Micro, Mezzo & Macro Levels of Implementation:
An Examination of Minnesota's Cultural and Ethnic Minority Infrastructure Grant Program

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Abstract

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Purpose: Using Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program as a case study, this dissertation, using a multi-paper format, analyzes how race, ethnicity, and culture interact with large-scale, system-wide implementation projects at the micro, mezzo, and macro levels. CEMIG funded 21 agencies over $8.83 million in workforce development efforts (e.g., assist individuals in obtaining mental health licensure) for 281 individuals, clinical and ancillary services, and EBP training for cultural and ethnic minority populations from 2008-2017.

Methods: Data used for these papers was varied, including 62 online survey responses from clinical trainees, over 1000 grant documents gathered and maintained by Minnesota's Department of Human Services (DHS), and 23 interview transcripts from 27 participants collected between summer 2017 and fall 2018. While the primary method of data analysis was qualitative content analysis, multiple regression was used to assess the relationship between

challenges and supportive services among clinical trainees who participated in the CEMIG program and responded to the online survey.

Findings: Micro-level findings indicate that while there was no statistically significant relationship between clinical trainees and their demographics, education debt amount, or perceived level of graduate training for the mental health licensure exam, in comparison, services and supports, specifically financial assistance with test fees, were found to be beneficial. The qualitative component of the survey found that clinical trainees experienced the exams as culturally biased and were warned that the licensure exams are challenging and required code-switching behaviors to be successful. Mezzo-level findings separated grantee agencies into four types: sovereign, legacy, transitional, and grassroots; themes generated described the differential need, based on agency typology, to create internal infrastructure, attend to hidden bias, and maintain autonomy during the grant contract process. Macro-level findings demonstrate the participants perceived that the grant program perpetuated inequities by neglecting to promote the program, advocate for clinicians of color, and coordinate isolated policy ecology systems.

Discussion and Implications: Findings from these studies highlight the complexities of racial and cultural identity in the implementation process. At the micro level, the need for clinical trainees to engage in codeswitching behaviors to succeed, questions the role of the licensure exam in assessing competence or cultural assimilation. At the mezzo level, findings suggest that when including non-legacy agencies, more technical assistance and funding for data reporting and contract management should be included. Further, government or private funders should engage in conversations that uncover hidden biases that affect relationships and implementation processes with sovereign, transitional, and grassroots agencies. Last, at the macro level, suggestions for process improvement included enhanced data collection, innovation cross-fertilization, and stakeholder advocacy involvement. Especially within policies engaging with disparate communities, including ethnicity-specific mental health provider

advocacy groups in the stakeholder advisory board and collaborating with these advocacy groups for grant program development and data collection efforts are critical for project enhancement and sustainability. Further research is needed to describe differences in implementation based on culture and ethnicity within mental health settings, as well as examining institutional norms, such as licensing exams that clinicians of color may experience in discriminatory ways.

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DEDICATION

I am filled with gratitude to my Oma for lighting the path for higher education with her Master's degree in 1937, my mother who taught me how to love teaching and sharing knowledge with others, and my Opa who never wavered in his relentless quest to have one of his offspring acquire a doctorate. My only sadness is that they did not live long enough to see what their encouragement created.

INTRODUCTION

The goal of this dissertation is to investigate the role of race and ethnicity within large-scale, system-wide policy implementation projects at the micro, mezzo, and macro levels. Using the Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program as a case study, this dissertation seeks to uncover ways in which race and systemic bias can permeate implementation, even when the policy of focus is an equity-based initiative. As implementation science has struggled to integrate culture (Cabassa & Baumann, 2013), it is essential to critically analyze how race and culture can affect implementation at the clinician, agency, and macro policy levels.

Within the mental health implementation literature, large-scale, system-wide infrastructure projects have become a prominent focus (Powell et al., 2017; Skriner et al., 2017; Southam-Gerow et al., 2014). Studies have investigated the inner and outer contexts of implementation (Aarons, Hurlburt, & Horwitz, 2011), taking a particular focus on individual clinician characteristics (Powell et al., 2017; Skriner et al., 2017), organizational characteristics (Skriner et al., 2017), and system-wide collaborative processes (Beidas et al., 2016) that contribute to success and sustainability of new interventions. While these large-scale, system-wide infrastructure programs are located in racially and ethnically diverse locations, such as Los Angeles County (Southam-Gerow et al., 2014), Philadelphia, Pennsylvania (Beidas et al., 2016), and New York state (Nadeem, Weiss, Olin, Hoagwood,& Horwitz, 2016), the studies are colorblind to racial and ethnic differences within clinicians, mental health agencies, and leadership styles. This dissertation seeks to contribute to the literature by acknowledging that mental health agencies and clinicians are not a homogenized culture and that exploring racial and cultural differences at the clinician, agency, and policy levels can be beneficial for successful implementation of public policy.

The CEMIG program lends itself well to exploring racial and cultural differences at multiple levels during the implementation process. CEMIG was the smallest and least defined component of a much broader 2007 Minnesota's Governor's Mental Health Initiative. The Governor's initiative targeted a fractured service system involving mental health, chemical health, and physical health care, credentialing and licensing barriers, mental health professional education, cultural competence, and inconsistent access to services across the state (MMHAG, 2005). The broader infrastructure development initiative focused on access, quality, innovation, and accountability within Minnesota's public mental health system (DHS, 2006).

The CEMIG program was a product of three intertwining factors. The first was that Minnesota's population was becoming increasingly more diverse. Second, there were concerns that the ethnic make-up of the mental health workforce did not match the client population, especially individuals on Medicaid. Third, there had been unsubstantiated assertions that social workers from cultural and ethnic minority populations were experiencing more difficulty than their White peers in getting licensed (Alexander & Johnston, 2008; Minnesota Board of Social Work, 2008; McDonald, 2006). The theory behind the grant program was that if the mental health workforce more closely resembled the state's population, the racial disparities in the utilization of mental health services rates would decrease. A secondary purpose of the grant program was that once licensed, culturally specific mental health providers could bill Third Party insurance companies for reimbursement, financial stability would be enhanced for the clinician, mental health agency, and industry overall.

CEMIG provides an excellent opportunity to investigate issues of race and culture in the implementation process of a system-wide mental health initiative. During the years 2008-2017, CEMIG funded 21 agencies with $8.83 million in workforce development grants for 281 individuals, clinical and ancillary services, and EBP training for cultural and ethnic minority populations. This case study pulls from over 1,000 grant documents (request for proposal

applications, outcome data reports, and progress statements) created during this 2008-2017 period, 62 online survey responses, and 23 interview transcripts with 27 participants collected between summer of 2017 and fall of 2018. Participants included Department of Human Services (DHS) administrators, agency grant managers, advocacy group representatives, university professors, and non-DHS state employees. As a large-scale, systemwide infrastructure development program that targeted agencies and clinicians of color, it provides a useful experiment to investigate how race and culture interact with implementation processes.

This dissertation addresses issues of race/ethnicity and implementation in a series of three papers. Paper one, "Testing Competence or Cultural Alignment?: Codeswitching through Mental Health Licensure Exams," discusses micro-level factors of implementation. Clinical trainees of color report experiencing more difficulties in the professional licensure process, especially with the exam. In this mixed-methods study, sixty-two clinical trainees from cultural and ethnic minority backgrounds, who participated in the CEMIG statewide diversity workforce initiative, were surveyed regarding demographics, education debt, graduate training experiences, services they received, and experiences in the exam-taking process. Multilinear regression demonstrated no statistically significant relationship between clinical trainee backgrounds and challenges in the exam process; however, in comparison, services and supports, specifically financial assistance with test fees, were found to be beneficial in assisting clinical trainees in the exam process. The qualitative component of the study found that clinical trainees experienced the exams as culturally biased and were warned that the licensure exams are challenging and required code-switching behaviors to be successful, which provoked anxiety and significant preparation. Implications for mental health professional disciplines regarding cultural bias and systemic racism are discussed.

In paper two, "Legitimacy, Resource Dependence, Implementation, and Racial/Ethnic Agency Identity: A Case Study of Minnesota's Cultural and Ethnic Minority Infrastructure

Grant," mezzo level implementation factors are investigated, with particular emphasis on agency self-identity and implementation processes. Organizational theory literature often ignores the role of racial and cultural identity within social service agencies; meanwhile, government and private funders are targeting culturally based partners in equity initiatives. Using Minnesota's CEMIG program as a case study, the role of legitimacy, funding sources, isomorphism, racial and ethnic identification, and infrastructure at the agency level is explored. Using qualitative content analysis, this study analyzes over 1,000 grant documents and 18 interview transcripts that include the experiences and perspectives of state administrators and grant recipients. Grantee agencies are separated into four types: sovereign, legacy, transitional, and grassroots. Themes generated include the cost of racism, needing to bend and stretch, and a desire to run a different race. Implications for funders on ways to improve grant management with culturally identified agencies are discussed.

In paper three, "Exploring Minnesota's Cultural and Ethnic Minority Infrastructure Grant: An Application of the Policy Ecology of Implementation Framework," the social and political contexts of CEMIG's implementation are analyzed. Although the literature is growing regarding large-scale, system-wide implementation programs, the broader political and social contexts, including race and ethnicity, are frequently ignored. Using the Policy Ecology of Implementation framework (Raghavan, Bright, & Shadoin, 2008), Minnesota's CEMIG is examined to investigate the role of social and political contexts in the implementation process and the barriers they create. Data from 22 interview transcripts from DHS administrators, agency grant managers, university educators, advocacy group representatives, and mental health board members, along with more than 1,000 grant documents were qualitatively analyzed using content analysis to reveal three themes concerning how the participants experienced program implementation: invisibility, isolation, and inequity. Findings demonstrate the participants perceived that the grant program perpetuated inequities by neglecting to promote the program,

advocate for clinicians of color, and coordinate isolated policy ecology systems. Strategies for future large-scale, system-wide mental health program implementation are provided.

This dissertation explores how issues of race and culture permeate the implementation process at micro, mezzo, and macro levels. Specifically, paper one demonstrates that clinical trainees of color are told to pretend to be White in order to navigate the professional licensure system which ignores racial and ethnic differences (e.g., by not collecting demographics of applicants) and seems to evaluate acculturation to White professional culture more than competence. Paper two demonstrates that even though mental health agencies can have distinct racial and ethnic identities, implementing programs in a colorblind manner places an undue financial, staffing, and ethical burden on non-legacy agencies. Lastly, paper three demonstrates that racial and ethnic bias at political and social contextual levels are perpetuated in the implementation process through unequal distribution of resources, isolation, and a lack of transparency. Findings from all three papers indicate how institutional racism (Kolivoski, Weaver, & Constance-Huggins, 2014) and hidden biases (Wangari Walter et al., 2017) can infiltrate implementation processes, even when racial disparities are the focus of the policy intervention.

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TESTING COMPETENCE OR CULTURAL ALIGNMENT?: CODESWITCHING THROUGH MENTAL HEALTH LICENSURE EXAMS

Background

Over the course of the late 1900s, mental health professions, including psychology, marriage and family therapy, social work, and clinical counseling, embraced licensure to establish their scope of practice, maintain professional standards, and create consumer protections (Colangelo, 2009; Dyeson, 2004; Robiner, Arbisi, & Edwall, 1994). In order to ensure competency and consistency across clinicians, each discipline created accreditation standards for graduate training programs (Colangelo, 2009; Kosinski, 1982; Robiner et al., 1994), post-graduate training and supervision expectations (Crane et al., 2010; Robiner et al., 1994; Goldstein, 2007), and licensure standards (Crane et al., 2010; Robiner et al., 1994). Each state administers the required competency exams for licensure (Woodcock, 2016) in partnership with a national organization, such as the Association for Social Work Boards (ASWB).

These processes are ubiquitous throughout the mental health community and are considered standard practice today (Bilbus & Boutte-Queen, 2011). Literature regarding licensure practices within psychology, marriage and family therapy, and clinical counseling disciplines has not revealed practitioner or training institution dissatisfaction with the accreditation standards, supervision requirements, or exam procedures (Colangelo, 2009; Kosinski, 1982; Robiner et al., 1994). However, even though the profession of social work accepted licensure (Dyeson, 2004; Bilbus & Boutte-Queen, 2011), social work, as an institution, has demonstrated more skepticism and critical resistance than the other mental health professions to the process (Grise-Owens, Owens & Miller, 2016).

Historically, skepticisms shared within the social work literature have centered around concerns about validity of the licensure exam (Albright & Thyer, 2010; Johnson & Huff, 1988; Marson, DeAngelis & Mittal, 2010) and the perceived disconnection between the exam format

(multiple choice questions) and social work coursework (Black & Whelley, 1999; Thyer, 2011). Additionally, both social work researchers and state boards have been expressing concern over racial disparities within the licensure process (Boutte-Queen, 2003; McDonald, 2006). Voicing concerns about the Whiteness of the ASWB exam committee, social workers have questioned whether the social work licensure exam questions and processes are culturally biased against non-White and first-generation college and graduate students (Bibus & Boutte-Queen, 2011; Boutte-Queen, 2003). Further, state social work boards within Minnesota, Texas, and California have investigated experiential differences in the examination process for individuals from immigrant and cultural minority groups and found that the multiple choice format to the exam created additional barriers for applicants and discounted cultural variability in acceptable responses (McDonald, 2006).

While there may be a compelling social justice argument, details concerning racial disparities in the licensure process have been difficult to ascertain. In research investigating practitioner difficulties with the professional licensure process (e.g., preparation for exam and the multiple choice exam format [Boutte-Queen, 2003; Graybow, 2015]) race is used to describe participants (Boutte-Queen, 2003, Graybow, 2015) but is not as a focal point of the study. Meanwhile, information gathered for a white paper for Minnesota's Department of Human Services (DHS) has described difficulties individuals from cultural and ethnic minority backgrounds experience in the licensure process due to financial obstacles, cultural bias, testing method, application process, personal preparation, supervision logistics, practice needs, emotional and career support, and workplace factors (Aby, 2018). Some state licensure boards have asserted that there are higher failure rates for foreign-born and English Language Learner (ELL) applicants (Bibus & Boutte-Queen, 2011; McDonald, 2006), requiring accommodations and forms of alternative licensure. However, these assertions are based on anecdotes rather than numeric data.

Although allegations of racial bias linger within the literature and in practice, to date, a close exploration of how individuals from cultural and ethnic minorities experience the mental health licensure exam process has not occurred. This lack of data is especially concerning as the prevalence rates of serious mental illness for adults of two or more races and Native American/Alaskan Natives are amongst the highest in the United States (NIMH, 2017), indicating a need for a culturally diverse and competent workforce. Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG), a training grant for clinical trainees from cultural and ethnic minority communities, provides a natural experiment to survey and explore yet unheard perspectives of individuals engaged in the mental health licensure process. This study seeks to investigate the role that race, language, education debt, perceived level of examination preparation through graduate training, being a first-generation college student, and immigrant status contribute to challenges in the licensure examination process, and if there are tangible support services, such as supervision, licensure preparation support, paying for licensure fees, and exam preparation courses, that can be utilized to overcome potential barriers. Because these exams provide gatekeeping functions for various professions, it is helpful to inspect perceptions and experiences of racial and social class bias in the process. This study aims to contribute to the current research gap within the literature by expanding the knowledge base on factors that represent barriers and supports in the mental health licensure process for communities of color. Research questions for this exploratory study include:

1. How did the clinical trainees anticipate and experience the licensure process?
2. Do factors such as education debt, perceived level of examination preparation through graduate training, being a first-generation college student, and immigrant status contribute to challenges in the licensure examination process? and
3. What services or supports during post-graduate training were considered the most helpful in the licensure process?

Method

Setting

Conversations about the disparate number of licensed social workers from communities of color (Alexander & Johnston, 2008; McDonald, 2006; Minnesota Board of Social Work, 2008) began in Minnesota during the 1990s. Over the last 20 years, Minnesota has tried various strategies to increase the diversity of licensed social workers (Bibus & Boutte-Queen, 2011; Minnesota Board of Social Work, 2008) and has conducted multiple investigations to uncover both the barriers to licensure and potential solutions (Alexander & Johnston, 2008; Bibus & Boutte-Queen, 2011). The Minnesota Board of Social Work argued that there is a high failure rate for foreign-born and ELL applicants (Bibus & Boutte-Queen, 2011; McDonald, 2006); however, data to substantiate this claim are unavailable because ASWBs and most behavioral health boards in Minnesota do not record demographic data of test takers or board applicants. Minnesota mental health boards, including Marriage and Family Therapy, Psychology, Social Work, and Behavioral Health, have created accommodations, such as allocating increased test-taking time for individuals who have a first language other than English. However, only the Board of Social Work has substantively engaged in this issue through activities such as grandparenting licensure and creating a provisional license for individuals who speak English as an additional language or are from an ethnic minority community and provide services within that community.

In 2007, Minnesota engaged in a sizeable multifaceted infrastructure initiative to bolster and support the publicly funded mental health system by focusing on increasing access, quality, innovation, and accountability (DHS, 2006). A smaller component of the grand initiative included the Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program to fund workforce development efforts, clinical and ancillary services, and evidence-based practice training for individuals who identify with a cultural and ethnic minority community. This program contracted with 21 agencies from 2008 through 2016, allocating $8.86 million to

achieve these goals. Program documents demonstrate that 281 individuals, engaging in various types of mental health services from mental health behavioral aides to clinicians, received clinical supervision, mentoring, or training through the CEMIG program (Aby, 2018).

CEMIG Program Components

Grantee agencies provided myriad services to clinical trainees to assist in licensure testing, clinical acumen, and obtaining supervision hours. Services paid for by the grant included the following: clinical supervision, examination preparation support (e.g., test-taking skills, practice tests), continuing education units, licensure test fees, examination preparation courses, license fees, study-group time, tutoring for English writing, university course work, internship stipend, mentoring services, clinical supervisor training, intergroup dialogue groups, advanced clinical training, and training in evidence-based practices. Each grant-receiving agency provided a unique combination of these allowable expenses during their grant period.

Participants

The CEMIG program documents list 281 individuals who received clinical supervision, mentoring, or training that was paid for or provided through the CEMIG program (Aby, 2018). Of those individuals, 104 currently have a clinical license in Minnesota from one of the four behavioral health boards and are licensed mental health professionals. Fifty-nine hold a graduate-level license (i.e., LGSW, LAMFT, or LPC) and are still working toward their independent clinical license. Twenty individuals are current applicants with their board but do not have a license; 98 are not eligible for a clinical license, are not working within Minnesota, or have had their license terminated or expire. More than half the clinical trainees were from the social work profession (approximately 60%). The next highest group was marriage and family therapy. The fewest representatives were in psychology. No psychiatrists or psychiatric nurses were within the clinical trainee group.

Sampling

Current addresses are publicly available for approximately 183 CEMIG clinical trainees. Address lists from all four behavioral health boards were acquired, and then a survey was emailed or mailed with an accompanying cover letter to each person who had participated in the CEMIG training program. The method of contacting the clinical trainees was determined by behavioral health board procedures and what information is publicly available. The Department of Human Services cosigned the letter inviting individuals to participate in the survey. Information about the study was also sent to grant agency representatives encouraging them to remind and urge current and former employees/participants to complete the survey.

Procedures

The survey was developed on the basis of data provided in exploratory interviews (Aby, 2018) for another component of this multistage case study (Stake, 2005) and through evaluating research that describes difficulties experienced by individuals from cultural and ethnic minority populations in the standardized testing (Donahue & Thyer, 1992; Dunlap, 1979) or licensure examination process (Bibus & Boutte-Queen, 2011; McDonald, 2006). Using a social justice approach in the development of the survey (Cornelius & Harrington, 2014), two clinical trainees who participated in the program and a graduate supervisory committee provided consultation. Designing, editing, and testing the survey with input from the clinical trainees attended to potential cultural and language nuances (Cornelius & Harrington, 2014) that might inhibit or create challenges in the survey process. To assure respondents that completing the survey can be a mutually beneficial process (Cornelius & Harrington, 2014), the informed consent procedure at the beginning of the survey specifically informed them that the Minnesota DHS and mental health boards would receive only aggregated results without any personal identifiers. Participants received a code for a $15 Amazon gift card to compensate them for their time.

Variables

Table 1.1
Variables Typology and Measurement

Variable class	Variable name	Description
Demographics	*Race*	Respondents could choose all that applied: Black or African American; Asian American/Pacific Islander; American Indian or Native American; Hispanic/Latino; White or European American.
	Gender	Male, Female, or Other
	Age Range	20-29; 30-39; 40-19; 50-59; 60-69; 70+
	Current Area of Practice	Options included: Direct Service (clinical mental health); Direct Service (non-mental health); Public Policy; Management; Clinical Supervisor; Community Practice/Advocacy; On-leave; Other
	Location of Practice	Rural or Urban/Suburban Practice
	Licensure Status	Current license and specific mental health discipline
	Client Population	Age range of client population and if the clinician is of the same ethnic background as clients
	First-Generation College Student	Yes/No
	First- or Second-Generation Immigrant	Yes/No
Exam Attempts	*Graduate Exam*	Number of attempts taking the graduate exam
	Clinical Exam	Number of attempts taking the clinical exam
	Combined	The combined number of attempts taking both exams
Education debt	*Acquired Student Loans*	Yes/No
		$0-$10,000; $10,001-$20,000;

Variable class	Variable name	Description
	Debt Amount	$20,001-$30,000; $30,001-$40,000; $40,001-$50,000; $50,000+
Graduate training	*Preparation for Clinical Work*	Yes/No
	Preparation for Licensure Exam	None, Somewhat, Fully Prepared
CEMIG support services	*Clinical Supervision*	Yes/No
	Examination Preparation Support	Yes/No
	Examination Preparation Course	Yes/No
	Paid for Licensing Test Fees	Yes/No

Demographics

Demographic information such as race, gender, age range, the current area of practice, the location of practice, licensure status, and client population were collected from the clinical trainees on the survey.

Immigrant Status

Survey respondents indicated if they identified as having first- or second-generation immigrant status. Because prior research has suggested that individuals for whom English is not their primary language are more likely to experience difficulties with the exam questions (Alexander & Johnson, 2010; McDonald, 2006), clinical trainees were asked not only if they were an immigrant or came from an immigrant family but also if they used the ELL accommodation when taking their exams (e.g., extra time).

Graduate Exam

Mental health licensure, with psychology as an exception, requires two exams within the state of Minnesota. After graduation from a graduate clinical training program, but before sitting for the clinical exam, a clinical trainee from social work, marriage and family, and clinical

counseling must take the graduate level exam. Only by completing this exam and the appropriate number of supervised practice hours, may clinical trainees take the clinical exam. This survey asks clinical trainees to report how many times they attempted the graduate exam.

Clinical Exam

Before obtaining licensure as a mental health professional, all clinical trainees must take the clinical exam for their discipline. This exam generally occurs after they have taken the graduate exam and completed 3 to 4 years of supervised clinical practice. Once clinical trainees pass this exam, they may practice independently without supervision. This survey asks clinical trainees to report how many times they attempted the clinical exam.

Combined

This variable combines the number of attempts for the graduate and clinical exams.

Education Debt

Previous studies indicate that more than a quarter of MSW graduates owe at least $40,000 in educational loans and that it often comes from credit cards rather than government or private education loans (Yoon, 2012). The survey contained questions regarding whether the clinical trainee acquired student loan debt during graduate training and, if so, provided a range of amounts from which to choose.

First-Generation College Student

Clinical trainees answered whether they were the first person in their family or within the first generation of their family to attend college. Previous studies have associated difficulty with licensure exams with individuals from first-generation college families (Meyers, 2016). Concerns regarded not having family members or informal networks that understand the licensure process and a lack of community support (Aby, 2018; Meyers, 2016).

Graduate School Preparation

Respondents stated whether they felt like their graduate program prepared them for clinical work and whether their graduate program prepared them for the licensure process and exams. Clinical trainees could answer whether their graduate program prepared them none, somewhat, or fully for the licensure process. Clinical trainees then could describe what type of preparation their graduate training program provided, ranging from preparation courses to mock exam questions, presentations on the licensure process, mentoring, school-sponsored study sessions, student-run study sessions, financial assistance or scholarships for licensure fees, and alumni program follow-up services.

Supervision

A core component of the CEMIG program was to provide clinical and licensure-specific supervision for clinical trainees. The supervision would assist clinical trainees in the requirements for licensure and insurance billing. Clinical trainees were asked in the survey if they received this service tied to the grant and whether they found it beneficial in their licensure experience.

Examination Preparation Support

Among the myriad allowable grant program activities, grantee agencies were encouraged to provide examination preparation support (e.g., test-taking skills, practice tests) for their clinical trainees in advance of taking the exam. Clinical trainees answered if they received this service from the grantee agency and whether they found it beneficial.

Paid for Licensing Test Fees

An often accessed grant program activity was for grantee agencies to use grant funds to pay for licensing test fees on behalf of the clinical trainee. Financial assistance allowed the clinical trainee to avoid the financial burden of paying for the test fees, which ranged from $500 to $1200. Clinical trainees stated if they received this service, and if so, whether they found it beneficial.

Paid for Examination Preparation Course

Another highly used grant program activity was paying for a discipline-specific (e.g., psychology, marriage and family therapy, or social work) preparation course before sitting for the licensure exam. Grantee agencies would not instruct clinical trainees in these courses but would use grant funds to pay for preparation course fees. Clinical trainees stated if they received this service and if so, whether they found it beneficial.

Data Analyses

Study data were collected and managed using REDCap electronic data capture tools hosted at the University of Washington. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3) automated export procedures for seamless data downloads to common statistical packages; and 4) procedures for importing data from external sources (Harris, Taylor, Thielke, Payne, Gonzalez, Conde, 2009). Information gathered from the online REDCap (Harris et al., 2009) survey automatically generated an Excel spreadsheet, and respondent identification was attached to each of the respondent's answers. After the survey period closed (10/8/19-12/5/19), all identifiable information was deleted from the spreadsheet. Information regarding demographics and participation in the CEMIG program was analyzed using basic descriptive statistical methods. All statistical analyses were conducted using Rstudio (R Core Team, 2013). Both linear and multiple linear regression analyses were performed using the variables mentioned above with the rates of testing at the graduate exam, clinical exam, and combined levels.

Select questions regarding perceptions, experiences, and challenges/supports were provided in open-ended-answer formats, thus lending more to qualitative content analysis. Data collected through the survey were input into a spreadsheet, and coded in that format. During the first cycle of coding, both descriptive and structural coding were utilized (Saldaña, 2016).

Descriptive coding (Saldaña, 2016) allows the coder to write a brief description of the emotions or actions involved in the text. Structural coding (Saldaña, 2016) organizes and determines the frequency of similar responses regarding the perceptions, challenges, and supports of survey participants. After the first round of coding, data matrices were generated to sort and organize responses according to frequency and sentiment (Miles, Huberman, & Saldaña, 2014). The survey data were compared with responses acquired from the grant managers and DHS administrators participating in a concurrent study (Aby, 2018), assessing for ideas of convergence or examples of negative case analysis (Gilgun, 2015; Wu, Wyant, & Fraser, 2016). Using inferences gathered through the development of the matrices, pattern coding, which pulls together concepts and codes into more meaningful units of analysis or themes, was employed for the second round of coding (Saldaña, 2016).

To enhance and secure credibility, transferability, auditability, and confirmability the following steps were conducted: peer debriefing, memoing, and data triangulation. These contributed to the rigor (Morse, 2015) of this study. Peer debriefing, as well as consultation with a supervisory committee (Wu et al., 2016), assisted in thinking through research strategies and theme generation. Memoing throughout the process created an audit trail of analytical steps and procedures used to collect and analyze data (Gilgun, 2015; Wu et al., 2016). Data triangulation was employed with the addition of information garnered from interviews with DHS administrators and grant managers (Wu et al., 2016) and was used in matrix generation.

Results

Sample Characteristics

Full demographic information for the clinical trainees can be found in Table 1.2. Clinical trainees (n = 62) could mark all races/ethnicities that were applicable in the survey. Almost half of the respondents identified as Asian American; the primary ethnicity was Hmong (20 individuals). While 63% of the respondents identified as first- or second-generation immigrant,

only 11% utilized the ELL accommodation for more time while taking the exam. Every respondent had attended graduate school, and 82% had incurred loans during their education. Fifty-two percent of the respondents carried more than $50,000 in school loan debt. At the time of the survey, 74% of the respondents stated that they currently work in community mental health and 68% reported that a license is required for their employment. The majority of respondents are currently engaged in clinical practice, with 34% identifying as supervisors or managers. Lastly, 71% report that they currently work within their own cultural community.

Table 1.2
Demographics for CEMIG Clinical Trainee Participants

	Clinical Trainees *n (%)*
Gender	
Male	8 (13%)
Female	54 (87%)
Race	
African American	20 (32%)
Asian American	27 (43%)
European American	8 (13%)
Native American/Alaskan Native	7 (11%)
Latino/a	6 (10%)
Multiracial	7 (11%)
Did not identify	1 (1%)
Age Range, years	
20-29	6 (10%)
30-39	35 (57%)
40-49	13 (21%)
50-59	6 (10%)
60-69	1 (1%)
70+	0
Did not identify	1 (1%)
1st- or 2nd-generation immigrant	39 (63%)

1st-generation college student	45 (73%)
Utilized ELL accommodation for exam	7 (11%)
Education	
Attended graduate school	62 (100%)
Incurred loans	51 (82%)
Loan amount	
$0-$10,000	5 (8%)
$10,001-$20,000	3 (5%)
$20,001-$30,000	4 (6%)
$30,001-$40,000	1 (1%)
$40,001-$50,000	5 (8%)
$50,001+	32 (52%)
Graduate program prepared for clinical work	42 (68%)
Graduate program prepared for the exam	
None	23 (37%)
Somewhat	34 (55%)
Fully prepared	3 (5%)
Employment	
Work in community mental health	46 (74%)
Work in a rural area	9 (14.5%)
Client population	
Age range, years	
0-5	14 (22.5%)
5-18	47 (76%)
18+	46 (74%)
Same ethnicity as clients	44 (71%)
A license is required for employment	42 (68%)
Currently licensed	49 (79%)
Social work	28 (45%)
Marriage and family therapy	13 (21%)
Clinical counseling	11 (18%)
Psychology	4 (7%)

Note. CEMIG = Cultural and Ethnic Minority Infrastructure Grant.

Clinical Trainee Experiences

Clinical trainees, when questioned about what they had heard about the exam before taking it, gave two primary responses: it was difficult, and they would need to engage in code-switching to pass. Most respondents stated that peers and mentors had warned them that the test was extra tricky for clinicians from cultural and ethnic minority backgrounds and was particularly difficult for people whose primary language was not English. These warnings provoked anxiety and fear, creating worry that there were "trick questions" and that the exam was "catered towards white people" (Table 1.3). Furthermore, mentors suggested to the clinical trainees that because the exam was written for White people, to pass the test, they would have to pretend they were White as they answered the questions. Numerous individuals were told to "think like a White male" or pretend they were "an older Caucasian woman from a rural area." Messages from clinicians of color who had gone before them were that the only way to pass the exam was to code-switch and think/act like a White person.

Clinical trainees were also asked to describe their experiences in the exam test process (Table 1.4). Respondents voiced themes of anxiety and experiencing the test as culturally biased. Clinical trainees stated that they felt panicked during the exam, kept second-guessing themselves, and felt traumatized by the experience. Respondents voiced that the questions were worded confusingly and they had to slowly read each item multiple times to check for accuracy and to calm their nerves. However, there was the opposite response as well, that due to anxiety and the messages of difficulty they had heard before taking the exam, the clinical trainees had extensively prepared for the exam and felt confident. Multiple people endorsed the practice courses and other CEMIG program resources as the reason they felt ready for the exam. Last, respondents stated that the experience was stressful for them due to cultural or past trauma history. Of note, at least one referred to the experience as being detainee-like, that the process of

rigid rules, fingerprinting, and being monitored evoked feelings of imprisonment or capture. Others voiced strategies of having to pretend that they were someone else to answer the questions the "right" way or that the ethics scenarios "didn't reflect [their] cultural values" and they "felt conflicted when choosing the answer." Although the clinical trainees did not challenge the need for having licensure exams, there was an overwhelming feeling that their experience was different from that of the White population, because the clinical trainees had to change their thinking to be more "White" to pass the exam.

Table 1.3
Themes on the Community's Perspective on Mental Health Licensure Exams

Question:	What did you hear about the licensure exam from other mental health clinicians of color before you took the exam?
Theme:	Participant quotes:
Difficult	*I was informed it was a difficult test for people of color and for those who speak English as a second language.*
	That it was difficult and catered towards white people. Also, that there were "trick questions."
	I heard it's very, very difficult to pass. The graduate schools don't prepare them for the exam and they didn't learn enough from the general clinical courses to pass the exams.
Code-switching	*They said when taking the exam, to think like a White male and not as what you would usually do in an ethnic clinical setting because the test is made and graded by the majority population and race.*
	Walk into the exam as if you were an older Caucasian woman from a rural area. If you did this, you would be fine.
	Know how to take the test, and answer the questions from a White cis-man's perspective since that is where the questions come from.

Table 1.4
Themes on the Licensure Exam Experience

Question:	Please describe your experience during the license exam taking process. (How did you feel during the exam? Did you feel prepared? What do you remember most about exam taking?)
Theme:	Participant quotes:

Anxiety	*Extremely traumatic. I am a good test taker. I spent a lot of time preparing. All of my pretests indicated that I had a high rate of passing, and it was still awful. I was convinced I had failed (truly, this is not modesty). I was surprised when I got my scores and saw that I had passed by a wide margin. I have talked with several other folks who also passed who also share that experience. They are also all people of color.*
	After taking the test for the first time, I felt prepared prior to going into the test; however, due to high anxiety, the test was very difficult. It took me all 4 hours to complete the test and most of the time I was panicking. Some of the questions were confusing.
	I was anxious; it was the most stressful experience in my professional career, and I passed the first time. I requested special accommodations and the prep classes were the biggest assistance to helping me pass!
Preparation	*I felt confident and prepared due to the prep courses I took for the exams which were paid for by the CEMIG grant.*
	I felt prepared before taking the written exam, but felt some of my studying was useless when I sat for the exam. I felt prepared and equipped, but nervous for the oral exam. I remember my determination to pass on the first try.
	I gave myself plenty of time to study and felt prepared. I passed the first time.
Culturally biased	*I was very nervous and anxious. The materials to review were overwhelming and too broad. English is my second language, so I felt very worried if I understand the questions correctly. The way the exam was formed didn't make sense to me and it was hard to understand what they wanted. I had to try to think out of my own cultural perspective or sometimes the opposite in order to get it right. Ethics were the hardest because of the scenarios didn't reflect my cultural values and hard for me to think straight. I often felt conflicted when choosing the answer.*
	I felt like a detainee regarding the entire orientation process, cameras, fingerprinting, raising of hands if I need a break. NOT too prepared, more stress as a result of the testing, lower score the second time sitting for the exam. I remember the process the most and the unsuccessful score.
	The best advice I received was to know and understand the test content areas and format, including time management. Also, to answer questions not to my liking personally, but answer it the way the "average social worker" would.

Predictors of Exam Passing

Within this sample of 62 individuals, who had participated in the CEMIG program, 49 are currently licensed to provide mental health services; the remaining 13 respondents indicate that they have not yet attempted a licensure exam. This number includes both individuals with a practitioner license (they have taken the graduate exam and are still receiving supervised practice) and those with a clinical license (individuals who have taken the graduate exam and the clinical exam and can practice independently). The rates of not passing the exam the first time were low. Seven individuals stated that they had taken the graduate exam more than once, and ten individuals reported they had taken the clinical exam more than once.

Three separate multilinear regression models were run to assess for the predictors of difficulties with the exam and the benefits of the supports that CEMIG trainees received. The model to predict the challenges with the exam and to assess the benefits of the supports that CEMIG trainees received included the variables first- or second-generation immigrant, student loan debt, first-generation college student, graduate school preparation for the licensure exam, clinical supervision, examination preparation support, paid licensure fees, and paid for an exam preparation course. These variables were analyzed against the number of times the tests were taken for the graduate exam, clinical exam, and both exams (Table 1.5). None of the challenge variables (e.g., first- or second-generation immigrant, student loan debt, first-generation college student, graduate school preparation for the licensure exam) in the model were shown to have statistical significance within this sample group.

Table 1.5

Predictors of Challenges and Success with the Mental Health Licensure Exams

Variables	Graduate exam		Clinical exam		Combined (both exams)	
	Coefficient	*SE*	Coefficient	*SE*	Coefficient	*SE*
Immigrant	0.10	0.18	0.79	0.24	0.16	0.41
Debt	-0.004	0.03	0.006	0.046	0.16	0.07

First gen. college	0.17	0.19	-0.16	0.25	0.24	0.42
Grad. school preparation	0.09	0.13	-0.03	0.18	0.13	0.29
Clinical supervision	-0.27	0.25	-0.43	0.34	-0.68	0.57
Examination prep support	0.29	0.20	0.189	0.27	0.46	0.45
Paid licensure test fees	0.34	0.21	0.86**	0.29	1.27*	0.48
Paid for exam prep course	-0.18	0.19	-0.34	0.27	-0.42	0.44

Note. Gen. = Generation; Grad. = Graduate.
*$p < 0.05$. **$p < 0.001$.

As shown in Figures 1.1 and 1.2, overall support services within the CEMIG program were more positively associated, though not statistically significant, with success than the predictors for challenges. Paying for licensure test fees is shown to be statistically significant for individuals taking the clinical exam and both exams variables. These results indicate that the support services received by the CEMIG clinical trainees were quite helpful, especially concerning financial assistance with licensure test fees, and helped to negate potential challenges in their licensure exam experience, as voiced by the qualitative data.

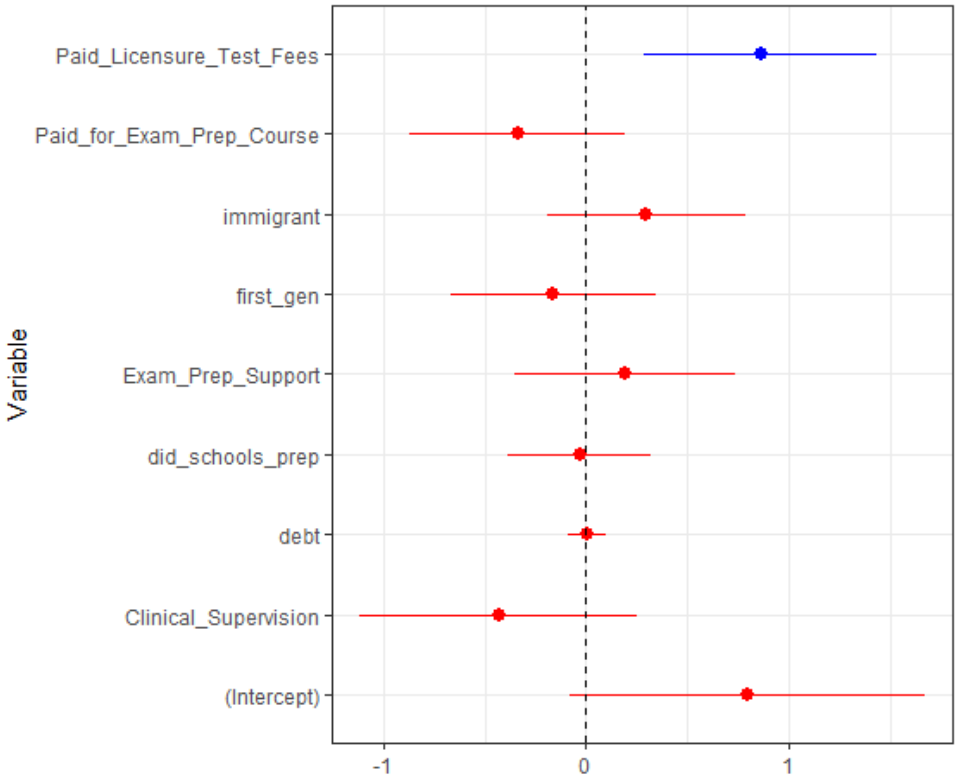

Figure 1.1. Coefficient Plot for Clinical Exam

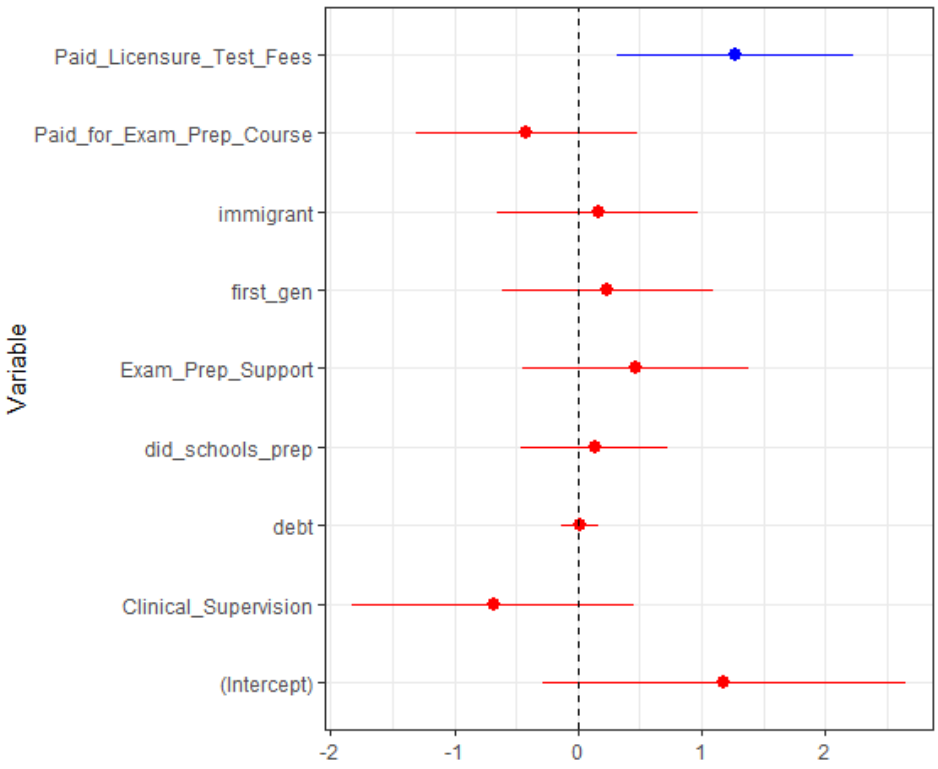

Figure 1.2. Coefficient Plot for Combined Exams

Discussion

Although this study does not shine any light on the predicting factors of challenges for individuals from cultural and ethnic minority groups taking mental health licensure exams, it does speak to the role that support services, mainly financial, can play in the process. Within this group of clinical trainees from cultural and ethnic minority backgrounds, the rates of having to re-take the graduate or clinical licensure exams were low. It is difficult to interpret this finding as there are no published investigations based on race or ethnicity that establish typical rates of passing exams. Further, CEMIG is the only known state-funded grant program within the United States to increase the number of mental health professionals of color.Of note is the role of support services from the CEMIG program and the feelings expressed by the clinical trainees of both their anticipation of the exam and the experience of taking the exam itself.

There is a statistically significant positive relationship between the CEMIG program paying for the licensure testing costs and individuals passing the exam. Because licensure testing costs can run from $500 to $1000 depending on the discipline, support is a substantial form of assistance when an individual faces a stressful test that determines professional advancement on multiple levels, including financial. The CEMIG clinical trainees received years of coaching, mentoring, supervision, and other support services that served to bolster their efforts as they pursued licensure.

Second, in both the questions regarding anticipation and the experience of the mental health licensing boards, clinical trainees discussed a need to pretend to not be of their cultural background and to answer as a White person would. This process of code-switching, defined as the ability to adopt behaviors and responses to each social context even when they constitute potentially conflicting value systems (Morton, 2014), was endorsed by many clinical trainees as the only way they could succeed at this professional milestone. Advice to code-switch was passed down from mentors and supervisors to clinical trainees, and they recorded how they would ignore their cultural responses to "play the game" and pass the test, so they could return to practicing with communities of color. The voices of these clinical trainees demonstrate that although the mental health boards may view their exams as “color-blind,” allowing for equal access for all applicants on an unequal playing field (Kolivoski, Weaver, & Constance-Huggins, 2014), the exams are not experienced in the same way across cultural groups. This practice of having one cultural group’s ideas as the color-blind norm demonstrates institutional racism that is self-reinforcing (Golash-Boza, 2016), causing individuals from cultural and minority backgrounds to have to take on the views and beliefs of the dominant group to reap social benefits (Morton, 2014). The code-switching process becomes exceptionally problematic in professional disciplines, especially as the country's demographics continue to change and become more diverse. It is concerning that even though social justice is a core component of social work’s Code of Ethics (National Association of Social Workers, n.d.), as is

nondiscrimination along with a commitment to justice within psychology (American Psychological Association, n.d.), marriage and family therapy (American Association for Marriage and Family Therapy, n.d.), and clinical counseling (American Mental Health Counselors Association, 2015), practitioners of color state that the discipline's licensure exam excludes their cultural framework. The difference between the professional codes and the experiences of the clinical trainees of color demonstrates a misalignment between the purpose of the exam (to ensure competence and public protections) and the practice (to enforce White culture within professional disciplines). It is essential that mental health professions investigate potential cultural bias within their licensure exam process to ensure that they are not restricting entry on the basis of cultural differences rather than competence in the field.

In addition, clinical trainees' responses demonstrate the concept of "stereotype threat" (Good, Aronson, & Inzlicht, 2003; Toretsky, Mutha, & Coffman, 2018): the process by which individuals from cultural or ethnic minorities shoulder the added burden of being viewed by others through external messages of negative stereotypes, causing individuals to reread and recheck answers multiple times, in an attempt to be perfect (Toretsky et al., 2018). Stereotype threat is twofold in that it creates more stress for the exam-taker and then creates more "self-assessment" of their frustration (Steele & Aronson, 1995), which compounds their time and effort during the exam process (Steele & Aronson, 1995). Given that the key populations that might suffer from stereotype threat are cultural minorities and women (Steele & Aronson, 1995), the CEMIG clinical trainee population is mostly doubly affected. Furthermore, appropriated oppression (Banks & Stevens, 2018) moves the conversation from focusing on an individual's internal processes, such as second-guessing exam answers as a result of negative stereotypes, to how social systems create environments that disseminate messages of devaluation of cultural groups that influence internal beliefs about the self and one's community (Banks & Stevens, 2018; McCloud, 2016). This theoretical concept corresponds with respondents commenting that, after being warned of how difficult the test would be for them to pass and of the need to

code-switch, they felt a need to recheck answers and assumed that they had failed. The responses strongly suggest that the clinical trainees were attending to negative stereotypes and social messages about clinicians of color and the mental health board exams.

Although researchers have been discussing systemic and structural racism in education for several years (DeCuir & Dixson, 2004), this is a newer conversation in mental health professional disciplines. Having a standard exam that is not culturally tailored to any one group (color-blind) is inherently normalizing a White perspective, due to the pervasiveness of White privilege (DeCuir & Dixson, 2004; Kolivoski et al., 2014) within U.S. society. As the clinical trainees stated, they experienced the exam process as devaluing their own cultural and ethnic values, so much so that they had to pretend to have a separate values system to gain professional success. The mental health professions, as experienced by the CEMIG clinical trainees, are structured in a way that supports racial inequality that limits opportunities for individuals who do not have a White perspective or cannot code-switch, which describes an institutionally racist system (Kolivoski et al., 2014). It is incumbent on all mental health disciplines to engage in antiracism or social justice initiatives to reflect on how each profession is welcoming and accepting of cultural views and norms outside of White or European American culture. This process could include implicit bias training for the creators and administrators of the exam as well as individuals on state or national professional boards (Toretsky et al., 2018). Last, state boards should investigate other means to deemphasize the exam during the process of the antiracism work (Toretsky et al., 2018), perhaps following the Minnesota Board of Social Work's provisional license for individuals who speak English as their nonprimary language, allowing extended supervised practice to speak to competence instead of the exam (Minnesota Board of Social Work, n.d.).

As the United States continues to diversify in population, there is a growing need for the mental health workforce to be culturally and linguistically prepared for the demographic change.

In 2016, the National Institute of Mental Health (NIMH) reported that 18.3% of all adults in the United States experienced mental illness (NIMH, 2017). The prevalence of serious mental illness was highest among adults reporting two or more races and Native Americans/Alaskan Natives (NIMH, 2017). Recipients of mental health services will be seeking a diverse and culturally competent workforce. It remains to be seen if the licensure process can ensure that.

Limitations

This study focused on the responses of clinical trainees from cultural and ethnic minority backgrounds who received services and supports through a workforce development grant program within Minnesota. Whereas this study gives a further description on experiences and beneficial support services for clinicians of color in the mental health licensure process, it does not address the needs and experiences of individuals who are isolated and lacking support. Further research is needed to address the experiences, challenges, and support needs of clinical trainees of color who are not involved in a workforce development program.

Besides a limited population (i.e., clinical trainees in the CEMIG program), there was a low response rate to the survey. Given that the CEMIG program has been in effect for more than 10 years, it is entirely possible that individuals did not respond because they forgot or were unaware that they were registered in the CEMIG program, which may have had a different name within their agency or clinical training program. An additional factor is that the survey was administered online; grant managers have stated that clinical trainees have had difficulty completing computer-based forms and outcome management tools required for the grant (Aby, 2018). Also, the means of connecting with individuals was based on their recorded address with their mental health board, which may have changed or may not be an email address they check with frequency. Further research with clinical trainees should occur during grant period enrollment to ensure follow-through and better response rates.

Last, future research should be conducted with the mental health boards and exam organizations to assess for race and social equity concerns in the test process itself. Because mental health boards and testing agencies are not uniformly keeping track of race and ethnicity data for their applicants, it is difficult to assess the pass rates for the general population. Initiating pilot studies with the general mental health provider population to investigate challenges and supports during the licensure process would be a tremendous step in assessing racial and social disparities within the process.

Implications for Behavioral Health

Results of this survey suggest that clinical trainees of color are warned that the licensure exams are challenging, require cultural and ethnic minority test takers to engage in code-switching to be successful, provoke anxiety, require significant preparation, and are experienced as culturally biased. In addition, it is suggested that services and supports, such as paying licensure exam fees and exam preparation courses, can be instrumental in helping clinical trainees of color pass licensure exams even if they are first-generation college students, first- or second-generation immigrants, have high amounts of graduate school debt, and feel like their graduate training programs did not prepare them. Last, mental health professional disciplines should engage in a self-assessment process regarding racial bias in licensure exams to assess whether they are screening for cultural similarity or practitioner competence.

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LEGITIMACY, RESOURCE DEPENDENCE, IMPLEMENTATION, AND RACIAL/ETHNIC AGENCY IDENTITY: A CASE STUDY OF MINNESOTA'S CULTURAL AND ETHNIC MINORITY INFRASTRUCTURE GRANT

Introduction

Implementation literature seeks to understand the connections between agency type, culture, and implementation efficacy (Aarons, Sommerfeld, & Walrath-Greene, 2009; Willging et al., 2018). The research to date has documented factors such as agency size, location, mission, funding sources, level of isomorphism in the mental health community, and leadership styles. Meanwhile, identity-based nonprofit organizations (IBNPs), formed through a common identity, have been shown to experience accountability demands from their community that may differ from those required to maintain their legitimacy with funders, community members, and staff (Ospina, Diaz, & O'Sullivan, 2002). Thus, missing from implementation science literature is an understanding of the effects an agency's racial and ethnic identification and sense of legitimacy has on implementation processes. In addition, both researchers and government institutions have begun exploring the role of institutional racism and hidden bias within large human service institutions (King County, n.d.; Wangari Walter et al., 2017), necessitating a closer examination of how culturally based agencies navigate and experience interactions with large institutions, such as funders. However, little is known about how different expectations of accountability, markers of legitimacy, and factors of institutional racism affect implementation of large-scale public grant programs, especially within culturally based agencies.

As such, to begin to address the aforementioned knowledge gap, this case study investigates the role of agency size, location, mission, funding sources, level of isomorphism, racial and ethnic identification, and infrastructure at the agency level to better understand the impact state funding requirements and involvement has on small, grassroots culturally and racially identified agencies.

Specific research questions include:

1. How do grassroots culturally and racially identified agencies position themselves as legitimate during the application process of a large-scale, public grant program?
2. How does their identification of legitimacy influence their experiences during the implementation of the public grant-program?

Exploring the ways in which culturally and racially identified agencies position themselves as legitimate and examining their experiences in large-scale, statewide implementation projects are important as governments, private foundations, and researchers seek to find solutions to disparate health outcomes across racial and cultural groups. Information garnered through this study may serve to create cross-cultural partnerships and bring more grassroots, community-based providers into state and national health equity conversations.

The subject of this case study, Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program, is fertile ground to explore how an agency's identity, connection to a specific racial and ethnic community, internal organizational culture, and agency structure contribute to the implementation of a large state initiative. CEMIG aims to increase the quality, access, and efficacy of mental health services across the state (Department of Human Services [DHS], 2006). Specifically, this grant program, nested within the broader 2007 Governor's Mental Health Initiative, was tasked to develop a culturally diverse, competent mental health workforce and to increase access to mental health services for individuals from communities of color who lacked health insurance (DHS, 2006). To accomplish this legislative mandate, each grant cycle DHS published a request for proposal (RFP) that encouraged responding agencies to assert their legitimacy for this funding source and propose programming to increase access to quality mental health services and workforce development opportunities for communities of color. Responses varied greatly due to agency size, client population needs, clinical trainee demographics, and leadership within the agencies. These agencies varied widely in history of

grant funding and outcome reporting. Regardless of these differences, the selected proposals were entered into standardized state contract templates and were monitored using uniform outcome metrics.

Literature Review

This paper first provides information surrounding the grant program and guiding concepts for institutional theory, resource dependence, and implementation science. A description of methods, findings, and implications for future practice will follow.

Theoretical Background

Implementation science has long looked at the inner context of an agency (Aarons Hurlburt, & Horwitz, 2011; Birken et al., 2017) through both institutional theory (Aarons et al., 2009; Willging et al., 2018) and resource dependence theory (RDT) (Willging et al., 2018) lens. Common inner-context factors that affect implementation include organizational culture and climate, leadership, fiscal viability, and staffing (Aarons et al., 2011). Implementation studies have sought to uncover the differences in process due to agency type (Aarons et al., 2009), managerial perspectives (Willging et al., 2018), and organizational characteristics that promote clinician adoption of evidence-based practices (EBP) (Skriner et al., 2017). Although these studies bring forth much-needed information to improve translational research and the implementation of large-scale, public policy initiatives, the studies have continued a pattern of ignoring differences of racial identity and cultural factors within organizational functioning. The studies may have recorded race of the clinicians receiving training of EBPs (Olin et al., 2016; Skriner et al., 2017) but have not examined how the implementation process was affected by clinician cultural and ethnic differences. Further, in large implementation studies, there is no discussion of the different types of clinics (non-profit, for-profit, government-run), which assumes a homogenized clinic setting, regardless of the mission or focus of the agency. This colorblind approach (Foldy & Buckley, 2014) denies the current and historical experiences of

cultural and ethnic minority communities with institutionally racist systems (Wangari Walter et al., 2017) and the effects of implementation when Whiteness is perceived as ordinary (DeCuir & Dixson, 2004; Ford & Aihihenbuwa, 2010).

Implementation science is not alone in being colorblind in regards to organizations and organizational theory. Institutional theory (IT) posits that institutions, such as a mental health centers, use tools such as legitimacy and isomorphism (Meyer & Rowan, 1977) to facilitate survival as they participate in large-scale, public policy initiatives (Scott, 1995). Legitimacy is obtained as organizations align with rigid government regulations, professional discipline norms, and socially expected standards of interaction and behavior (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). As legitimacy is a founding requirement for obtaining resources (DiMaggio & Powell, 1983), organizations engaged in similar practices, such as mental health services, seek to mirror one another, creating institutional isomorphism (DiMaggio & Powell, 1983). This results in standard-reinforcing, normative processes with individuals in the same professional discipline or those engaged in the same type of service industry (Scott, 1995), processes that govern behavior and create frameworks by which individual clinicians within an agency interpret both their work and workplace (Scott, 1995). These compounding processes generate mental health professionals who are socialized through professional disciplines to comport in a normalized fashion, where Whiteness is privileged (Kolivoski et al., 2014), that functions "appropriately" in any mental health center. Theoretically, this socialization process assists in the implementation of policy initiatives and EBPs at the agency level, creating processes to normalize a standardized clinical practice that is embedded within White and institutionally racist systems (Wagari Walter et al., 2017).

In a similar vein, RDT also focuses on an agency's quest for survival. However, RDT focuses more than IT on the agency's response to external elements that attempt to control the organization's existence (Garrow & Hasenfeld, 2010; Oliver, 1991). For example, in this

theoretical perspective, agencies comply with Medicaid requirements to receive payment (Garrow & Hasenfeld, 2010). Yet, inherent in the receiving of the funds from external sources is also the agency attempts to maintain as much autonomy as possible (Garrow & Hasenfeld, 2010). There are several strategies utilized by organizations to reduce the influence of others to promote survival, such as mergers, joint ventures, relationships through the board of directors, political action, and executive succession (Hillman, Withers, & Collins, 2009; Pfeffer & Salancik, 1978). RDT argues that an organization is continually negotiating autonomy for resources with their external environment. Implementation science utilizes RDT to bring forth significant ideas concerning the external policy system, financing system, and leadership factors (Aarons et al., 2011; Raghavan, Bright, & Shadoin, 2008) during the process to enhance viability and longevity of a large-scale implementation project.

Collectively, implementation science, RDT, and IT suggest that agencies that are in the same line of business with the same funding streams would use similar strategies to attend to regulatory and financial constraints placed on them by the government funder. However, silence on matters of race or difference within implementation science, IT, and RDT implies a colorblind framework (Kolivoski, Weaver, & Constance-Huggins, 2014). Although RDT discusses powers external to the agency (e.g., government and funding opportunities) that limit and constrain agencies and motivate acts of self-preservation, IT is quiet on all matters of power and oppression (Lok, 2017; Willmott, 2015), and neither engage in discussions of race or institutional racism. Additionally, among implementation science studies, race and ethnicity for clinicians are often described in the demographic section but never utilized within the analysis, and the racial and cultural identity of agencies within large metropolitan areas is never addressed as a potentially relevant variable for implementation (Aarons et al., 2016; Beidas et al., 2016; Brookman-Frazee et al., 2016).

Implementation science, IT, and RDT, therefore, carry forth universalistic ideologies that do not address the role and influence of race and culture. Assuming that institutions all want to look similar or that there is uniformity in how an agency carries out its mission unaffected by the forces external to the organization, such as racism or gender oppression, ignores an awareness of how cultural differences in problem-solving and communication patterns contribute to organizational processes and organizational culture (Foldy & Buckley, 2014). As demonstrated in a case study investigating accountability within four Latino agencies, the authors found that culturally based non-profits have unique understandings of how to show accountability to their communities and how to demonstrate legitimacy with the public (Ospina, Diaz & O'Sullivan, 2002). These agencies often intertwined service delivery and advocacy and were created by and for the community (Ospina et al., 2002). These differences in accountability and sense of legitimacy, have been shown to alter communication patterns with funders and community partners (Ospina et al., 2002). Meanwhile, government and professional institutions are in the process of discovering how systemic racism has created structural bias and disparate health outcomes, and has limited the voice of cultural and ethnic minority communities (King County, n.d.; DHS, n.d.; Wangari Walter et al., 2017). Government and private funders are moving towards equity models in attempts to dismantle long-standing, disparate health outcomes and discrimination within large institutions (Braveman, Arkin, Orleans,Proctor, & Plough, 2017; City of Portland, n.d.). While there is substantial movement within the private and public sectors towards using grant funds to promote equity, there has been little research into uncovering how culturally based agencies interact with large institutions and what kind of additional or alternate resources they may need during program implementation. These realities (in combination with implementation science, IT, and RDT's undertheorizing the influences of race and ethnicity in how organizations function, implement policies, and interact with external environments) indicate a substantial gap within the current research literature.

State Infrastructure Development Programming

Implementation science, IT, and RDT concepts have been used to explore inner and outer contextual factors affecting implementation within rigorous investigations of large state-system programs. These studies have clarified the importance of stakeholder engagement and communication (Beidas et al., 2016; Southam-Gerow et al., 2014), clinician engagement (Nadeem, Weiss, Olin, Hoagwood, & Horwitz, 2016), internal agency organizational climate (Skriner et al., 2017), and leadership engagement (Stewart et al., 2017) in successful implementation and sustainability. For example large-scale, state-funded infrastructure projects in Los Angeles County (Brookman-Frazee et al., 2016; Southam-Gerow et al., 2014) demonstrated how clinician adoption and utilization rate of EBPs are tracked through insurance claim data (Brookman-Frazee et al., 2016) as well as modeling EBP training methods to enhance sustainability within agencies over time (Southam-Gerow et al., 2014). The city of Philadelphia (Beidas et al., 2016; Powell et al., 2017; Skriner et al., 2017; Stewart et al., 2017) project has demonstrated that clinicians employed in agencies with higher levels of transformational leadership had greater knowledge of EBPs; meanwhile clinicians with more resistant cultures and higher rates of financial rewards for EBPs had less knowledge of EBPs (Powell et al, 2017). In addition, potential threats to implementation sustainability included mental health center financial stability and turnover (Beidas et al., 2016), and barriers to engagement with EBP models resulted from lack of leadership awareness (Stewart et al., 2017). In Illinois, a statewide EBP initiative demonstrated that a multi-level approach was critical for system change, including policy changes, stakeholder education, and clinician training (Starin et al., 2014). Clinician drop-out rates and the merits of learning collaboratives (Nadeem et al., 2016; Olin et al., 2016) were assessed within New York's EBP initiative, and the findings demonstrated that younger clinicians and those in rural areas were less likely to drop out from EBP training models (Olin et al., 2015) and that learning collaboratives facilitated engagement and longer tenure in training programs (Nadeem et al., 2016). Last, Washington State used a geographic information

system approach to identify service need gaps for training and adoption in EBP implementation (Walker, Hurvitz, Leith, Rodriguez, & Endler, 2016).

These studies have contributed to knowledge concerning clinician, agency, and state system factors that influence the inner and outer contexts during the implementation process (Aarons et al., 2011). However, they are all silent on issues of cultural and racial identity and assume a homogenized understanding of the implementing agencies. In fact, in the few instances when clinician race is indicated (Powell et al., 2017; Skinner et al., 2017), it is not incorporated into the analysis or used as a factor to assess for adoption or sustainability of EBPs in clinician practice. To date, none of the studies investigating policy or EBP adoption have focused on how race or ethnic identification of clinician or agency affected implementation processes.

Minnesota CEMIG Program

In comparison with the previous studies discussed above, the CEMIG program is an excellent vehicle for investigating contextual factors of implementation with clinicians and agencies that have a strong racial and ethnic minority identity. CEMIG is a product of the 2007 Governor's Mental Health Initiative in the State of Minnesota (DHS, 2006). This mental health initiative, combined with federal parity legislation such as the 1996 Mental Health Parity Act and the 2008 Mental Health Parity and Addiction Equity Act (Center for Medicare and Medicaid Services [CMSa], n.d.), sought to build infrastructure within mental health providers and transfer ongoing financial support of the industry to health insurance companies for payment. In order to facilitate the transfer of financial responsibility to the health insurance system, agencies needed to create internal billing systems, comply with insurance record-keeping practices, and meet provider credentialing standards, including but not limited to mental health professional licensure.

To assist agencies in developing their internal infrastructure, the CEMIG program financially supported supervision and training efforts, therapy services for individuals who were uninsured or underinsured, and technology required to facilitate third-party (insurance) billing. Many agencies that received this funding were first-time recipients of grants from DHS, Mental Health Division. Grantee agencies ranged widely in size, years of operation, tax status, and internal structures. As this grant program targeted the cultural and ethnic minority communities in Minnesota, the program selected respondents who demonstrated a consistent track record of being embedded in immigrant, Native, or Black communities. Further, the grant offered a unique opportunity to see how cultural identification, source of legitimacy, and professional norms interplay with strategies to obtain financial resources as agencies interact and comply with CEMIG requirements and other DHS regulatory functions.

Purpose of the Study

This purpose of this study is to explore how culturally based agencies undertake their program implementation of a large-scale, state infrastructure program and the unique barriers or opportunities available. This paper seeks to expand the understanding of institutional, resource dependence, and implementation theory by broadening the conversation to include agencies that have a strong racial and ethnic identification. The target audience of this paper is state agencies and large, grant funding organizations that partner with culturally based grassroots mental health agencies as they implement grant-funded or EBP programs.

Methods

Study Context

This study focuses on CEMIG grantees from the years 2007 through 2016. During that time, 21 agencies received $8.83 million in grant funds that supported supervision, training, and licensure supports for 281 individuals (Aby, 2018). The original implementation study was funded by the Minnesota's Department of Human Services (DHS) to evaluate the efficacy of the

CEMIG grant program. In the process of analyzing data to answer questions surrounding DHS's role in the implementation of the CEMIG program, grantee organizational differences were noted, such as the capacity and types of support needed by grantee agencies. As such, this study further examines CEMIG grant documents and the interview transcripts of grant-recipients' program managers to understand the experiences of grant agencies better as they navigated CEMIG implementation and state contracting requirements. This study investigates the mezzo-level experience of the CEMIG program; two other concurrent studies that are papers 1 and 3 of this dissertation focused on the micro and macro perspectives.

Sample and Data Collection

For this study, both grant documents and interview transcripts were examined to better understand the agency-level experience during the implementation of the CEMIG grant program. All available CEMIG documents were collected in June 2017, including RFPs, RFP responses, grant contracts, grant renewal proposals, grantee reporting data submitted to DHS, and proposed and reported budget information. Participant recruitment and interviews took place in two phases. In the first phase, 17 interviews were conducted with 22 participants in fall 2017. The second phase of recruitment yielded an additional interview in fall 2018, resulting in 18 transcripts. Current and former DHS grant program administrators, agency grant managers, and Minnesota behavioral health board representatives were contacted to participate in the implementation study. Thirteen of the 20 current or former agency grant managers elected to participate during the first phase. Several of the grant managers were unavailable due to retirement, changing positions/agencies, or DHS not having up-to-date contact information. Two representatives from the four behavioral health boards in the State of Minnesota agreed to participate in the study.

All potential participants were contacted via workplace emails or social media (LinkedIn or Facebook) messaging services inviting them to participate in a study examining the

implementation of the CEMIG program. When possible, follow-up phone calls to solicit study participation were made a week after the initial invitation email. Interviews were scheduled at the time of the participants' choice, with several occurring over the telephone due to geography limitations of the researcher. Recruitment resulted in 22 participants in 17 interview sessions (two grant agency interviews included multiple participants) in the first phase. Among this sample were 9 immigrants, 4 Asian Americans, 1 Native American, 3 Latinos, 3 Africans, and 11 European Americans. Five study participants had dual perspectives because they had been clinical trainees within the grant program before advancing to other positions, such as a grant manager or DHS administrator (Table 2.1).

Table 2.1:
Sampling Table and Participant Demographics

Race	DHS Administrator	Grant Manager	Mental Health Board Representatives
African or African American	3	2	
European American	3	5	2
Native American		1	
Latino		2	
Asian American	1	3	

Interview sessions lasted approximately 60 minutes using a semi-structured interview guide, and each participant signed an informed consent form before the interview. Interviews were mostly conducted in the participant's office or conference room; three interviews were conducted via the phone. Each interview session was digitally recorded, and professionally transcribed into a Microsoft Word document and reviewed for accuracy. The interview transcripts were then indexed with the grant documents within Dedoose (SocioCultural Research Consultants, 2018). As interview questions were based on implementation literature (Aarons et al., 2011; Raghavan et al., 2008) and focused on the implementation and delivery of the CEMIG program (Table 2.2), additional theoretical purposive sampling (Padgett, 2008), along with an expansion of the interview guide, took place to facilitate inductive analytic expansion development (Padgett, 2008). Theoretical purposive sampling, phase two of recruitment and interviewing, was conducted through an inductively derived process to explore themes created during the secondary data analysis process necessary to answer these research questions (Padgett, 2008). Five agency grant managers, who were unavailable during the

original recruitment period, were re-contacted during phase two, yielding one additional African American participant, who was interviewed to explore agency characteristics; this interview was conducted via video conferencing in fall 2018.

Table 2.2:
Sample Interview Questions

Sample Interview Questions	*Could you describe your agency's process in applying for CEMIG funding? How did you determine you met criteria for the grant? How did you build your proposal?* *What were the key factors in your agency that made applying for the CEMIG program possible? (e.g., organizational characteristics, culture, leadership, values, and connection to RFP language of legitimacy)* *Could you describe your agency's process of implementing the CEMIG contract? What was the program? How did it function?* *What was your interaction like with your State grant manager during your CEMIG contract? How often did you interact?* *Have your agency's processes changed because of the CEMIG program? (like billing insurance, contracting, service programs)* *Did you have to create new infrastructure to attend to the grant requirements?* *Did your agency have difficulties meeting the grant contract deliverables? If you did, how was that handled by the State?*

Data Analysis

The data sources for this multistage case study (Stake, 2005) were varied to develop ideas of replication and convergence (Gilgun, 1994; Palinkas et al., 2015). This paper includes an analysis of CEMIG grant documents, including the RFP responses, progress statements, and proposals to extend funding, which highlight implementation processes and infrastructure development throughout the grant period. The first stage of data analysis included a content analysis of the organizational characteristics of grantee agencies. Specifically, a grid of the grantee agencies was developed to collate information concerning staff number, annual budget, population served, clinic certifications, and other available infrastructure information. This grid

assisted in clarifying the similarities and differences in agency characteristics that may have contributed to grant program implementation.

All documents and interview transcripts were uploaded to the Dedoose system, which facilitated the following round of coding and theme generation (SocioCultural Research Consultants, 2018). The second stage of analysis, using process and provisional coding, included the first cycle of coding of the interviews and grant documents (Saldaña, 2016). Provisional codes stemmed from organizational culture and institutional theory literature. Code mapping (Miles, Huberman, & Saldaña, 2014) was used to organize the codes and generate themes. Throughout this process, several strategies were employed to seek negative case analysis (Gilgun, 2015), which contributed to theory exploration and development (Gilgun, 2015). Finally, theoretical coding (Saldaña, 2016) was used to integrate and synthesize categories and analysis for theory building (Saldaña, 2016).

To enhance and secure credibility, transferability, auditability, and confirmability the following steps occurred: peer debriefing, memoing, negative case analysis, data triangulation, and member checking, all of which contribute to the rigor (Morse, 2015) of this study. Peer debriefing, as well as consultation with a supervisory committee (Wu, Wyant, & Fraser, 2016), assisted in thinking through research strategies and theme generation. Memoing throughout the process created an audit trail of analytical steps and processes utilized to collect and analyze data (Gilgun, 2015; Wu et al., 2016). Negative case analysis was used during the theory building process (Gilgun, 2015) to test concepts and check the veracity of the emerging analysis (Gilgun, 2015). Data triangulation was employed with the addition of information garnered from the second-phase additional grant manager's interview (Wu et al., 2016). Lastly, the member checking process was conducted through theoretical purposive sampling during the secondary data analysis (Padgett, 2008). This approach assists with trustworthiness and credibility while clarifying themes and ideas with the additional study participants.

Reflexivity

There are numerous ways in which I have interacted with this grant program and clinical licensure within the State of Minnesota. I am a European American female and licensed to practice clinical social work in both Minnesota and Washington states. As I was a DHS administrator for this grant during the Children's Mental Health 2011-2013 cycle, I could have been a participant in this study. I interviewed former coworkers and colleagues with whom I had worked in my capacity as DHS administrator. I chose not to include an interview with myself to limit my voice and perspective within this study's findings. My previous experiences in my role as a clinical social worker, employment at DHS, and relationships with the study participants could have altered responses provided by participants and influenced my understanding of the research process (Finlay, 2002); to account for potential bias, I engaged in memoing, peer debriefing, and member checking.

Findings

The findings are separated into two sections. In the first section, CEMIG agencies are classified according to commonalities and differences found within their agency documents, websites, and program material that demonstrate how they positioned themselves as legitimate applicants for the CEMIG grant program. The second section discusses how grantee agencies experienced the CEMIG program implementation and how that varied based on how they described their identification of legitimacy. Data collected from agency representatives regarding data reporting and grant management, invoicing and billing, and communication with DHS staff generated three larger themes that will be discussed below, including (1) cost of racism, (2) bending and stretching, and (3) different race to run. For clarity and anonymity, quotations are altered as needed; phrases of speech, identifying information, and names of others have been omitted in quotes, whereas other clarifying data has been added to generalize localized information or terms. No alteration has been made to the meaning or context of the

quotations below. Participants have been given pseudonyms to assist with readability while maintaining anonymity.

Agency Types

Twenty-one agencies received funding from the CEMIG program from 2007 through 2016. Grantees ranged from well-established, endowed clinics with annual budgets of over $24.5 million that are nationally known for providing psychotherapy and rehabilitative services for children and adults to small, independently owned and operated limited liability companies that employ fewer than 20 people and have no web presence. How agencies differentiated themselves and attempted to establish legitimacy and merit for receiving grant funds were separated into four categories: (a) Sovereign Agencies, (b) Legacy Agencies, (c) Transitional Agencies, and (d) Grassroots Community-Based Agencies. As described in Table 2.3, CEMIG grantee agency types were determined utilizing legitimacy, annual budget, financial stability, clinic licenses or certifications, organizational structure, and mission statement.

Table 2.3:
CEMIG Agency Types

	Sovereign agencies (2)	**Legacy agencies (5)**	**Transitional agencies (5)**	**Grassroots community-based agencies (9)**
Assertion of legitimacy	Tribal Nation (Indian Health Service or service provider through the Tribe)	Bureaucratic structure (comprehensive service continuum)	Endorsements by Others (agencies transitioning from grassroots to legacy or new to mental health services/specializing with cultural communities)	Endorsements from the Community
Annual budget	Undisclosed (Tribal Sovereignty)	$10 million +	$2 million-$10 million	< $2 million
Financial stability	Funding embedded within Tribal government	Funding through contracts, grants, private donations, and insurance billing; healthy reserves (including foundations)	Funding through local county contracts, some private grants, insurance billing	Tenuous finances; lack of reserves; LLC organizations; multiple joint ventures and partnerships
Clinic license or certification	Contracting with CMS through Public Law 93-638. Certification to provide case management and rehabilitative services for children and adults	Mental health center licensure; certification to provide case management, rehabilitative services; and a continuum of care, including day treatment, school-based services, residential and/or	A mixture of mental health center licensure, rehabilitative services certification, or large contracts in housing, chemical dependency services, or other highly regulated industry	Range of certifications to provide rehabilitative services, peer recovery support services, or no previous interactions with state bureaucracy

		intensive community-based services		
Organizational structure	Larger bureaucratic structure with grant writers, administrative departments, and legal representation through the Tribal Nation	Grant writers, data managers, robust administrative departments	Administrative personnel including grant management, billing, and accounting	Minimal administrative infrastructure, executive director fills gaps in the structure
Relationship to DHS	History of grants with DHS through the Behavioral Health Division. Specialized technical assistance staff within the Behavioral Health Division for Tribal providers	History of grants, minimal interaction preferred with DHS, multiple licenses and certifications	Seeking mentoring and relationship building with DHS, minimal experience with DHS grants	Lack of previous relationship with DHS, adversarial on some points, seeking infrastructure building technical assistance
Mission statement	Focus on providing services for Tribal member and individuals living within tribal jurisdictions	Broader mission and vision statements seeking promotion of overall well-being and support	Broader mission for general well-being for a culturally specific population or targeting at-risk, impoverished communities	Focus on social justice for culturally specific populations

Note. CEMIG = Cultural and Ethnic Minority Infrastructure Grant; LLC = limited liability company; CMS = Center for Medicare and Medicaid Services; DHS = Department of Human Services.

Sovereign agencies established their legitimacy upfront within the RFP process through their status as Indian Health Services or Tribal Nation providers of mental health services. Each Tribal Nation within the state of Minnesota offers mental health and chemical health services to their Tribal members; these Tribal endorsed providers can bill Medicaid at the encounter rate through their Tribal 638 Facility status (DHS, 2017). Encounter billing, in combination with being a part of the Tribal Nation service system, provides an additional layer of financial stability and bureaucratic structure for the providers. As a sovereign agency describes financial connections with various levels of government within the RFP: "currently the program receives funding through the State Indian Federal Block Grant, Purchase Service Agreement with [the local] county, Indian Health Service and Third Party Reimbursement dollars." Tribal Nations mental health providers have a long history of interaction with DHS that have created "strong collaborative relationships with tribal, county, and state agencies," partly because the department has technical advisors designated to serve tribal communities.

Legacy agencies identified their legitimacy through their bureaucratic structure, long tenure of receiving DHS grants, and history of outcome reporting. These clinics, often nested within the agency's larger social service continuum, have existed in Minnesota since the late 1800s or early 1900s. Legacy agencies have budgets of more than $10 million with diverse funding sources. Over the past few years, as the social service system has changed, legacy agencies have merged and gotten larger, creating more bureaucracy that includes development departments targeting government, private foundation, and individual donation resources. Legacy agencies are mental health centers licensed by the state and have certifications to provide both children's and adults' rehabilitative mental health services and consequently receive higher reimbursement for Medicaid services. These agencies, primarily known for providing mental health or community social services, were not established by or for people of

color; however, due to their large catchment populations, some have generated culturally specific programs. As demonstrated in grant outcome data, whereas legacy agencies that did not have culturally specific training had trouble maintaining staff of color and maximizing CEMIG program funds, those that did demonstrated great success with training clinicians and assisting them in getting licensed as mental health professionals and clinical supervisors.

Table 2.4:
Legacy Agency Outcomes

Legacy Agency	**Proposed Number of Clinical Trainees**	**Actual Number of Clinical Trainees**
Legacy A	15	6
Legacy B	22	6
Legacy C	6	8
Legacy D **	68	78
Legacy E **	110	89

**Created internal institute to support clinical trainees of color

Transitional agencies tended to be midsized agencies run by persons of color with culturally specific services or White-run agencies that were attempting to branch into either mental health services or specific programming targeting communities of color. Some transitional agencies are licensed as mental health centers, conform to the same administrative regulations, and receive the same higher reimbursement level as legacy agencies. However, there is a reliance on an external source to validate competence, which they do not feel is obtained on their own or with adherence to state regulations. The types of endorsements were varied: One agency reported that they were one of the "Top 25 Employers" in the area, and another cited an endorsement by Oprah, but most referenced how they were a part of the Cultural Providers Network or a local county children's mental health collaboratives as a way to indicate they were trustworthy in responding to cultural community needs. Within RFP

applications, culturally specific agencies described endorsements from White institutions, such as newspapers or government officials, whereas White agencies leaned on statements from and membership to cultural brokers and agencies. These agencies generally had budgets ranging from $2 million to just under $10 million. The midsized White agencies that are branching into culturally specific services with the grant funding encountered a similar problem to their legacy agency peers: CEMIG training programs were difficult to maintain unless they became a prime area of business for the agency. For example, an agency that hired one or two clinicians to deliver culturally specific therapy to the children in the shelter was less likely to finish its contract than the agency that developed an EBP therapy model for cultural populations that was embedded within the agency. Grant documents from a transitional agency described how funds were underspent because their referral system had not been prepared for the new service:

> We encountered difficulties in the amount and frequency of referrals made to the program. This was perplexing to us, as we knew the need for the service existed at a very high rate of incidence and the numbers of children programs enrolled were very high. After careful analysis we discovered a few surprising issues. First, the teachers working within the [education program] and in the area school district partners shared with us that they were not making frequent referrals as they were not accustomed to having such a referral source and in the past have exhausted all of the resources and expertise in their own programs prior to making a children's mental health referral.

As the program was not embedded in their agency's system, it was often overlooked; money was left unspent and proposed outcomes were not achieved.

Those in the last category of CEMIG agency reported their legitimacy through cultural connections with the community. These agencies described themselves as more "grassroots," founded within the past 20 years, and developed with a multicultural or specific cultural set of values. All these agencies have a mission statement that is tied to immigrant status or specific cultural group identity. These grassroots agencies are generally first responders to the community around them after police shootings, gang fights, and natural disasters. Imani, an African American grant manager, described how her grassroots agency receives referrals directly from the community:

> They come from churches. They come from schools. They come from organizations. Even some gang members have referred people from the gang over here to our office to get help, especially when they were dealing with their own grief and loss and it was affecting them.

Additionally, another agency specifically started a mental health program in response to the I-35 bridge collapse in 2007. These agencies were small, had about 20 to 30 employees, and often have contracted hourly rather than full-time positions. Grassroots, community-based agencies were often first-time grantees with DHS, and sometimes this was their first grant with any funder. These agencies tended to have budgets of under a million dollars per year; finances were often stretched tight, and Medicaid was the primary or only source of revenue for the clinic.

Finally, during the tenure of the grant, five of these small grassroots, community-based agencies went out of business. For instance, within the first year, a grassroots Latino agency closed without notice, and another agency found themselves in financial and legal trouble after partnering with a seedy management group. Cindy, a DHS administrator, described her process of trying to do a fiscal review:

> I go to get the financial records, very simple to just check payroll. There's just a few people, very simple, should just have a sheet of paper, [a] couple of things, couple of paychecks, I'd be good. I'd be out of there. Because this was not an audit…I started asking questions. I couldn't get answers. Then I find out that they really didn't do any of their own books, that this other organization did the books. And they were kind of a pass through…the agency that was supposed to be renting their building had not paid their rent in two months and was evicting them. [DHS had] been paying [the agency] who turned it over to this [other] agency who then did not pay…[DHS] had a bad contract because [the legal papers] didn't exist. They hadn't even filed the papers – this organization didn't exist anywhere other than someone opened a door and named it.

The dual role of both financially running a mental health agency and clinically supporting clients was often tricky for CEMIG grantees that were grassroots and culturally based. The agencies had complicated financial agreements with vendors for billing and accounting practices. Reports of difficulties maintaining payroll were not rare. These grassroots agencies were very connected to their communities but lacked financial resources or stability.

Experience of CEMIG Program Implementation

Agency grant managers who described their experience implementing the grant came from all types of agencies described above. One sovereign, two legacy, one transitional, and four grassroots, culturally based agencies, which comprise 14 individual participants, contributed to these findings. Specific names of agencies are omitted to protect anonymity.

Whereas the CEMIG program was created to support building infrastructure within culturally specific mental health services in the state of Minnesota, there was a rift between legacy and culturally specific grassroots agencies from the beginning. Grassroots agencies voiced feeling like they were in the shadows of legacy agencies for funding and resources. Meanwhile, legacy agencies argued that they were more efficient than grassroots agencies and could better spend the dollars to achieve the primary goal of the grant funds. For instance, during an interview with Mai, a manager of a legacy agency expressed:

> We want to have a stronger workforce and we want to have people licensed and trained.... I think that they [DHS] have a desire to build the capacity of smaller firms to train. Those almost don't go hand in hand—because we had the infrastructure that we do, we can take a small dollar amount and extremely efficiently train and license people and build a workforce. But on the other hand, if their goal is to build an infrastructure where it does not exist, it's not going to be a very efficient use of funds.... [Is] the goal to get as many people licensed as we can and in the workforce? Or is the goal to build the capacity within organizations who don't have it?

This bifurcation of goals within the CEMIG program created a system where the legacy, sovereign, and transitional agencies experienced DHS involvement, grant management, and program implementation differently from culturally based grassroots agencies. However, agency grant managers, regardless of agency type and size, universally described the mental health system as financially precarious, especially for providers of color, because of the low insurance reimbursement and lack of funding for staff time when clients failed to attend appointments. To counter the lack of control, agencies attempted to maintain survival without losing their sense of self, described in the following ways: the cost of racism, bending and stretching, and a different race to run.

Cost of Racism.

Most agency grant managers, regardless of their type, discussed "systemic racism and biases [that] continue to create barriers for us to run the race." This systemic bias was discussed in three ways: client/practitioner, agency access, and power relationships. Tim, a legacy agency manager, described the financial reality of the mental health system primarily stemmed from poor reimbursement rates: "The barrier for a lot of us is still financial. The [Medicaid] rates aren't really getting any better." Tim further asserted that financial difficulties were compounded in mostly White Minnesota due to racism, especially for a general-population clinic:

> I had staff who would turn over more clients, and there's really no way to support that work if you come in and you get all the clients that reject you—because they know you or because your language is different. The cost on the agency just seems to be raising. There's a financial cost to [a mental health clinic] for client-based racism. Like if a client has an assumption about what Muslim people are like based on all of the stuff that's going on, that they're probably going to say, 'Well, I don't want to work with this Muslim person,' but they're not going to say, 'I don't want to work with you because you're Muslim.' They're just not going to show up again.

Beyond having difficulty with client turnover, legacy agencies also discussed the need to provide more supervision and support for their practitioners of color who were exhausted by the racism of their clients, being the only person of color on their team, and the stress of having to take the licensure exam multiple times. Due to the inability to bill insurance for supervision time, the CEMIG grant was a crucial way to help buffer both the agency's and the provider's heightened support requirements.

Grassroots agency grant managers also described the Medicaid rate structure, based on infrastructure, as systemically racist. In a list of 67 mental health centers in the state, only four have culturally specific or identified programming. This distinction affects agencies in two ways: payments and grant access. In Minnesota, certified mental health centers receive a substantial increase in fee-for-service payments for psychotherapy services. If an agency complies with all of the documentation, staffing, infrastructure, and clinical meeting requirements, Medicaid pays

$127 for a 60-min family psychotherapy session, yet only $99 if you do not have the clinic certification. The dilemma with this payment structure is whether the mental health center rules require adherence to a structure that is not culturally appropriate for a non-White client population or a non-White agency. Imani, representing the grass-roots agency perspective voiced ambivalence with the isomorphic expectations of therapy and mental health clinic norms:

> Therapy is a White structured…mechanism. But I find ways to be translational and how to meet the requirements but do it in a way that's culturally congruent. One of the things with [mental health center certification] is particularly around the record keeping and…around the hierarchical nature of the way the clinic has to be. But it's also affiliated with higher pay.

Imani furthered, arguing there was a desire to translate the regulations into more culturally appropriate structures: "It would be really helpful if we got [mental health center certification] to have the ability to be bicultural, bilingual—translating…language into our everyday practices." Rules and regulations created in the mirror of legacy agencies seemed to be in a different language that required substantial interpretation to fit. Grassroots agencies argued the Medicaid rules discriminated against non-conforming, non-isomorphic agencies that wanted to be more culturally based and fluid in power structures, which created a systemic barrier to higher Medicaid reimbursement rates and economic stability.

The second way that being a certified mental health center affects agency financial health is through grant funding eligibility. Often DHS grants required applicants to have a mental health center license or be certified to provide rehabilitative services. Connecting Medicaid payment and access to funds with clinic type and certification status was a way that grassroots grant managers stated they experienced exclusion in a culturally based manner: "When they have grant requirements that say you have to have [a mental health center license], they're automatically telling us we can't participate." However, due to the differences in reimbursement funding, grassroots, culturally based agencies did not have mental health clinic status through the state; hence, they reported feeling more dependent on the grant funds to help subsidize their

clinic. This lack of diversity in their funding stream, a result of unequal access, created a stronger reliance on the few grants they were able to acquire.

The DHS administrators were tasked mid-contract period with the responsibility to trace grant funds in the financial reporting (including payroll, audits, and bank statements), the grassroots agencies described feeling like there was a substantial relationship cost in meeting the new state expectation of financial reconciliation of their budget. The reconciliation process caused substantial difficulties for multiple agencies, mainly because many subcontract financial and insurance billing services. Tavo, a grassroots agency founder, reported how he experienced this financial review:

> But if we had known this from the beginning, we'd be able to structure it. And it would be easier for them and us. And so that type of technical thing is very important. And we have to be able to tell the accountant there that this is for [the] grant. And sometime, they may not code it that way because it's still the same checking account. And when you deposit that, when you send them – they just look at what you put down. I mean, accountant is garbage in, garbage out. And so, I don't have to explain it, but I'm just saying, some agenc[ies] just don't have what it takes, unless they are given some [technical assistance]. I think that's an assumption—an assumption goes all across—assumption that if you have a business, you should be able to do this.

This grant manager felt caught in the middle between the state's request and his accountant's process. The DHS rule change demonstrates a power difference that they can exert at any time. Tavo continues to voice concern that his smaller, more entrepreneurial agency is being targeted and disrespected:

> But I don't want to be held accountable for [a] thing that I feel is really suspicious. Do you do that to other foundations? Do you do that to this or that organization? …I know two agenc[ies] had to be let go because of the same way that—and when you do that, it's a loss to that community. They need to be more trusted. They need to walk people through the system, and give people benefit of [the] doubt.

Tavo reports feeling like agencies, are treated differently on the basis of their type. He also hypothesized that other agencies have had contracts end due to bias and financial constraints. Tavo argued that grassroots, culturally based agencies were scrutinized more heavily and given

less leeway than legacy agencies, which, was not altogether untrue. Zahra, a DHS administrator, reflected that acquiring financial data varied widely and required more coaching at grassroots agencies than at legacy agencies:

> When I would go out, they didn't have any problem to talk about. They're just like [Legacy Agency D]. You'll go out there, their invoices, everything well-organized. Right. But you go to one other agency, and you're trying to ask a document. They can't even show you a bank statement that reflects…all that. So, we want to avoid that, whereby when you get there, that's when they're rambling to find the documents that you need. So, that's why I would go out to let them know, this is what I would expect.

The imposition of a new accounting requirement at the end of a contract period demonstrated exertion of power by DHS that fractured a relationship with grantees who experienced financial questions as a lack of trust, discrimination, and disrespect.

Bending and stretching.

Whereas legacy agencies announced that "this grant was much easier than other grants to try to manage" or that this grant was "probably the best one I've had with the state overall, I think things went really well," sovereign, transitional, and grassroots agencies voiced different experiences. RFPs, data reporting, and financial billing augmented the description provided by grant managers, as they described the varied experience for the grassroots agencies.

Legacy, sovereign, and transitional agencies generally have staff who are responsible and the capacity to research grant opportunities, write grants, and manage the needed data collection. A legacy grant manager, Chu, described how this infrastructure eases his burden: "because we have a program developer that will work alongside with us…is a luxury. I'm not sure if a smaller clinical program out there would have the same kind of assistance, but we are very fortunate." To be able to attend to all possible grant opportunities, the program developer and the program manager meet weekly for two hours. Chu described how the program developer collects all the information and gets input and approval from upper management; this creates a

smooth and efficient process. This system has been developed and refined over years, allowing the program manager to focus attention mostly on the program rather than funding.

Meanwhile, a participant from a grassroots agency described the grant-seeking process that developed each time, which might include "staying up without sleep for 4 days trying to answer questions that a grant writer could do in 2 minutes, takes 2 two hours." Support staff, supervisors, and supervisees provide initial feedback on the grant application. Within a grant re-application document, a small grassroots agency described their process:

> The second step was that individual calls were made to each supervisee requesting their input on the development of the budget as well as targeted interventions. Finally, two conference calls were scheduled during which staff members were paid for their time.

Because there was no specific individual tasked with grant writing as a primary responsibility, it became a collaborative opportunity for everyone to share in the work and development. This collective process caused the agency to bend and stretch; it was circular and took more time but was also much more inclusive of all voices at the agency.

The second way that the agencies described needing to bend and stretch during the implementation of the CEMIG program was in data managing and reporting. Legacy agencies again voiced that data reporting was simple. For instance, Mara, a legacy agency grant manager explained:

> I think one of the things that has made us a lasting grantee here is that we have somebody who we can dedicate to doing the data. It's not a small amount of data, and I think most of the grantees that we've spoken to have said it's an onerous process to constantly be chasing people.

The DHS data manager, Amelia, remembered that "we had so many problems trying to just get people to fill out the forms, and we made them very, very, very, very simple," which contradicted the current grassroots agencies assertion, "we had to bend and stretch a lot" to comply with the data requests. Zahra, a DHS administrator, reported that she would get panicked emails on the mornings that outcome data were due from grassroots agencies:

> And they were emailing me at 3:00 in the morning, "We just finished the data." And guess what? They did it on the wrong form. So, tell me, sometimes you see those emails, and then you're like, oh, my goodness, do I tell them, this is the wrong form? What do we do? Those are some of the challenges we see.

Besides sometimes filling out the wrong forms at or after deadlines, an African American grassroots agency described the barriers to accomplishing the data reporting requirements during a renewal request:

> One of our largest problems in this area involved being able to consistently administer and utilize outcome measures to inform our treatment process. At first, many clinicians saw the requirements to use the [measurements] as bothersome tasks required by the state. In addition, staff did not understand or value the measures that we were using. Many staff missed the initial trainings on the use of scales and supervisory staff failed to follow-up during weekly meetings…we have decided that we should also infuse better practice guidelines within our agency.

To comply with the DHS outcome requirements, Imani, a grassroots agency manager, described the many strategies, which stretched their capacity, including gift cards and raffles. For instance:

> Eventually, we developed a system to integrate the use and tracking of data on a weekly basis within our clinic by hiring an intake coordinator…. Clinicians are also asked during supervision to review their outcome data as a part of the treatment planning process.

These steps are then reviewed in the supervision of the supervisors to keep both responsible for missing data. This example is mirrored within a current transitional agency experience. A transitional agency manager, Teresa, voiced that when they got the grant around 10 years ago, "it was frustrating for me because I felt kind of on my own… Part of what we were doing with the grant was to build capacity [but]…we were so early in that process." However, the current grant manager, Diego, from the same agency stated that the data reporting was easy due to the electronic health record system that had been established in Year 1 of their CEMIG grant. Through the grant paying for electronic health records, requiring data, and enforcing DHS contract requirements, the agency stretched, and infrastructure developed.

Finally, agencies had to bend and stretch when attending to DHS financial systems. A common concern was that the contracts annually followed the state fiscal year, July 1 to June

30. This only became a problem during periods of renewal that required a new contract to be signed before work could be done or in 2011 when the state shut down due to an impasse between the legislature and the governor. Due to state bureaucratic issues, sometimes there was a 2- to a 4-month delay between contracts. For agencies that only had supervision training, the potential delay was manageable. It was especially feasible for legacy agencies that have substantial internal support, Mai reported that: "The foundation…provide[s] about 40% of the actual cost, and then the state would give us the other 60%." That allows for other funding to subsidize the agency when the state is slow in writing and renewing contracts. However, for agencies that used funds to pay for direct service costs for uninsured clients, this was unbearable. For instance, one agency manager from a grassroots agency stated:

> So there's a whole quarter gone by when we can't, and we're prohibited from doing grant-eligible services. So what happens to the kids that you're seeing in June who are without insurance? Ethically, morally, do you stop seeing them for 3 months? Do you refer them to another agency that you know is not a [culturally specific] agency for them to start over? Or do you see them for free? Which really, you can't afford.

The agencies with limited financial reserves were asked to bend and stretch between their ethics and their wallets due to the state contracting system.

Different race to run.

As discussed above, agency grant managers, particularly from grassroots agencies, feel like they are at a disadvantage compared with the legacy agencies, due to their infrastructure, DHS's bureaucratic system, and financial barriers. For instance, Imani, one grassroots manager described her experience of disparities on a professional or agency level:

> It's like the race is a mile, and our White colleagues have gone three-quarter mile and then we're at the starting line, and they tell us to catch up. That's what it feels like. So, if there's a way they can understand that and at least make the race fair or give us a different race to run—that's what I hope. I feel like we can catch up, because we know how to run fast, with heart.

With the issues of Medicaid reimbursement, difficulties with financial bookkeeping and lack of economic reserves, grassroots agencies were struggling to keep up in a system that did not recognize non-conforming, culturally based differences.

Transitional and grassroots agency managers seemed to go back and forth over whether they wanted to run a different race (maintain non-conforming ways) or were willing to run faster in the current one (in order to achieve financial stability). The primary way that agencies asserted interest in changing the rules was to provide a more culturally congruent method when billing for grant services. The Children's Mental Health grants had, for years, been fee-for-service. Each unit of supervision, psychotherapy, or training session had been submitted to the grant like a supplementary form of insurance. Fee-for-service billing assured the state that they were not paying for therapist salary time in addition to billing Medicaid for a unit of service. The supplementary form of insurance causes difficulties for grantees. Sovereign, transitional, and grassroots agencies stated that their grant billing and insurance billing systems were not integrated. Using the grant as a form of supplementary insurance was also not helpful for agencies because it could not buffer in cases where clients did not arrive for appointments. Both Diego and Dan, transitional agency managers, stated that "if [the next grant] is fee-for-service, probably it won't be a good fit for us." Agencies were not willing to apply for CEMIG funds that would only support services for uninsured individuals because then the grant lacked any other financial benefits and was incompatible with their system.

There was also a move to gain freedom from perceived shackles inherent in the standard procedures found within legacy agencies. One transitional agency relayed how they had built a relationship and financial agreement with a sovereign agency; this allowed the grassroots agency to bill for therapy services under the 638-facility encounter rate. The encounter rate is an all-inclusive, per-visit payment based on annual encounters for the agency, as well as total agency costs (CMSb, n.d.). Dan, the agency manager, described their new financial stability as

"absolutely a result of the encounter rate." He continued to describe the alternative: "If you look around, you see, I don't want to say it too pejoratively, but like, therapy factories. You have situations where you have 8 to 12 therapists who…need 30 hours of therapy a week to make it happen." Beyond arguing that their client population, inner-city Native Americans, did not regularly attend therapy on a fixed schedule, he asserted that their clinic wanted to attend to a family rather than individual clients. In a system that records an individual client, unit of service, and diagnosis code, their clinic wanted the financial freedom to serve the client system.

Whereas the previous agency was able to change the rules of the game with the encounter rate, staff at another grassroots agency decided to run faster by creating their own format for diagnostic assessments that aligns with Medicaid rules but focuses more on relationships and ecology. Their agency is "highly critical of insurance companies and the *DSM* [*Diagnostic and Statistical Manual of Mental Disorders*]." In order to feel true to their mission while "captur[ing] revenue that's available to us at the same time" they have developed "what we think is arguably a good replacement to the DSM." They criticize while creating their own replacement; they adhere to the dominant culture's standards while creating a protest document.

Finally, grassroots agencies do small and large things daily to have their spaces *feel* like they are engaged in a different race and maintaining their cultural identities. With actions ranging from having popcorn, drinks, and cocoa to addressing each other as brother and sister, grassroots agencies try to create spaces that let clients feel "like they're coming home." This creates an atmosphere where:

> Some of our clients, they come to the office early just to sit down and just be here and relax and just be among it. And even our clinicians, who most of them work here part time, work primarily at White agencies. They come into the office and they just say "phew." We have a welcoming spirit that involves libations, food, drink when people come—that's the way we do it culturally.

These steps create an organizational culture that is centered on ethnic and racial culture norms, rather than isomorphic mental health clinic norms. Although this does not change the race that the agency is running, it allows rest and reprieve to prepare for the next leg.

Discussion

This study contributes to the growing implementation literature on larger state infrastructure policies (Beidas et al., 2016; Brookman-Frazee et al., 2016; Powell et al., 2017; Skriner et al., 2017; Stewart et al., 2017) by focusing on the experience of culturally specific programming, staff, and agencies during the implementation of a statewide grant program. Grant managers discussed how their experiences in the implementation process, including grant writing, grant management, data reporting, and billing, differed according to their agency type and means of establishing legitimacy for the CEMIG program. Agencies differentiated themselves in the RFP stage as sovereign, legacy, transitional, or culturally based grassroots agencies. The findings demonstrate that agencies had a varied experience concerning the cost of discrimination, need to bend and stretch to meet DHS requirements, and desire to run a different race.

Adding to the broader institutional, resource dependence, and implementation theory conversation, this study brings the perspective of agencies run by and for individuals from cultural and ethnic minority populations. Traditionally, IT views that institutions will begin to look more isomorphic due to following the same regulations, professional disciplines, and standards of legitimacy (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). However, in this case study, sovereign and culturally based grassroots agencies specifically defined their legitimacy as *not* being isomorphic with the legacy agencies that have traditionally held grants and certifications with the government. They established legitimacy from their community rather than from an overseeing governmental bureaucratic structure. The RDT discusses how agencies

negotiate the acquisition of funds with their need to protect and maintain autonomy (Garrow & Hasenfeld, 2010; Oliver, 1991). This case study describes the strategic decisions made by agencies to turn down funding if it was fee-for-service, to create collaborative partnerships for billing purposes, and to advocate for DHS rules to be more culturally appropriate. Agency grant managers were specific that these decisions were not necessarily based on a need for autonomy but on cultural identity. To facilitate the agency's mission and maintain legitimacy with their population, agencies prioritized cultural identity over financial prosperity. Finally, in regard to implementation theory, this case study adds billing infrastructure, data collection methodology, financial stability, and cultural adaptations as additional inner contextual factors that may affect the deployment of a new policy or practice across a large-scale system with culturally based providers.

The findings of this case study demonstrate several potential strategies that state agencies can utilize to increase the involvement of sovereign, transitional, and culturally based grassroots agencies within larger state initiatives. As described by a legacy agency grant manager, a state agency needs to decide whether the mission of the program is to implement the policy or to create infrastructure where one does not currently exist. If it is the latter, there needs to be more technical assistance provided to the agencies who are new to EBPs, grant contracts, and data reporting. The state agency can initiate conversations with the culturally based agencies to create relevant processes that correspond with the mission of the agency and fit the needs of the client population while generating the data and outcomes required for the funding (Terrana, 2017). Besides technical assistance, the funder should also earmark funds to support the internal infrastructure development, as this is crucial for success and often not accounted for financially within the contracts (Never & de Leon, 2017).

Beyond fiscally supporting infrastructure development, it is important for state government systems to engage in dialogues that may uncover systemic biases that discriminate

against organizational partners who are not legacy agencies. Given that government funding is a significant source of income for social service providers (Ashley, 2014), it is incumbent on the institution with the power and resources to investigate systemic racism and hidden biases (Wangari Walter et al., 2017) that deny the weight and benefit of cultural differences. Color-blind policies that assume a standard type of agency or service structure ignore the reality that these structures were created to benefit and support whiteness (Kolivoski et al., 2014). As we move toward creating connection rather than distance across cultural groups (Foldy & Buckley, 2017), it is crucial that state agencies be honest about cultural differences and approach policymaking in a color-cognizant fashion (Foldy & Buckley, 2017). Several organizational resources can be made available to individuals working from a dominant identity position (Cray, 2017), such as committing to having diversity training, a culture of learning and development, and norms that encourage dialogue surrounding race (Cray, 2017). With these added steps, state agencies can bring a color-cognizant approach while addressing their hidden biases when revising Medicaid and clinic requirements to be inclusive of the needs of various cultural populations. These strategies would also be beneficial for implementers of large-scale EBPs within a state system.

Minnesota's CEMIG program is unique and avant-garde in its purpose. Even though there were differences in how agencies experienced the grant, all participants were emphatic that the program was beneficial and had contributed positively to the agency and clinical trainees. It is important to recognize that not all mental health agencies have similar structures, standards of legitimacy, or internal processes, which can vary significantly due to race and cultural identity as well as connection to a grassroots community (Ospina et al., 2002). Grassroots agencies may risk financial stability to maintain autonomy and accountability within their communities (Garrow & Hasenfeld, 2010; Ospina et al., 2002). These differences play a significant role in policy and program implementation; further research should explore how to tailor

implementation models with diverse agencies. Implementation can only be enhanced with funding internal infrastructure development processes and bringing color-cognizant approaches that address systemic racism and hidden biases to state policy making and grant programs.

Limitations

This study has several limitations. First, that data analyzed for this study comes from one state with one infrastructure development program with data and perspectives over 10 years. Moreover, although the sample was quite diverse, there was limited participation due to the broad time frame, retirements, and difficulties reaching individuals who had changed employers. There was also a lack of symmetry across agency type that agreed to participate in the interview process; some agencies were overrepresented in the sample group. My role as a former DHS administrator means those interview responses may have been affected by previous relationships. All of these factors may limit generalizability; however, the descriptive results that are given here correspond with other work that investigates concepts of legitimacy within culturally based agencies (Terrana, 2017) and provides interesting information to be tested further in larger multicultural implementation projects. Further research is warranted to uncover differences within implementation strategies among culturally based agencies when implementing the same intervention.

Conclusions

Disentangling how agencies identify their legitimacy has been a helpful exercise to uncover the differing experiences of participant agencies in the CEMIG program in the state of Minnesota. Agency managers, along with their grant documents, demonstrate how identity relates to seeking and tolerating rigid structures from funders. This information is beneficial for state policymakers and individuals wishing to create large-scale implementation processes with multicultural agencies. Revealing details of how agencies experience the cost of racism, attempts to bend and stretch to meet funder guidelines and ongoing practices of resistance to the dominant race can assist funders in understanding how contracts are practiced at the ground

level. Although further research is needed to determine how identity and legitimacy affect implementation of a single intervention across agencies, this study contributes much to the discussion of how state programs need to further discussions of color cognizance (Foldy & Buckley, 2014) in outreach, daily working practices, and funding mechanisms for agencies that do not identify as legacy agencies.

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IMPLEMENTING STATEWIDE PROGRAMS OUTSIDE OF A VACUUM: APPLYING THE POLICY ECOLOGY OF IMPLEMENTATION FRAMEWORK

Introduction

In the last few years, several large-scale, system-wide, Evidence-Based Practice (EBP) implementation initiatives in community mental health have been the subject of research inquiry. Even though these large-scale, system-wide implementation efforts have occurred within racially and ethnically diverse jurisdictions across the country, such as Los Angeles County (cf. Beidas et al., 2016; Brookmann-Frazee et al., 2016; Nadeem, Weiss, Olin, Hoagwood, & Horwitz, 2016; Olin et al., 2016; Powell et al., 2017; Skriner et al., 2017; Southam-Gerow et al., 2014; Walker, Hurvitz, Leith, Rodriguez, & Endler, 2016), the studies are silent on social and political factors, such as consumer advocacy, cultural competence, racial disparities, mental health stigma, competing legislative priorities, and workforce development initiatives (Raghavan, Bright, & Shadoin, 2008; So, McCord, & Kaminski, 2019).

Describing implementation in a vacuum ignores long-standing concerns from cultural and ethnic minority groups regarding systemic racism (Wangari Walter et al., 2017), hidden bias amongst clinicians, "clinical colonization" (Willging et al., 2012) and historical oppression and cultural trauma (Walker, Whitener, Trumpin, & Migliarni, 2015). Also, studies focus on a particular government initiative, ignoring potential competing or supporting legislation that can affect the implementation of large-scale, system-wide initiatives. Ignoring social and political contexts relevant to the implementation process perpetuates hidden bias within large systems by assuming that the needs of all clients and clinicians are the same (Wangari Walter et al., 2017) and that social structures (e.g., clinical licensure, education systems, and Medicaid regulations) apply equally across populations (Ford & Airhihenbuwa, 2010).

Recent literature investigating government-sponsored EBP system change has focused on individual clinicians, organizational characteristics, and policy issues (e.g., funding, contracting,

and collaborations) that contribute to the implementation process, and yet is silent on social factors (e.g., racial or socioeconomic issues of patients or clinicians, disparities, or historical trauma or oppression) and political factors (e.g., mental health board regulations, Medicaid policies, and competing government initiatives). Studies focused on individual clinicians have examined rates of adoption (Powell et al., 2017; Skriner et al., 2017) and drop-out (Olin et al., 2016), levels of adherence and training strategies (Nadeem et al., 2016; Southam-Gerow et al., 2014; Starin et al., 2014), and ongoing utilization (Brookman-Frazee et al., 2016). These are helpful to understand how clinicians incorporate EBPs into practice, but do not explain if there are disparate rates based on racial or cultural identity and are silent on issues outside of the clinical encounter or organizational level (Powell et al., 2017; Skriner et al., 2017). Research focusing on organizational characteristics in large system initiatives has demonstrated how EBP acquisition factors include clinician engagement strategies and agency stress levels (Skriner et al., 2017) as well as leadership views on EBPs (Stewart et al., 2017), but have not shed light on whether racism, mental health stigma, and/or agency cultural identity play a role in organizational culture and climate. In these studies, individual clinician and leadership demographics are listed, but never developed as a potential factor or attribute that could affect implementation processes and agency cultural identity is unexplored.

The studies that have investigated larger system factors (e.g., funding, contracting, and legislative support) highlighted the importance of the leadership in both the agency and higher levels of government when institutionalizing practices through funding, creating contracts, fostering ongoing collaboration and champions (Beidas et al., 2016); introducing new tools, such as geographic information systems to create equity in access across system locations (Walker et a., 2016); and describing the oft-competing needs in timing for policymakers and researchers with expertise in implementation of EBPs (Rubin et al., 2016). However, these studies have evaluated polity implementation in a vacuum, without examining competing or complementary government or insurance company initiatives that could significantly affect implementation.

For instance, while it is helpful to demonstrate strategies that can create needed infrastructure during implementation, there is little discussion of the effects of elections, funding cuts, or insurance authorization processes on implementation.

One potential analytic tool that helps uncover social and political factors, the Policy Ecology of Implementation (PEI) framework, was created to emphasize the role of the broader ecology in the implementation process (Raghavan et al., 2008). Using an ecological model, PEI views implementation in context with all of the systems that interact with an initiative (Raghavan et al., 2008). Often these systems within a large-scale, system-wide program include the individual clinical encounter, provider agency, government regulatory agency, graduate training programs, political institutions (e.g., mental health boards and legislation), and social issues (e.g., stigma and cultural factors). Using the PEI as a theoretical framework, this current study, nested within a larger mixed-method multi-case study (Stake, 2005), seeks to develop nuanced explanations of how external forces influence implementation at the state government, grant-making agency, and individual clinician levels. The research questions that guided this case analysis include:

1. How do social and political contexts (Raghavan et al., 2008; e.g., race and ethnicity, disproportionality, stigma, and mental health board regulations) influence or create barriers in the implementation process of a large-scale, system-wide program?

2. What are strategies within the policy ecology (social, political, agency, organizational, and clinical encounter levels) that help improve the implementation process of a large-scale, system-wide program?

Given the aforementioned knowledge gaps, this study examines Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program to understand better how political and social contexts promote and limit policy implementation at the state level. The CEMIG

program is a component of a larger infrastructure development initiative focused on access, quality, innovation, and accountability within Minnesota's public mental health system (Department of Human Services [DHS], 2006). The state of Minnesota allocated $8.86 million from 2008 through 2016 to fund 21 agencies in workforce development efforts, clinical and ancillary services, and EBP training for cultural and ethnic minority populations.

This study examines the perspectives and experiences of DHS grant administrators, agency grant managers, mental health board representatives, faculty in graduate clinical training programs, and cultural minority clinician advocacy group leaders regarding the social and political contexts of statewide program implementation. A greater understanding of how social and political factors are experienced at each level of the policy ecology is crucial, as these perspectives are rarely discussed within implementation literature. Addressing systemic racism and hidden biases within implementation processes are needed and can assist in future large-scale, system-wide projects with multicultural populations. After a brief overview of the PEI framework, methods (including the study context) will be described, followed by the research methodology, findings, and implications for future practice.

Policy Ecology of Implementation Framework

The PEI framework focuses on the ecology surrounding the individual clinical encounter using an EBP (Raghavan et al., 2008). PEI addresses the multiple contexts that influence therapy provision: the organizational (enhanced reimbursement, training and continuing education units), agency (contracts and bids, insurance payment systems, outcome assessments), political (legislation, parity laws, loan forgiveness, elimination of structural stigma, consumer involvement), and social (stigma; Raghavan et al., 2008). The PEI framework focuses on policy levers, strategies that policymakers use at different levels to affect clinical encounters through provider agencies, regulatory or purchaser agencies (such as DHS), state and federal legislation, and mental health stigma or racial bias (Raghavan et al., 2008). The

framework is often cited for bringing payment strategies (e.g., enhanced reimbursement rates), professional organizational factors (e.g., EBP continuing education requirements), and regulation congruence (e.g., group psychotherapy requirements matching EBP fidelity standards) to the forefront when implementing EBPs (Wiltsey Stirman, Gutner, Langdon, & Graham, 2016). Because this conceptual framework is structured to look at implementation within an ecological context, it is well suited for addressing system interactions and competing factors (Figure 3.1).

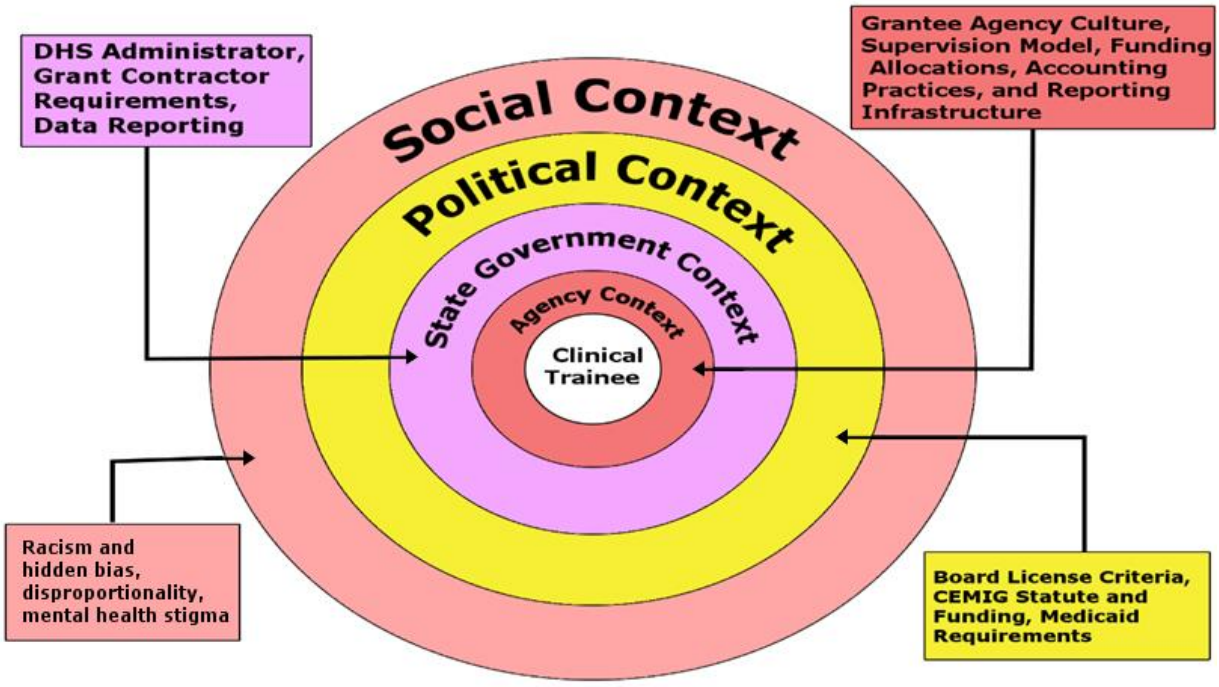

Figure 3.1. A Policy Ecology of Implementation for the CEMIG program

Adapted from "Toward a Policy Ecology of Implementation of Evidence-Based Practices in Public Mental Health Settings," by R. Raghavan, C. L. Bright, & A. Shadoin, 2008, *Implementation Science, 3,* p. 26. doi:10.1186/748-5908-3-26

The PEI framework has been often mentioned in the literature to reference critical ingredients that are beneficial for successful implementation, but it has rarely been applied. There is one example in which PEI was used to describe the transformation of Philadelphia's behavioral health system (Powell et al., 2016). Authors described intervention strategies utilized

by implementers that addressed potential barriers at the social, political, agency, organizational, and clinical-encounter levels (Powell et al., 2016). This study's qualitative approach was informed by the PEI framework, highlighting the social and political levels of the program's ecology. To date, there has not been a utilization of the PEI framework that moves beyond description to use the layers of ecology to critically analyze a significant policy initiative at the state level.

Implementation literature rarely focuses on how policies, systems, and social problems interact with one another in the implementation and sustainment process. The information gathered within this study is unique because it probes how external factors (e.g., race and ethnicity, disproportionality, mental health stigma, along with legislative, professional discipline, and educational policies) are perceived to affect the program's implementation and sustainability. Further, it addresses various policy levers that policymakers can utilize during planning to enhance systemic adoption and utilization of a new intervention, workforce development program, or policy change. Using qualitative methods, CEMIG as a platform for inquiry, and the PEI framework in combination allows for insight into how race, culture, and systematic biases are experienced within the implementation process.

Methods

A case study design was used to highlight how race, ethnicity, and systematic bias are experienced within the implementation process. This design allows for in-depth, comprehensive, and systematic investigation of social and political factors from the perspectives of key stakeholders during the CEMIG implementation (Yin, 2014). Case studies are used to examine sustainability and implementation factors within public health programs (Scheirer & Dearing, 2011) and how a phenomenon occurs within a real-life context (Baskarada, 2014; Yin, 2014). Multiple data sources were used in this case study to facilitate triangulation (Palinkas et al., 2015).

Study Context

By the end of the 1990s, Minnesota was shifting from mental health services that were grant-funded and contracted to those that were reimbursed via health insurance. This switch required infrastructure changes at many levels: promoting mental health licensure, increasing the number of individuals on health insurance throughout the state, and revising psychotherapy regulations to standardize services. Although these processes were undertaken for the whole state, the effects of trauma in various ethnic communities (e.g., the school shooting in the Red Lake Nation, young Somali immigrants returning to Africa to join Al Shabaab, multiple police shootings, and a second wave of Hmong refugees who had spent more than 20 years living in camps in Thailand) highlighted the need to target specific efforts within the cultural and ethnic minority populations in Minnesota. It was in this vein that the CEMIG program was added to the broader 2007 Governor's Mental Health Initiative, which aims to increase access, quality, and positive health outcomes of mental health services across the state (DHS, 2006).

The CEMIG legislation (Minnesota Session Laws, 2007) funds a combined mission: to both increase the number of mental health practitioners and professionals from cultural and ethnic minority communities and require that grant recipients meet third-party insurance billing practices. To fulfil the obligations of the legislative mandate, DHS selected proposals and then contracted with mental health provider agencies to provide an array of services, including but not limited to clinical supervision, mental health services, EBP training and implementation, and licensure support services (e.g., paying for preparation courses, licensure fees, and exam fees). The 2- to 5-year agency contracts varied widely by the agency in amount, allowable expenses, and outcome reporting requirements.

Sample and Data Collection

Using a critical case sampling design, the CEMIG program was selected (Cresswell, 2014; Palinkas et al., 2015). Critical cases are information rich and can generate knowledge development (Patton, 2002); items that are observed in this case can occur in similar settings,

(e.g., other large-scale, systemwide implementation programs) which lends itself to demonstrating a potential pattern (Palinkas et al., 2105). For this case study, the data sources are varied to develop ideas of replication and convergence (Gilgun, 1994; Palinkas et al., 2015).

Data sources are a mixture of documents and interview transcripts. All available CEMIG documents were collected from DHS archives in the summer of 2017; the more than 1,000 documents include requests for proposals (RFPs), RFP responses, grant contracts, grant renewal proposals, grantee reporting data submitted to DHS, and proposed and reported budget information. Twenty-eight (N=28) key informants were interviewed for this case study, yielding 22 interview transcripts; multiple interviews included several participants and one interview was located in a poor audio setting and although no recording was collected, copious simultaneous notes were taken. Participant recruitment took place in two phases, fall 2017 and summer 2018. Current and former DHS grant program administrators, agency grant managers, Minnesota behavioral health board representatives, university professors, and cultural community professional advocates were contacted to participate in the implementation study (Table 3.1).

Table 3.1:
Sampling Table and Participant Demographics

Participant Demographics					
Race	**DHS Administrator**	**Grant Manager**	**University Educator**	**Advocacy Group Representative**	**Government Representative (including Boards)**
African or African American	3	2		1	
European American	4	5	2		3
Native American		1			
Latino		2			
Asian American	1	3	1	1	

*One participant held both an advocacy group representative role and another role in the process

Forty-two potential participants were contacted via workplace email or social media (LinkedIn or Facebook) messaging services. When possible, follow-up phone calls to solicit study participation were made a week after the initial invitation email. While no one directly declined participation, at least half of the contacted potential participants did not respond to the request. Interviews were scheduled at the time of the participants' choosing, with several occurring over the telephone due to geographic limitations of the researcher. Original recruitment resulted in 22 participants in 17 interview sessions (two grant-making agency interviews included multiple participants). Two board representatives, 13 grant managers, and 7 DHS administrators participated in the interviews. Five of the individuals interviewed had been clinical trainees within the grant program in addition to their status as a grant manager or DHS administrator. Theoretical purposive sampling for the second phase of interviews was conducted through an inductively derived process to explore themes generated during the secondary data analysis process necessary to answer these research questions (Padgett, 2008). Six additional interviews exploring social and political contexts surrounding the CEMIG implementation were conducted in late summer 2018. This group of participants included DHS management, a representative from the Minnesota governor's office, an agency grant manager, three graduate education professors, and a cultural community professional advocate (Table 3.2).

Table 3.2:
Job Roles

	Personnel	Function
DHS Administrator	Mental health division staff, employed by DHS	Administered, monitored, or supervised CEMIG grant activity
Agency Grant Manager	Supervisors and contract managers from agencies that received CEMIG grant contracts	Monitored agency contracts, collected data for DHS, developed and implemented CEMIG programming at the agency level
University Educator	Current or former professors within graduate clinical training programs	Teach and conduct research within graduate programs within Minnesota
Advocacy Group Representative	Representative of an advocacy group	To promote the interests and grow the workforce of mental health clinicians of color
Government Representative (including Boards)	Government employees within the administrative branch of the state	To enforce and regulate mental health board statutes, or to provide political consult to the governor's office

Interviews lasted approximately 60 minutes. Each participant signed an informed consent form before the interview. The interviews were digitally recorded, professionally transcribed, and then checked for accuracy by the author. The transcripts were indexed with the grant documents within Dedoose (SocioCultural Research Consultants, 2018) and coded within that system. The interview questions were based on implementation literature (Aarons et al., 2011; Raghavan et al., 2008) and focused on the implementation and delivery of the CEMIG program (Table 3.3). For the second phase of interviewing, additional theoretical purposive sampling (Padgett, 2008) was conducted, along with further development of the interview guide. This additional step allowed for inductive, analytic expansion (Padgett, 2008) to follow themes

developed in the initial round of coding and analysis. The Human Subjects Division within the University of Washington determined this study did not meet the federal criteria for research and thus did not require an Institutional Review Board review.

Table 3.3:
Sample Interview Questions

Sample Interview Questions	*What were the environmental factors that influenced the implementation process (e.g., state and federal policies, inter-agency collaboration, and other funding influences)?* *What were the other system changing initiatives occurring at the time of your grant proposal and implementation (e.g., Great Recession, ACA, Medicaid changes)?* *Are you aware of other initiatives in the State that are working towards increasing the number of mental health professionals from cultural and ethnic minorities?* *What might be other policies that contribute to an individual's ability to get a license? Have there been any substantial changes in the past 10 years to those requirements that could influence licensure obtainment?* *Please describe conversations you have engaged in as an advocacy organization surrounding the licensure application and exam process.* *What do you consider to be the barriers clinicians of color experience in the licensure process?*

Data Analysis

This paper incorporates interview transcripts and grant document analysis including the RFP responses, progress statements, and proposals to extend funding that highlight implementation processes and infrastructure development throughout the grant period. The first cycle of coding included provisional and process methods simultaneously (Miles, Huberman, & Saldaña, 2014; Saldaña, 2016). The case study data were coded using provisional codes (Miles et al., 2014; Saldaña, 2016) that were taken from the PEI framework (Raghavan et al., 2008). Also, the transcripts and study documents were coded using the process method of coding (Miles et al., 2014; Saldaña, 2016). Process coding allows the researcher to document the action and actual experiences of the participants that contribute to routines and consequences for behavior (Saldaña, 2016). Provisional and process coding during the first cycle of coding

separated actions and experiences into ecological levels of the PEI. After the first cycle of coding, code mapping was used to reorganize the codes into categories and condense them into central themes or concepts (Miles et al., 2014; Saldaña, 2016). The second cycle of coding used pattern coding, which allowed for explanatory or inferential codes that arose and generated emergent themes (Miles et al., 2014; Saldaña, 2016).

To enhance and secure credibility, transferability, auditability, and confirmability the following steps were taken: peer debriefing, memoing, negative case analysis, data triangulation, and member checking, which contributed to the rigor of this study (Morse, 2015). Peer debriefing, as well as consultation with a supervisory committee (Wu, Wyant, & Fraser, 2016), assisted in thinking through research strategies and theme generation. Memoing throughout the process created an audit trail of analytical steps and processes utilized to collect and analyze data and afforded the opportunity to be reflective about positionality and bias and how that might have influenced the data collection and analysis (Gilgun, 2015; Wu et al., 2016). Negative case analysis was used during the theory-building process (Gilgun, 2015) to test concepts and check the veracity of the emerging analysis (Gilgun, 2015). Data triangulation was employed throughout the process (Wu et al., 2016). The additional theoretical sampling allowed for member checking and theme generation (Wu et al., 2016).

Findings

In this study, the analysis identified several social and political system factors (e.g., siloed systems, experiences of racism, and cultural bias) that influenced and created barriers in the CEMIG implementation process. The themes derived from the analysis, *invisibility, isolation*, and *inequity,* help to illuminate how social and political factors influenced the implementation process. Further descriptions of the themes along with quotations from participants are in the following section. Some of the participants' words were modified to enhance readability by eliminating repeated phrases, qualifiers such as "you know," and habitual phrases such as "um"

or “like.” Because many of the participants are first-generation immigrants, slight modifications have occasionally been made to adhere to English grammar and disguise dialects.

Invisibility

The theme invisibility points to how the struggles of clinical trainees of color were unrecognized, the program was unknown in the community, and the outcomes of CEMIG were untallied. While there was little awareness of the CEMIG program amongst non-program participants (e.g., graduate program faculty, advocacy group representatives, and mental health board representatives), all participants acknowledged that there were not enough mental health professionals from cultural and minority groups in the state and that there were substantial social and political barriers to decreasing the disparate representation of people of color in the mental health professions.

The first marker of invisibility was the clinical trainees themselves. Concerning the number of clinical trainees of color and their experience in the licensure process, the boards repeatedly stated that “85 to 90% of all of our licensees report being Caucasian” and that “it is still a very highly dominated Caucasian profession in Minnesota, so this topic of conversation [racial bias in the licensure process]…is usually in response to conversation happening elsewhere.” Additionally, the exams are run by national organizations that either do not request demographic data of the applicants or do not share that information with the state board. The licensure system does not ask for racial and ethnic information, making it possible for disparities to remain unknown.

Further, graduate training programs stated that they were not informed by their graduates of color about difficulties passing the exams. One social work program professor stated that although their program does not keep track of the passing rates, “we are able to, the only feedback we get is we can call [the Association for Social Work Boards] and ask for our pass rates for our school.” Another university professor discussed how there used to be a survey that

followed graduates to learn about jobs, salary information, and licensure, but this ended years ago. Neither the boards nor the graduate training programs were following success and failure in the licensure process by race, nor were they made aware of programs in the community designed for clinical trainees of color by DHS. The lack of communication created a system of invisibility where both cultural and ethnic minority clinicians issues and supports were hidden.

The second major issue was that individuals within the universities, mental health boards, governor's office, and advocacy organizations had either not heard about the CEMIG program or had only tangential involvement in years past. While sometimes participants from universities or advocacy groups knew about an individual grant agency's program, especially those focused on interns within graduate training programs, they were unaware of the larger DHS program. Last, a few agency grant managers lamented that the CEMIG program was not better advertised or promoted by DHS:

> …I wish that the grant was probably a little more well known in the community or who are the recipients of these grants and if they're doing something that other organizations can participate in or learn more about it. I feel like maybe sometimes grantees have these grants and they're doing things that are specific for their organization but we don't really know what these outcomes are.

With the lack of program visibility, it was difficult for agencies to share what they had learned with each other and create a learning community. DHS granted dollars to agencies to develop programs but did not share that information with the greater community. The CEMIG program was not a secret for DHS, nor was it a primary area of focus. There was no information on the DHS website about CEMIG. There were limited group meetings amongst CEMIG grantees. These practices were in stark contrast to early childhood mental health and EBP training programs that were also a part of the 2007 Governor's Mental Health Initiative. The lack of program visibility allowed for pockets of innovation without a public discussion of the grant or the problem the grant was trying to fix. While social factors such as racism and hidden bias were not identified by participants as the reasons that kept DHS quiet about the grant program, there

was an acknowledgment that the lack of conversation kept the program from being promoted at the legislature, with the mental health boards, and in the provider community.

The last marker of invisibility is with the grant outcomes themselves. Nine DHS employees administered this grant program over the 10-year grant period, which resulted in many documents being lost. During data collection, substantial effort was taken to retrieve items on personal DHS servers for employees who had changed positions or to comb through shared server folders, but these actions did not fill all gaps. DHS's accounting system changed during this grant program period, making it impossible to get the earliest financial data. During grant program administration, grantees started emailing their grant administrator with outcome reports, invoices, and program renewal requests. There was no standard practice or expectation for how grant administrators would transfer information from individual email accounts to shared servers or grant management accounts. This problem was underscored twice in 2016 when an employee's DHS laptop crashed, and all grant documents with outcome reporting information were lost and when a different employee left DHS before moving all grant contracts, RFPs, and outcome information to a shared server.

Further, each grant manager created their own data reporting requirements: narrative, surveys, service counts, and individual psychometric data were all used inconsistently throughout the 10-year grant period. The agency grant manager completed the data outcome reports and focused on overall program requirements. The lack of consistent data collection and management meant that DHS could neither demonstrate the pervasiveness of the problem to the legislature, mental health boards, or clinical training programs nor boast about the grant's success. Without data to support the grant efforts, CEMIG was constantly under political threat for budget cuts at the department and legislative levels, which impacted program sustainability. Further, without data, there could be no legislative push for changing mental health board practices for keeping demographic data and broadening provisional licensure standards.

Isolation

Participants expressed feelings of isolation between the grant program, DHS, mental health boards, the mental health community, and graduate training programs. This isolation manifested in conversations of professional roles and lack of collaboration. Within this policy ecology, each system within the state government and political contexts seemed to be self-contained. The mental health boards, DHS, graduate training programs, state workforce initiatives all function within their individual sphere of influence and have unique roles.

For instance, mental health boards firmly believe their primary purpose is to protect the public as a regulatory body and while others are emphatic that the boards could take a leading role in changing mental health professional demographics, a DHS administrator stated that she:

> …was sitting at another meeting somewhat recently and the statement was made—it was somebody who had talked to a board. The board was like, "well, where's the proof that our tests aren't culturally competent?" . . . Well, the fact that you don't even keep demographics, like isn't that convenient that you don't even keep demographics to be able to show who's passing your tests and who's not? . . . what blows my mind is how closed they are to looking at their role in what they could be doing differently to try to address this.

However, mental health board representatives, focusing on public protections and their legislative mandate, are hesitant to engage in outside conversations about barriers and disparities in the licensure process, especially those pertaining to reducing requirements. For instance, one representative expressed:

> *I think regulatory entities really have to be cautious, and I think, there's the risk of, when you're looking at barriers to address concerns, if you reduce standards on the face of it, I think that has the potential to open up risks, and so, there has to be a real strategy and there has to be real sound rationale.*

The separation between the mental health board view of their role and the DHS Administrator's view is stark. The isolated work between the two systems keeps conversations about public protections and a lack of diversity within the mental health workforce as being two separate issues, rather than aspects of the same problem.

Additionally, even though there are areas of overlap between graduate training and mental health boards (e.g., professors teach students who will take board exams or social work professors are required to be licensed in the state of Minnesota), there is a lack of coordination between the two entities. Besides not being aware of licensure rates after graduation, there is isolation between educational training and demonstration of competence within the licensure process; a graduate professor explained how their role is to:

> …prepare [students] for the lessons and exam [but] I think even our own professors are removed from that exam process. No one really knows what is in the exam unless you order an exam sample booklet and you look through the questions or you're an exam writer. Things like that. Our professors are not involved at that level. We don't specifically prepare students for the exam. But we do have workshops, seminars, and information sessions about the licensing process.

While the student or licensure applicant may see education and licensure as components of the same process, the systems that are in charge of each step are separate and isolated from each other. Instead of strategically targeting interventions to assist each silo in this process to better attend to clinical trainees from cultural and ethnic minority groups, CEMIG funded mental health agencies to retroactively fill in the gaps. The legislative and institutional norms within the education and mental health licensure system that perpetuated the current siloed system influenced CEMIG implementation and placed an undue burden on the grantee agency to retroactively fix knowledge gaps.

These feelings of isolation prompted both the boards and the agency grant managers to call for cross-system collaboration. A mental health board representative emphasized that a one-size-fits-all solution, like a grant program, could not make a substantial difference in changing the demographics of the workforce:

> …it really has to be a statewide, a systems, a regulatory professional… all the pieces of the system have a potential opportunity and responsibility to shore it all up… it's got to be a multifaceted approach, and it's not just the examination.

Noting issues of long perpetuated disparities, participants voiced concern that interceding at the point of licensure application was insufficient to change the effects of poverty and racism that

often translated to difficulty with exams and access to employment and mentoring opportunities. Taking a more grant-specific focus, the agency grant managers, looked more to DHS to provide leadership to dismantle the isolating systems. Charging DHS with ownership of the grant program and grant data, this agency grant manager chastised DHS with the consequences of not coordinating between systems to create change:

> DHS is sitting in the middle between the boards and the clinical training sites. Through this grant the clinical training sites have the resources to help get people supervision, get them in study groups…get them as prepared as we possibly can to take the test…. If DHS has the data that says, even with all of this, even with people getting trained as well as we possibly get them trained, something seems to be happening at the board side of things…. [DHS] has the ability to go to the boards and say—on a policy side not an advocacy side—is there anything we can do to make the whole system work better? Because it has to be both sides of that equation.

By continuing the grant program in a vacuum, DHS perpetuated the self-contained systems. Without an organization to coordinate between the multiple systems within this policy ecology, the graduate programs, mental health boards, and DHS were able to continue business as usual that perpetuated the knowledge gaps in both education and issues of systemic racism within the field. The grant managers continued their plea to have a louder voice speaking to the separate ecosystems. One grant manager explained:

> I think that in order to be more successful, [DHS] needs to be able to work with the licensing board. Having some kind of strategies or support from the state, whether it is to the Department of Behavioral Health to have a louder voice as a community, to provide—to advocate for our participants…to be able to have a voice in talking about some of these challenges out there.

The lack of a unifying cross-system voice, according to the grant managers, limited the effects of their post-graduate clinical training programs. There was considerable frustration that clinical training sites were being tasked with shouldering the burden of teaching concepts that were not covered during graduate training, such as test taking skills, how to navigate culturally-based ethics questions, and English fluency. Grantee agencies were seeking a policy voice to challenge the systemic issues, feeling hopeless because small grants of $50,000 to $100,000 were not sufficient to attenuate years of disparities and bias.

Inequity

Along with issues of invisibility and isolation, concepts of inequity materialized during the interviews and grant documents. Participants described inequity in workforce development programs, in the licensure exam process, and within the mental health community. From feeling tokenized to unwelcome, participants, especially agency grant managers and advocacy group representatives, described an unfriendly environment for mental health professionals of color.

During the grant period, there were many workforce development initiatives, sponsored by the federal and state governments that attempted to address the shortage in the mental health workforce overall. Loan forgiveness was a primary topic of conversation in the legislature and committee meetings. It was also mentioned that issues of people of color were never the *focus* of the workforce initiatives but instead were popular *add-ons* to the more significant issue, an issue that might be addressed when there were more legislators of color or political support.

The loan forgiveness programs were also seen as a shining star that could help all individuals, regardless of race or ethnicity, on the path toward mental health licensure. One individual explained, "[this] was one of the most exciting investments that the legislature and the state put forward to really put some money out there to make a difference." These programs are run through the MDH and often sought board representatives to serve as reviewers; there was broad community support for the task forces to support these programs. The task forces were able to increase the eligible licensure type of mental health professionals (expanding beyond psychologists and psychiatrists) but were not able to increase the total number of individuals who could participate within the state; as recounted by the governor's office representative:

> …loan forgiveness, that costs money. I think some of the loan forgiveness stuff that expanded to social workers was in there, and they didn't put more money towards it; they just added another profession to the pool, which is budget neutral but expands the number of people in the pool. So, things like that. And fewer dollars available.

Although the Mental Health Summit called for 50% of the increase of loan forgiveness funds to go to clinicians of color, this ignored that most of the positions are in rural Minnesota, which is predominantely White. Prioritizing clinicians of color, according to an advocacy group representative, is much more needed "because so many practitioners of color don't have rich parents who can pay for part – or all – of their education, and so they end up with these crazy, massive student loans; they need some way of just living." The general philosophy on most of the committees, per the governor's office representative, was that there needed to be "more cultural awareness and sensitivity [when working with] people from different cultural communities," rather than promoting culturally specific providers, which according to her was perhaps a result of the current demographics of the legislature:

> …at the legislature, it's a bunch of white people. There are very few legislatures of color, and the more left-wing members are more likely to bring it up and try to make sure that legislation is inclusive, but it takes a lot of effort, and it's not a default. It hasn't risen to the level where actual real action and more than lip service.

The lack of diversity allowed committees and the legislature to focus on general shortages rather than issues of disparities. Even though, perhaps, the financial needs were more significant for practitioners of color, the hesitancy to add more financial resources and cultural requirements to the loan forgiveness program, perpetuated the inequities within workforce development conversations.

The next inequity discussed by the participants was cultural bias within the exams themselves. Grantee agency representatives, DHS administrators, university professors, and advocacy representatives made statements that flatly asserted that the exams were cultural tests "based on White middle-class culture and White academics." Conversations with the boards on whether exams could be altered to be more culturally diverse in perspectives were received with great resistance, with responses, as described by an agency grant manager, such as "Well, this is the national test. This is what we're going with." Agency managers of all backgrounds described how they were coached by national test exam instructors teach practitioners of color to "think

like a White man" to pass the test. Another participant, a university professor, described how her students had been advised to "imagine you're a 40-year-old White woman from Nebraska," which is a great challenge to "imagine yourself through a world view that is foreign to you." The professor pondered: "why are these folks not making it through the licensure process? …It goes back to things like issues around barriers and oppression. Not accommodating for differences. Do it our way." She furthered posited that if the exam was structured in a more culturally diverse way, it "might actually challenge students from the dominant culture. They might be challenged too, in a good way, to think about these case scenarios in a different way." While individual agencies created trainings to attend to the cultural bias within the exams, other agencies focused on English language courses or test taking skills. However, there was a sentiment expressed by numerous agency grant managers, that they were being tasked to fix a problem that was beyond their scope and questionable to their morals. Teaching clinicians of color how to "think like a white man" for the sake of an exam, often ran counter to their own values of social justice, even if it was just a means to an end. The foundation of the exams in a White/dominant culture framework, according to the professors, agency grant managers, DHS administrators, and advocacy representatives created a biased test that served as a gatekeeper for individuals who were unable or unwilling to think like a White person during the exam period.

The issues of inequities were also reported at the clinical trainee level as well. An advocacy group representative described how when he entered the profession "people were not inviting…. [I]t was an awful experience, because you were treated like you shouldn't be there, and you didn't enjoy it." Although according to him, this has evolved, the memories of having "White people, who would laugh [when] I would come out in the waiting room…. I would have White professionals who would refuse to see me" parallel with current examples of clinicians being rejected for being Muslims. Grant managers would describe Eurocentric trainings that discount the experience of both providers and clients of color, forgetting how certain social

roles, such as those of the police, immigration officials, or the educational system are not safe or nurturing for individuals from cultural and minority backgrounds. An African American grantee representative stated that these are constant reminders of being trained in a "Eurocentric model" that perpetuates the "systemic racism and biases [that] continue to create barriers for us to run the race." The inequities mirrored across the policy ecology for individuals involved within this grant program.

Discussion

This study adds to the growing literature investigating large-scale, system-wide projects by examining how social and political factors influence and create barriers in the implementation processes (Beidas et al., 2016; Brookmann-Frazee et al., 2016; Nadeem et al., 2016; Olin et al., 2016; Powell et al., 2017; Skriner et al., 2017; Southam-Gerow et al., 2014; Walker et al., 2016). This study's findings can be useful for two primary audiences: policy makers and implementation researchers. For policymakers, the results herein may assist them in applying this conceptual framework when developing a comprehensive, multifaceted policy intervention. For implementation researchers, this case study may be used to identify community and policy-maker partners while developing implementation plans for EBP models and other clinical intervention techniques.

This study's findings that (a) invisibility, (b) isolation, and (c) inequity demonstrate that policy levers at one level are insufficient for greater adoption and sustainability. The participants described feeling like the CEMIG program was unknown, isolated from other systems, and perpetuated larger social inequities. As the PEI framework describes (Raghavan et al., 2008), a multisystem approach is needed to implement an initiative successfully. The CEMIG program targeted their policy levers at the agency context level, hoping that it would be sufficient within this workforce development initiative. Often when the PEI framework is invoked, it is to remind

policymakers that unfunded mandates are difficult to sustain (Rubin et al., 2016; Wiltsey Stirman et al., 2016); this case study demonstrates that money alone is also insufficient.

At the clinician/clinical encounter level, the largest struggle was the lack of data. Unfortunately, due to the lack of data collection by the boards on issues of race and ethnicity, the CEMIG program began with no baseline data. The invisibility of the target problem the grant was trying to alleviate was only heightened with the grant's difficulty with their data reporting. Collecting data on target implementation strategies is crucial to the success of any implementation project (Proctor, Powell, & McMillen, 2013). Because the grant program was targeted at the agency/organizational level, DHS did not have frequent direct communication with the clinical trainees enrolled in the program or throughout the state. Using agencies as a conduit is simpler for grant management but limits feedback from the recipient to the funder of the program. By not communicating directly with the clinical trainees, DHS has continued the cycle of not knowing how many times each trainee takes the exam, how much preparation is required, and which strategies are utilized to maximize outcomes. The lack of data, both quantitative and qualitative, forces DHS administrators to use secondhand data from the agency, which hinders DHS from being able to advocate for the clinical trainees with other systems. Future infrastructure programs might therefore, include consistent data collection regarding the outcomes and experiences of the recipient. These data can assist in legislative, stakeholder, and replicability efforts as well as in monitoring contract outcomes and program efficacy (Proctor et al., 2013). Hearing directly from the constituent is essential for program management, advocacy, and ongoing funding, especially when working with an invisible population within a "colorblind" system.

The primary focus of DHS's attention was spent at the agency/organizational level. DHS sought proposals, created contracts, and requested outcome reports from the 21 agencies with which it had contracts. The provider agency level is known as being the central role for

implementing policy and EBPs (Aarons et al., 2011; Southam-Gerow et al., 2014) because culture and climate are vital components when working with individual clinicians to change practices (Aarons et al., 2011). However, the provider agency is the least likely level to be able to make the system-wide change, because it is dependent on larger collaborative networks and funding (Aarons et al., 2016; Powell et al., 2016). Within this case study, the provider agencies specifically voiced concern that they were shouldering the burden of ending workforce disparities without enough support from state institutions, which added to their isolation. The literature discusses how important it is for agencies to have access to "cross-fertilization" and institutional learning with other providers engaging in similar practices (Aarons et al., 2016; Powell et al., 2016). Although the CEMIG program occasionally had grantee meetings for agencies to come together, learn about DHS requirements, and share success or struggle stories, there was no infrastructure created for agencies to generalize insights (Powell et al., 2016). Other successful large infrastructure programs have found that creating an innovation center or consulting position for the implementation process has helped share ideas and dismantle implementation barriers across provider agencies (Powell et al., 2016). Adding in this infrastructure at the organizational level would assist in institutional learning and create building blocks for provider sustainability (Powell et al., 2016). Further, especially when implementing programming for populations experiencing health or workforce disparities, community building is particularly compelling in addressing hidden biases and systemic barriers (Chin et al., 2012; Crary, 2017).

At the state regulatory or DHS level, there were many concerns within this case study: lack of advocacy, lack of data management, and lack of creating collaboration and engaging stakeholders. The absense of these activities seems to be partly the result of the DHS administrator functioning as a grant manager instead of as a consultant/hub of an innovation center as described above. Although sustainability for implementation projects requires institutionalization of funding, contracting, and systems improvement (Aarons et al., 2016), it

also requires fostering of ongoing collaborations among different levels of government, advocacy groups, provider agencies, constituents, and related systems (e.g., clinical training programs; Aarons et al., 2016). With DHS focusing on contracting and grant management, there was little time to market to stakeholders (Aarons et al., 2016) or create a stakeholder advisory council (Starin et al., 2014), both of which have been shown to enhance program sustainability and success. Without marketing or stakeholder engagement, the clinical training programs, mental health boards, and advocacy programs—all key institutions that could support legislative and policy work—were unaware of the CEMIG program. The grant program existed in isolation, prohibiting collaborative efforts and buy-in from key stakeholders.

As noted above, the difficulty of the CEMIG program was the lack of exposure to the mental health boards, clinical training programs, and even mental health provider advocacy groups. At the political level, this isolated grantee agencies and clinical trainees from potential strategic partners because there was a lack of understanding that clinical trainees of color were having trouble passing licensure exams. With the mental health boards not recognizing this as an issue and the governor's office not conducting oversight of the boards, the invisibility of the grant program and the needs of the clinical trainees continued. Beyond the lack of communication with the state mental health boards, there was minimal interaction among the grant program, the mental health workforce initiative, and tuition forgiveness programs run through MDH. Here again, having a stakeholder advisory council (Starin et al., 2014) and fostering ongoing collaboration among levels of government, advocacy groups, clinical training programs, and provider agencies (Aarons et al., 2016) would have been beneficial to help push for simple policy changes that could lead to greater change, such as requiring mental health boards to keep demographic data of applicants and licensed clinicians. This stakeholder body could also serve as a conduit for collaborative practices among the systems and help the potential for discriminatory practices toward clinicians of color to become a first-tier issue and focus of system-wide policy change.

Last, at the social level of the PEI framework, it is essential to look at how stigma and racial disparities interact with implementation. There were multiple ways that the participants voiced the effects of stigma and racial disparities, in both the lives of the clinical trainees and mental health professionals of color but also in the lack of visibility of the program itself. As discussed by both representatives from culturally specific, mental health professional development/advocacy organizations, they had not been included in the development, outreach, or implementation of the CEMIG program. There are at least four or five state-based, culturally specific, mental health professional development organizations that could be included in the stakeholder advisory council to disperse the information gained from the grantee agency programs and reach a broader base of cultural and ethnic minority clinical trainees. These mental health professional development organizations include pipeline programming to foster interest in the profession, academic and career mentoring, and professional learning communities (Moua, Vang, & Yang, unpublished). Given that these organizations are engaging in similar processes within specific cultural communities, they would be essential voices to include in more substantial policy discussions and a fundamental way to transition the issue of barriers to licensure for clinicians of color to the forefront.

These findings demonstrate that the implementation of any policy or intervention does not occur within a vacuum. Several areas are identified that would promote success for the CEMIG program and other similar large-scale implementation programs: including consistent data collection methods that explore financial, historical, and logistical experiences in the licensing process; creating an innovation center that allows for cross-fertilization and technical assistance for provider agencies; crafting legislation that requires mental health boards to collect demographic data on applicants; and developing a multisystem stakeholder advisory council that includes multiple state agencies, culturally specific professional development organizations, grantee agencies, clinical trainees, and the innovation center. External issues such as disparities, racial bias, mental health stigma, competing or complementary programs, and other

regulatory bodies affect and create the experience of implementation in a way that can perpetuate greater social problems, such as systemic racism. Adding these policy levers to large-scale implementation projects is important because creating policy at only one level of the PEI framework impedes implementation and sustainability (Raghavan et al., 2008).

Limitations

The information for this study is limited to the perspectives of key stakeholders in one state with one infrastructure program. Implementation methods used in this case study are unique to this type of infrastructure development program and may not be as applicable to other statewide policy programs. Participant recruitment, though ethnically diverse, was not all-inclusive, and there were limits due to time frame, retirements, and availability. My being a former DHS administrator might have skewed some of the responses, either by participants assuming I understood peripheral facts or by previous relationships inhibiting responses. These items may limit generalizability; however, the descriptive results given here correspond with information provided in other large-scale implementation programs (Aarons et al., 2016; Powell et al., 2016) and demonstrate the need for examining the role of race and ethnicity in implementation literature. Further research is warranted to describe differences in implementation based on culture and ethnicity within mental health settings, as well as examining institutional norms, such as licensing exams that clinicians of color may experience in discriminatory ways.

Implications for Practice

This study adds to the literature in two primary ways by addressing underlying social (e.g., race and ethnicity, disproportionality, and stigma) and political (e.g., legislative, professional discipline, and educational policies) factors that influence and create barriers to the implementation of large-scale, system-wide policy initiatives. Based on the participants' experiences, the following policy levers are suggested to enhance implementation within an

ecological context (Table 3.4): enhanced data collection, innovation cross-fertilization, and stakeholder advocacy involvement.

Table 3.4:
Potential Policy Levers

Level	Potential policy levers	Barrier addressed
Agency context	▪ Creating cross-fertilization opportunities between agencies ▪ Providing technical assistance to share lessons across programs	▪ Lack of feedback between programs ▪ Lack of connections among grantee agency programs and with other systems (mental health boards, clinical training programs)
State government context	▪ Conducting consistent data collection and program evaluation (including quantitative and qualitative methods) that explore financial, historical, and logistical experiences in the licensing process ▪ Creating an innovation center that includes technical assistance and cross-fertilization efforts ▪ Creating a stakeholder advisory board	▪ Lack of data to describe problem to key stakeholders, including policy makers, state mental health board representatives, and national license exam boards ▪ Lack of feedback between programs ▪ Lack of connections among grantee agency programs and other systems (boards, clinical training programs)
Political context	▪ Creating a stakeholder advisory board ▪ Developing state-agency collaboration (with MDH/loan forgiveness programs) ▪ Promoting legislation that requires mental health boards to keep demographic data	▪ Decreases isolation between systems of government and creates a political entity to promote legislation and policy changes ▪ Creates baseline data to assess severity and pervasiveness of problem
Social context	▪ Including ethnicity-specific mental health provider advocacy groups in the stakeholder advisory board and collaborating with these advocacy groups for grant program development and data collection efforts	▪ Allows advocacy groups to provide feedback to various systems ▪ Provides advocacy groups with ways to continue facilitating mentoring that can assist in licensing process

There are several tangible strategies that future large-scale, system-wide implementation projects could use to address potential social and political context barriers. Beyond having baseline data at the beginning of the implementation project, there needs to be a secure, on-going plan for collecting outcome and demographic data during the lifetime of the project. Future infrastructure development programs might, therefore, expand the role of the governmental administrator to include community engagement with stakeholders and provider agencies to create institutionalized learning and promote cross-system connections. This is particularly important for programming addressing complex social issues that contribute to racial inequities, as strong leadership is needed to help systems uncover and attend to hidden biases and structural racism disparities (Wangari Walter et al., 2017). If the governmental administrator cannot accomplish this role, the technical assistance and cross-fertilization functions could be attended to through a private, separately funded innovation center (Powell et al., 2016). Last, future large-scale, system-wide implementation projects could create stakeholder advisory boards that cross systems and contain a variety of perspectives, including but not limited to: consumer groups, cultural and minority clinician advocacy groups, other state departments, graduate training programs, provider agencies, and mental health board representatives.

Conclusion

Increasing the number of mental professionals from cultural and ethnic minorities will continue to be of high importance in the coming years. The Department of Health and Human Services (2016) projects that there will be shortfalls for psychologists, clinical social workers, and marriage and family therapists by 2025. Addressing issues of disparities within the licensure process is of crucial importance for both states and professional disciplines, especially for social work that holds social justice as a critical ethical principle (National Association of Social Workers [NASW], n.d.). Using the PEI framework for addressing large-scale social problems and creating multitiered policy programs is helpful because it includes various

systems that are required for successful implementation; it is crucial for policy implementers to include race and ethnicity as factors within the political and social contexts.

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CONCLUSION

This dissertation investigated how issues of race and culture affect the implementation of large-scale, system-wide programs at the micro, mezzo, and macro levels. Using Minnesota's Cultural and Ethnic Minority Infrastructure Grant (CEMIG) program as a case study, data was gathered from over 1000 grant documents, 22 transcripts, and 62 survey responses. The first paper evaluated feedback from the clinical trainees who received services and supports as they went through the mental health licensure process. The second paper investigated the role of racial or cultural identity within a grant-receiving agency in the CEMIG implementation process. The third paper sought to uncover perceived influences of the social and political contextual (e.g., race and ethnicity, disproportionality, stigma, and mental health board regulations) factors surrounding CEMIG's implementation.

Using data from 62 online survey responses from individuals who are current or former clinical trainees within the CEMIG program, the relationship between potential challenges and supportive services before taking the licensure exam with exam taking success was assessed using multilinear regression. The data demonstrated that none of the potential challenges were statistically significant factors in test-taking success, but that supportive services, particularly financial assistance with test-taking fees, were beneficial. Within the qualitative portion of the survey, respondents were asked what others had told them about the exam before taking it and their experiences taking the exam. Respondents reported that they experienced the exams as culturally biased and were warned that the licensure exams are challenging and required code-switching behaviors to be successful. These findings indicate that mental health boards should re-assess their "colorblind" exams for cultural bias. Beyond the need to record race and ethnicity data within the mental health licensure process, further research should be conducted with the mental health boards and exam organizations to assess for race and social equity concerns in the test process itself. Initiating pilot studies with the general mental health

provider population to investigate challenges and supports during the licensure process that are tied to race, ethnicity, or economic class would be a first step in assessing racial and social disparities within the process.

The second paper investigated mezzo level implementation factors, with emphasis on agency self-identity in the implementation process. Data from 18 interview transcripts with Department of Human Service (DHS) administrators, agency grantees, and mental health boards and over 1000 grant documents were used to separate agencies into four types: sovereign, legacy, transitional, and grassroots. The following themes were generated to describe the experiences of the grant agencies in the implementation process: the cost of racism, the need to bend and stretch, and a desire to run a different race. Implications for future large-scale, system-wide implementation programs suggest that when including non-legacy agencies, more technical assistance and funding for data reporting and contract management should be included. Further, government or private funders should engage in conversations that uncover hidden biases that affect relationships and implementation processes with sovereign, transitional, and grassroots agencies. Future research is needed to uncover agency level differences within the implementation processes when culturally diverse agencies are implementing the same evidence-based practice intervention.

In the final paper, social and political contexts (such as race and ethnicity, disproportionality, stigma, and mental health board regulations) are investigated within the implementation of a large-scale, system-wide implementation program. Data from 22 interview transcripts from DHS administrators, agency grant managers, university educators, advocacy group representatives, and mental health board members, along with more than 1,000 grant documents were qualitatively analyzed using content analysis. Themes that represented the perceived influences and barriers within program implementation were invisibility, isolation, and inequity. Participants indicated that the implementation process perpetuated inequities by

not promoting the program or advocating for clinicians of color within the mental health system. Further, there was substantial concern that components of the mental health system (e.g., training programs, DHS, mental health boards, community providers) were isolated from each other. Suggestions for improvement in the implementation process included enhanced data collection, innovation cross-fertilization, and stakeholder advocacy involvement. Especially, within policies engaging with disparate communities, including ethnicity-specific mental health provider advocacy groups in the stakeholder advisory board, and collaborating with these advocacy groups for grant program development and data collection efforts are critical for project enhancement and sustainability. Further research is needed to describe differences in implementation based on culture and ethnicity within mental health settings, as well as to examine institutional norms, such as licensing exams that clinicians of color may experience in discriminatory ways.

There are several implications for implementation policy and practice within this dissertation. While there are traditional difficulties noted, such as lack of consistent data collection and retention, lack of communication across agencies, and lack of technical assistance, there are several issues that are more related to institutional racism and hidden bias that require strategic intervention. The first strategy to combat institutional racism in the implementation process is to assess the "problem" or intervention for systemic racism or hidden bias. As demonstrated in paper one of this dissertation, DHS promoted license acquisition without questioning the exam process or potential cultural issues that created disparate rates of licensure. The second strategy requires the funder, whether it be a governmental or private foundation, to assure that both the intervention and the implementation process acknowledges that disparities and hidden bias exist at all levels (e.g., clinical encounter, organizations, and policy). For example, this case study demonstrated that targeting the intervention at the agency level to train clinical trainees, perpetuated the assumption that the licensure and exam processes were color and culturally neutral, rather than culturally problematic for clinical

trainees of color. Next, the funders need to incorporate equity into contracts, technical assistance, and agency infrastructure development based on need and agency identity rather than providing equal access to funds across agency types. As shown in paper two of this dissertation, agencies require different levels of assistance to implement contracts for new interventions; the funder should incorporate a needs-based assessment in the contracting phase to assure that each organization receives the support they require to be successful. The fourth strategy requires that funders, researchers, and individuals involved in the implementation process to engage in transparency and anti-racism training. As demonstrated in all of the papers, there was a pervasive need to engage systems in anti-racism work; clinical trainees, agency grant managers, and policy practitioners noted that systemic racism and hidden biases infiltrated the implementation process at various points. Next, it is essential for implementation projects to create inclusive stakeholder advisory boards that can help address social and political problems as they arise. Paper three illustrated how having a stakeholder advisory board could assist programs in navigating challenging social and political landscapes while providing necessary feedback from the community on the efficacy of the program and implementation processes. Finally, it is crucial to obtain key stakeholder buy-in (e.g., state and federal government officials, national mental health organizations, and insurance companies) that support system change and program sustainability.

This dissertation demonstrates that mental health agencies are not homogenous in identity or workplace processes. It is essential to recognize racial and cultural differences among clinicians and mental health provider agencies when implementing large-scale, system-wide mental health program implementation. As demonstrated by the clinical trainees and agency grant managers, “colorblind” processes reinforce systemic biases and create an added work burden for individuals from cultural and minority groups to codeswitch and bend and stretch. Future research regarding large-scale, system-wide implementation programs needs to include information about mental health provider agency cultural identity within their analysis along

with additional details regarding how agency identity affected implementation processes. Further, this dissertation demonstrated that individuals and agencies from different cultural backgrounds experience policy and program implementation differently; this needs to be taken into account in future research and policy endeavors. With demographic changes and the increase of mental health professionals from diverse backgrounds, it is incumbent on professional disciplines, government institutions, private funders, and university systems to examine institutional norms for systemic racism and hidden bias, as demonstrated within this dissertation.

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Willging, C. E., Gunderson, L., Green, A. E., Trott Jaramillo, E., Garrison, L., Ehrhart, M. G., & Aarons, G. A. (2018). Perspectives from organizational managers on implementing and sustaining evidence-based interventions in child welfare. *Human Services Organizations: Management, Leadership & Governance, 42*(4), 359-379. doi:10.1080/23303131.2018.1495673

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Woodcock, R (2016). Abuses and mysteries at the Association of Social Work Boards. *Research on Social Work Practice, 26*(2), 225-231.

Wu, S., Wyant, D., & Fraser, M. (2016). Author guidelines for manuscripts reporting on qualitative research. *Journal for the Society of Social Work & Research, 7*(2), 405-425. doi: 2334-2315/2016/0702-0012

Yin, R. (2014). *Case study research design and methods*. Thousand Oaks, CA: Sage Publications.

Yoon, I. (2012). Debt burdens among MSW graduates: A national cross-sectional study. *Journal of Social Work Education, 48*(1), 105-125.

Martha J Aby, MBA, MSW, LICSW ***Curriculum Vitae***

University of Washington School of Social Work mjaby@uw.edu
4101 15th Ave. NE
Seattle, WA 98105-6299

EDUCATION

PhD	**University of Washington** Social Welfare Dissertation title: Micro, Mezzo & Macro Levels of Implementation: An Examination of Minnesota's Cultural and Ethnic Minority Infrastructure Grant Program Committee: Amelia Gavin (chair), Charles Lea, & Megan Moore	June 2019 (expected)
MBA	**University of Minnesota** Business Administration	December 2007
MSW	**University of Minnesota** Social Work	May 2001
BA	Macalester College English and Women & Gender Studies	May 1998

AWARDS, HONORS, GRANTS, & FELLOWSHIPS

School of Social Work Dissertation Award	4/2019
J. Scott Briar Dissertation Award	4/2019
Kath Wilham Travel Award	3/2018
TL1 Interdisciplinary Research Fellowship (TL1 TR000422) National Institutes of Health, Institute for Translational Health Science	6/2017-3/2018
University of Washington School of Social Work Travel Award	1/2018
Doctoral Scholars Institute Training Fellowship The Network for Social Work Management	6/2017
TL1 Interdisciplinary Research Fellowship (TL1 TR000422) National Institutes of Health, Institute for Translational Health Science	6/2016-9/2017
University of Washington School of Social Work Travel Award	4/2017
Graduate School Fund for Excellence and Innovation Travel Award	10/2016
University of Washington School of Social Work Travel Award	4/2016
Rising Star Alumni Award College of Education and Human Development, University of Minnesota	4/2015

TEACHING INTERESTS & EXPERIENCE

Interests

Clinical social work (specializing in mental health diagnosis and treatment planning), Human Behavior and the Social Environment, Social Welfare policy, and macro practice (organizational theory and practice).

Experience

Social Work 520: Multigenerational Policy Winter 2019
Sole Instructor
University of Washington
Focus on state and federal policies for multigenerational practice.
Masters level.

Social Work 500: Intellectual and Historical Foundations of Social Work Fall 2018
Sole Instructor
University of Washington
Focus on social work history and foundational theoretical perspectives for the profession. Masters level.

Social Work 513: Practice IV (Community Change Practice). Spring 2017 & 2019
Sole Instructor
University of Washington
Focus on organizational structures and macro change. The implication of system resources and configurations for meeting human needs are considered. The role and function of generalist social workers to understand and advocate for system development and change is emphasized. Masters level.

Social Welfare 312: Methods III: Communities and Organizations Spring 2016
Sole Instructor
University of Washington
Focus on macro systems in a diverse society using the generalist perspective. The implications of system resources and configurations for meeting human needs are considered. The role and function of generalist social workers to understand and advocate for system development and change is emphasized. Undergraduate level.

Social Welfare 402: Human Behavior and the Social Environment Fall 2015 & 2016
Sole Instructor
University of Washington
Focus on understanding human development across the lifespan. Integrates biological, psychological, structural, environmental, political, global, and socio-cultural perspectives. Explores the relationship between the person and the environment including families, groups, organizations, communities and institutions. Undergraduate level.

Social Welfare 200: Introduction to Social Work Fall 2014
Teaching Assistant
University of Washington
Overview of social work profession and social welfare system.
Undergraduate level.

Social Work 8451: Assessment and Engagement in Clinical Practice Fall 2012 & Spring 2013
Adjunct/Community Faculty
University of Minnesota
Focuses on developing clinical assessment and engagement social work skills including learning mental health diagnostic codes and classifications, interviewing skills, assessment writing skills and techniques, a biopsychosocial perspective and engagement strategies. Masters level.

Social Work 8051: Psychopathology Summer 2007; Fall 2007-2011
Adjunct/Community Faculty
University of Minnesota
Focuses on core concepts in psychopathology including DSM IV TR codes and criteria, assessment skills and diagnostic assessment basics. Masters level.

Social Work 8202: Methods II: Families and Groups Spring 2008
Adjunct/Community Faculty
University of Minnesota
Prepares students for work with groups, families and children in family-centered, community and prevention practice. Covers engagement, assessment, intervention and evaluation that emphasizes building on service user and community strengths. Framework of course views human development and behaviors as products of interactions of persons with various environments. Masters level.

Social Work Field Seminar 2005-2008
Community Field Liaison
University of Minnesota
Co-facilitated a seminar for social work student interns. Masters leve

RESEARCH INTERESTS & EXPERIENCE

Interests

Investigating the social justice implications of how states and the federal government fund and implement mental health services and infrastructure efforts using critical and feminist qualitative research methods.

Experience

Micro, Mezzo & Macro levels of implementation: An examination of Minnesota's Cultural and Ethnic Minority Infrastructure Grant Program 6/2018-current

Survey development and administration of CEMIG clinical trainees and secondary data analysis of interviews and CEMIG public documents.

All Over the Map: A Case Study of Minnesota's Cultural and Ethnic Minority Infrastructure Grant program. 6/2017-3/2018
Qualitative implementation study of CEMIG program using content analysis and thematic analysis of over 1000 documents and 17 interviews with 22 participants. Data collection and analysis funded through MN's Department of Human Services and TL1 fellowship.

Where Everyone Knows Your Name: Primary Care in Community Mental Health. 5/2016-current
Interviewing 7 providers and 5 clients concerning the experience of receiving primary care in a mental health setting.

"This is a Decade Process:" A Case Study of Integrated Care in Community Mental Health 6/2016-11/2017
Interviewing 11 key informants and observing staff concerning the development, implementation and sustainability efforts of integrated care programming in a community mental health clinic 1 year after a Center for Medicare and Medicaid Innovation grant ended.

Sanctioned Resistance: New Public Management in Community Mental Health. 9/2015-6/2016
Interviewed 11 therapists and supervisors in 4 community mental health clinics in Washington and Minnesota concerning their experience with therapist billable expectations.

PUBLICATIONS & PRESENTATIONS

Government Publications

Aby, Martha J. (2018). All over the map: A case study of Minnesota's Cultural and Ethnic Minority Infrastructure Grant. Minnesota Department of Human Services, Mental Health Division.

Intensive Treatment Services for Foster Care: Minnesota State Statutes 256B.0946 (2014).
Medicaid benefit for children and youth in foster care to receive intensive treatment within a foster care setting.

Children's Mental Health Hospital Discharge/Transition to the Community Action Plan (2014).
Summarized workgroup recommendations for augmenting children's mental health services within the State of Minnesota; compilation of multiple smaller workgroups and community involvement with over 40 providers, consumers, parents, advocates and insurance representatives.

Child and Adolescent Behavioral Health Services Legislative Report (2014).
Report describing analysis of current functioning for Minnesota's Child and Adolescent

Behavioral Health Services facility in Willmar, Minnesota and future recommendations, complying with Minnesota Session Laws 2013, section 108, article 4, section 29.

Children's Mental Health Announces New Service: Youth Assertive Community Treatment. (2012).
Provided clarification on a new Medicaid service including billing expectations, paperwork and team certification requirements.

DHS Provides Clarification on Child Welfare and Juvenile Justice Mental Health Screening (2009).
Provided policy clarification on grant program in Minnesota requiring child protection and juvenile justice workers to screen children for mental health disorders.

Peer-Reviewed Publications

Aby, Martha J. (Under Review). "This is a decade process": A case study of integrated care in community mental health. *Journal of Behavioral Health Services & Research*.

Peer-Review Conference Presentations

Aby, Martha J., Harrop, E., Willey, C. (2019) Leveraging the Reflexive Self in Research: Reflections on Cultivating a Self-Reflexive Practice. (Roundtable). *Society for Social Work Research*. San Francisco, California.

Aby, Martha J. (2018). "This is a Decade Process:" A Case Study of Integrated Care in Community Mental Health. *Society for Social Work Research*. Washington, D.C.

Aby, Martha J. (2017). Convenience, Community and Trust: Making Decisions about Health Care Service Providers. *International Congress of Qualitative Inquiry*. Champaign-Urbana, Illinois.

Aby, Martha J. (2017). Sanctioned Resistance. *Network for Social Work Management*. New York, New York.

Aby, Martha J. (2016). Making Physical Health Care More Convenient: The Client Experience of Services in a Mental Health Setting (poster). *Qualitative Health Research*. Kelowna, British Columbia.

ADDITIONAL PROFESSIONAL EXPERIENCE

Seattle Children's Hospital, Seattle, Washington 7/2015-curent
Per Diem Social Worker
Provide financial assistance, assessment and crisis intervention services to children and families receiving inpatient care.

Minnesota Department of Human Services, St. Paul, Minnesota 12/2008-8/2014

Clinical Capacity Development Specialist
Develop new Minnesota Health Care Program benefits (Youth Assertive Community Treatment, Intensive Children's Mental Health Treatment

Services in Foster Care, Psychoeducational Services and Outpatient Treatment Rule). Conduct clinical reviews for Children's Residential Treatment. Trainings and grant management.

Mental Health Consultant
Technical assistance to 22 counties, mental health providers, Tribal nations and consumers in Minnesota. Grant management (including children's mental health screening and cultural and ethnic minority infrastructure grant). Trainings throughout state on Medicaid requirements.

Face to Face Health & Counseling, St. Paul, Minnesota. 7/2007-11/2008
Director of Mental Health
Provide leadership and direction to mental health department; direct supervisor to 12 therapists. Responsible for grant writing, department budget, strategic planning, and hiring.

Choices Psychotherapy, Brooklyn Park, Minnesota 1/2007-7/2007
Clinical Program Supervisor
Clinical supervisor for practitioners providing rehabilitative services. Diagnostic assessment services for new clients. Hiring and employee performance review.

Ramsey County Community Human Services 9/2001-1/2007
Project Assist Clinician
Provided diagnostic assessment and brief intervention to children and families in the child protection and juvenile justice systems.
Crisis Clinician
Diagnostic, crisis assessment, and brief intervention mobile services to children and families in Ramsey County.
Children's Mental Health Case Management: Initial Response Team
Case load of 15 recently diagnosed or in crisis children, helping to navigate the public mental health system.

PROFESSIONAL AFFILIATIONS & SERVICE

Social Work License

Washington LICSW LW60517736 (Active since 2015)

Minnesota LICSW 15389 (temporary leave)

Academic Service

PhD Application Reviewer, University of Washington 2018-2019
PhD Program Committee Student Representative (Elected), University of Washington 2015-2017
MSW Application Reviewer, University of Washington
Member Social Justice Committee 2016-2018
MSW Application Reviewer, University of Minnesota 2014-2015
MSW Curriculum Development, University of Minnesota 2011-2013

REFERENCES

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