact” center was established in San Juan County, which ranks second in the State in proportion of the population that is Native American. This center currently offers both Native American and non-Native American services users referrals to behavioral health and social service providers.

Some tribes and pueblos also benefited from interactions with the SE. For example, one of the State’s larger tribally operated behavioral health programs received substantial assistance from the SE to become credentialed to provide services under Medicaid. Program administrators spoke glowingly of the SE employee who had been assigned to assist them through this process. Other tribal programs appreciated community-specific assessments undertaken by the SE, particularly in the later years of the reform. These assessments provided data to plan for infrastructure upgrades, including the introduction of information management systems.

There was general agreement that the community reinvestment program administered by the SE had aided tribes and pueblos. Through this program, the SE was required to “reinvest” a fixed percentage (generally 3%) of its contract dollars to fund community-based behavioral health initiatives. The dollars allotted through this program each year facilitated the expansion or establishment of new tribally run services, such as inpatient and outpatient substance-abuse treatment services for Native American youth. Tribes and pueblos also benefited from enhanced access to “prevention dollars,” which were used to fund several community-based initiatives aimed at reducing the devastating toll of substance abuse in Native American communities, including a tribal drug court for at-risk youth.

New funds were also made available for annual tribal summits that provided opportunities for information exchange, networking, and training to both providers and service users from tribes and pueblos. Scholarships were allocated to service users and their families to attend these summits and similar events sponsored under the reform.

Finally, Native American providers were pleased about increased access to training on topics ranging from co-occurring disorders, early child mental health, and traditional and Western approaches to mental health screening and diagnosis, counseling theory, and psychopharmacology.

Insufficient Knowledge

Despite these successes, participants increasingly suggested during each wave of data collection that State officials often lacked basic knowledge of tribal governments, health care structures, and overall administrative systems. The problem of insufficient knowledge created challenges for the officials in their attempts to secure tribal support for reform

initiatives. Contracting processes posed particular challenges, as one clinical director explained:

The State doesn't understand that when you bring in monies to our tribe, it's a long process.... The terms and conditions of that contract have to be read and thoroughly taken care of. [You] have to look at the sovereignty issues.... Then finally getting [it to Tribal Council's] Health and Social Services [Committee]. You have to have a Council delegate to now sponsor that contract. It's tough. So, having the dollars is one thing, and the process to utilize those dollars is a totally different thing.

Without practical knowledge of how tribal bureaucracies work and how to navigate them, the Purchasing Collaborative and the SE could not easily establish the administrative arrangements needed to facilitate the timely flow of funds to tribal programs.

In one example, the Purchasing Collaborative selected a single tribe to apply for funds to pursue local efforts to establish evidence-based substance-abuse prevention initiatives across law enforcement, tribal court, and behavioral health systems. An award was made in 2008, several months after submission of the application, allowing 4 months for implementation. Through this award, the State (via the SE) was to provide the tribe's law enforcement agency with financial support to purchase equipment and overtime pay for officers to increase enforcement activities related to substance abuse, and to make referrals to a clinical case management team to be convened by a tribally operated behavioral health program. This arrangement required an intergovernmental agreement and internal approvals that would make it possible for the tribe to accept funds originating with the State. The tribal participants in this endeavor were unable to obtain the necessary agreement and approval within the 4 months covered under the contract period, and grew frustrated with the requirements of the SE contracting process, which further delayed receipt of funds. Because the State would not allow them to carry over funds to the next fiscal year, efforts to move forward with this initiative were eventually abandoned.

Native American providers involved in direct service delivery were also frustrated with the contractual language used to engage them under the reform. They emphasized difficulties in negotiating contracts between tribal entities and the SE, and suggested that the process was long and cumbersome. Tribal leaders felt misunderstood by representatives from the Purchasing Collaborative and the SE, believing their suggestions for service provision were also ignored during contract negotiations. One leader asked, "How do you like negotiating a contract with someone in North Carolina who has no idea about tribal land? How do you even do that?"

Key administrators at the IHS grew weary of contract negotiations in which their counterparts at the SE failed to recognize their agency's status as a federal entity. They were also concerned about SE attempts to build in contractual requirements that potentially led to cost shifting by holding the IHS financially responsible for enrolling service users in programs administered by the SE. One clinical director clarified why the IHS, an agency that has long suffered from insufficient workforce capacity, was reluctant to take on this contractual burden:

The SE has shown us numbers: "It only takes seven minutes, only ten minutes, only five minutes [to enroll a client]." That is too much time, in my opinion! Even if it takes seven minutes per client, you might have eight clients in a day. You have to set aside an hour to do this!

Several participants invoked the term *mythology* when describing how State and SE officials approached system delivery issues in Native American communities. They

suggested that State officials were often unfamiliar with how health services within these communities were typically organized and delivered. One community leader explained:

Those big shots up there [in Santa Fe, the State capital] think that IHS, 638 [tribally operated programs] and the BIA can take care of the needs of all the Native Americans in the State of New Mexico.... That's a myth. It's been a myth for years!

Another community leader confided, "One State staff [member] said to me, 'Oh, you guys get free health care. What are you bellyaching about?'" This belief implied that Native Americans had little to complain about in relation to other New Mexicans with regard to State efforts to reform behavioral health services, and was repeatedly encountered throughout our 5-year study period.

Adjusting to Managed Care

Lack of familiarity with managed care administrative protocols, particularly those related to service authorization and electronic enrollment, billing, and reimbursement processes, adversely affected agencies serving Native Americans. Participants asserted that these agencies were not provided enough training, technical assistance, and infrastructure support, which they needed to operate effectively within the State behavioral health system. The new and untried SE information technology (IT) system instituted to enroll clients and process claims was considered problematic, at best. Some agencies decided not to tap into funding streams available under the reform, thus bypassing the IT system altogether. For other agencies, increased paperwork diverted provider attention away from direct service delivery. These agencies found that they were unable to maximize billing and reimbursement under the reform because of insufficient infrastructure and administrative constraints. Most agencies, as described above, experienced persistent problems contracting with the for-profit SE to deliver services. Agencies also could not rely on reinvestment dollars as a reoccurring source of funding to sustain expanded or newly established programs. As a result, they remained reliant on non-State funding sources, such as tribal, federal, county, or municipality. Thus, the reform had the effect of discouraging tribal participation in State-funded programs and system change processes.

Providers expressed frustration working under managed care, consistently arguing that utilization review protocols favored Western medicine and were not sensitive to Native American diagnoses, healing modalities (i.e., sweat lodges and other ceremonies), and traditional counseling. They argued that utilization reviewers were not well versed in service practices associated with non-Western modalities. Reimbursement rates were also low, and did not adequately cover the costs of materials and preparation time. Providers also expressed concern over a lack of parity with Western services. For example, with the exception of residential facilities that could incorporate traditional counseling into a bundled rate, agencies were paid a fixed rate of \$30 per unit for traditional counseling sessions lasting 1 hour, such as talking circles and cultural mentorship. Yet, the fee schedule reimbursed more than twice as much for 1 hour of comparable Western services (for example, \$115 for group therapy, \$75 for skills training, and \$64 for comprehensive community support; Johnson & Charton, 2008). Despite the widely heralded focus on enhancing provision of culturally competent services, participants felt there was inadequate appreciation for the vital role of Native American approaches to health and healing.

Uniform Screening Procedures

In the early years of reform, the Purchasing Collaborative mandated that all providers receiving public funds for treatment services implement the self-administered Addiction Severity Index–Multimedia Version (ASI-MV, 2009), a relatively new technology for

evaluating substance abuse among service users. Providers had been mandated in years past to implement the conventional ASI, a face-to-face, structured interview that took about 30 minutes to complete and provided basic diagnostic information on service users prior to, during, and after treatment for substance-abuse problems. Providers in our study admitted that they had never really cared for the ASI but, in compliance with the mandate, they would perform the interview, fill out the accompanying paperwork, and then send the data to the State for analysis. A common complaint was that the State never shared the results of its analyses, a problem that Purchasing Collaborative officials hoped to resolve via the ASI-MV. On their promotional Web site, the creators of the ASI-MV described this computerized screening instrument as “less expensive and more effective” than its predecessor because it eliminated the need to train staff and use them to administer the interview, while yielding “real time” data that could be incorporated into clinical work.

Despite the instrument’s stated strengths, there were several reasons why providers in New Mexico, and those serving Native Americans specifically, were reluctant to adopt the ASI-MV (2009). First, the equipment and software needed to comply with this ASI-MV implementation mandate were expensive, and the costs had to be incurred by these organizations alone. Most organizations also lacked appropriate accommodations, or private space in which to locate this equipment. One community mental health center with a large Native American clientele did not have enough space for a waiting room, but had to displace two therapists from their offices to set up private computer kiosks and thus comply with the mandate. Complicating matters, providers needed training in the ASI-MV if they were to incorporate the resulting data into their clinical work. However, even when the training was offered free of charge by the State or the SE, the associated costs of travel and loss of billable hours comprised a source of stress within provider organizations.

Native American providers also harbored concerns regarding the use of screening and assessment instruments developed for use in one culture within another culture. Although a Native American version of the conventional ASI existed, it was tailored for tribes in South Dakota—not tribes in the southwestern United States, let alone in New Mexico. Providers faulted the ASI for neglecting the cultural values of local tribes and pueblos.

There was also widespread agreement that the biomedical criteria implicit in the conventional and computerized versions of the ASI were problematic, and did not accurately reflect indigenous understandings of health, illness, and treatment. According to providers, Native American service users responded to the questions asked with suspicion and, as one provider noted, even worried about “being tricked into saying something that [would] get them into trouble.”

The literacy and linguistic considerations commonly raised by providers were profound. In their experience, even Native American service users who were English speakers had trouble comprehending and responding to ASI interview questions, whether implemented face to face or via a computer terminal. A lack of experience navigating touch screens (emblazoned with background images of White people in urban areas) and low literacy levels complicated use of the ASI-MV. One provider underscored this point and its implications for service users: “People don’t come in right away and say they are illiterate. They’re embarrassed.”

The electronic mode of administration also interfered with rapport building, maximizing rather than minimizing possibilities for clinical uncertainty in provider encounters with service users. Another provider explained:

The ASI-MV is culturally insensitive and does not take into account the relational aspect of Native people in the assessment process.... These factors will negatively

affect the information we derive from the ASI-MV, rendering the data invalid and making it more difficult to develop appropriate treatment plans.

Because neither the ASI nor the ASI-MV (2009) had been translated for any Native American population, unbillable provider hours had to be expended on this task. Despite assurances that the ASI-MV would save time and money, bilingual staff typically needed 2 to 3 hours to help Native American service users complete the “self-administered” interview.

For the most part, the Native American providers felt that their complaints regarding the ASI-MV (2009) had been minimized. They also did not take seriously an invitation from the designers of the instrument to participate in “one or two” conference calls to help ensure its cultural appropriateness. The irony of being asked to donate their time to adapt an instrument that a non-New Mexican company would “own” and might very well make them purchase a site license to use was also very much on the minds of these providers. In the end, the ASI-MV was not widely adopted by provider organizations specializing in care for Native Americans.

Evidence-Based Treatment Practices

The architects of the reform heavily emphasized the adoption and delivery of evidence-based practices (EBPs) by publicly funded providers in New Mexico. These practices included manualized interventions for which scientific evidence had demonstrated improved service user outcomes. They consisted of specific guidelines, usually outlined in a manual, which were to be implemented in a structured manner (Aarons, 2004).

In light of their experience with the ASI-MV (2009), Native American providers in our study were less than likely to support EBP implementation. Approximately one third of such providers in each wave of data collection consistently argued that EBPs generally lacked empirical data on efficacy and effectiveness among Native American people. The resources needed to adapt and implement EBPs for Native American contexts were also limited, and many providers resented suggestions from Purchasing Collaborative and SE officials that they just needed to do some minor “tweaking” of existing EBPs to ensure appropriateness. Several providers also admitted that they were unlikely to implement EBPs if mandated to do so by the Purchasing Collaborative or the SE, likening such mandates to a form of “clinical colonization.” One clinical director asserted, “I have a problem with outside funders saying that we need to use evidence based approaches.” Providers suggested that the State government needed to engage in greater consultation with tribes if they were to solicit “buy in” to facilitate implementation.

Nevertheless, two Native American programs made strides in adapting and utilizing a pair of EBPs for substance-abuse treatment: motivational interviewing, a client-centered, directive method for encouraging change in alcohol and drug use behavior (Miller & Rollnick, 2002), and community reinforcement and family training, which makes use of formal and informal community resources, including professional health and social service providers, relatives, and friends in supporting a person’s recovery (Meyers & Miller, 2001; Meyers, Miller, Hill, & Tonigan, 1998). Native American providers were generally supportive of both practices, believing that they did not conflict with either cultural or treatment preferences of service users. One provider explained, “I don’t have a problem with motivational interviewing because it is based on many of the principles and the values of Native American clients, including individuality, respect, and empathy, and allowing the client to decide their destiny.” In contrast to other EBPs, researchers had begun testing both approaches in Native American treatment settings, including the programs in which we conducted our research. The providers in these venues received special training; implementation was financed

through external grant funds. The training and economic support facilitated acceptance and use of both EBPs.

Throughout the study period, participants argued that “practice-based evidence,” largely referring to traditional healing modalities, needed to be taken as seriously as EBPs. There were, however, divergent perspectives across tribes on whether these modalities should be formally incorporated into the professional treatment system. Members of the Navajo Nation, which has a long history of supporting efforts to advance reimbursement of traditional healing modalities in these systems (Kunitz & Levy, 1994), were more likely to lean in the direction of incorporation than people who identified as pueblo. Although one tribe benefited from an allocation of \$225,000 to fund “traditional treatment” in the early years of the reform, the monies to tribes and pueblos for services based on “practice-based evidence” were minimal. A small number of participants stated that reimbursement rules and regulations on the federal level (e.g., those related to Medicaid) prevented the Purchasing Collaborative and SE from fully supporting use of these services.

Community Input Mechanisms

Participants were critical of the State–Tribal Consultation Protocol, suggesting that it had constrained the ability of tribal leaders to provide “real” input into the reform. They were skeptical that it was possible to engage in meaningful dialogue with representatives from several tribes and pueblos simultaneously when meetings were time delimited and held infrequently, and agendas were predetermined. At one consultation meeting, a pueblo leader pointedly addressed State officials about this matter:

Out of fairness to the governors [senior pueblo officials] here, you should come visit us. You pose a lot of questions to us. I feel I need my experts to add information to what I say. I’ve been dealing with federal, State government for a long time, and I’m not interested in being a check mark: “Yes, we consulted for four hours....” My problem is the uniqueness of tribes in terms of way of life, culture, and traditions. We’re all different. We sit here for this four-hour consultation, but I feel it’s not enough time. For me to be a leader of a sovereign [pueblo] nation, to be given ten minutes [to speak] is disrespectful. You should come to [our pueblo] to speak with me and my experts.

Similar concerns were articulated by the Native American community leaders we interviewed; they suggested that the consultation process to date had lacked substance, and that in-person visits conducted at tribes and pueblos would facilitate better working partnerships and understanding between entities. Some participants, however, argued that even if the Purchasing Collaborative and SE had been more proactive about conducting such visits, the political leadership of certain tribes and pueblos might not have been entirely receptive, with priorities outside of behavioral health care occupying much of their attention and time. Frequent changes in this leadership also contributed to fluctuating support related to behavioral health care.

The Native American subcommittee of the Behavioral Health Planning Council received mixed reviews. The subcommittee played an instrumental role in amending legislation—New Mexico State Statutes Annotated 1978, §§ 61-9A-14.3 (2007)—that allowed certified alcohol and drug abuse counselors with experience to become grandfathered into the State-funded behavioral health system as licensed counselors, thus making it possible for them to bill for services under the reform. Despite this success, 4 years after the subcommittee was convened, one of its original members felt his time was “spent better elsewhere,” so he stopped attending. Several participants lamented the lack of power accorded to the subcommittee, suggesting that its once enthusiastic membership suffered from poor leadership, that it had few notable accomplishments, that its agendas were shaped by State

interests, and that its membership did not provide adequate representation for the diverse Native American population. Moreover, individuals with actual decision making authority within tribes, such as elected officials and department/agency directors, did not regularly participate. Even key IHS administrators, who once felt supportive of the reform, lost interest in participating for the above reasons. Other participants blamed this state of affairs on a lack of support from the tribes and pueblos. One participant observed, “Some of us in the tribes don’t take advantage of the opportunities for input provided by the subcommittee.”

The majority of participant concerns regarding community input centered on the Native American local collaboratives, or LCs, which were reliant on volunteer labor and insufficiently funded and resourced. The roles, responsibilities, and expectations accorded to LCs by the Purchasing Collaborative were not always clear, which created frustration, particularly for those in leadership positions. The Purchasing Collaborative initially mandated that all LCs receiving official recognition have 51% “consumer” (service user) and family membership. Participants argued that several challenges—distance, transportation, compensation, and bureaucratic meeting structures—impeded active participation of service users and other stakeholders in LC meetings and various reform events in an ongoing, meaningful fashion. Even though these same challenges confronted nontribal LCs (Kano et al., 2009), they disproportionately affected the Native American LCs. For example, although the nontribal LCs covered contiguous regions, one of the two Native American LCs included off-reservation Indians and no less than 21 culturally diverse and geographically dispersed tribal and pueblo populations with distinct behavioral health needs. Since the onset of reform, Native American advocates lobbied the Purchasing Collaboration repeatedly for permission to establish additional LCs to ensure fuller representation. The Purchasing Collaborative denied this request, claiming that it could not afford the costs involved in supporting new LCs. When it finally agreed to expand the number of Native American LCs from two to five in 2009, eight groups applied for recognition. However, the selection criteria for the final three remained opaque to those participants active in LC affairs; the expansion did little to resolve the representational and logistical challenges of the LC described above.

Of greater concern, participants did not believe their voices, as filtered through the LC system, actually mattered. Reflecting on the various assignments, such as selection of legislative priorities and assessment of community needs, which the Purchasing Collaborative had given to the LCs, one community leader observed,

Even after we do all of the work—work without pay—and we get all the input from the LC, the input is taken to the policymakers who are mostly in Santa Fe, and then there’s nothing. It just sort of sits there. There’s no feedback. There’s no comment. There’s no system change at all.

Throughout our study, the community leaders and other participants active in the LC initiative repeatedly observed that the Purchasing Collaborative and the SE were not forthcoming with solid evaluation data relevant to their communities. Such data were needed to shed light on reform implementation and impacts, determine community needs, and inform decisions regarding future reform processes.

Across the board, participants did not believe that any of the community input mechanisms created by the State were particularly effective in conveying Native American concerns to the Purchasing Collaborative. A second community leader argued,

When [the reform] first started, I think Native Americans got the idea that we were gonna be at the table finally. I think that’s still our hope. We’re still voicing our opinion. As to the reality of what our opinion means or is heard or what happens with it after that, I have no idea.

A third community leader stated,

[The Purchasing Collaborative is] not transparent. ... A lot of times, decisions are made and they're already made. It's a done deal by the time we hear about them. That hasn't created good feelings among everyone involved. They say you have a voice, but you're powerless in any decision making.

Only a small handful of the Native American service users ($n = 6$; 5%) in our study were involved in the LC initiative. None had family members who took part. Many of these participants suggested that the idea behind this initiative had merit, and were particularly keen on taking part in the LCs during the early period of reform. This enthusiasm waned over time, with service users arguing that their perspectives were not adequately represented. One service user stated, "Our consumer representative [in the Behavioral Health Planning Council] hasn't talked to another consumer in ages!" A second service user noted that it was not uncommon to encounter LC members claiming to be family representatives who were, in fact, direct service providers. Believing that LC meetings tended to be dominated by providers, this individual was suspicious of the mandate to include service users and families in the LC initiative: "Somebody, somewhere along the line, said you have to have consumers. But they [the providers] bully them. They manipulate them out of decisions.... It's a provider-run, provider-oriented system." In general, these few Native American service users believed that for the LCs to serve as a viable mechanism through which to voice their specific opinions and concerns regarding behavioral health care, more aggressive recruitment measures were in order, as well as efforts to cultivate leadership capacity within this otherwise disenfranchised group.

Effects on Service Users and Families

Ninety-six percent ($n = 110$) of Native American service users and families were unaware of the reform throughout the study period. The majority of concerns they expressed had little to do with treatment provision under the reform, but focused more broadly on "problems in living" related to housing, transportation, personal finances, and the lack of employment and educational opportunities. At a structural level, participants also talked about the damaging effects of mental health stigma in their communities, clarifying that this stigma, combined with existing racism toward Native Americans, had exacerbated their problems in living. Many of these individuals continued to receive services from the IHS or tribally supported programs and, when they were actively engaged in treatment, they tended to be satisfied with the providers they encountered.⁴ Over time, however, their providers had become disenchanted with the reform.

The high marks assigned to providers were not because of changes in service delivery practices under the reform. Service users appreciated providers, particularly case managers, who were willing to lend a hand with their problems in living, typically by helping them to: find rides, sign up for public assistance to obtain Social Security benefits and food and housing assistance, and get linked to other services within the community. In one program that specialized in treatment for Native Americans, service users could simply "drop in" and

⁴We undertook a quantitative examination of mental health symptoms, satisfaction, and utilization among Native American ($n = 70$), Hispanic ($n = 122$), and White service users ($n = 110$) in our broader study using the Brief Symptom Inventory (Derogatis, 1993; Derogatis & Melisaratos, 1983) and the Experience of Care Health Outcomes Survey (Daniels, Shaul, Greenburg, & Cleary, 2004) across the three data collection periods, and analyzed publicly available claims data. Symptom reduction did not vary by ethnicity, by geography, nor by an ethnicity-by-geography interaction (data available on request). There was no statistically significant reduction in symptoms for Native Americans. Satisfaction ($p < .10$) increased more for rural vs. urban service users; however, this geographical discrepancy was not apparent for Native Americans. There were no statistically significant changes in satisfaction for Native Americans. By and large, utilization increased (5.2%) across service users. Hispanics showed statistically greater increases in utilization than Whites (7.8% vs. 2.2%). The increase for Native Americans was intermediate (5.4%) but not statistically different than the increase for either Hispanics or Whites.

meet with case managers on an as-needed basis. Service users were thankful for this level of access made possible by a combination of county, tribal, and federal funding. Echoing sentiments expressed by others, one service user stated, “Just knowing that those people [providers] are there is helpful. They do try to make a difference in how you manage your care and also, they give you some options as far as what you can do for yourself.” Service users also appreciated the access to culturally based psychoeducation and healing modalities available in the Native American behavioral health programs but largely funded through sources other than the reform.

Family members were typically unaware of the particular issues facing service users with mental health concerns and the treatment options available to them. Older family members, including those who did not speak English fluently, were especially unaware. Knowledge related to struggles with substance abuse was more common, although also limited. In sum, the reform did very little to increase knowledge, engage family members in the treatment process, address their unique challenges in providing social support and other forms of assistance to loved ones grappling with mental health or substance abuse issues, or help them to advocate for higher quality services.

Discussion

In general, community leaders, providers, and others interviewed for this study suggested that solid collaboration should be the hallmark of any initiative to implement quality behavioral health care for Native American people in New Mexico. Participants felt strongly that improved collaboration among tribes and pueblos, the IHS, tribally operated programs, off-reservation facilities, the Purchasing Collaborative, and the SE were needed to accomplish the goal of effectively addressing the mental health and substance-abuse treatment needs of Native Americans. Our research lends insight into possible strategies for achieving this goal. These strategies are not only relevant to New Mexico, but to other states with large Native American populations. Based on the themes and issues identified in our analyses, we suggest six key strategies or considerations for reform.

First, tribes and pueblos need to be consulted prior to the inception of new programs and services if they are to be implemented properly or sustained within Native American communities. In our study, several participants contended that tribes and pueblos had been consulted only after key decisions regarding such programs and services had been made by State officials and the SE. Participants suggested that the formal consultation process should take place in the early stages of planning; such consultation also needs to take place in a more consistent fashion. Inclusion of tribes and pueblos in initial planning would not only demonstrate recognition of and respect for the sovereignty of each tribe and pueblo, but also result in more effective collaboration given the unique governmental and health care systems within each nation. At the same time, participants argued that community leaders, providers, and service users need to become more assertive in educating tribal officials about behavioral health care issues, and encourage them to take part in consultation activities. Without the support of tribal leadership, participants argued, effective collaboration aimed at improving behavioral health service delivery for Native Americans is not possible.

To truly engage tribes as partners, the participants were adamant that states and their corporate partners must affirm the insights and labors of Native American stakeholders involved in reform efforts, demonstrating how their input influences system change processes. This is essential to counter the long history of marginalization of Native American traditional practices and beliefs, and disenfranchisement of indigenous peoples (Gone 2003, 2004; Goodkind et al., 2010). Toward the close of the 5-year study period, the

majority of participants who had been active in the reform, typically via the LCs, were discouraged from devoting further time and energy to system change efforts, citing the lack of transparency within State-level decision-making processes as their greatest frustration. At least one participant took it on herself to successfully advocate for resources to meet her tribe's behavioral health needs through direct appeals to the State legislature, thus bypassing the Purchasing Collaborative altogether. This advocacy contributed to the restoration of approximately \$2 million in behavioral health service funding for prevention programming in both Native American and rural communities.

Second, on the most basic level, technical assistance and other resources must be made available to providers specializing in services for Native American populations if they are to participate in public insurance programs or operate successfully under a statewide managed care reform. In our study, participants claimed that tribes, with rare and notable exceptions, had not received the intensive assistance they needed to tap into new funding streams, such as Medicaid, so that behavioral health programs would become "self-sustaining" and "revenue generating."⁵ Moreover, workforce limitations, such as insufficient numbers of licensed clinicians, created credentialing problems for tribes with interests in billing under Medicaid. The lack of incentives for providers to pursue education and licensure also created obstacles. Thus, an important aspect of successful reform might be the creation of alternative credentialing and licensure requirements for some types of Native American providers (Goodkind et al., 2010).

Furthermore, few tribal behavioral health programs had computer infrastructures to enroll clients or process claims to receive payment for services under the reform. Providers seeking reimbursement for non-Western healing services also encountered difficulties with unfamiliar utilization review protocols. Several programs decided that it simply was not worth the trouble to seek reimbursement under the reform, and opted not to participate at all. Administrators at the IHS were perturbed that they had to continually educate staff at the SE who lacked basic knowledge of the nuances of contracting with federal agencies and tribal facilities, and were reluctant to assume the uncompensated burden of client enrollment.

Third, on the broadest level, states with large Native American populations must require that their employees and contractors recognize the necessity of and receive ongoing training on how to successfully navigate the varying array of tribal and federal systems implicated in the reform. Without working knowledge of how tribes organize and administer health care, both parties are likely to experience otherwise avoidable obstacles that affect their ability to finance and establish new programs for tribal populations. In our study, participants argued that State policymakers and SE employees were typically naïve, lacking knowledge of the rights of Native Americans in relation to health service access and delivery. Even though cultural competence is demanded of providers receiving public dollars (Barone, 2010), a similar expectation should be placed on the parties that manage those monies and oversee reform. The perpetuation of myths about tribal and federal systems, and about Native American people in general, is particularly disconcerting, and will likely require targeted and aggressive education campaigns to address. It is possible that the State-Tribal Collaboration Act, passed by New Mexico's state legislature in 2009, will play a critical role in debunking such myths, because it mandates effective communication between State agencies and tribes, promotes training on Native American issues and cultural competency

⁵The Navajo Nation experienced the reform differently than the other tribes and pueblos, possibly because it had greater consistency in political leadership, dedicated key administrative and clinical staff to collaborate with the SE, and an established behavioral health care infrastructure. Given its stronger positioning, this tribe benefited from Medicaid credentialing assistance, funding for youth prevention programs, and reimbursement for traditional services.

within State agencies, and forces State agencies to collaborate with tribes in the development and implementation of new policies issued by the State government.

Fourth, reimbursement for traditional healing practices and teachings should be at parity with Western-oriented treatments. At the reform's outset, the State heavily promoted Native American healing and use of traditional healers or counselors (New Mexico Interagency Behavioral Health Purchasing Collaborative, 2004, 2005). Non-Western healing modalities and services were to be celebrated and reimbursed under the reform. To an extent, this goal was realized, although services were funded at a much lower level than comparable Western-oriented services, which led to disparate salaries for Native American practitioners and beliefs that their work was not held in particularly high esteem. The majority of participants in our study felt that if the Purchasing Collaborative was to highlight the inclusion of traditional healing modalities and practitioners as a distinguishing feature of the reform, then serious steps needed to be taken to ensure that both were funded at appropriate levels. This would ensure the viability of these practitioners and treatments, and demonstrate the genuineness of reform intentions. There are innumerable examples of Western political entities making promises to Native American communities and nations without providing the resources and support necessary to fulfill them.

Fifth, reform efforts must acknowledge existing limitations of EBPs in relation to Native Americans and provide adequate support for adapting EBPs and for building evidence for existing practices within communities. Participants believed that the Purchasing Collaborative and SE needed to facilitate greater collaboration with tribes and pueblos and adequately fund initiatives to adapt Western-oriented screening instruments and EBPs if they were to mandate use of them in Native American contexts. Participants, particularly community leaders and direct service providers, expressed substantial consternation with the ASI-MV (2009), asserting that their concerns regarding the use of this instrument had been largely discounted by the Purchasing Collaborative and SE. They were equally as frustrated with efforts to bring up EBPs in Native American communities, arguing that such efforts were not appropriately resourced. Although participants appreciated discussion of programs based on "practice-based evidence," examples of reform-related support of such programs were uncommon during the study period.

Finally, for any reform effort to prove successful in the long term, greater outreach to service users and families is warranted. Without outreach, those otherwise eligible for state-funded services are unlikely to receive them, and the ability of families to advocate for loved ones remains limited. A key priority should focus on increasing knowledge of available treatment options and how to access them. Outreach in clinical and community venues might raise awareness of the reform, and connect service users and their families to a revamped LC initiative. Outreach could be facilitated via a combination of print, radio, television, and Web-based media. State resources are likely necessary to tackle logistical barriers, such as distance and transportation, which prevent service users and families from seeking services or taking part in community input processes. Targeted outreach is also relevant for providers comprising the front line of interaction with service users and families. We argue that effective outreach ultimately requires recognition that Native Americans face numerous health and social inequities, including lower mean household incomes, higher levels of unemployment and education, and higher rates of morbidity and mortality (U.S. Public Health Service, Office of the Surgeon General, 2001a, 2001b). Thus, it is important to build supports within behavioral health systems that address these stressors (Goodkind et al., 2010). Service users' satisfaction with providers offering such supports was evident in our results.

Limitations

Although these research findings help clarify relationships between State-initiated policy change and the perceptions and experience of diverse Native American stakeholders, we recognize certain limitations. The sample size might be considered large by qualitative standards, but this work focuses on a small number of community leaders, providers, service users, and families, and therefore does not represent all Native Americans affected by reform. We do not assess the perspectives of State and SE personnel and other non-Native American stakeholders; such views are described in our other reform-related articles.⁶ The reform reflects a 10-year process; here, we report only on the first 5 years of implementation. However, the findings are relevant to midcourse corrections pertaining to the New Mexico reform, and can inform future processes for engaging tribes in State policy.

Conclusion

The New Mexico reform offered unprecedented opportunities for including Native American perspectives in State policy, despite concerns regarding insufficient consultation with sovereign tribes and pueblos during the reform's development and implementation. After 5 years, the participants noted few improvements within the existing workforce and service delivery infrastructures found in Native American communities. A number of participants also objected to the imposition of the Western diagnostic and screening procedures and EBPs favored under the reform, without careful consideration of culturally specific understandings of the etiology of behavioral health problems and how they are best treated. Participants also observed that logistical barriers impeded wide-ranging Native American involvement in reform activities.

Although Native American participants appreciated State outreach to their communities, many articulated suspicions that such outreach was more superficial than substantive in nature. Our observations and analyses suggest that these concerns might be warranted. Regardless, further interaction between State and tribal governments and increased input from Native American constituents are positive attributes of reform, and have the potential to contribute to meaningful engagement to improve health services and greater emphasis on clinically competent and culturally appropriate approaches to wellness and healing. New Mexico's State–Tribal Collaboration Act might help to address these important concerns.

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⁶Non-Native American stakeholders expressed attitudes and opinions of the reform that resembled those discussed in this article. For example, providers who did not work in Native American communities repeatedly spoke of frustration related to transition issues and IT system and electronic paperwork requirements (Willging, Waitzkin, & Lamphere, 2009). Problems related to these requirements were also the subject of an investigation by State officials (Willging & Semansky, 2010). The reform did little to improve or fund the delivery of either culturally competent services or evidence-based practices in the publicly funded behavioral health system as a whole (Semansky, Altschul, Sommerfeld, Hough, & Willging, 2009; Willging et al., 2009). Finally, many of the problems related to community engagement documented in this analysis were not unique to Native American stakeholders, but were also raised by other advocates, providers, and service users in the broader LC initiative (Kano et al., 2009).

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