

Evaluating the Impact of the Mental Health Services Act (MHSA) on Reducing Disparities in Access

Deliverable 2c:

Final Analysis of the Impact of MHSA on Reducing Disparities in Access

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Executive Summary

The Mental Health Services Act (MHSA), also referred to in this report as “the act,” mobilized the means for unparalleled coordination of resources to serve children, youth, adults, older adults, and families who have mental health needs. It embodies a historic opportunity to promote progress toward statewide goals of improving access to and enhancing the quality of mental health care, especially for people with mental health needs who are un(der)served. A central and longstanding goal of the MHSA has been to identify and reduce mental health disparities in un(der)served groups. The need for a better understanding of the impact of the MHSA on mental health disparities in un(der)served communities through the lens of MHSA stakeholders has become more pressing due to the prevalence of barriers to care and treatment in California, where the population is diverse and the need for mental health services is high.

The significance of this report is supported by three compelling reasons. *First*, this report serves as an evaluation of the impacts of the MHSA on individuals and families, their communities, and the service delivery system in responding to mental health disparities; it also evaluates the quality of the outcomes of the public mental health system for un(der)served groups in California. In this report, “mental health disparities” refers to a difference in treatment, access, or outcomes in certain population groups that are not justified by differences in that group’s health status, preferences, or socio-demographic composition in the general population. *Second*, this report highlights what stakeholders—consumers and family members, advocates, policy makers, and service providers and administrators—consider evidence of improvement and gaps in mental health services and outcomes. *Third*, the findings from this report are intended to aid the Mental Health Services Oversight and Accountability Commission (MHSOAC) in its efforts to measure the effectiveness of MHSA in improving service access and treatment outcomes in groups experiencing disparities in mental health care.

We used information obtained via a series of key informant interviews with 21 participants in administration, advocacy, consumer care, research, and policy roles. We also convened three focus groups that included 16 Latino immigrants, four transition-age youth from the lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) community, and 22 older adults and caregivers to address three research questions. The research questions, and the key findings from each, are as follows:

1. How has the MHSA helped to address and reduce health disparities for un(der)served groups?

- Prevention and Early Intervention (PEI) funds have been used to establish a set of community-identified strategies to reduce mental health disparities among un(der)served groups.
- Promoting Full Service Partnerships (FSPs) as part of a “whatever it takes” approach to help individuals with serious mental illness has begun to transform mental health services to a recovery-focused system of care. Although FSPs have attained productive results, their effectiveness has not been well documented or reported.

- Emphasis on application of peer-to-peer strategies that focused on education and support services has led to development of statewide educational campaigns to reduce stigma.
- More progress needs to be made in (a) community involvement, (b) strategies to increase workforce diversity, and (c) integration of consumers and family members by implementing and evaluating new strategies via MHSA-funded innovative programs, and later adopting those that are shown to be effective. Those approaches will help fulfill the act's mandate to improve access and enhance the quality of mental health care of un(der)served groups.

2. What are the most common barriers to the effective delivery of mental health care for un(der)served groups in California? In what ways has MHSA helped to mitigate these barriers, and what problems still persist?

- Key informants viewed individual barriers such as language, stigma, geography, lack of knowledge of services, and cost of available care as significant factors that limit access and availability to care and treatment.
- Key informants assessed organizational barriers such as quality and range of care, service capacity, and adequacy as persistent gaps in the appropriateness and capacity of mental health services and providers in serving un(der)served groups.
- The views of key informants suggested several ways that MHSA has and/or can do more to mitigate individual and organizational barriers. First, the implementation of the MHSA meant an expansion of mental health services to current consumers and to historically hard-to-reach segments of un(der)served groups. Second, increasing culturally competent programs in ways that resonate with the targeted un(der)served group is vital to ensure that services are adequate and appropriate. Third, obtaining community-informed perspectives to increase culturally competent programs and community outreach and engagement is a step in the right direction to mitigate barriers to care. This observation suggests that the MHSA should continue to expand services to un(der)served groups while, at the same time, enhancing the act's efficacy via a cultural-and-community-informed perspective.
- Shortcomings in funding allocations that impede the abilities of programs to meet the needs of un(der)served groups must be overcome in order for MHSA to reach its full potential in becoming a mental health transformational framework.

3. What are the current gaps and persistent issues for un(der)served groups?

- An overarching theme that emerged among most focus group participants was an evident lack of general knowledge of MHSA-funded services, treatment options, and locations. Insufficient knowledge and awareness of services is concerning, given the purpose and intent of the MHSA: to provide services that are not already covered by federally sponsored programs or insurance programs.

- Compounding an existing knowledge gap, low literacy and limited English proficiency among un(der)served groups create an initial need for MHSA-funded programs that educate people on how to navigate the mental health system and use of other community support systems to locate services and transportation services.
- Numerous un(der)served communities regularly encounter similar barriers when seeking mental health care. For example, immigrant Latinos, LGBTQ transition-age youth, and older adults reported the cost of care and lack of insurance as persistent barriers to seeking and accessing care. This finding suggest that individuals from these groups are not knowledgeable or have not been successful in finding MHSA-funded services, which are available no cost or low cost to people who lack coverage.
- The responses by focus group participants emphasized that the MHSA should focus on (a) language proficiency, (b) cultural competency, (c) diversity and inclusion, and (d) the integration of consumers and families when attempting to strengthen linkages between the mental health system and un(der)served groups.

In conclusion, our findings of this report suggest that MHSA has and continues to have an impact on reducing disparities among un(der)served groups. The findings indicate that key informants recognize MHSA's commitment to invest in resources that build the capacity of un(der)served communities. For example, informants acknowledged Prevention and Early Intervention (PEI) and Full Service Partnerships (FSPs) as two major examples that strengthen the linkages between un(der)served groups and access to care. Furthermore, we have learned through this study that more must be done to increase culturally competent programs and community outreach and engagement in order to ensure that services are adequate and appropriate to targeted un(der)served groups. This study is grounded in community-based participatory research (CBPR), by obtaining stakeholders' perspectives to assess the effectiveness of the MHSA on delivery of services for un(der)served groups. As a result, the persistent focus of MHSA on mitigating barriers to care constitutes a step in the right direction. We encourage the continued integration of stakeholder perspectives, so that diversity in perspectives drives the conversation about community-informed access to care and treatment. That strategy emerged as a consistent theme throughout this report as a significant means to help MHSA continue transforming mental health services that mirror the composition of un(der)served groups in California. In this report, our stakeholders describe their experiences with and perceptions related to access and appropriateness of mental health services, which were expanded under the MHSA. We propose that this report, including the incorporation of public responses to the draft of this report, serves as part of an ongoing dialogue between administrators of mental health services and the people they serve.

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Introduction

“To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals’ or families’ insurance programs.”

– Mental Health Services Act: Purpose and Intent

The Mental Health Services Act (MHSA), also referred to in this report as “the act,” mobilized the means for unparalleled coordination of resources to serve children, youth, adults, older adults, and families who have mental health needs. It embodies a historic opportunity to promote progress toward statewide goals of improving access to and enhancing the quality of mental health care, especially for people with mental health needs who are unserved or underserved. A central and longstanding goal of the MHSA has been to identify and reduce mental health disparities in unserved, underserved, and inappropriately-served populations (hereafter referenced as un(der)served groups). The need for a better understanding of the impact of the MHSA on mental health disparities in un(der)served communities through the lens of MHSA stakeholders has become more pressing due to the prevalence of barriers to care and treatment in California, where the population is diverse and the need for mental health services is high. A recent study derived from the California Health Interview Survey (CHIS) revealed that one in five (or 4.9 million) adults in California reported needing support for a mental health problem (Grant et al., 2011). After estimating the presence of serious psychological distress, the investigators noted that about 2 million adults in California presented with serious mental health needs. Of these 2 million Californians, only half received mental health treatment in the past year, one quarter received some treatment, and the remaining quarter received minimal treatment.

Research also has established that ethnically and racially diverse groups face multiple barriers in accessing and utilizing high-quality mental health treatment; such groups include older adults; transitional age youth (TAY); the lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ) community; foreign-born individuals; and individuals with limited English proficiency (Aguilar-Gaxiola et al., 2012; Sorkin, Pham, & Ngo-Metzger, 2009). Difficulty navigating mental health systems, low numbers of ethnically diverse service providers, lack of culturally and linguistically competent care, limited transportation, and stigma are among the barriers that prevent vulnerable groups from accessing services and treatment (Clark et al., 2013). Access to mental health treatment among un(der)served groups is complex and often associated with stigma. For example, within California, Asian and African American males, foreign-born Latinos and Asian Americans, older adults over the age of 65, and young adults 18–24 years of age report unmet mental health needs due to stigma concerns (Clark et al., 2013).

American Indians and Alaska Natives, biracial Californians, sexual minorities, and single heads of households presented with high levels of mental health needs. U.S.-born Latinos also were found to present with twice the risk for mental health needs in comparison to foreign-born Latinos. Young adults 18–24 years of age, older adults 65 and older, those with low levels of education and limited English proficiency, foreign-born Latinos and Asians, as well as Asian

Americans and African Americans were found to be less likely to receive any form of treatment. When looking at health coverage, Grant and colleagues (2011) found that individuals without coverage and individuals with access to public health insurance were strongly associated with higher mental health needs among all adults interviewed. Paying careful attention to the underlying issues and needs of un(der)served groups, and avoiding the assumption that access to health coverage alone will improve their mental health status, are vital in reducing disparities and simultaneously improving the health of all communities in California.

The significance of this report is supported by three compelling reasons. *First*, this report serves as an evaluation of the impacts of the MHSA on individuals and families, their communities, and the service delivery system in responding to mental health disparities; it also assesses the quality of the outcomes of the public mental health system for un(der)served groups in California. In this report, “mental health disparities” refers to a difference in treatment, access, or outcomes in certain population groups that are not justified by differences in that group’s health status, preferences, or socio-demographic composition in the general population. *Second*, this report highlights what stakeholders—consumers and family members, advocates, county supervisors, and mental health service providers and administrators—consider evidence of improvement and gaps in mental health services and outcomes. *Third*, the findings from this report are intended to aid the Mental Health Services Oversight and Accountability Commission (MHSOAC) in its efforts to measure the effectiveness of MHSA in improving service access and treatment outcomes in groups experiencing disparities in mental health care.

The Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA), approved by California voters in November 2004, has created a historic opportunity to expand programs to serve children, youth, adults, older adults, and families who have mental health needs. Inspired by innovative models of mental health treatment offered in California—such as those enabled and evaluated via Assembly Bill (AB) 2034, a recovery-oriented model targeting the homeless—the MHSA constitutes an unparalleled mechanism to improve timely access to services for un(der)served groups and to reform the fragmentation of mental health systems and services (Cashin, Sheffler, Felton, Adams, & Miller, 2008). The MHSA increased funding for county mental health programs, while promoting progress in the improvement of services for children, transitional-age youth (TAY), older adults, and families (California Department of Mental Health [DMH], 2011). MHSA obtains its funding from a 1% tax imposed on California residents whose income exceeds \$1 million annually. To date, MHSA has funded an estimated \$7.4 billion for counties during fiscal years 2006–2007 through 2011–2012 (California State Auditor, 2013). Lawmakers hoped that by taxing Californians who have the highest incomes, the MHSA would obtain the revenue to expand funds for mental health services, while protecting existing vital state services from being cut (DMH, 2011).

The MHSA's funding is divided into five main funding initiatives: (1) Prevention and Early Intervention (PEI), (2) Workforce Education and Training (WET), (3) Capital Facilities and Technological Needs (CF/TN), (4) Innovation (INN), and (5) Community Services and Supports (CSS), which include the Full Service Partnership (FSP). These five areas furnish guidelines for expenditure of the MHSA monies (i.e., funds distributed to county departments of mental health). The act also outlines its nine values as a framework to increase access to mental health care and to ensure a consumer-driven mental health system (MHSA, 2004, as cited in UCLA Center for Healthier Children, Families, and Communities, 2011, 2013). These nine values are:

1. Client and family involvement and engagement
2. Disparities in access and outcomes
3. Cultural competency
4. Recovery/resiliency and wellness orientation
5. Integrated mental health services
6. Integration with substance abuse services and primary care
7. Community partnerships and systems collaborations
8. Stakeholder involvement throughout the public mental health system
9. Co-occurring disorder services competency

Achievements of the Mental Health Services Act (MHSA)

Since its implementation, the MHSA has achieved numerous accomplishments throughout California. An evaluation of consumer services and supports found reductions in homelessness, psychiatric hospitalizations, incarcerations, and physical health emergencies, along with improvements in mental health functioning in adults and older adults, although no improvements

occurred in employment status or evidence of improved educational outcomes (UCLA Center for Healthier Children, Families, and Communities, 2011). Reiter and colleagues (2012) determined that the availability of consumer-run and consumer driven-services has increased throughout the state. The MHSA has offered funds for development of Full Service Partnerships (FSP), which are intensive case management services throughout the state for individuals who have serious mental illness. The MHSA led to the development of the *California Strategic Plan on Reducing Mental Health Stigma and Discrimination*, a 10-year plan to fight stigma and discrimination related to mental health problems (Clark et al., 2013). Research also associates the MHSA with a reduction in involuntary psychiatric holds, as a result of enhanced access to community-based resources (Bruckner, Yoon, Brown, & Adams, 2010). Other research, specifically exploring 12 California counties, found that the MHSA prompted an increase in availability of evidenced-based treatments, peer support services, and culturally competent care in 141 mental health programs in those counties (Cashin et al., 2008).

Building on past achievements, the California Reducing Disparities Project (CRDP), Cultural Competence Planning (CCP), and collaboration to increase stakeholder engagement are among the activities that represent MHSA's commitment to reduce mental health disparities in care. Given the importance of these projects to the MHSA, we briefly explore literature that relates to these statewide projects.

California Reducing Disparities Project (CRDP)

To better understand and respond to the mental health disparities affecting diverse groups within the state, the Mental Health Services Oversight and Accountability Commission (MHSOAC) in 2009 authorized funding for the California Reducing Disparities Project (CRDP) targeting five un(der)served groups: (1) African Americans; (2) Asian/Pacific islanders; (3) Latino/as; (4) Native Americans; and (5) lesbian, gay, bisexual, transgender, queer and questioning (LGBTQ). The aim of the CRDP was to identify community-defined solutions and strategies, including meaningful culturally and linguistically competent programs and services to meet the unique mental health needs of the five racial, ethnic, and cultural populations identified for the CRDP. The CRDP is supported by the California MHSA Multicultural Coalition (CMMC). Formed on March 2011, the CMMC aims to identify challenges in access to care among underserved communities and to recommend solutions for the development of more culturally and linguistically appropriate mental health systems. Composed of representatives from various underserved communities throughout California, the CMMC offers the CRDP valuable insights from diverse multicultural perspectives, inclusive of consumers and family members, that have not been previously represented in mental health systems (Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), 2013).

In 2012, the population-specific reports for the five identified groups were completed and disseminated. The CRDP is entering its implementation phase and is in the process of putting into action the identified practices and strategies at local levels. The population-specific reports from the five Strategic Planning Workgroups (SPWs) representing the African American, Asian and Pacific Islander, Latino/a, LGBTQ, and Native American communities informed the development of a comprehensive, statewide strategic plan to reduce mental health disparities.

Overall, the population reports developed by the five SPWs found similar barriers related to accessibility, availability, appropriateness, affordability, and advocacy. The SPW reports also present a framework or roadmap for each un(der)served group, with community-defined strategies and solutions to reduce disparities, while at the same time transforming the public mental health system. Summaries of the five SPW reports can be found in the 2014 *California Reducing Disparities Project Strategic Plan to Reduce Mental Health Disparities*.

We anticipate that, when the comprehensive CRDP Strategic Plan is publicly released in the spring of 2014, the practices and strategies that the CRDP identified will be implemented and integrated in all MHSA-funded programs. The CRDP strategic plan calls for an evaluation component to determine the effectiveness of the community-defined evidence in reducing disparities listed in the SPW reports. While we acknowledge that the release of the comprehensive CRDP strategic plan is in its initial stage, we endorse its intentions to combine the community-identified strategies from the five SPW reports, and implement and assess the effectiveness of these interventions.

Cultural Competence Planning (CCP)

In addition to activating the CRDP, California also is the first state to require each county to submit Cultural Competence Plans (CCPs) delineating strategies for resolving their own disparities (California Office of Multicultural Services, 2011).¹

The goals of the CCPs were to:

1. Establish standards and requirements to create consistency in the reporting of data. This drive toward consistency was designed to enable the former California Department of Mental Health (DMH) to monitor improvements in the creation of more culturally competent county mental health systems over time.
2. Improve access and the quality of care in mental health services for un(der)served racially and ethnically diverse Medi-Cal beneficiaries.

The UC Davis Center for Reducing Health Disparities recently reviewed CCPs, the most recent of which were submitted in 2010, and presented findings in a separate report supported by the MHSAOAC.² Additionally, the Mental Health Services Division of the California Department of Health Care Services is preparing plans for revision and future assessments of the CCPs, so that counties may continue to formulate and submit their plans to reduce mental health disparities.

¹ As defined in CCP of 1997: A set of congruent practice skills, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations (adapted from Cross et al, 1998).

² Please refer to the *Analysis of the Mental Health System Response to Reducing Disparities in MHSA Systems of Care From Available County Care Obtained Through County Submitted Information*, completed by the UC Davis Center for Reducing Health Disparities.

Collaboration Activities to Increase Stakeholder Engagement

In 2012, the MHSOAC partnered with the UCLA Center for Healthier Children, Families, and Communities to conduct a statewide participatory evaluation. Participating mental health consumers and family members recommended evaluation of specific MHSA-funded services with emphasis on consumer perceptions of these services (e.g., ease of access, appropriateness of services, continuity of care, and recovery orientation). The services that the UCLA Center evaluated included peer support services, employment support services, and crisis intervention services. In this evaluation the UCLA research team conducted a mixed-methods analysis that included the “lived experience” of ethnically diverse individuals, consumers of mental health services, parents of children who have received mental health services, and family members. Of a total of 949 individuals who were surveyed, 40 were interviewed to explore their various experiences and perceptions of services. Findings suggested services are accessible and individualized for most, but remain elusive for individuals with disabilities and for homeless people. No differences occurred in employment or housing status among those who received or did not receive services. Yet, those who did receive employment and housing services found those services contributed to improvements in their living situations. Access to services also positively correlated to service experiences as well as to perceptions of personal recovery and resilience.

An evaluation that the UCLA Center for Healthier Children, Families, and Communities conducted in 2012 found little evidence suggesting stakeholder involvement in the public mental health system; the low level of participation impedes the progress of MHSA-funded services for un(der)served groups. This key finding underscores the idea that the effectiveness of a progressive public mental health system depends on stakeholder involvement and representation of un(der)served groups. A 2011 systematic review of existing MHSA evaluations, studies, and county documents similarly found that stakeholder involvement in MHSA-funded services and their evaluation was minimal (UCLA Center for Healthier Children, Families, and Communities, 2011). For example, one study mentioned involvement of consumers in only one county’s FSP program. Two additional county reports noted consumer involvement; one county highlighted a PEI program that supported consumer leadership roles, while the other described consumer involvement in program planning. Seven additional counties also described consumer involvement in peer support programs, steering committees, advocacy groups, and as program support staff. Those findings contrast strongly with the requirement for all counties receiving MHSA funding to develop and implement a stakeholder planning process to guide their MHSA-funded programs. Recognizing the value of involving stakeholders in program planning, MHSOAC is supporting an evaluation of county MHSA stakeholder planning processes. Specifically, the MHSOAC-sponsored evaluation will assess counties’ local planning processes. This is a step in the right direction to adequately evaluate the degree to which counties involve stakeholders and to ensure the full participation of stakeholders in MHSA-funded mental health services. In spite of this step, advocates for communities of color and underserved communities argue that attention and outreach to people who have sufficient knowledge of and connection to these communities remain inadequate.

A recent audit of the MHSA conducted by the California State Auditor and released in August 2013 also reported the need to improve stakeholder involvement in program planning and services. The state audit indicated that MHSA *requires* counties to create plans for addressing the mental health needs of their communities, to include stakeholders in the planning process, and to subsequently update plans annually. While the four counties (Los Angeles, Sacramento, San Bernardino, and Santa Clara) reviewed in the audit complied with stakeholder involvement requirements through the inclusion of stakeholders in planning processes, the counties did not consistently document these intentions in their MHSA plans and annual updates, which were shared with stakeholders. Again, adequate evaluation and engagement approaches to initiate and strengthen stakeholder involvement can lead directly to a better understanding of the needs of un(der)served groups. This notion is interwoven with access to quality of care and treatment that so many un(der)served groups aspire to attain. Disparities among un(der)served groups are large and continue to impede their path to wellness if the key stakeholders are not at the table.

Purpose and Research Questions

The overall aim of this report was to apply community-based participatory research methods to conduct an analysis of consumer³ and family member perspectives regarding impact of the MHSA on disparities. Using a qualitative approach, we examined stakeholders' perspectives on the effectiveness of MHSA. Specifically, three questions guided this evaluation and subsequent report. They are:

1. How has the MHSA helped to address and reduce health disparities for un(der)served groups?
2. What are the most common barriers to the effective delivery of mental health care for un(der)served groups in California? In what ways has MHSA helped to mitigate these barriers, and what problems still persist?
3. What are the current gaps and persistent issues for un(der)served groups?

³ Although the terms “client” and “consumer” often are used interchangeably, this report consistently uses the term “consumer” in reference to persons who are actively partaking in mental health services.

Research Methodology

We engaged multiple stakeholders in this evaluation. Stakeholder involvement included participation in key informant or focus group interviews, engagement on our advisory panel, and critiquing a draft version of this report, which was circulated for public comment for a period of thirty days (see **Appendix F** for feedback and responses). This section of the report includes a description of our project design, which explains the methods and instruments used in data collection, the stakeholders involved in data collection and review, and the process of data analysis that led to our findings.

Study Design

This section describes our approach to this evaluation, which consisted of four parts: (1) qualitative and community-based participatory research (CBPR) methods, (2) systematic document review, (3) establishment and engagement of a Community Expert Advisory Board (CEAB), and (4) interviews with key informants and stakeholder groups. Each of these methods is described in detail below.

Qualitative Methods and Community-Based Participatory Research (CBPR)

The purpose of qualitative methods of research is to gain an understanding of the experiences of those engaged in mental health services. *Qualitative methods* consisted of interviews with key stakeholders, including mental health administrators, advocates, and providers associated with mental health service delivery, as well as individuals at risk of and living with serious mental illness, their family members, and personal caregivers, who were part of historically un(der)served groups. Interviews were employed in order to have an open-ended, directed conversation that could explore stakeholders' "firsthand knowledge and experience" with California mental health service systems and the impact of the MHSA. **Appendix A** contains a diagram of the methodology employed in this report.

CBPR was used with qualitative methods of sampling, data collection, and analysis, in an effort to understand the perspectives and values of persons and groups that are not adequately represented by traditional, more quantitative models of research (Denzin & Lincoln, 2000; Minkler & Wallerstein, 2010). CBPR involved inclusion of typically un(der)served subgroups in the research processes of data collection, interview participation, analytic feedback and review. Inclusion of un(der)served subgroups in the research process involved collecting data from un(der)served groups as well as enabling persons from these groups to participate in crafting guiding questions (i.e., those questions that helped guide data collection during the interview process) and in interpreting responses to these questions (part of data analyses). We engaged various stakeholders at different levels—consideration of interview topics, identification of interviewees, review of drafted report findings for analytic clarity, and gaps in responses. Engagement of specific stakeholders is described in detail throughout this report. Our approach to understanding diverse stakeholder perspectives (including administrative, advocacy, service provider, consumer, and family perspectives) on the ability of the MHSA to reduce disparities in

access, quality of services, and outcomes also involved a content review of current documents relevant to understanding mental health services, consumer needs, and disparities (Minkler & Wallerstein, 2010).

Establishment and Engagement of a Community Expert Advisory Board (CEAB)

The Community Expert Advisory Board⁴ was formed to give community members a means to offer informed insight into community perspectives and needed levels of engagement. Our CEAB was composed of four leading mental health services experts and peer advocates; they included executive directors, advocates, and peer supporters of several un(der)served groups, including Native Americans, older adults, young adults (TAY), and consumers with lived experiences and their families. Members of our CEAB advocate for improved treatment and resource support for mental health needs in Northern and Southern California.

Our CEAB assisted in identifying relevant experts for interviews based on the goal of representing diverse populations, geographic regions, counties, and services in California. We also aimed to ensure a diversity of viewpoints (i.e., provider, consumer, administrator, service agency representative, mental health activist, or family members of a mental health services consumer). We solicited participants to represent and/or articulate the experiences of un(der)served groups, including, for example, Native Americans, people living with serious mental illness, and LGBTQ communities. Specifically, our CEAB assisted in targeting additional key informants beyond those initially identified by MHSOAC and our project team. After compiling a broad-ranging list of potential key informants, our CEAB assisted in the selection of 24 key informants to represent diverse viewpoints and experiences with MHS administration, programs, and services.

Our research team met with the CEAB four times during an eight-month period, and solicited comments frequently during these meetings via telephone calls as well as by electronic mail. Our team sought advice from the CEAB regarding gaps in our list of key informants for interviews, including their informed understandings of the relationship of the potential key informant to the MHS as well as the types of underserved populations, racial and ethnic communities, and geographic areas the key informants represented. CEAB members provided a critical eye that helped to inform the selection of a range of key informants who could speak to the need of diverse persons and communities. Engagement with our CEAB assisted us in refining our initial list of key informants, as well as our strategy for sampling informants and specific focus group participants, based on the barriers that impede their access to appropriate and effective care. Our CEAB generated especially useful suggestions that were pivotal in identifying, recruiting, and sampling of mental health-care advocates and consumers and in ensuring the relevance of our plan to consumers and family members. Following data collection and preliminary analyses, members of our CEAB reviewed and critiqued a draft of our report, and their suggestions have been incorporated into this report. After producing several iterations of the key informant list and conducting discussions about the key informants to be interviewed with our CEAB, we targeted 24 key informants for interview.

⁴ Names of CEAB members are withheld in order to protect their confidentiality.

Systematic Document Review: Scope of Study and Topics of Interest

To inform our exploration of stakeholder viewpoints and experiences, we conducted a systematic review of relevant literature and documents. We concentrated on developing an interview guide for stakeholders that would assist us in accomplishing an essential goal: Describe the recent climate of MHSA with specific attention to varying perspectives that might reveal insight into further questions that need to be explored. The answers to those questions would improve understanding of the impact of the MHSA on the reduction of disparities in access, quality of services, and outcomes.

We compiled an exhaustive list of documents based on specific recommendations by MHSOAC as well as academic and other documents that met the following criteria:

1. Seminal academic, peer-reviewed articles related to mental health disparities among diverse racial, ethnic, cultural, and LGBTQ groups;
2. Publications from consumer advocacy groups, such as the National Alliance on Mental Illness (NAMI) or the California Network of Mental Health Clients (CNMHC);
3. Evaluation reports completed by MHSOAC contractors;
4. Selected County Cultural Competence Plans, which outline each county's plans to improve the cultural competence of MHSA-funded mental health programs;
5. Selected MHSA plans and annual updates, which contain current information on programs funded by MHSA (e.g., California Reducing Disparities Project Populations Reports).

Appendix B includes the specific list of documents on which our review was based.

A subset of the research team conducted the systematic review, which involved a methodical and iterative examination of all documents that met the five criteria. As a part of their systematic evaluation, the reviewers made special note of the following items reported in the documents:

1. Current perceptions of the MHSA;
2. MHSA-related contributions to the California mental health delivery system;
3. Recent questions posed about the mental health delivery system and specific populations served;
4. Challenges and benefits of service delivery and quality;
5. Groups that are un(der)served in existing service delivery programs; and
6. Expressed recommendations for improved service delivery and administration of MHSA-funded programs.

Reviewers also identified, where specified, subgroups or topics of interest that require further exploration and explanation.

While we reviewed numerous documents, as described, specific documents highlighted particular topics and subgroups of interest and repeatedly emphasized important guiding questions for key informant and focus group interviews, which were specifically relevant to the goals of contract Deliverable 2. The documents we reviewed, important topics presented therein, and relevant interview questions are presented in **Appendix C**.

The documents, related concepts, and guiding questions listed in **Appendix C** provided an unobtrusive method for exploring various stakeholder opinions. The benefits of unobtrusive methods, such as document review, are that they are low in cost and illuminate some of the assumptions and persistent questions of stakeholders. The questions following from these documents helped in shaping an initial template for what eventually resulted in a refined list of guiding questions for interviews with key informants and focus group participants (see **Appendices D and E**, respectively, for the guiding questions and prompts for these interviews).

Interview Structure, Content, and Participants

We conducted two types of interviews: Key informant interviews (Gubrium & Holstein, 2001) and focus group interviews of un(der)served subgroups (Bloor, Frankland, Thomas, & Robson, 2001). All interviewees gave informed consent before participating in the interview. Key informants were compensated \$35 each for their participation in an interview. Focus group participants were offered light refreshments and compensated \$35 each for their participation in a single focus group interview. In addition, caregivers who took time off work to participate in group interviews were given a \$100 gift card, and those who assisted with transportation were reimbursed for mileage. All interviews were digitally recorded and transcribed verbatim for analysis.

Key Informant Interviews

An experienced interviewer conducted key informant interviews of 45–90 minutes over the telephone. Interviews were guided by an interview script that contained a set of guiding questions and prompts, which were used to explore a range of viewpoints and experiences. **Appendix D** contains the script used for key informant interviews.

Key informants consisted of stakeholders in administrative service and delivery or in the provision or receipt of care. Those identified as potential candidates for interviews served central roles within specific communities (e.g., community leaders, religious leaders, advocates, health educators); direct(ed) community-based agencies; or were identified as consumers, family members, and/or persons actively engaged in community health treatment, prevention and promotion at the grassroots level within communities of concern. Through multidisciplinary team review, consultation with MHSOAC during biweekly meetings, and two rounds of CEAB input and discussion, we examined our entire list of potential key informants. We then divided the list into substrata, which defined the potential key informants' diverse relationships to and experiences with California mental health services and the MHSA. We then purposively sampled from among each of the substrata to ensure diverse representation of key informants in these substrata.

During the months of August through October 2013, a total of 24 key informants living in Northern, Central, and Southern California were identified for interview. Of the 24 persons selected, 21 agreed to participate in an interview; one potential participant could not be interviewed during the time frame allotted for data collection, and two did not respond to a minimum of three attempts to contact by telephone and e-mail.

Although a total of 21 key informant interviews were completed, only 19 of the 21 participants voluntarily completed demographic questionnaires. The demographic data that the 19 interviewees submitted indicated that participants ranged from 26 to 73 years of age (with a mean of 52 years of age); participants included 10 women, eight men, and one participant who identified gender as queer. Among our sample, six identified as LGBTQ and the remaining sample identified as heterosexual. Five participants identified as of Hispanic ethnicity; 14 as non-Hispanic White. Self-reported racial identification included eight Whites, three Asian Americans, two African Americans, one Native Hawaiian, one Native American, and two biracial participants. Thirteen informants reported having a graduate degree, one held a college degree, and two attended some college; the rest of the sample reported having a high school degree. All but one key informant was employed at the time of interview. Thirteen participants reported earning more than \$100,000 annually, two earned between \$50,000 and \$60,000, and one reported earning less than \$20,000 in the previous year; the remaining three did not report their income. All the participants reported having health insurance. The reliance on volunteers and recruiting participants based on our CEAB recommendations may have led to a somewhat larger non-Hispanic White and highly educated subpopulation. Three of the 19 reported accessing a mental health provider in the previous year. **Table 1** below summarizes key informants' responses when asked about their primary role with mental health services in California.

Table 1. Interviewee's Primary Role With Mental Health Services

Informant-identified mental health service roles	N
Administrative	8
Advocacy/activism	5
Consumer or consumer care provider	3
Research	2
Policy maker	1
Total	19

Focus Group Interviews

Focus group interviews were conducted in locations familiar and convenient to participants and lasted 70 to 90 minutes. Groups were led by a trained moderator and by a community member who assisted with group recruitment. Interviewers used an interview script that contained a set of guiding questions and prompts, which were used to explore a range of viewpoints and

experiences. **Appendix E** contains the script used for focus group interviews. The moderator was skilled in using the interview script as well as in clarifying unclear concepts or terminology for diverse participants. Trained moderators have the capacity to respond to the needs of specific participants and to ensure that participants understand the kinds of questions being asked. In addition, the inclusion of community members helped to ensure clarity in the presentation of interview questions. Our team shared the interview guide and analytic plan with our CEAB, and we revised our questions in response to the feedback we obtained. Our set of guiding questions was then reviewed and approved by our institutional review board (IRB), which includes community members local to the institution. Before conducting the focus group interviews, we piloted the questions in a focus group interview with members of the general public, and adapted minor changes to question wording based on their suggested feedback.

Focus group participants were purposefully targeted based on several factors, including discussions and recommendations by MHSOAC, identification during key informant interviews, critical review and discussion with our (CEAB), and factors that our literature review identified as significant barriers to effective care. Three populations were targeted for focus group interviews, based on their experiences of multiple and significant barriers to appropriate mental health service. Latino Immigrants in the Central Valley (Merced County) were selected for interview based on barriers related to geographic, language, and immigrant status. LGBTQ transitional-age youth (Sacramento County) were selected for interview based on barriers related to age (18–24 years)⁵, relation to adult parents or guardians, and gender/sexual orientation. Older adults and caregivers (San Diego County) were chosen for focus group interview based on potential barriers related to age, familial engagement/ surrogacy, comorbidity, and health-related conditions. The factors around which focus group participants were selected affect multiple groups, not simply those selected for interview. Our goal was to learn from these groups about the multiple and diverse barriers to appropriate and effective mental health services delivery and to use these data as starting points for exploring the barriers encountered by other un(der)served groups who face similar obstacles.

Focus groups were conducted in three California counties—Merced, Sacramento, and San Diego—between mid-October and late November 2013. These counties were selected from among the counties in California due to their geographic location, size, and diversity of their constituencies. A total of 42 persons participated in focus group interviews. Focus groups varied from four to 22 participants.

Latino Immigrant Group (Merced County)

The Latino immigrant focus group was conducted in Spanish, the native language of the groups' participants, and held in California's Central Valley. Individuals were recruited through an English as a Second Language (ESL) program that is subsidized by MHS Innovation funds. ESL class leaders and community health workers assisted in recruiting focus group participants

⁵ We did not attempt to recruit or interview youth under the age of 18 because the consent processes require different protocols than those covered by our Institutional Review Board for this project.

beyond the 10 participants enrolled in the ESL class. Members of the ESL class were encouraged to bring a family member or friend to participate in the group discussion.

The focus group had 16 participants, two of whom declined to complete a demographic questionnaire. The 14 participants who completed a questionnaire ranged from 22 to 54 years of age (with a mean of 34 years of age); they included five women and eight men. All but three participants reported that they were married. Only two individuals completed 12th grade or obtained a GED. Five participants reported being unemployed; those who stated that they were employed reported annual incomes ranging from \$10,000 to \$50,000. Three participants stated they earned \$10,000–\$20,000, five earned \$20,000 to \$30,000, and four participants reported earning between \$30,000 and \$50,000 in the previous year. Only one of the 14 persons who completed the questionnaire reported that they had health insurance. When asked about their mental health status, six reported having “excellent” mental health, six reported having “good” health, one reported “very good” health, and one reported “fair” mental health. Two of the participants reported use of a mental health provider within the past year.

LGBTQ Transitional Age Youth Group (Sacramento County)

The LGBTQ transitional-age youth focus group was held at a local meeting site for LGBTQ youth. Recruitment for this group was particularly challenging, despite intensive consultation with LGBTQ advocates and contact with various LGBTQ service providers. Several agencies and programs servicing LGBTQ youth were contacted for permission and assistance to recruit potential participants from active support groups; these groups, however, were hesitant about granting contact to these youth, considering them particularly vulnerable because of their sexuality and mental health-related issues. We, therefore, reached participants for this group by way of Listserv posts and distribution of flyers. These methods of recruitment also preserved the confidentiality of LGBTQ youth associated with our contact persons and organizations.

The focus group of LGBTQ transitional-age youth consisted of four participants, all of whom submitted demographic information. Participants ranged from 18 to 26 years of age (with a mean of 22.5 years of age); all of the participants identified as women. Two identified as lesbian/gay, one as bisexual, and one as pansexual. Two participants said they were each in an unmarried committed couple relationship, one was married, and one has never been married. All of the participants identified as White, with two of the four reporting being Latina. Three participants reported attending college, and the formal education of the remaining member ended with completion of the 12th grade. Participants claimed annual incomes ranging from less than \$10,000 to \$40,000. Two persons noted that they had health insurance. Two described their mental health status as “excellent”, one as “good,” and the other as “fair.” One of the participants reported use of a mental health provider within the past year.

Older Adult and Caregiver Group (San Diego County)

The older adult and caregiver focus group was convened in an urban area of San Diego County. Older adults and caregivers of older adults were recruited with the assistance of community health workers, mental health program coordinators, and prevention services managers associated with San Diego County Behavioral Health Services as well as Adult and Older Adult

Behavioral Health Services. We included both older adults and caregivers, because limitations of multiple comorbid conditions limited some older adults from participating in focus group discussions. Therefore, caregivers were encouraged to participate, so as to share the perspectives of these consumers. The focus group was conducted in the facility of a community organization serving multicultural older adults, supported by MHSA prevention and early intervention funds. The community health workers, program managers, and coordinators assisted in recruiting diverse older adults and caregivers from various communities throughout San Diego County. The group included 22 participants, three of whom reported being caregivers for family members who were older or experiencing a serious mental illness and were in need of services.

All of the participants completed a demographic questionnaire. Participants ranged from 52 to 80 years of age (with a mean of 66 years of age); participants included 14 women and eight men. Nine participants reported being married; two were divorced; six were widowed; two were separated; and three were never married. Fifteen of the participants identified their ethnicity as Latinos. Twelve identified their race as White; five as Asian American; two as Mexican; one as Latino; and two did not list their race. Four participants reported never having formal schooling; eight had less than a high school education; two completed high school and/or obtained a GED; five had enrolled in some college courses or earned a four-year college degree; and three attained a graduate degree. Only eight participants reported their annual income, all claiming less than \$10,000 in the past year (the others declined to state their income). Only one member of this group reported having an “excellent” mental health status; six reported their status as “very good”; six participants reported having a status of “good”; five described their status as “fair”; two described their health as “poor”; and two did not report their mental health status. Among our older adult participants, 15 said they had health insurance, and four participants reported seeing a mental health service provider within the past year.

Data Analysis

Our data analysis included “fact checking” by our interviewees and by way of a 30-day public comment period, which were used to assess the relative accuracy of the data collected and our interpretation of these data. All persons who participated in an interview (key informant or focus group) or assisted in recruitment of focus group participants were sent our analysis of the interview data for review. Approximately 15% of persons who participated in a key informant or focus group interview or who assisted in participant recruitment provided feedback to our original report (Deliverable 2b). We have incorporated and responded to interviewee and public comments made on a draft of this report, which was circulated on February 15, 2014.

We reached theoretical saturation in the themes presented in this report. Theoretical saturation is the point at which key informants and members of focus groups became redundant in their responses to guiding interview questions and contributed no new data, and when additional responses might be predicted on the basis of those already provided (Morse, 2004). In qualitative methods of analyses, saturation (redundancy in response patterns) is the point at which a sample is considered significant in size (Morse, 2004). Although we reached saturation in the general barriers focus group participants described, we suggested that further delving into

the barriers experienced by various groups will yield more nuanced understandings of how multiple factors create or enhance barriers for diverse un(der)represented communities.

Key Informant Interviews

Analysis of key informant interviews involved an iterative and inductive process of transcript review by multiple members of the multidisciplinary team. In our first set of meetings, we created an outline of the key themes and ideas that we observed emerging from key informant responses to guiding interview questions and probes (guiding questions are shown in **Appendix D**). Next, we established a framework for examining those themes and ideas, based on the examples prevalent in key informant responses (Miles & Huberman, 1994). Our team generated a list of themes that included identification of salient (recurring) factors and associated “stories” and their contexts, and examined these factors across all 21 key informant interviews (Denzin & Lincoln, 2000).

To address our specific research questions, team members convened multiple meetings that were intended to:

1. Outline what key informants described as the greatest successes and accomplishments of the MHSA, and for which groups;
2. Develop a list of what key informants reported that they perceived to be significant barriers to the effective delivery of mental health care, and describe specific barriers for the most un(der)served groups;
3. Examine discussions about the groups that key informants believe have experienced the greatest disparities in mental health services, prior to and following the establishment of the MHSA; and
4. Ascertain what informants perceive that the enactment of the MHSA has done in an attempt to mitigate some of the barriers that exist for the un(der)served groups in California.

Focus Group Interviews

Analysis of focus group interviews involved an iterative and inductive process of transcript review by multiple members of the multidisciplinary team (Miles & Huberman, 1994; Morgan & Krueger, 1997). We used a method similar to that employed for analyzing key informant interview data (Denzin & Lincoln, 2000; Miles & Huberman, 1994). We created an outline of the key themes and ideas that we observed emerging from focus group members’ responses to guiding interview questions and probes (the interview script and guiding questions are shown in **Appendix E**). However, to better understand the experiences and needs of un(der)served groups and their families, we examined the barriers related to the special needs of the focus group population; gaps in mental health services delivery and consequences for mental health and related quality of life; and group recommendations for accommodating community needs (Morgan & Krueger, 1997).

All research team members discussed and reviewed this list of themes and contexts obtained from interview data, and a computer-based coding system was established using a computer software program for indexing, searching, and comparing themes that emerged from the data.⁶ A research assistant uploaded data from the transcripts into an online computer program so that each of the transcripts could be systematically indexed and searched for the persistent themes, enabling methodical exploration of the context of these themes across key informant interviews and focus group transcripts.

⁶ Dedoose. Qualitative Research Data, accessed December 19, 2013, from <http://www.dedoose.com/>.

Findings

This section explores our three research questions:

1. How has the MHSA helped to address and reduce health disparities for un(der)served groups?
2. What are the most common barriers to the effective delivery of mental health care for un(der)served groups in California? In what ways has the MHSA helped to mitigate these barriers, and what problems still persist?
3. What are the current gaps and persistent issues for un(der)served groups?

To examine these questions, we first describe the recurring responses (themes) that emerged from the interviews, and we excerpted statements relevant to these themes. Following the presentation of each research question, the recurring themes, and example interview excerpts, we offer a brief summary of our findings to address each of the three questions highlighted below.

None of our focus group participants had an awareness of the Mental Health Services Act (MHSA), its ability to respond to health disparities, or most common barriers to the effective delivery of mental health care services in California (issues that pertain to questions 1 and 2 above). As a result, we offer information that our key informants offered to address the first two research questions. Our presentation of findings pertaining to our third research question is based on key informant viewpoints of consumer experiences and the actual experiences described by our focus group participants. The fact that none of our focus group participants had an awareness of the MHSA or its impact suggests that opportunities for increasing awareness and potential engagement of consumers that have not yet effectively been employed.

Key Findings to Research Question 1: How has the MHSA helped to address and reduce health disparities for un(der)served groups?

The key informants were encouraged about the progress and contributions of the MHSA programs in reducing disparities in mental health services for the un(der)served groups in California. In particular, key informants applauded the Prevention and Early Intervention (PEI) programs' focus on targeting early onset of mental health needs through innovative and less stigmatizing approaches among un(der)served groups. In addition to reporting on the value of PEI programs, the key informants commented on Full Service Partnerships (FSPs) as a critical component to increasing mental health recovery and reducing disparities. Key informants also reported being worried about data collection that does not proportionately reflect the diversity of people who are served by FSPs. We elaborate more on this below.

Prevention and Early Intervention (PEI)

PEI programs, which constitute a central component of MHSA, are important to the various un(der)served groups, including African Americans, Asian Americans, Latinos, LGBTQ, and Native Americans, as described in the Strategic Planning Workgroups (SPWs)⁷ reports, because the programs and activities are defined by and for each community. Despite MHSA's success in tailoring services and treatment to the needs of un(der)served groups, the persisting need of tracking and evaluating program-related outcomes using adequate and systematic approaches to data collection and reporting demands more attention. Key informants agreed that PEI could more effectively help to reduce health disparities among un(der)served groups if consistent data collection standards and requirements were in place to increase rigorous evaluations that would validate the utility and outcomes of PEI.

Full Service Partnerships (FSPs)

An overarching goal of FSPs is to align the MHSA funding with the recovery and resiliency of individuals and families, emphasizing a viewpoint consistent with MHSA's value of recovery based on resiliency and wellness. Most key informants described FSP programs as effective in providing "whatever it takes" to serve consumers' needs and lead them toward recovery.

As a programmatic part of the MHSA's Community Services and Supports component, FSPs have helped to reduce disparities by expanding services to diverse ethnically and racially un(der)served groups. This idea was best expressed in the words of one key informant:

"Some of the first pools of monies with the FSPs were dollars set aside that gave employment opportunities, housing.... Family members who will call me wanting their loved ones to be engaged from ethnic communities ... and a lot of these communities of color ... that wasn't somethin' that was open and available to them, in a lot of counties. By the time each county had so many slots, they were largely White Americans who got those kinda boutique-style [read: specially tailored to client needs] programs. And then, you know, by the time the slots were filled up there was not much of those services for the Latino or API communities. None for non-English speakers, and maybe a few for, you know, bilingual consumers." (DS400090)

A majority of informants noted that the impact of FSPs is not adequately reported, and consequently successes are not sufficiently tracked. In particular, the stigma that individuals or family members experience while attempting to identify mental health issues, or that consumers and their families might experience as they move within the mental health system, require acknowledgement and redress. Key informants said that FSPs and PEIs both have the same problems with data collection and evaluation, which are outlined above. Descriptions of these problems included lack of systematic data collection and insufficiently rigorous analysis of service delivery and consumer outcomes. Key informants expressed concern that data collection activities do not document the diversity of participants who are served by FSPs and, therefore, suppress understanding of the scope and impact of services provided for un(der)served groups, most particularly those highly marginalized groups whom these services may not reach.

⁷ Please refer to our description of the California Reducing Disparities Project in the Introduction.

Other Achievements

Interviewees reported additional achievements in peer support services, efforts to reduce stigma toward mental health disorders, expansion of outreach activities for hard-to-reach groups, and community involvement in service development. A type of innovative MHSA-inspired strategy to create systems of services and support to enhance service to un(der)served groups is reflected in the following excerpt:

"I think the biggest success was the great expansion of the full service partnership slots.... We had, you know ... maybe a thousand or something before MHSA, you know ... like, whatever it takes.... Now we've got about 7,000 slots. So that's ... a huge improvement.... It used to be only for adults; now we have full service partnership slots for kids, for transition-aged youth, and older adults, as well.... Another [success] was ... that it kind of stabilized us through the fiscal downturn and without it everything would have come apart. And the third thing is the ... prevention and early intervention has gotten us the ability to try new things, like with faith communities and primary health-care practices that we would never have been able to do otherwise." (DS400074)

In summary, an overall increase in the provision of promising programs and services (that our key informants consider to be some of MHSA's greatest accomplishments) has increased the diversity and number of consumers served in mental health treatment. The respondents believe that acknowledging and acting on the early identification and mental health intervention of individuals and families may decrease serious mental illness. That is, accurate and early detection of mental health conditions for un(der)served groups are critically important in effective delivery of mental health care and treatment.

SUMMARY OF FINDINGS

Key informants said that the great successes of the MHSA include:

- Use of Prevention and Early Intervention (PEI) funds has translated to a set of community-identified strategies to reduce mental health disparities among un(der)served groups.
- Promoting a "whatever it takes" approach by means of Full Service Partnerships (FSPs) to help individuals with serious mental illness has begun to transform mental health services to a recovery-focused system of care. Although FSPs have made a contribution, it has not been well documented or reported.
- An emphasis on implementing peer-to-peer strategies that focused on education and support services led to the development of statewide educational campaigns to reduce stigma.
- Recognizing that in order to fulfill the act's mandate to improve access and enhance the quality of mental health care of un(der)served groups, more needs to be done with (a) community involvement, (b) strategies to increase workforce diversity, and (c) integration of consumers and family members by implementing and evaluating new strategies via MHSA-funded innovative programs and later adopting those that are shown to be effective.

Key Findings to Research Question 2:

What are the most common barriers to the effective delivery of mental health care for un(der)served groups in California? In what ways has the MHSA helped to mitigate these barriers, and what problems still persist?

While the implementation of the MHSA is a historic step toward improvement of a fragmented mental health system and has made significant strides in California, it is not immune to formidable obstacles in its attempts to improve mental health services in a large and increasingly diverse state. Key informants discussed some of the most common barriers for the effective delivery of mental health care for un(der)served groups in California. Along with describing these barriers, they discussed persistent problems and targeted solutions that might be used to resolve them.

Common Barriers to Effective Delivery of Mental Health Care for Un(der)served Groups

Common and persistent barriers can be classified as barriers related to individuals and families seeking mental health services and those hampering the systems and organizations that furnish mental health services. Key informants identified eight impediments: (1) language, (2) cost of available care, (3) quality and range of care, (4) stigma, (5) geography, (6) service awareness, (7) knowledge of services, and (8) service capacity and adequacy. Key informants anecdotally identified numerous barriers that deter un(der)served groups from receiving effective mental health services (see **Table 2**).

Key Informants described the implementation and success of the MHSA, related programs, and services as having the potential to more effectively respond to the needs of diverse consumers and families. The importance of reaching out to diverse groups, however, validates the need for a mental health services workforce that is ethnically, culturally, and linguistically concordant with growing and intended consumer bases. In addition, engagement with more diverse and un(der)served groups further highlighted the fact that some groups or a subset of members were not accessing services or were underutilizing services available to them, thus increasing the gap in services between those who receive adequate mental health resources and those who do not. To rectify some of these barriers to care for un(der)served groups, key informants encouraged an increase in community-defined best practice models, such as collaboration with faith-based and other community-based organizations for outreach, education, and treatment.

Table 2. Persistent Barriers Described by Key Informants

Barrier type	Interview quotes
Individual barriers	
Language	<i>“When you look at the ethnic minorities, I think that they are still underserved and there are several reasons. [N]umber one, we don’t have enough clinicians who speak the different languages or are culturally competent to serve the minority populations.” (UDS400088)</i>
Stigma	<i>“The biggest barrier is still the stigma as it exists in particular communities. So that’s why we’re trying to focus on the outreach—to reduce stigma. But as the media demonizes mental illness, like that guy who said, ‘the guy who kept all those women captive for years was the face of mental illness,’ I mean, whatever is wrong with him, it’s not the face of mental illness. You know, he’s just bad.” (Unicode 003)</i>
Geography	<i>“Individuals who are ... located in the hinterlands [in more rural or agricultural areas] may not have transportation to get to one of the [closest urban providers]. They’re basically kind of stuck. They don’t get anything. Now, even accessing the system in the way it’s set up in [name withheld for confidentiality] County now, to get a clinician you know, they’re only really sort of open certain days. So if you’re having a mental health crisis, your choices are to wait to have that crisis on the days that they are serving this area, or to go to [specific psychiatric service facility—name withheld for confidentiality] and 51 [psychiatric hospitals] and get 5150’d.” (DS400082)</i>
Knowledge of services	<p data-bbox="183 1167 396 1228">Public awareness of services</p> <p data-bbox="183 1289 396 1409">Understanding the mental health system and how it works</p> <p data-bbox="430 1136 1435 1409"><i>“Foster families shouldn’t have to hunt around to get services. They ought to be provided with information and training that says, ‘if you experience any of these kinds of behavior, do not wait. Call these numbers immediately.” (UDS400082)</i> <i>“I think it may be related to educating the providers better. Because locally, where I reside, there are people [clients in need of care] in FSPs who don’t know that this program is funded by the MHSA because the providers don’t educate them around it. ... [D]o they tell them that this program is a full-service partnership and what the core values of the MHSA are? Many providers do not, and I’ve seen that firsthand.” (Unicode 011)</i></p>
Cost of available care	<i>“There are many places that have sliding scale but still their minimum, like \$25.00 ... that’s too much. [T]hose same people either don’t qualify for Medi-Cal or ... Medi-Cal mental health services for adults if you don’t have especially—if you don’t have the classic, you know, schizophrenia, bipolar, whatever, you don’t get anything [you won’t get services]. Like, if you’ve got couples issues that you really need to work out, you’re not gonna get services.” (DS400075)⁸</i>

⁸ MHSAOAC notes that the MHSA was intended to provide services for no or low cost to individuals who don’t have insurance and cannot otherwise receive services.

Organizational barriers	
Quality and range of care	<i>“There’s two levels of care. In fact ... those that get MHSA services because they’re sick enough [will] get everything. And the rest of us that were promised services are not getting anything.... [T]he sick folks through MHSA and FSPs and severely mental ill ... the safety net is catching them. But it’s just kind of, like, people have felt that there are gaps in ... not so much access, but in the range of programs [and services].... So that’s where that needs assessment is so important, that everything starts with the stakeholder process. And if you don’t have racial ethnic minorities or underserved clients on the stakeholder process, you won’t have the right needs assessment, and you have these people saying, ‘look, here’s a need. You built this MHSA web and it’s got this huge hole.’” (DS400071)</i>
Service capacity and adequacy	
Inappropriate service	<i>“However, when you look at percentages where [African Americans] are receiving services ... it’s jails and prisons and state hospitals, and again I think obviously due to discrimination, maybe not direct, I mean, you know, intentional.... I know there’s a study by Dr. Lonnie Snowden that shows that they [African Americans] are disproportionately over-diagnosed as schizophrenic, you know, and dangerous, and again, just like I think probably African American boys are, you know, labeled and thought to be disruptive ... that they get put in detention, or kicked out of school more often. So, that’s why we think you have to talk about not only unserved, but poorly served, or inappropriately served.” (Unicode 005)</i>
Lack of adequate service	<i>“The different communities of the Arabic-speaking world need to be reached. They have not been.... The numbers are not small.... In the Bay Area there are many Arabic communities. In Southern California, Los Angeles, and in San Diego, there are sizable numbers of Arabic-speaking populations.... I would say they are underserved. Some [of these] communities certainly have been unserved.” (Unicode 011)</i>

Potential Avenues for Mitigating Barriers to Providing Mental Health Services

The enactment of the MHSA has illuminated persistent problems for un(der)served groups. Key informants discussed some of these persistent problems, some of which have been brought into clearer light in the context of mental health programs and services created or made more accessible for un(der)served groups due to the MHSA. Key informants provided insight into some of the factors that allow certain barriers to persist, and offered potential sources of and solutions to these problems. Below we describe three types of obstructions to the effective identification of needed services and their delivery to un(der)served groups, including difficulties related to the appropriateness of engagement strategies, prioritization of services and allocation of funds, and systems of tracking and monitoring.

Challenges Related to Appropriateness of Engagement Strategies

Clear and specific channels for appropriate service delivery. Despite the intent of the MHSA to offer early treatment intervention and to prevent involuntary treatment, key informants

said that consistent mental health care services were performed most commonly in “crisis” situations or in institutionalized circumstances (e.g., hospital emergency departments and jails) rather than in community-based settings (such as community mental health clinics).

“In the African American community ... you see a lot of the mental health encounters occurring in criminal justice settings ... for children and youth that would be juvenile hall ... situations where their custody has been removed.... Families would experience that the system has failed them.... Because you don't have the history, and you have individuals that might have substance abuse issues as well, they go into a jail setting [and] they're angry, they're isolated. They're misunderstood.... There's no history in working with them. They're often over-medicated, or perhaps misdiagnosed.... It's a vicious circle of not getting the broad supports they need.” (DS400072)

Descriptions of “inappropriate care” were common for informants who discussed institutional settings as the primary locale for the delivery of mental health-related services. Mental health providers, consumers, and families of people who have serious mental illness noted that emergency departments, while not the best alternative for mental health care, are often the only type of service available to people with serious mental illness or in crisis.

Many informants described the inappropriate use of services and untrained staff for some un(der)served groups, including those with serious mental illness, older adults with comorbid conditions, and African Americans. Interviewees' examples related to the treatment of African Americans illustrates that although un(der)served groups, like African Americans, do receive mental health services, the treatment they receive is not entirely appropriate.

“So when you don't effectively serve this population, they come into our system in our high-end institutional-based services.... [W]e should have done a better job to keep them from entering these systems.... How can we help that individual and their family come out and understand ... what issues do they need to work on [and] what their illness is about? How do we build the support? How do we use better strategies? One of the things that I think needs to happen in the future is looking at some of the strategies we're developing with MHSA....” (DS400072)

Informants perceived that potential consumers encounter difficulties in accessing services when they do not have insurance, are undocumented, seek support-related services (such as housing or financial support) rather than counseling services, or do not present with a mental health diagnosis rendering their condition critical enough for attention.

“In our county, and probably many other counties, the boards of supervisors have taken positions that there are no services going to be afforded to people who are uninsured or undocumented.... If the board, any board in any county, took a position that really went counter to a basic mental health [care protocol] ... as professionals, we would object to that collectively.... But nobody says anything. Everybody's fine with it ... they should be getting services through MHSA.... In fact, you're the administrator of MHSA funds.... [Y]ou have people who still are very high need, they're very acute, but they're undocumented or uninsured for whatever reason, and they don't get anything. You only see them when they come into crisis.” (DS400092)

This interviewee's description of perceived denial or constraints on service provision for undocumented persons by county administrators highlights the ambiguity and lack of direction to counties and providers on how to proceed with services for undocumented persons. MHSA must resolve this uncertainty and establish clear guidelines on serving undocumented populations.

Planning for and development of an adequate and well-trained workforce. Key Informants and stakeholders all requested more proactive strategies for responding to the needs of people with serious mental illness, including planning for and development of a more adequate and well-trained workforce in settings where people “in crisis” or living with serious mental illness could best be served. Specific barriers to developing an adequate workforce to serve mental health needs in California is highlighted by this stakeholder comment:

“The MHSAs are assistive in many areas of administration [but] the problem persists in the hiring of individuals with lived experience. Although there are some positions available, there is no end in sight for those of us working on the front lines with limited time to go to training that is time consuming and often becomes obsolete. The reason for the funding is to assist the community with more alternatives than incarceration and other forms of restraint.” (Public commentary, February 19, 2014)

In addition, some stakeholders have noted that parameters for the use of MHSAs funding and the availability of treatment for people living with serious mental illness highlight the lack of community-based psychiatric services, including adequate staffing or appropriate training for primary care and other providers who eventually care for patients who suffer with mental illness. Family members and mental health care providers noted the absence of training for personnel who are not licensed physicians or psychiatrists.

Development of culturally competent programs. The processes of planning for and developing a well-trained workforce in a state that has begun to engage more diverse groups highlight a need for developing culturally competent programs and increasing delivery by culturally concordant providers. Informants were clear that defining and developing “culturally competent programs” takes time and involves a level of sensitivity to community outreach and engagement that existing systems are not adequately prepared to deliver effectively. One interviewee explained:

“You wanna create that sense of safety and ... pay attention to the gender issues. You know, have a continual understanding. Continue to understand the cultures that you’re dealing with and let ways of the people and the values guide you in creating the programs. You don’t wanna go into a community that you do not know and say, ‘Oh, we have parenting classes for you.’ Can you imagine anything more disrespectful? Because that message is that you are going in to someone you don’t know and saying: ‘Here. We’ll show you how to parent. You don’t know how to parent.’ Well, that’s the last thing you wanna ever do. You know? But when you go in and say, ‘We have an opportunity to help the children succeed,’ and present it that way, to succeed not only academically but also in the community, then every parent is interested in that. So there are sensitive approaches that need to be crafted and implemented to do that.” (Unicode 011)

Key informants regard culturally competent programs as those that address the needs of the community, including appropriate framing of the program and delivery of its contents in ways that resonate with the targeted population, with respect and humility. Another informant spoke to the importance of culture and cultural sensitivity in informing valuable interventions for diverse ethnic communities:

“I think you have to learn more about the different communities. There’s been a lot of press about the gardening project in the central part of the state that reaches the Hmong communities. That’s their way [to achieve] wellness or having therapy without it being called therapy. So things like that I think are responsive and sensitive to the cultures, but not a whole lot is being done about that. The Native Americans and learning about their healing circles and naming ceremonies. For me that’s important because when they talk about their historical trauma over the generations, what comes to mind are the historical traumas in my own culture

of the Palestinian occupation and how people are affected that way.... You connect by learning from other cultures, and that information sharing is important whether we hear it at a cultural competence conference or in a group setting, or whatever venue it might be.” (Unicode 11)

As this informant implies, programs grounded in the culture and history of the intended service communities are more likely to appropriately and effectively serve those communities. The importance of a culturally competent workforce cannot be overstated, and should be informed with sensitivity to the fact that individuals in some ethnic communities may choose to seek care outside of their communities due to the potential for stigmatization.

Community outreach and engagement. Key Informants identified community outreach and engagement as a vital component for enhancing the efficacy of the MHSA. Strides that must be made in order to enhance outreach and engagement include obtaining community-informed perspectives related to assessment of health-care needs, increasing awareness of available services and avenues for accessing services, and targeting hard-to-reach communities.

With regard to obtaining community-informed perspectives, key informants agreed that diverse stakeholder engagement is often neglected. In particular, existing strategies for incorporating the voices of diverse ethnic communities were described as less than ideal methods for garnering input from those who are underserved. One informant typifies the scenarios described by interviewees who discussed this barrier.

“These stakeholder meetings, or these big public forums, are not the most effective way to get the voices or the opinions of underserved communities. First of all, it’s just not a forum where they’re comfortable.... [F]or example, I’ll just use the Asian community. It’s not culturally valued to get up at a meeting and say, ‘well I think you should give me this. You should give my community this because we deserve this....’ People that are newly immigrated ... are outnumbered and then they are out-yelled.” (Unicode 005)

Another interviewee echoed this concern, underscoring the need to involve more consumer and minority persons in decision-making situations to increase diversity and community representation.

“The programs are driven by whatever the stakeholders in the community decide. And gauging the minority folks who come to the stakeholder meeting to make decision[s] is also another difficult thing. Right? It’s very hard to involve people who are ill and [part of a] minority group to come to the meeting to make decision[s] in how the system could create program[s] to serve them, because they don’t have a voice. And so you ended up having a lot more non-minorities show up to your stakeholder meetings and, by virtue of that, they become the ones who decide which programs should be funded.” (DS400088)

Key informants presented examples of barriers that must be overcome in order to increase awareness of and access to services for un(der)served groups. The following quote illustrates how specific strategies for community outreach and engagement could begin to erode this barrier:

“I think that educational workshops ... would be important. Meeting in the people’s community, instead of expecting them to go to [a] county office or town hall meeting. Maybe going to churches, or temples, or community centers [would be a more effective approach].” (Unicode 019)

Finding adequate outreach and engagement mechanisms for marginalized and un(der)served groups could be a first step in involving un(der)served communities in critical decision-making

opportunities and in the development of culturally and linguistically sensitive avenues for treatment.

While interviewees noted that potentially effective mechanisms for community outreach and engagement were diverse, they described traditional mechanisms for message delivery as woefully inadequate for reaching most of the audiences and populations intended to be served by the enactment of the MHSA—especially marginalized groups, including older adults with co-morbid conditions that include physical disabilities, those living with serious mental illness and their families, and the LGBTQ community. One interviewee described the following scenario as part of a typical outreach strategy for informing and engaging underserved communities:

“In one meeting they were saying, oh, we have access to PBS. And then we were accessing 90 percent of the population, and we are reaching however many millions. I say, excuse me, in our community we don’t watch PBS. They would be watching the Latino channel, watching the Chinese channel, but not watching PBS.... And then even how you do the promotion is also important. If you only do it in PBS, and people are not going to watch it or [in the] Sacramento Bee [newspaper], people may not read it. They read their own ethnic newspaper, listen to their ethnic radio station or TV station. And that is a fact in California.” (Unicode 019)

Some informants claimed that the most effective approach for outreach and engagement would be to target specific communities based on the disparities that they face.

“For example, if it was shown that the Latino community had a disproportionately low penetration rate, or that the dollars spent on people from the Latino community were low compared to [other groups], then design a program targeted towards a particular racial or ethnic community. Right now I think, for political reasons, that is not done as often as it should be ... because the policymakers and the community advocates at the table are not from our [underserved] communities.” (Unicode 005)

Stakeholders offering public comment about the draft of this report suggested that specific strategies related to messaging, along with communication by health services providers, could yield potentially effective methods for increasing awareness of MHSA-funded services and engaging un(der)served communities.

Some stakeholders suggested that providers and organizations who receive MHSA funding should be responsible for informing consumers about the source of funds for that care and the values that support its funding. Lack of awareness related to resources for mental health care can disempower communities. Greater awareness of available services and their funding sources not only provides community members with information about the availability of resources in their local community but may also allow them avenues for input in the type and delivery of services. In response to findings that focus group participants were not aware of MHSA principles and values, one stakeholder commented:

“If focus group participants had no awareness about MHSA principles and values, a provider receiving MHSA funding bears responsibility to inform and educate recipients about core values of wellness, resiliency, recovery and the power of hope to pave [a] pathway to quality and dignity in life. This can do a lot for a person’s engagement, success and motivation.” (Public commentary, March 6, 2014)

Prioritization of Services and Allocation of Funds

Nearly all key informants described the need for consistent financial support for programs to reach their targeted populations. Funding availability, allocation, and strategies used to acquire funding are factors that influence the success of programs targeting un(der)served groups.

Funding availability. Interviewees who identified themselves, or their role with the California mental health services system, as related to an underserved community acknowledged that the MHSA was one of the first programs to make funds available to meet the mental health needs of these communities. Some interviewees elaborated that the MHSA was the first initiative to fund grants to programs serving underserved communities; the Mien and LGBTQ communities were named specifically.

“For the first time we’ve gotten this small grant. This is the first time that the [Mien community] is receiving some services that’s, you know, related to mental health.... Before this we’ve just, you know, raised funds ... we do events, and we ask for contributions from people that know the community, and we don’t have rich friends, unfortunately. Just small money here and there, and a couple of small grants. Ten thousand. Twenty thousand. Fifty thousand. Just the small amount of money, and we’re a small shop, so, we are able to just kind of keep things afloat.” (DS400085)

Many interviewees noted that the MHSA made funding available for the California Reducing Disparities Project, which aims to identify the state’s most un(der)served groups and to develop community-defined strategies for the delivery of culturally competent care in their communities. In this regard, one informant described the specific use of MHSA funding for a stigma reduction program targeting the African American community and people in need of housing.

“We received a large grant for doing stigma-reduction work, which is a large portion of our funding, which comes through MHSA funding.... So, this is all of our stigma reduction work.... [It] is making a difference in the housing sector for reducing stigma, and in the African-American community....” (DS400083)

Frustrations related to the availability and stability of funding remain, however, in spite of these tangible activities, as one informant summarized:

“The problem is, like, I mean, we can identify gaps and we can identify best practices through the reports, but there isn’t any plan for money for implementation, you know?” (DS400078)

Concerns with allocation of available funds. Some key informants expressed concerns that current MHSA funds are not reaching all un(der)served groups in need of service. Linked to these concerns was the perception that larger, more established programs were allocated funds more frequently than community-based organizations with stronger connections and intentions to assist un(der)served groups.

“All these different organizations [receiving funds for services] ... are predominantly White, predominantly middle class, predominantly, you know, [with] a certain perspective. Not that they’re bad agencies, necessarily. But they are the reason why we [LGBTQ community] continue to remain unserved and underserved.... What tends to happen is that maybe, like, there’s one or two big agencies that always get the funding. And then the rest of the state gets nothing.” (DS400075)

One interviewee perceived that some ethnic groups (e.g., Arab Americans) have been overshadowed by the state’s more populous ethnic groups (i.e., Latinos and Asian Americans) that have been targeted for services. The same interviewee proposed that problems with data

management (i.e., aggregation of the data or not collecting data with regard to the important parameters that create disparities) can make un(der)served groups invisible.

"Funds seem to be funneled to the communities that have been served, such as the African-American community, services to the Latino community, some services to the Chinese, the Filipino. And it seems to revert back to the same groups time and time again. I don't think that there's a lot of attention paid to those that need to be reached, such as the Arabic communities, and other communities like the Burmese and Japanese. What are the needs? But in order to find out, you gotta build relationships with them. You can't just rely on the data because a lot of the groups that I bring up are lost in the data. Arabic people are under the White category. How are you gonna find out about them? You gotta disaggregate not only the ethnicity but also the heritage. You know, Arabic ethnicity is fine, but it doesn't go far enough. You need to find out about the Palestinian community in a county such as [county name withheld for confidentiality]. You need to find out about the Lebanese community in [county name withheld for confidentiality], and various other counties throughout the state. That's heritage that's key to really reaching the communities and finding out more about them." (DS400092)

A number of key informants perceived many contractors who were hired by counties to complete MHSA-funded projects as not fully trained to conduct culturally appropriate outreach and engagement with vulnerable populations.

"Is the same old, same old, people being given funds to go do work, and still the underserved populations are not really being properly addressed. So for example, in the stigma discrimination, Stigma and Discrimination Reduction Program that CalMHSA has been funding with MHSA dollars, the five authors of the [population] reports ... met with some of their contractors, and we all came away with this feeling that these contractors don't have a clue how to deal with our populations. So they're getting all this money [but] they don't know how to work.... They're saying they're working with our populations, but, when we ask them specific questions, the answers we got back—at least I certainly got back—a very broad brush, 'sure, we're reaching out to the LGBTQ community.' What does that mean?" (DS400075)

Strategies for acquiring and maintaining funding. Some informants referenced difficulties in acquiring funding or expanding the funding currently available for services that might be appropriately serving un(der)served groups. For example, one participant described a program funded by Innovation funds that was found effective in reaching the underserved, but that could not remain active due to lack of continued funds.

"For example, we have a program right now that is \$1.4 million that will end June 2014. And it's a hospital-based program with peers and family members to transition clients to outpatient treatment in primary care clinics as well for treatment. And it works. The evidence has demonstrated that it's fantastic. It works in the hospital. We've seen all the reductions in hospitalization, emergency psychiatric response teams, emergency departments, et cetera. We need to replicate this in the system. Which funding is available to community services and support for the MHSA funding? Or if I don't have any more money, redesign existing programs that do not have such outcomes.... There's no [apparent] structure with the MHSA⁹ right now to sustain the programs that they found to be effective under the innovation." (DS400091)

Another participant indicated that MHSA is funding several promising pilot programs, but that no existing resources are available to evaluate their effectiveness. Most concerning to interviewees was the understanding that some funds have been used to maintain and sustain previously existing programs, rather than for the development and provision of additional services.

⁹ The MHSOAC states that once a county demonstrates the efficacy of a program or innovative project, the program may receive funding through CSS or PEI. Below we describe inconsistencies in monitoring practices that might restrict counties from adequately demonstrating efficacy.

Interviewees often perceived this strategy as a misuse of funding, attributable to the current economic strains affecting the state, and to substantial budget cuts that have impeded mental health programs.

Several interviewees expressed concern about the use of PEI funding to sustain pre-existing programs rather than the intended new PEI services. Key informants spoke about the funding difficulties and using new funds to replace funds for existing programs, which they believe does not reflect the intent of the MHSA to expand the number of services to the underserved. For example, several interviewees notably expressed awareness of service providers who had vigorously applied for prevention and early intervention funds. These interviewees added that as part of the strategy to acquire these funds, existing programs were renamed or redesigned so that funding might be made available through this mechanism.

"Well ... this is hard to say because, you know, what other state has something like the MHSA? But I would want to say that it almost feels like everyone is doing a pilot work. You know? Pilot study. And that the programs need more resources—need more funds so that these programs can expand and so that the oversight can also expand." (DS400084)

Interviewees were skeptical, however, that the new programs that were developed sought new consumers or truly offered the type of "new" services that PEI funds required.

"Counties were not supposed to use MHSA funds to support an existing service. But, yet somehow it was done in a way to use this pool of money to cover other services—to cover the shortfall in the Medi-Cal or the mental health fund. And many of the contractors for different counties are dealing with the same group of population, so how can they change all of the sudden from a treatment population to an early intervention population?" (DS400076)

Stakeholders offering public comment have noted that some county programs have seen an increase in consumers served by the mental health system and the number of volunteers trained to assist older adults with comorbid conditions. The successes of some of these new programs under PEI, however, have been overshadowed by inconsistent efforts at tracking the success of the programs.

Systems of tracking and monitoring. Key Informants described efforts at tracking and monitoring MHSA-related programs as lacking in focus, inconsistent, and diffuse. They attributed most difficulties with tracking and monitoring to county-specific differences in interpreting and executing the intent of the MHSA.

"I don't think we have much of an oversight on all of this MHSA. And I don't have to tell you that. I mean, that report came out last month talking about that. The oversight piece is really poor, has really been poorly carried out. And it probably has to do with, you know, most county [governments] and the state are trying to rush the money in the street for programs, and really don't have time to really take a careful look at 'are they effective? How have they been done?' We just take it at street value, but we really don't do a really good assessment." (DS400088)

Key informants noted that problems with assessment have been inevitable due to the lack of best practice models and inconsistency in the types of data collected and in formats for ensuring reliability.

"Right now the best practice, for example, is to ask someone 'what is your current gender identity,' and usually there's a bunch of check boxes. What should be on those check boxes is also a whole other issue.

And then you ask 'what sex were you assigned at birth?' But apparently someone just told me while we were doing our report that there was new research coming out showing that youth don't respond well to that two-part question for some reason. So, in one school assessment thing that they do, the youth risk something or other, they are asking sexual orientation but they still aren't asking gender identity because they haven't figured out how to do it for youths.... We need to figure out how to ask the question to get the proper data, because bad data will only come out as bad conclusions then." (Unicode 006)

Variation by county in the type of data collected and the practices used to collect those data have created difficulty in assessing the impact of the MHSA for un(der)served groups and in developing standardized practices for program management, and contract and funding monitoring. Furthermore, inconsistent practice patterns disrupt demonstration of program efficacy (and potential eligibility for funding that rewards innovation).

Program management. Multiple informants identified problems with program management as barriers to understanding effective mental health services and service delivery for un(der)served groups. Difficulty with program management created some unintended negative consequences for interventions that some informants considered excellent interventions.

"So this wonderful program at [name of program withheld for confidentiality] ... got defunded by the county. Because here's what the county did: The county took MHSA money and started a new program. Now Mental Health Services Act was not there to supplant current programming. It was supposed to enrich [programs]. That's not what happened. Across the state what happened was people found ways to circumvent that by closing down existing programs or rebranding some as something else." (Unicode 006)

Those programs that continued to exist following the enactment of the MHSA showed increases in enrollment of MHSA-targeted populations, yet these increases have been evidenced mostly in less expensive programs, or those that key informants identified as "providing fewer resources" or lesser "quality services" unlike some of the "full-service, Cadillac programs."

"When you look at the total numbers, did we increase access for people of color? It'd probably say yes. But when you start breaking down those numbers, and you start looking at your most expensive programs, like your ACT programs ... I can assure that what we're gonna find is that, in our outreach programs, in our crisis programs, and those system-development programs within MHSA, we [the underserved] may be represented, so when they do the total beta numbers, they may look very good. But when you start breaking them out by financial investment and you start looking at ... resources, how do communities of color fare? ... Our most expensive, highest, and best programming is not being made available to the communities that were supposed to be prioritized. So, my conclusion is that you've created these MHSA programs, these Cadillac programs that are really wonderful, 24/7 everything, and you only created them for the same people who are already in your systems." (DS400092)

The following excerpt summarizes the perspectives of informants who expressed frustration with the disconnection between the MHSA's intentions and the consequences of its enactment for un(der)served populations.

"Really look at the system of all the programs that have been implemented since 2005 and give it an honest criticism, or whatever, an honest look at it and say: 'Hey, have all these program met the intent of the MHSA?' ... MHSA has improved lives for people who are or who have been in treatment. MHSA has not improved life for those that are underserved because they are still underserved." (DS400088)

Contract monitoring. Some interviewees perceived the oversight of contracts at the county level as a main component of monitoring mental health service provision under the MHSA. A

few interviewees described difficulties with county-level monitoring practices, including ensuring contractor adherence to project-approved goals, as described in this excerpt:

“So, we’ll do contract monitoring and we’ll do data reports and ... we actually have program monitors who are responsible for tracking who is being served and making sure [that service delivery is] in compliance with what we put in their contracts. So if you get an actual caseload profile that looks different from what we put into their contracts, then we have to work with them about remedial action to correct that or, if they’re saying that they’ll have a certain number of bilingual staffing and they don’t have it, so they can’t fill the positions, then we have to sort of look at what our options are in terms of getting them on the right track.” (Unicode 008)

Some concerns about differences in monitoring practices revealed suspicions about hidden agendas or, more broadly, whether unevenness in county-level monitoring practices can ensure that the MHSA delivers what it was intended to deliver: service to the un(der)served communities. Added to concerns regarding consistent and appropriate monitoring, key informants stated that when discussions of monitoring do occur, accessibility is restricted and venues typically are not open to the public.

“They have an MHSA coordinators meeting, for example, and every county has an MHSA coordinator. ... [T]he coordinators have monthly conference calls and sometimes, I believe, they meet in person.... Members of the public are not allowed at those calls or meetings unless expressly invited.” (Unicode 005)

Monitoring funding use. When informants were asked about how funds were monitored, and whether they knew of evidence that the funding allocated to un(der)served communities actually reached those communities, most indicated that they “did not know if or how funds are monitored.” Those who discuss monitoring in any detail claimed that funding monitoring appears to be county-specific and dependent on the priorities and practices of individual counties.

SUMMARY OF FINDINGS

Reference to the common barriers that impede achievement of effective delivery of mental health care for un(der)served groups emerged as a consistent theme.

- Key informants viewed individual barriers such as language, stigma, geography, lack of knowledge of services, and cost of available care as factors that are significantly responsible for limiting access and availability to care and treatment.
- Key informants regard organizational barriers such as quality and range of care, service capacity, and adequacy, as persistent gaps in the appropriateness and capacity of mental health services and providers in serving un(der)served groups.
- The views of key informants suggested several ways that MHSA has and/or can do more to mitigate individual and organizational barriers. First, the implementation of the MHSA meant an expansion of mental health services to current consumers and to historically hard-to-reach segments of un(der)served groups. Second, increasing culturally competent programs in ways that resonate with the targeted un(der)served group is vital to ensure that services are adequate and appropriate. Third, obtaining community-informed perspectives to increase culturally competent programs and community outreach and engagement is a step in the right direction to mitigate barriers to care. This suggests that the MHSA should continue to expand services to un(der)served groups while at the same time, enhancing the act's efficacy via a cultural-and-community-informed perspective.
- For MHSA to reach its full potential in becoming a mental health transformational framework that meets the needs of un(der)served groups, existing inequities and other shortcomings in funding allocations must be rectified.

Key Findings to Research Question 3:

What are the current gaps and persistent issues for un(der)served groups?

In response to the third research question, we asked the key informants to identify un(der)served groups with the greatest need, followed by asking focus groups to discuss issues affecting un(der)served groups.

Key Informant Identification of Underserved Groups

When asked which groups were perceived to be at greater risk of exclusion from mental health care services, key informants identified the un(der)served groups in **Table 3** as the groups with the greatest need of outreach and improved treatment delivery.

Table 3. Identified Groups With the Greatest Need of Outreach and Improved Treatment

Recommended groups	Number of key informants identifying group
African Americans	8
Latinos	6
Asian Americans	5
Transitional-age youth	5
Immigrants	5
LGBTQ persons	4
Older adults	4
Individuals with limited English proficiency	3
Middle Eastern and Arabic persons	3
Native Americans	2
Person living with a serious mental illness	2
Family member of a person living with a serious mental illness	1
Single parents	1
HIV-positive consumers	1
Homeless persons	1
Incarcerated persons	1
Northern Africans	1
Disabled persons	1
Poor persons	1
Russian or Slavic persons	1
Rural or geographically isolated regions	1
Risk of suicide or suicidal ideation	1

Importantly, the selection of un(der)served groups that we investigated in our report was based on the un(der)served groups' experiences of multiple and persistent barriers to care. Our report did not investigate all groups in **Table 3**, which we acknowledge as a limitation and emphasize that with adequate time and funding, more groups in **Table 3** can be examined.

Our goal in conducting focus groups was to understand the ways in which specific barriers prevent access to diverse un(der)served groups. To accomplish this, we focused the viewpoints of key informants on the major barriers to service for un(der)served groups. We then examined these barriers, focusing on those that were described as affecting the greatest number of persons, and cut across diverse groups. The obstacles we found to be most significant, based on our interviews with key informants and review of existing documents, were barriers due to the degree of perceived stigma in accessing mental health services, immigrant status, linguistic and cultural barriers, age-related difficulty in accessing appropriate care or shortcomings in mechanisms for engaging appropriate care, and geographic availability of resources for mental health care (see **Table 3**). Next, we identified three specific un(der)served groups, whose experiences reflected a combination of these barriers.

Gaps and Persistent Barriers to Receiving Appropriate Mental Health Services for Un(der)served Groups

Despite their differences, a series of common themes emerged from interviews in the three focus groups regarding experiences with California mental health services. Very few participants stated that they knew where and how to access necessary mental health service. The lack of general knowledge of MHSA-funded services, treatment options, and location was evident among most focus group participants. Their unfamiliarity with those services is concerning, given that the purpose and intent of the MHSA is to provide services that are not already covered by federally sponsored programs or insurance programs. Without knowledge of the MHSA, participants were also unaware of low-cost services that the act supports. Knowledge of MHSA funding available to serve low-income groups can empower potential consumers to seek these services by reducing their reluctance that is based on cost or lack of insurance.

Common barriers to receiving appropriate mental health services and treatment included the cost of care, the location of care, delayed care-seeking, family relationships, comorbid conditions, lack of concordant care, provider or program inaccessibility, lack of awareness of services, and insufficient outreach. **Table 4** below summarizes some of the common barriers that impede delivery of appropriate mental health services for the diverse groups with whom we consulted with via the focus groups. Although we discuss each of these barriers to adequate mental health care separately, obstacles for un(der)served groups are overlapping and often intertwined with other social difficulties. In addition, the same barriers may impede members of diverse un(der)served groups in differing ways.

Table 4. Common Barriers to Receiving Appropriate Mental Health Services

Recurring themes	Latino immigrant group (Central Valley) N=16	LGBTQ and youth group (Sacramento) N=4	Older adult group (San Diego) N=22
Costs of care or lack of insurance	No insurance coverage Deterred from seeking services due to cost	No money for treatment	Lack of insurance coverage Low-income (deciding between cost of care and home expenses)
Location of services or transportation	Transportation to appointments was problematic in rural areas of the Central Valley Needed service is provided only in larger hospital (not local clinic)		Lack of transportation
Delayed care-seeking	Postponing treatment because they did not receive high-quality treatment	Postponing treatment because it was not concordant with needs	Could not access care prior to age 65 (did not meet criteria for Medi-Cal)
Family relationships		Parents' insurance Providers violate confidentiality and involve parents (or fear of this happening)	
<i>Issues of privacy and confidentiality related to family</i>			
<i>Responsibilities related to family members</i>	Not knowing how to help family members in need of treatment		Affected by the problems of (younger generation) family members with mental health needs
Comorbid conditions			Physical pain
Lack of concordant care <i>Adequacy of services</i>	Services were more available for women	Care inappropriate to transgendered persons	
<i>Cultural competence of services and providers</i>	No access to a provider for proper screenings to avoid crises	LGBTQI-focused care is part of suicide prevention	Vicarious trauma
<i>Language and literacy-related issues</i>	Do not receive interpretive service when needed Low literacy Limited English proficiency	Not receiving care from well-trained professionals who understand the needs of the LGBTQ community	Difficulty completing forms for service engagement Low literacy Limited English proficiency
Awareness of services or lack of outreach to community	Lack of knowledge of specialty mental health care for family members	No directory of services No educational campaigns for youth or adults in need of care Not knowing where to go for specialized and confidential LGBTQ care	Difficulty understanding enrollment processes Could not find services for themselves or others Caregivers of family members lacked knowledge of how to access services

Barriers to Receipt of Appropriate Care

Only a small number of participants claimed to understand how to navigate the mental health system or engage county support services, such as low-income housing, transportation, care-

giver assistance programs, and financial supports, when they or a family member experienced a mental health-related crisis. Stigma affected all groups in several phases of the help-seeking process in various ways—from identifying and informing others of the need to find a provider, to entering treatment, and remaining in treatment. Stigma is embedded in several of the decisions reported in the focus group excerpts below. Adequate attention and sensitivity to stigma in public policy and messaging related to issues of mental health and serious mental illness may, in fact, provide a starting point for enhancing awareness and engaging relevant persons in appropriate mental health services and treatment.

Lack of knowledge associated with cost of care or lack of insurance

The cost of health-care services commonly is a barrier, often driven by lack of knowledge about free and reduced-cost health-care options. Very few participants stated that they knew where and how to access necessary mental health service. We discerned a lack of clarity about insurance coverage and knowledge about free and reduced health-care services associated with the MHSA. For example, even participants without insurance who were aware that they could access mental health services did not do so because they thought they would have to pay for services, which they could not afford. MHSA can and should rectify widespread misperceptions about availability of free and low-cost care. Nevertheless, the cost of care and coverage became a barrier that varied across the three stakeholder focus groups. Some of those in the older adult and caregiver group stated that they delayed seeking mental health services until they were eligible for Medicare because they did not qualify for Medi-Cal assistance programs, and that paying out-of-pocket for mental health services would require compromises in taking care of other responsibilities related to maintaining their housing.

LGBTQ youth stated that the problems of cost were frequently linked to the type of insurance under which their care was covered. One youth explained:

“I’ve heard of people getting denied based on income and things like that because like actual income and like what you can afford doesn’t always match up. Like maybe your parents make money or you make money, but it’s all going to your house and bills, and you literally have nothing left. And they’re like, well, you make this much amount of money, so we expect you pay \$100. You know what I mean. It’s like I can’t afford that.”

Participants in the Latino immigrant group discussed the complex matter of cost related to mental health referral from a primary-care provider.

Focus group leader: *“When you go to the doctor and the doctor tells you that you have depression and recommends that you go to the counselor; do they charge you two bills?”*

Focus group participant (female): *“Yes, you have to pay.... It’s another cost. It’s not covered by any program.”*

Focus group leader: *“Do people normally go [to a counselor]?”*

Focus group participant (female): *“No, because they don’t have the money.”*

Focus group participant (female): *“They would rather try to deal with their problem themselves, and do not go [to a counselor] because they do not have the money.”*

Focus group leader: *“This program that existed before offered a fixed price with which they [clinics] would give you many services.”*

Focus group participant (female): *“Yes, they [clinics] would give you the services for what you needed. You would only pay \$30 and with that they would treat you, and if you were referred somewhere else you didn’t have to pay extra. You just showed them a paper that was given to you and you received the other services needed. I think that program is going to end soon since they are removing a lot of the help.”*

Those from the Latino immigrant focus group discussed their experience with mental health care as an “add on” to care; whether or not the cost would be covered was not consistent. Those who reported having the care covered (as a part of a primary-care visit where a mental health referral was made) stated that they would seek care. Others in the Latino group reported that they would delay or decline seeking care due to the additional cost.

Location of services or transportation

Many participants reported that transportation to an appropriate mental health clinic or appropriate provider was problematic. For example, some Latino immigrants living in Merced County stated that they sought mental health services at a large primary-care clinic in their rural community. A majority of participants stated, however, that not all people living in the Central Valley know about this clinic or where to go for mental health services. As the following discussion excerpt shows, unfamiliarity with services, combined with lack of transportation, impedes people from accessing services.

Focus group leader: *“How far is it [the clinic]?”*

Focus group participant (female): *“15 miles.”*

Focus group leader: *“Can you go there [the clinic] on a bus?”*

Focus group participant (female): *“No.”*

Focus group participant (female): *“The bus arrives at 5 a.m., and if you have an appointment at 9 a.m. you have to stay over there all day; it’s the only bus. If there was a small bus for the [name withheld to protect confidentiality] community, the people may be happier.”*

Focus group leader: *“Do you think that the people who live further away know about the [primary health] services and where to go?”*

Multiple participants: *“No, not all of them”.*

Focus group participant (female): *“Very few.”*

For many older adults, transportation even to local clinics is a persistent need.

“Lack of transportation is a constant issue because, for example, she gave a ride to a couple people in this group and if she hadn’t, they would not have been able to participate. So, it’s a constant need, so, I can imagine, even for medical appointment, for eye appointment, for everything.”

Stakeholders offering public comments underscored that counteracting limitations in transportation is not a simple matter but would go a long way to remediate access impediments

for un(der)served populations, particularly the most marginalized groups, such as people living in rural areas, those with a serious mental illness, and older adults.

Delayed care-seeking

Despite their self-identified need for care, several participants admitted to postponing care due to barriers preventing them from accessing or receiving proper treatment. Members of the LGBTQ focus group reported a fear of initiating treatment because the care is perceived to be inappropriate or unavailable for their mental health-related concerns and needs.

“Generally LGBT people are more likely to go to a place that specializes for them because they just feel like—I personally feel more like they will understand where I’m coming from more instead of just being—you always have that fear that you’re gonna run into that person that’s super judging you, like they don’t understand you or they’re [on the] total opposite side of the fence from you.”

Those from the older adult group reported delaying care-seeking until the age of 65 because they did not qualify for Medi-Cal for mental health-care coverage.

“After 65, it became easier for her to seek services because when she went to the doctor, she was receiving more comprehensive medical care and even if it—if there was a mental health need that presented itself, the doctor said, ‘let me refer you to a counselor, let me tell you where to go.’ But before that, it was a little bit more pricey and she had to, you know, figure out a way to get a plan to take care of her.”

Even those who may have sought mental health-care services reported instances of delaying care and being reluctant to return for mental health-care services due to inconsistency in the quality of care they received, as a Latino immigrant group member explains in this excerpt:

Focus group participant (female): *“The service received varies [in primary clinics]. Sometimes they treat you well and other times they tell you [that you] have something and give you medications for it. Sometimes the problem doesn’t go away. They are only controlling it for a while—maybe a couple hours. When they send you to another place it’s the same. They may be able to control what you have for a couple days, but it doesn’t go away”.*

Focus group leader: *“Then what happens when a person goes and just receives medication, and their issue isn’t resolved?”*

Focus group participant (female): *“One doesn’t want to go back. If they return they are going to get the same thing. In time you may have to go back because the issue persists. It’s not enough.”*

Focus group leader: *“When another problem arises you go back and they treat you the same?”*

Focus group participant (female): *“Yes, it’s the same. They give you the same thing.”*

Focus group leader: *“If you go to the clinic and they don’t offer to give you anything, what do you do next?”*

Focus group participant (female): *“You have to look for an alternative.”*

Focus group leader: *“What type of alternative?”*

Focus group participant (female): *“Go to another clinic or another place.”*

These participants explained that having to find an appropriate avenue or setting for treatment is often discouraging and does not encourage them to seek out services when they identify a mental health-care need for themselves or a family member

Family relationships

Navigation of the mental health system appeared to be especially complex for focus group participants when seeking services for family members. Several members of the Latino immigrant and older adult focus groups reported being affected by mental health issues of family members. A participant from the Latino immigrant group stated:

“A lot of us haven’t had the need to look for one of those places; that is why we don’t know where those places are located. I got sent there from a clinic. It helped my daughter to go to the counselor. I think that going to see a counselor doesn’t mean that you are crazy. Sometimes people have depression, and it benefits those people to seek help from a counselor.”

Lack of experience accessing and navigating mental health systems, in addition to the stigma of having a mental health-related condition, can present barriers to appropriate care. This and the subsequent excerpts indicate how engagement of family members in prevention and outreach activities may enhance the timeliness, appropriateness, and perceived value of the services received.

While older adults discussed their experiences with family members, they emphasized what they referred to as the “vicarious trauma” they have experienced with family members (with or without mental health-related needs).

Female: *“We do have a lot of problems with children, grandchildren, or ourselves. But if we needed help [mental health treatment], we don’t want to meet if we have a problem.”*

Female: *“For us, we think you had to be billed crazy, you know, but no, we don’t—we’re not crazy. But we need it sometimes and we don’t have—we don’t know when to go. We—where do we go so we can have help, because we do have problems with our children?”*

Other populations who might experience vicarious or other trauma that could create barriers to receiving adequate mental health care include immigrant groups, many of whom have experienced historical trauma.

LGBTQ participants described a different set of issues with their family relationships. These issues were part of the complex intersection of their age and sexuality in addition to other factors. One participant explained:

“If we’re talking about using health insurance ... a lot of the times, people, when they need help, go to their parents and say like, ‘hey, mom and dad, hook me up with a therapist.’ But the problem is a lot of the times, there are strained relationships between like a particular group and like the parents. It’s not the easiest group to say ‘hey, like at least I can ask my mom and dad because [unintelligible] and if they do, it’s like conditional and it’s that whole, like, financial dependence. I know somebody that is—was going through a [gender] transition that applied with Kaiser, but it was through the parents ... because their parents kept like using that against them, like ‘well, if you don’t go through with your transition, then you can’t be on our health care,’ because the parents did not support it. Kind of like I think it’s—it’s really difficult because I think a lot of people try to go to their parents and, like, yeah, it’s not available. Like, it’s not really an option.”

Those who do use their parents’ insurance under these strained conditions fear that their confidentiality in treatment and decision-making will be disclosed by their health-care provider to their parents.

Lack of concordant care

Members of all three focus groups discussed multiple examples of problems with concordance in the needs of their communities and the quality and type of care provided. Participants described a lack of concordant care to meet mental health-related needs in three general areas: adequacy of services; lack of culturally competent care; and barriers with language and literacy.

Adequacy of services. A member of the LGBTQ youth focus group described her sentiments related to trying to access mental health services.

"I think a lot of people are still ignorant to it. I mean, you know, we—all the people now are growing up so far in a place that doesn't really talk about it [growing up LGBTQ]. Like no schools talk about it, you know, they don't go over the history of it. No one really understands it until you either know someone that's LGBTQ or you are and, like, you don't know anything about it. I mean, I've known tons of people that are like 'I didn't even know I was gay because I didn't even really know what that meant,' you know, and then they figure out, 'Oh, I am. Okay, that's what I am.' But it's like—it's hard when, you know, you have people that have gone to school and they're—you know, they're so advanced and they're in this profession [mental health providers], and they still don't understand."

Another participant in the same group stated:

"I think sometimes it kind of drives people from the community to not mention you are gay. If you're going to treatment, like, just don't mention it. You know, like, stick to the parts you want to talk about because if you mention anything else, it will look bad, so you avoid it and you don't talk about your relationships unless it's like a past one or something. You use gender-neutral names so you don't give away your orientation. It's just you try not to—and maybe they'll just think I'm a tomboy instead of a lesbian. I think sometimes we—you have an hour ... so you avoid those little parts that you just don't want to discuss because I think that they think I have already figured that part out [that I am gay] and it's like 'no, I don't want to talk about [it].' I already figured that part out. It's the other stuff that I want to talk about."

Participants in this group expressed the desire to discuss their sexuality in a context where it did not distract from other mental health-related needs and care. More than a distraction from care is the concern that the care received would not be appropriate if the larger context of care were not considered in terms of an LGBTQ consumer's gender or sexuality.

Focus group participant (female): *"A few of them [LGBTQ acquaintances] I remember attempted suicide—and had to be hospitalized."*

Focus group leader: *"Okay."*

Focus group participant (female): *"And then they didn't wanna speak to the therapist again after that incident happened."*

Focus group leader: *"Ohhhhh."*

Focus group participant (female): *"And the division where we were, we had a, like, a gay man doing therapy, so we really had limited access to other genders for therapists"*

Focus group leader: *"Um-hm" [affirmative].*

Focus group participant (female): *"So those were some big issues. ... When there are women who have been raped or attacked by a man, it's really hard for them to be around a man."*

Focus group leader: *"Yeah."*

Focus group participant (female): *“So, just, there are issues around men with the tr- ... trans girls—that could also, you know, be a problem when it comes to therapy.”*

A member of the Latino immigrant group expressed a concern about the services provided for men and the availability of those services, particularly for rural Latino men.

Focus group leader: *“Why do you think there are more resources for women?”*

Focus group participant (male): *“Because some of us just work, and women have time to go to the doctor and make appointments.”*

Focus group participant (male): *“Women are always at appointments, and men like me don’t know anything.”*

Focus group participant (male): *“Women take care of the children and have time to go.”*

Focus group leader: *“How would you recommend changing the schedule to give men more access to the resources?”*

Focus group participant (male): *“I would go on the days when I didn’t have to work, if I could have an appointment on those days.”*

Focus group leader: *“If the clinics had flexible hours?”*

Focus group participant (male): *“No, I would go on days when I wouldn’t have to work.”*

Work schedules with long work hours in addition to distance make access to mental health service especially difficult for rural Latino men.

Culturally competent services. Latino Immigrants expressed a strong need for culturally and linguistically competent mental health-care services, especially in times of crisis. A woman from the group described the following situation with her daughter:

Focus group participant (female): *There is a lack of interpreters at hospitals, especially when you go to the emergency room.*

Focus group leader: *Who are your interpreters? A friend?*

Focus group participant (female): *Once I took my daughter to the emergency, when she was younger, and none of the nurses spoke Spanish.*

In the context of stakeholders who experience significant stigma, the need for confidentiality from family, difficulty engaging appropriate services and programs, and a lack of interpreters or reliance on a family member for interpretation can compromise quality of care.

LGBTQ participants described experiences with providers they regarded as untrained or inadequately trained to understand the needs of their communities.

“I think—and that’s what a psychiatrist is supposed to do. They’re supposed to basically make you more educated about yourself. So, I mean, it would be nice if they already knew you, you know, and what you were going through. And to have them be educated and to go there and to not even have to like—to go there [and discuss sexual orientation when it is not relevant] not ... to even have to say that you’re gay because you’re not even coming there for issues like that, but just to have them already know about things like that so ... they don’t have to be [LGBTQ] as long as they just—they understand. They get it, you know, they’re not like—they’re past the point of being curious. They’ve talked to people and they’re not just reading it in a book, you know; you have to talk to someone to understand. Like you have to get other people’s experiences with that situation.”

Stakeholders who commented on the “fit” between consumers and their providers suggested that adequate training of diverse community professionals could enhance the quality of service for the most un(der)served groups, including marginalized ethnic groups and those with serious mental illness, in addition to persons who participated in our focus group discussions.

LGBTQ youth did not want to have to supply the “training experience” for their mental health providers. Many stated that the “fit” between their providers and their own mental health-related needs was conducive to adequate or effective care.

Language and literacy. Culturally and linguistically competent care includes, at a minimum, having interpreters available for care-related services. Beyond interpretation services, participants in the Latino immigrant group discussed how struggles with the English language and literacy with health-care forms have presented problems with engaging in mental health services. Members of the Latino immigrant group discuss some examples in the following excerpt:

Focus group participant (female): *“Sometime the receptionists are very rude [receptionists in clinics]. I wonder why they put some very unfriendly people to help.”*

Focus group leader: *“How are they rude to you?”*

Focus group participant (male): *“If you don’t fill out the paperwork correctly, they tell you to come back another day.”*

Focus group leader: *“They don’t help you fill out the forms if they are in English?”*

Focus group participant (male): *“There is times when you don’t speak English and you get the forms in English and you can’t fill them out. They just tell you to come back again and look for someone to interpret the forms for you.”*

Focus group participant (male): *“Return another day when that person isn’t there.”*

Focus group participant (female): *“What else can we do, we can’t stay there and argue. If that person is mad and you try to tell them otherwise....”*

Participants from the older adult group expressed similar frustrations with form-related literacy that sometimes prevented them from getting timely care. One participant who said she had difficulty enrolling in services due to her limited English proficiency and low level of literacy described her experiences:

“I just feel like the bureaucracy is tremendous, as you well know [when seeking mental health services]. So, filling out Medi-Cal forms, filling out applications for WIC or food stamps, you know, all of that is overwhelming, especially if you’re not familiar or English is your second language or you’re not very, you know, adept in the language. Filling out forms like that is enough to—and then if you have some mental issues, you know, it would be too hard.”

As this participant points out, a concomitant mental health need could further delay or impede the process of engaging in appropriate mental health services.

LGBTQ youth report learning about mental health-related issues and services by way of the Internet, where information quantity is far greater than information quality.

“A lot of that [finding out about mental health needs and services] happens on the Internet. I mean, like, especially if you come from a smaller town. Like here [name of county withheld], you have like a little bit more

options. I grew up in a small town so it would have been—it's a very closed-minded town so there really weren't any options for me and, you know, most of the—I figured out most of myself just by looking at things on the Internet, and I actually finally found like a web page that had other people, like, sharing who they were and I was, like, 'this is me. This is totally me.' So, that's, like, that's totally how I figured myself out, but—yeah, yeah, in smaller towns it's even harder.

The barrier that this participant describes regarding “small towns” is also characteristic of rural communities, where access to services or service-related support systems is limited.

Awareness of services or lack of outreach to community

Several participants in each of the three focus groups reported difficulty finding appropriate mental health-related care for their own needs or for those of a family member. All focus group participants with specialized needs reported a lack of awareness and difficulty in getting care that was appropriate to their needs or the needs of a family member.

Members of the LGBTQ youth group reported seeking information about mental health-related definitions, needs, and services on the Internet:

Focus group leader:

“But, like, as people are transitioning and growing into adolescence, where do people go to learn? Like you said, like, some—you know, there was one person who was, like, ‘oh, I didn’t even know who to ask.’ But where do people go to learn, and then not just learn about themselves and who they’re becoming and how they’re evolving, but where do they go to learn [when they] say ‘I might have depression?’ Or, ‘I might have anxiety?’ Like, what resources are out there to know?”

Focus group participant (female): *“Honestly, like, it’s like the Internet.”*

Those participants in both the youth and older age groups explained the impact of age as a factor in understanding and seeking mental health-related care. A participant in the older age group explained:

“You know, there’s issues of culture—I’m thinking it’s not just culture or your ethnicity; age groups, it’s also a culture, no? And you know, there’s a lot of conservatism in that sometimes we’re closed in not wanting—not necessarily not wanting, but not knowing how to branch out, where to find services. And many times we rely on the media television to tell us about mental health services or any health issue on where to go, and it’s obviously not doing a good job. And because, you know, for other reasons we’ve already talked about that there’s a lot of stigma, and people just don’t know when ... when an emergency presents itself, people just don’t know where to go. And she gave an example of a suicide she had in her family, and it was very shocking, of course.... When these crises happen in our families ... we realize, oh, this is mental health. Right? And where do we go for help?”

LGBTQ participants echoed these concerns with regard to specialty services for their communities:

Focus group participant (female): *“I don’t know where to go [for mental health services]. I don’t know how to get there. I don’t know how to pay for it. I don’t know how to fill out these forms. You know, there’s a lot of—a lot of, like, education component is a big part.”*

Focus group leader: *“What do you mean by ‘knowing where to go’?”*

Focus group participant (female): *“Knowing where to go or, you know, knowing what sort of—what is mental health? And I think once people figure it out, they’re like ‘I need to see somebody.’ But I think that for a long time, some people are just like, ‘oh, this is just the way I am’ and they don’t realize that. It’s just, like, what is mental health? Like when you’re reaching out to someone. It is a lonely process, and I don’t feel comfortable telling my parents or I don’t feel comfortable telling the school counselor. You know what I mean?”*

Those participants in the older adult focus group explained that they had difficulty understanding how to enroll or complete the appropriate forms in order to engage in mental health services, and they knew of no apparent resources for assisting older persons in accessing services. One group participant stated:

“There’s a need for help in filling out forms, enrolling in medical services. For example, she got stuck in filling out a medical form—a Medi-Cal application, and took, I’m assuming, weeks, months for her—[for] it to finally go through. And she would even go to the place, the Medi-Cal center, and they would tell her, ‘oh, no, we don’t offer that type of health care.’”

The interface between programs and funding exacerbates the confusion and appropriate provision of services for some populations, as explained in the excerpt above from the older adult group, suggesting a more seamless bureaucratic process that might allow older adults or those with multiple co-morbidities to more easily engage mental health and other care services.

SUMMARY OF FINDINGS

These findings represent the focus group participants' views about barriers to access to care and treatment based on experiences.

- An overarching theme about lack of general knowledge of MHSA-funded services, treatment options, and location was evident among most focus group participants. Insufficient knowledge and awareness of services is concerning, given the purpose and intent of the MHSA: to provide services that are not already covered by federally sponsored programs or insurance programs.
- Compounding an existing knowledge gap, difficulty with low literacy and limited English proficiency among un(der)served groups creates an initial need for MHSA-funded programs that educate people on how to navigate the mental health system and use of other community support systems to obtain mental health care and locate transportation services.
- Another key finding was the barriers that un(der)served communities had in common when seeking mental health care. For example, immigrant Latinos, LGBTQ transition-age youth, and older adults reported the cost of care and lack of insurance as a persistent barrier to seeking and accessing care. This finding suggests that individuals from these groups are not knowledgeable or had not been successful in finding MHSA-funded services, which are available at little or no cost to people without coverage.
- The responses by focus group participants emphasized that the MHSA should focus on (a) language proficiency, (b) cultural competency, (c) diversity and inclusion, and (d) integration of consumers and families when attempting to strengthen linkages between the mental health system and un(der)served groups.

Conclusion

The findings of this report suggest that MHSA has and continues to have an impact on reducing disparities among un(der)served groups, yet that impact and future directions need to be understood and informed, respectively, by continued stakeholder engagement that includes members of marginalized and un(der)served groups. Confusion remains, however, about the specific contents of some MHSA programs and a lack of systematic and sustained activities to evaluate their impact. We will not fully understand which types of strategies work, or under what conditions they work, if no efforts are made to develop community-based or evidence-based standards for evaluation of the implementation of these strategies.

Impact of the MHSA

The MHSA funds the largest expansion of mental health services in the past 50 years. More significantly, MHSA recognizes the need of a continuum of care by promoting prevention and early intervention to ensure early identification and avert the onset of a mental disorder in children and youth. MHSA also promotes the transformation to a recovery-focused system of care, which is targeted to individuals living with serious mental illness who are not receiving enough support to alleviate their risk of homelessness, incarceration, or hospitalization.

The findings of this report suggest that MHSA has and continues to have an impact on reducing disparities among un(der)served groups. The findings indicate that key informants recognize MHSA's commitment to invest in resources that build the capacity of un(der)served communities. For example, informants acknowledged Prevention and Early Intervention (PEI) and Full Service Partnerships (FSPs) as two major examples that strengthen the linkages between un(der)served groups and access to care. Furthermore, we have learned through this study that MHSA must do more to increase culturally competent programs and community outreach and engagement in order to ensure that services are adequate and appropriate for targeted un(der)served groups. This study is grounded in community-based participatory research (CBPR), by obtaining stakeholders' perspectives to assess the effectiveness of the MHSA on delivery of services for un(der)served groups. As a result, it constitutes a step in the right direction for MHSA to continue mitigating barriers to care.

Diverse stakeholders who offered critiques and suggestions through interviews or comments on a draft of this report during a period of public feedback observed that they have not seen many calls for stakeholder engagement, as the UCLA report had recommended. To date, stakeholder engagement has not been translated into an "actionable item" or meaningfully honored. We view this report as a step toward increasing the involvement and feedback of stakeholders. As such, we encourage the continued integration of stakeholder perspectives, so that diversity in perspectives drives the conversation about community-informed access to care and treatment. The importance of eliciting and using stakeholder feedback emerged as a consistent theme throughout this report as a significant means to help MHSA continue transforming mental health services that mirror the composition of un(der)served groups in California.

Challenges or Barriers

Increasing access to care for all of California's diverse and underserved groups is a formidable challenge. Prior to implementation of the MHSA, underserved groups faced a multitude of impediments to accessing care and receiving culturally and linguistically appropriate services. The MHSA has enabled California to review the progress of county mental health systems and has highlighted persistent and remaining obstructions in treatment access. Un(der)served groups continue to experience difficulty in accessing care due to several barriers, including language, cost of care or lack of insurance, stigma, geographic isolation, and in obtaining assistance in understanding mental health systems and funding sources. At the system level, improvements must be made in culturally competent treatment, outreach for underserved groups, and provision of care in appropriate settings through planning and development of a well-trained mental health services workforce, encompassing a range of mental health service providers. Large county mental health programs as well as smaller community-based organizations continue to experience difficulty in obtaining adequate funding to respond to these needs and to systematically monitor expenditures. Strategies for response need to also include appropriate evaluation and monitoring of existing programs, such as PEI and FSPs, proposed to expand their services to un(der)served populations.

While many of these barriers to treatment access and effective delivery of care existed before implementation of the MHSA, the MHSA's support of ongoing evaluations to explore its impact with underserved communities is a promising first step in overcoming key barriers for underserved groups. Through the findings of this report, which offers a voice to un(der)served groups, we obtain a picture of the matters most pressing to various communities and how we can begin to resolve them.

Strengths and Limitations

This report is part of a larger project that included a population-based approach on mental health disparities for un(der)served communities that remain following the implementation of the MHSA. Because this report focuses on the viewpoints of diverse groups of stakeholders on the impact of the MHSA on reducing disparities for un(der)served communities, it does not focus on the quality and quantity of county-level measurements, data or outcomes. The intent of this report is to help to inform larger, population-based analyses with diverse stakeholder viewpoints.

This report had some important strengths and notable limitations. Among its strengths are the qualitative and CBPR methods used to gather data from different sources (consumers, family members, mental health providers, administrators, advocates, and members of LGBTQ groups). Use of the MHSOAC and CEAB as resources and collaborators to design interview protocols and identify participants is another attribute.

Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of

participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.

Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy maker, researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI)); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.

In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.

Throughout our report, we have pointed to the impact of stigma on underserved communities, but we have yet to understand the full extent and scope of the role stigma plays in diverse communities on limiting access to care or diminishing quality of care or efficacy. Additional efforts must be made to assess the way in which stigma affects diverse underserved communities. Similarly, interviewees described the impact of multiple barriers to receipt of effective care or access to adequate treatment. While we have highlighted some of these intersections, future evaluations need to expand on the questions and issues we outline in this report in order to critically detail and clarify the impact of intersecting barriers and identify ways to remediate them. This report may serve as a point of clarification for some stakeholder perspectives and perhaps a point for framing questions about groups that this report may not

have been adequately represented. This report also offers further opportunity for formulating informed questions about California mental health services and for establishing a benchmark against which to measure future initiatives and improvements.

References

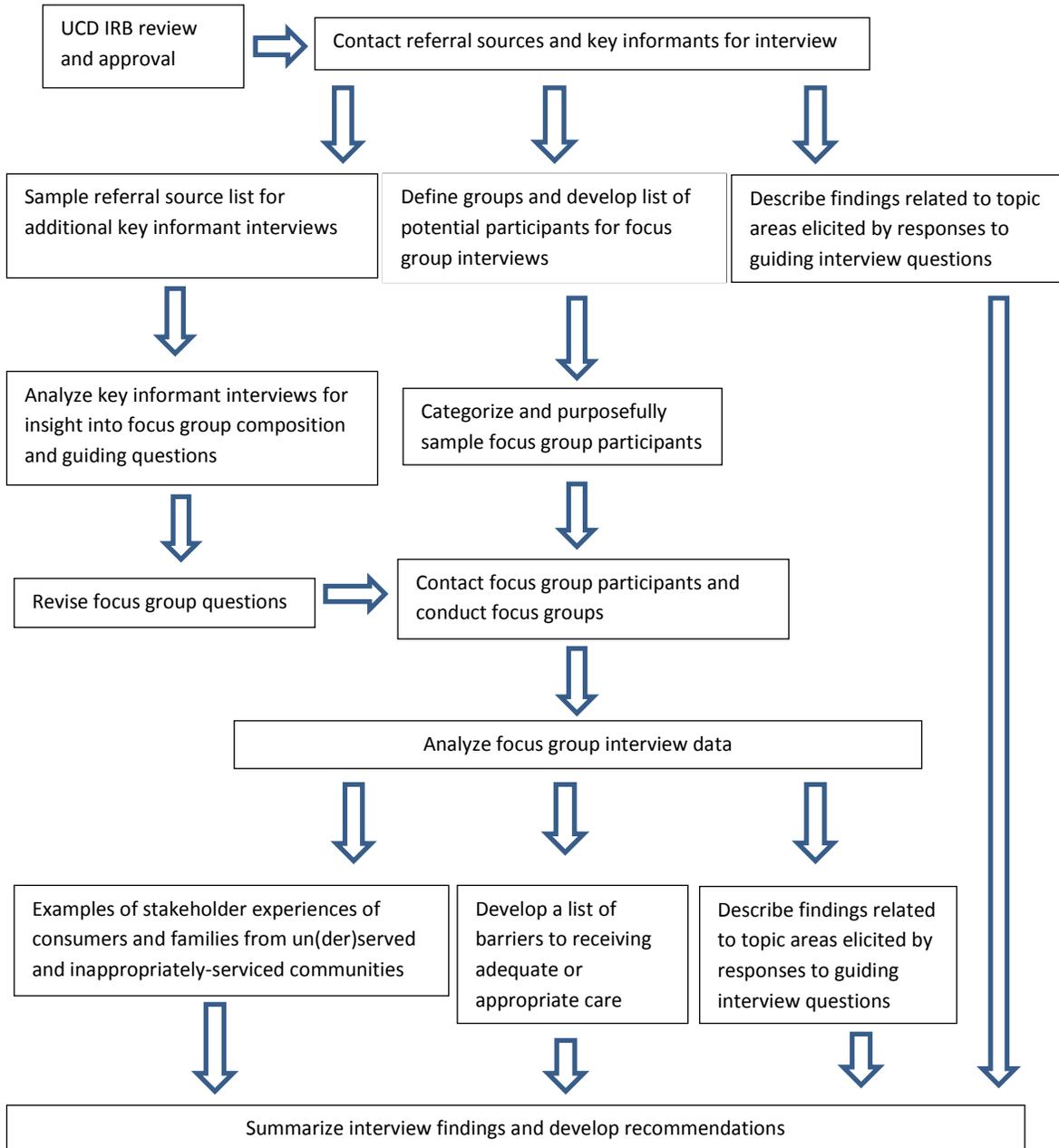
- Aguilar-Gaxiola, S., Loera, G., Mendez, L., & Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-defined solutions for Latino mental health care disparities: California Reducing Disparities Project, *Latino strategic planning workgroup population report*. Sacramento, CA: UC Davis.
- Alegria, M., Canino, G., Rios, R., Vera, M., Calderon, J., Rusch, D., et al. (2002). Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino Whites. *Psychiatric Services, 53*(12), 1547–1555.
- Alegria, M., Lin, J., Chin-Nan, C., Naihua, D., Cook, B., & Xioa-Li, M. (2012). The impact of insurance coverage in diminishing racial and ethnic disparities in behavioral health services. *Health Services Research, 47*(2), 1322–1344.
- Alegria, M., Perez, D. J., & Williams, S. (2003). The role of public policies in reducing mental health status disparities for people of color. *Health Affairs, 22*(5), 51–64.
- Bloor, M., Frankland, J., Thomas, M., & Robson, K. (Eds.). (2001). *Focus groups in social research*. Thousand Oaks, CA: Sage Publications, Inc.
- Brach, C., & Fraserirector, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research Review, 57*, Supplement, 181–217.
- Bruckner, T., Yoon, J., Brown, T., & Adams, N. (2010). Involuntary civil commitments after the implementation of California's Mental Health Services Act. *Psychiatric Services, 61*(10), 1006–1011.
- Cabassa, L. J. (2007). Latino immigrant men's perceptions of depression and attitudes toward help seeking. *Hispanic Journal of Behavioral Sciences, 29*(4), 492–509.
- California Department of Mental Health (2011). Mental Health Services Act (MHSA)—'overview' fact sheet (Sacramento, CA).
- California External Quality Review Organization. (2012). Overview of findings from CAEQRO statewide annual report of FY10–11. APS Healthcare. Microsoft PowerPoint presentation retrieved from <http://www.caeqro.com/webx/ee850bf>
- California Office of Multicultural Services. (2011). Fact sheet—county cultural competence plans.
- California State Auditor. (2013). Audit Report: Mental Health Services Act—The state's oversight has provided little assurance of the act's effectiveness, and some counties can improve measurement of their program performance. 212–122.
- Cashin, C., Scheffler, R., Felton, M., Adams, N., & Miller, L. (2008). Transformation of the California mental health system: Stakeholder-driven planning as a transformational activity. *Psychiatric Services, 59*(10), 1107–1114.
- Chow, J. C-C, Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5), 792–797.
- Clark, W., Welch, S. N., Berry, S. H., Collentine, A. M., Collins, R., Lebron, D., & Shearer, A. L. (2013). California's historic effort to reduce the stigma of mental illness: The Mental Health Services Act. *American Journal of Public Health, 103*(5), 786–794.

- Denzin, N. K., & Lincoln, Y. S. (Eds.). (2000). *The sage handbook of qualitative research*. Thousand Oaks, CA: Sage Publications, Inc.
- Edberg, M. C., Wong, F. Y., Woo, V., Doong, T. (2003). Elimination of health disparities in racial/ethnic minority communities: Developing data indicators to assess the progress of community-based efforts. *Evaluation and Program Planning*, 26(1), 11–19.
- Gee, G. C., Ryan, A., Laflamme, D. J., & Holt, J. (2006). Self-reported discrimination and mental health status among African descendants, Mexican Americans, and other Latinos in the New Hampshire REACH 2010 initiative: The added dimension of immigration. *American Journal of Public Health*, 96(10), 1821–1828.
- Grant, D., Padilla-Frausto, I., Aydin, M., Streja, L., Aguilar-Gaxiola, S., & Caldwell, J. (2011). *Adult mental health needs in California: Findings from the 2007 California Health Interview Survey*. Retrieved from <http://www.healthpolicy.ucla.edu/publications/Documents/PDF/MentalHealthreportnov2011.pdf>
- Gubrium, J. F., & Holstein, J. A. (Eds.). (2002). *Handbook of interview research: Context and method*. Thousand Oaks, CA: Sage Publications, Inc.
- LeCook, B., McGuire, T. G., & Zaslavsky, A. (2009). Measuring racial/ethnic disparities in health care: Methods and practical issues. *Health Services Research*, 66, 23–48.
- Lofland, J., Snow, D. A., Anderson, L., Lofland, L. H. (2005). *Analyzing social settings: A guide to qualitative observation and analysis* (4th ed.). Cengage Learning.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook*. Thousand Oaks, CA: Sage Publications, Inc.
- Minkler, M., & Wallerstein, N. (Eds.). (2010). *Community-based participatory research for health: From process to outcomes*. San Francisco, CA: Wiley.
- Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine*, 19(2), 120–126.
- Miranda, J., Lawson, W., & Escobar, J. (2002). Ethnic minorities. *Mental Health Services Research*, 4(4), 231–237.
- Morgan, D. L., & Krueger, R. A. (1994). *Focus group kit*. Thousand Oaks, CA: Sage Publications, Inc.
- Morse, J. (2004). Theoretical saturation. In M. Lewis-Beck, A. Bryman, & T. Liao (Eds.), *Encyclopedia of social science research methods* (pp. 1123–1124). Thousand Oaks, CA: Sage Publications, Inc.
- Nadeem, E., Lange, J. M., Edge, D., et al. (2007). Does stigma keep poor young immigrant and US-born Black and Latina women from seeking mental health care? *Psychiatric Services*, 58(15), 47–1554.
- Pescosolido, B. A. (1992). Beyond rational choice: The social dynamics of how people seek help. *The American Journal of Sociology*, 97(4), 1096–1138.
- Pescosolido, B. A. (2006). Of pride and prejudice: The role of sociology and social networks in integrating the health sciences. *Journal of Health and Social Behavior*, 47(3), 189–208.

- Pescosolido, B. A., McLeod, J. D., & Avison, W. R. (2007). Through the looking glass: The fortunes of sociology of mental health. In W. R. Avison, J. D. McLeod, & B.A. Pescosolido (Eds). *Mental health, social mirror* (pp. 3–32). New York: Springer.
- Pope, C., & Mays, N. (Eds.). (2000). *Qualitative research in health care*. Malden, Massachusetts: BMJ.
- Racial and Ethnic Mental Health Disparities Coalition (2013). *CMMC overview*. Retrieved from <http://remhdco.org/cmmc/cmmc-overview/>
- Reiter, M., Sinz, S., & SenGupta, S. (2012). Overview of findings from CAEQRO statewide annual report of FY10–11. PowerPoint presentation delivered to the California Department of Health Care Services.
- Snowden, L. (2005). Racial, cultural and ethnic disparities in health and mental health: Toward theory and research at community levels. *American Journal of Psychology*, 35(1/2), 1–8.
- Snowden, L., Masland, M., Ma, Y., & Ciemens, E. (2006). Strategies to improve minority access to public mental health services in California: Description and preliminary evaluation. *Journal of Community Psychology*, 34(2), 225–235.
- Sorkin, D. H., Pham, E., & Ngo-Metzger, Q. (2009). Racial and ethnic differences in the mental health needs and access to care of older adults in California. *Journal of the American Geriatrics Society*, 57(12), 2311–2317.
- UCLA Center for Healthier Children, Families, & Communities. (2011). Evaluation brief summary and synthesis of findings on MHSA values. Retrieved from http://www.mhsoac.ca.gov/Evaluations/docs/Del3B_Phase-II_MHSA-ValuesReport.pdf
- UCLA Center for Healthier Children, Families, & Communities. (2011). Evaluation brief summary and synthesis of findings on CSS consumer outcomes. Retrieved from http://mhsoac.ca.gov/Meetings/docs/Meetings/2011/May/OAC_052611_Tab8_UCLAEvalBrief.pdf
- UCLA Center for Healthier Children, Families, & Communities. (2013). *California's investment in the public mental health system: Prop 63 allocation and expenditures (FY 06–07 through 09–10)*. Retrieved from http://www.mhsoac.ca.gov/meetings/docs/Meetings/2013/FinancialOversight_102313_Tab5_UCLAReport_CAInvestmentInPublicMHSsystem.pdf
- Van Voorhees, B. W., Walters, A. E., Prochaska, M., & Quinn, M. T. (2007). Reducing health disparities in depressive disorders outcomes between non-Hispanic Whites and ethnic minorities a call for pragmatic strategies over the life course. *Medical Care Research and Review*, 64(5 Suppl.), 157S–194S.
- Vega, W. A., & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research. Special Issue: Barriers to Providing Effective Mental Health Services to Racial and Ethnic Minorities in the United States*, 3(4), 189–200.
- Wallerstein, N. B., & Duran, B. (2006). Using community-based participatory research to address health disparities. *Health Promotion Practice*, 7(3), 312–323.
- Wells, K., Klap, R., Koike, A., & Sherbourne, C. (2001). Ethnic disparities in unmet need for alcoholism, drug abuse, and mental health care. *American Journal of Psychiatry*, 158(12), 2027–2032.

- White, K., Haas, J. S., & Williams, D. R. (2012). Elucidating the role of place in health care disparities: The example of racial/ethnic residential segregation. *Health Services Research, 47*(2), 1278–1299.
- Williams, D. R., & Rucker, T. D. (2000, Summer). Understanding and addressing racial disparities in healthcare. *Health Care Financing Review, 21*(4), 75–90.
- Yoo, J., & Ward, K. J. (2012). *MHSA statewide participatory evaluation initial report phase III deliverable 2a-2 and 2b-2*. UCLA Center for Healthier Children, Families, & Communities. Retrieved from http://www.mhsoac.ca.gov/Evaluations/docs/Eval_MHSAStatewidePartEval_InitialReport_PhaseIII_Deliv2a-2And2b-2_103112.pdf

Appendix A: Diagram of Qualitative Methodology



Appendix B: List of Documents and Sources Reviewed for Qualitative Analysis

Pertinent Reports

- Aron, L., Honberg, R., Duckworth, K., et al. (2009). *Grading the states 2009: A report on America's health care system for adults with serious mental illness*. Arlington, VA: National Alliance on Mental Illness. Retrieved from http://www.nami.org/gtsTemplate09.cfm?Section=Grading_the_States_2009&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75459
- California External Quality Review Organization. (2011, October). *Statewide report prepared for the California Department of Mental Health, Volume I of III*. APS Healthcare. Retrieved from <http://www.caegro.com/webx/ee85071>
- California External Quality Review Organization. (2011). *Statewide report prepared for the California Department of Mental Health, Volume II of III*. APS Healthcare. Retrieved from <http://www.caegro.com/webx/ee85073>
- California Network of Mental Health Clients. (n.d.). *Comments on the State Department of Mental Health (DMH) draft proposed mental health services act (MHSA) capital facilities guidelines*. Retrieved from http://www.californiaclients.org/pdf/06_13_CNMHCCommentsonDMHDraftCapitalFacilitiesGuidelines.pdf
- California Network of Mental Health Clients. (2008, April). Recommendations to OAC. Retrieved from <http://www.californiaclients.org/pdf/CNMHC%20April%20Memo%20to%20OAC.pdf>
- Center for Reducing Health Disparities. (2009). *Mental health disparities summit final report*. University of California, Davis, Health System.
- Meisel, J. (2012, September). *MHSOAC evaluation master plan* [PowerPoint presentation].
- Pescosolido, B. A. (2006). Of pride and prejudice: The role of sociology and social networks in integrating the health sciences. *Journal of Health and Social Behavior*, 47(3), 189–208.
- Saumitra, S. Zhang, H., & Baler, S. (2008, November). *Measuring disparities using mental health performance indicators: The California external quality review experience* [PowerPoint slides].
- Scheffler, R. M., Felton, M., Brown, T. T., Chung, J., & Choi, S-S. (2010). *Evidence on the effectiveness of full service partnership programs in California's public mental health system*. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, School of Public Health.
- Technical Assistance Collaborative & Human Services Research Institute. (2012). *California Mental Health Substance Use Needs Assessment*. Submitted to the California Department of Health Care Services.
- Yoo, J., & Ward, K. J. (2012, September). *MHSA statewide participatory evaluation initial report: Phase III deliverable 2a-2 and 2b-b*. UCLA Center for Healthier Children, Families & Communities. http://www.mhsoac.ca.gov/Evaluations/docs/Eval_MHSAStatewidePartEval_InitialReport_PhaseIIIDeliv2a-2And2b-2_103112.pdf

Appendix C: Documents Reviewed and Resulting Potential Questions for Interviews

Contributing documents	Relevant constructs of interest	Guiding questions for interviews
<p>The Network-Episode Model (Pescosolido, 2006).</p>	<p>Perceived treatment need</p>	<p>How do individuals evaluate need for treatment within age, gender, and ethnically diverse communities? How do these individuals gather mental health information?</p>
	<p>Appropriateness of treatment</p>	<p>How do these individuals perceive the sociocultural fit of the available options? How do mental health consumers and their family caregivers compensate for limited services?</p>
	<p>Access and resources</p>	<p>Are there typical or regular informational sources of treatment for age, gender, and ethnically diverse communities? What resources do individuals turn to? [Inside and outside networks]</p>
	<p>Organizational culture</p>	<p>How do culture and climate within treatment organizations shape treatment options, bonds between providers and ethnically diverse consumers, and outcomes?</p>
	<p>Connections among organizations and people</p>	<p>How do the dynamics of organizing and financing treatment systems alter network ties in treatment sites, among providers, and between providers and consumers?</p>

Contributing documents	Relevant constructs of Interest	Guiding questions for interviews
Center for Reducing Health Disparities. (2009). <i>Mental Health Disparities Summit.</i>	<p>Needs of special communities</p> <p>Alternative services</p> <p>Special communities in need</p>	<p>In what ways does MHSA assess the needs of ethnic communities?</p> <p>What are the factors that are considered most important in the assessment of needs in ethnic communities? Are these factors considered universally important across all communities?</p> <p>What happens to ethnically diverse individuals who are denied MHSA services? Where do these individuals go? Can you describe whether or not they enter the system at another point with different needs/conditions?</p> <p>How has the MHSA included the Native American community in its development of services?</p> <p>How has the MHSA included the LGBTQ community in its development of services?</p>
California External Quality Review Organization (2011). <i>Statewide report prepared for California Department of Mental Health. Volume II of III.</i>	<p>Achievements and benefits of organization</p> <p>New practice strategies and implementation</p>	<p>What are the greatest successes and accomplishments of MHSA with regard to unserved, underserved, or inappropriately served age, gender, ethnically diverse groups? [Probe as to who or what groups benefitted.] What are the perceived gaps or issues yet to be addressed, including barriers to resolving these issues?</p> <p>Which practice patterns (and outcomes) demonstrate innovative ways of addressing the problems of ethnic and otherwise marginalized communities? Where have these practices been implemented most successfully? What have been the barriers to implementation in other communities experiencing disparities in mental health care access, service delivery and outcomes?</p>

Contributing documents	Relevant constructs of Interest	Guiding questions for interviews
<p>California External Quality Review Organization. (2011, October). California Mental Health Planning Council Cultural Competence Committee.</p>	<p>Barriers to effective delivery</p> <p>Important cultural advances</p> <p>Culturally competent care and service</p>	<p>What are some of the barriers to the effective delivery of mental health care for the populations you serve?</p> <p>What do you see to be the most important advances in terms of meeting the cultural needs of the community(ies) you serve?</p> <p>What do you consider to be culturally competent mental health care? How is this type of care planned for and/or delivered?</p>
<p>NAMI State Report Card for the State of California. (2009).</p>	<p>Funding and disbursement</p> <p>Response to needs of special populations</p> <p>Service safety nets</p> <p>Persistent barriers</p>	<p>Tell us about how MHSA funds are disbursed and managed in order to ensure service delivery to underserved communities.</p> <p>How does MHSA respond to the needs of mentally ill, homeless, and elderly people?</p> <p>What kinds of services or safety nets are available for people who are experiencing multiple social and psychological problems? Are the services they receive sufficiently meeting their needs?</p> <p>What sorts of barriers are persistent in the provision or accessibility of these services?</p>

Contributing documents	Relevant constructs of Interest	Guiding questions for interviews
<p>Scheffler, R. M., Felton, M., Brown, T. T., Chung, J., & Choi, S-S. (2010). <i>Evidence on the effectiveness of full service partnership programs in California's public mental health system</i>. Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, University of California, Berkeley, School of Public Health.</p>	<p>Potential risks and negative outcomes</p> <p>Mitigating negative consequences of underserved populations</p> <p>Improvements for underserved populations</p>	<p>What do you see to be the (most severe) consequences for populations accessing MH services? What groups do you see to be at the greatest risk for some of the most severe negative outcomes?</p> <p>Can you describe the ways in which the MHSA has helped to mitigate some of the unintended negative consequences for the unserved and underserved who seek care? [Probe for the ways in which the MHSA has done so for specific (marginalized) groups.]</p> <p>Are there improvements that have been made in specific populations that have provided lessons for how some of these less desirable outcomes might be best addressed?</p>

Contributing documents	Relevant constructs of Interest	Guiding questions for interviews
<p>Technical Assistance Collaborative & Human Services Research Institute. (2012). <i>California Mental Health Substance Use Needs Assessment</i>. Submitted to the California Department of Health Care Services.</p>	<p>Resources for monitoring service gaps</p> <p>Additional barriers to care</p> <p>Evidenced-based practice</p>	<p>How has the MHSA provided the resources or avenues for monitoring and responding to gaps in services? What innovative strategies have been used? What barriers to effective monitoring still exist?</p> <p>Can you discuss some of the factors external to the system or to individual ability to engage in types of care that affect mental health outcomes? [Probe here for specific subgroups and those with worse outcomes.]</p> <p>What are your views on existing evidenced-based practices? How are they responding to the ethnically underserved communities across gender and age span?</p>
<p>Yoo, J., & Ward, K. J. (2012). <i>MHSA statewide participatory evaluation initial report phase III, deliverable 2a-2 and 2b-2</i>. UCLA Center for Healthier Children, Families, & Communities</p>	<p>Insights of groups served on service delivery</p> <p>Peer- or family-based intervention and impacts</p>	<p>Describe the ways in which the opinions and experiences of mentally ill people have been assessed with regard to the delivery of services, service types, and their integration. What insights have these groups offered? How have these insights been translated into practice patterns?</p> <p>In what types of communities have the use of peer or family support-related interventions been the most effective? What have been the constructive effects of this type of engagement/intervention? In what ways does this type of engagement/intervention need improvement? What insights do you have about how this might be improved?</p>

Contributing documents	Relevant constructs of Interest	Guiding questions for interviews
Additional questions, arising from team discussion and review.	<p>Service availability and sufficiency</p> <p>Groups lacking access</p> <p>Consumer engagement</p> <p>Cultural competence</p> <p>Model practices</p>	<p>What is your perspective on the availability of MHSA services throughout the state of California? Are services sufficient or inadequate?</p> <p>Do any groups still lack access to MHSA programs? What prevents MHSA from reaching them?</p> <p>How do you view age, gender, and ethnically diverse consumer engagement with MHSA services? How do you define treatment retention? In your perspective, how has treatment retention changed since the establishment of MHSA?</p> <p>How have consumers, contractors, and providers responded to efforts to improve cultural competence among MHSA-funded programs? What types of critiques do providers and consumers give?</p> <p>In your opinion, have services become more culturally competent? In what ways? What impediments to improving cultural competence remain?</p> <p>Can you identify a model program or practice that you believe has achieved what you conceive to be culturally competent care?</p>

Appendix D: Key Informant Interview Script and Guide

Study goal: We're here today to talk with you about your experiences with California mental health services. We are particularly interested in your perspective about mental health services since the Mental Health Services Act of 2005—specific benefits related to care and service for un(der) or inappropriately served persons or groups *and* barriers to adequate and appropriate care. We will use what you tell us, along with the feedback we receive from other stakeholders, to evaluate mental health services for un(der) or inappropriately served persons or groups, and to make recommendations for addressing existing needs. We will be interviewing approximately 50 stakeholders in total. Approximately 20 stakeholders will be interviewed individually, and an additional 30 stakeholders, principally mental health care consumers, will participate in a focus group interview.

Participants' role: You are the expert in this discussion. We want to hear about your experiences and how your participation in the California Mental Health System [*state the stakeholder role here: administrator, provider, consumer, family member of consumer, activist*] has impacted you. Not everyone is going to have the same experience. We want to hear about a variety of experiences. We would like you to consider yourself someone who is representing others who might be like you and share your perspective—people who are your same age, gender, race, or who come from your neighborhood.

Rules of participation: We will be audio recording this conversation and taking notes, so that we can be sure to capture and accurately represent what you have to say. We need to make sure that we hear what you have to say, so we ask that you speak loudly and clearly.

Process: We have quite a few questions to ask you, and we would like to get to all of them. There may be times when I will have to move the conversation along. You have note pads and a pen in front of you to keep track of anything you would like to say that you might not have a chance to say [*these items were provided to interviewees*]. Please jot it down, and at the end of the interview, we'll try to get back to what you have noted.

Topics: We have several topics that we would like to discuss with you, including how the MHSA has changed your experience with the California mental health system. There are four topics that we will discuss related to your understandings of and experiences with mental health care. We'll begin by talking about how you or un(der) - or inappropriately-served groups might come to seek care. We'll then talk about where you or they might go to get help, and your perspectives on the kinds of services offered. As we discuss each of these topics, we will explore factors that have been particularly helpful in care seeking and receipt of care, and those barriers you think might need to be addressed in order to improve mental health care in California.

Do you have any questions before we begin? [Address questions and then begin the interview.]

Guiding questions (and follow-up probes) for key informant interviews

Tell us about your role and experience with California mental health services.

What are some of the barriers to the effective delivery of mental health care for the populations you serve? Can you describe the ways in which the MHSAs have helped to mitigate some of the unintended negative consequences for the underserved who seek care? [Probe for the ways in which the MHSAs have done so for specific (marginalized) groups.]

In what ways does MHSAs assess the needs of ethnic communities? What are the factors that are considered most important in the assessment of needs in ethnic communities? Are these factors considered universally important across all communities? How has the MHSAs included the Native American community in its development of services? How has the MHSAs included the LGBTQ community in its development of services?

Tell us about how MHSAs funds are dispersed and managed in order to ensure service delivery to underserved communities.

What happens to individuals who are denied MHSAs services? Where do these individuals go? Can you describe whether or not they enter the system at another point with different needs or conditions?

What are the greatest successes and accomplishments of MHSAs with regard to unserved, underserved or inappropriately served groups? [Probe as to who or what groups benefitted.] What are the gaps or issues yet to be addressed, and what have been some of the barriers to addressing these issues?

Which practice patterns (and outcomes) demonstrate innovative ways of addressing the problems of ethnic and otherwise marginalized communities? Where have these practices been implemented most successfully? What have been the barriers to implementation in other communities experiencing disparities in mental health care access, service delivery, and outcomes?

What do you see to be the (most severe) consequences for populations accessing MH services? What groups do you see to be at the greatest risk for some of the most severe negative outcomes?

How has the MHSAs provided the resources or avenues for monitoring and addressing gaps in services? What barriers to effective monitoring still exist?

Is there anything that we didn't ask about that you would like to say, or perhaps something you would like to add to your comments? Thank you.

Appendix E: Focus Group Interview Script and Guide

Study goal: We're here today to talk with you about your experiences with California mental health services. We are particularly interested in your perspective about mental health services since the Mental Health Services Act of 2005—specific benefits related to care and service for un(der) or inappropriately served persons or groups *and* barriers to adequate and appropriate care. We will use what you tell us, along with the feedback we receive from other stakeholders, to evaluate mental health services for un(der) or inappropriately served persons or groups and to make recommendations for addressing existing needs. We will be interviewing approximately 50 stakeholders in total. Approximately 20 stakeholders will be interviewed individually, and an additional 30 stakeholders, like yourselves, will participate in a focus group interview.

Participants' role: Thank you for participating in this focus group. You are the expert in this discussion. We want to hear about your experiences and how your participation in the California mental health system [*state the stakeholder role here: consumer, family member of consumer*] has impacted you. Not everyone is going to have the same experience. We want to hear about a variety of experiences. We would like you to consider yourself someone who is representing others who might be like you and share your perspective—people who are your same age, gender, race, or who come from your neighborhood.

Rules of participation: We will be audio recording this conversation and taking notes, so that we can be sure to capture and accurately represent what you have to say. We need to make sure that we hear what you have to say, so we ask that you speak loudly and clearly.

We will use a digital recorder to record your responses and will give the digital recording a code. The digital recording will not contain your identifying information. We will then transcribe the recording. All recordings will be stored in a locked cabinet in a secured office accessible only to the researchers of this study. Information gathered from these focus groups will be used to complete this evaluation and for future publications. The results of this study will be made public by the Mental Health Services Oversight and Accountability Commission. However, we will not publish any information that could be used to identify an individual subject.

This focus group should take about 1.5 to 2 hours of your time. Please note that this focus group is completely voluntary. You can decline to participate in this focus group, not respond to any question you do not feel comfortable answering, or you may end your participation at any time. The risks related to your participation in this focus group are minimal. However, it is possible that discussing the receipt of mental health services may cause you minimal discomfort.

Process: We have quite a few questions to ask you, and we would like to get to all of them. There may be times when I will have to move the conversation along. You have note pads and a pen in front of you to keep track of anything you would like to say that you might not have a chance to say [*these items were provided to interviewees*]. Please jot it down, and at the end of the interview, we'll try to get back to what you have noted.

Topics: We have several topics that we would like to discuss with you, including how the MHSA has changed your experience with the California mental health system. There are four topics

that we will discuss related to your understandings of and experiences with mental health care. We'll begin by talking about how you or your family member or friend might come to seek care. We'll then talk about where you or they might go to get help, and your perspectives on the kinds of services offered.

As we discuss each of these topics, we will explore factors that have been particularly helpful in care seeking and receipt of care, and those barriers you think might need to be addressed in order to improve mental health care in California.

Do you have any questions before we begin? [Address questions and then begin the interview.]

Guiding questions for focus group interviews

Please tell us a bit about yourselves. How are you connected to the California mental health services system?

How do you assess your own needs for mental health care and treatment? How do you gather your mental health-related information? Where do you get it?

Can you describe where you regularly go for mental health treatment? What other options for treatment do you have?

How do you perceive the “fit” of the options available to you and the kinds of needs you have? [Ask the interviewee to discuss specific examples.] What kinds of things do you do when you can’t get treatment for your mental health issues or when services are limited?

Can you discuss some of the factors that limit your personal ability to engage in the care that is available? What do these limitations mean for your mental health? [Probe here for specific examples.]

In your opinion, how does the kind of care you receive through the MHSA respond to the needs of mentally ill, homeless, and elderly people?

What kinds of services are available for people impacted by multiple issues? [Try to give examples of the sort that were brought up during the interview.] Are the services you receive meeting your needs?

In what ways do they meet your needs? In what ways do they fall short?

What sorts of barriers present themselves? [Probe for barriers specific to the focus group: ask immigrants about language barriers and accessibility of services for immigrants in rural areas; ask about elderly people who have comorbid conditions, age-related issues, and caregivers.]

Where have you seen the biggest impact of peer or family support-related interventions? Can you describe that impact? In what ways might this type of program need improvement? What insights do you have as to how this might be improved?

Has anyone ever asked you about your own experience in the mental health services system? [If so, who and what did they ask; when did they ask?] If you have been asked about your experience, what have been the insights that you feel you have been able to offer? Have you seen your suggestions or comments used in any way?

Is there anything that we didn’t ask about that you would like to say, or perhaps something you would like to add to your comments? Thank you.

Appendix F: Advisory Board & Public Comments/Feedback and Changes Adopted Matrix

Deliverable 2c Report Sections	Comments/Feedback Received	Changes Adopted
<p>I. Executive Summary Section</p>	<p>Comment (Advocate): The following is a troubling finding that needs continual attention: "The UCLA Center for Healthier Children, Families and Communities (2012) evaluation found little evidence suggesting stakeholder involvement in the public mental health system, which impedes the progress of MHSA-funded services for un(der)served groups. This key finding underscores the idea that the effectiveness of a progressive public mental health system depends on stakeholder involvement and the importance of representation from un(der)served groups. A 2011 systematic review of existing MHSA evaluations, studies, and county documents found the utility of stakeholder involvement on MHSA-funded services and their evaluation to be minimal (UCLA Center for Healthier Children, Families and Communities, 2011)."</p>	<p>Response: Thank you for your comments. In this section, we have attempted to clarify some of the issues regarding stakeholder engagement and how it informs our report by introducing the following statement:</p> <p><i>This study is grounded in community-based participatory research (CBPR), by obtaining stakeholders' perspectives to assess the effectiveness of the MHSA on delivery of services for un(der)served groups. As a result, the persistent focus of MHSA on mitigating barriers to care constitutes a step in the right direction. We encourage the continued integration of stakeholder perspectives, so that diversity in perspectives drives the conversation about community-informed access to care and treatment. That strategy emerged as a consistent theme throughout this report as a significant means to help MHSA continue transforming mental health services that mirror the composition of un(der)served groups in California. In this report, our stakeholders describe their experiences with and perceptions related to access and appropriateness of mental health services, which were expanded under the MHSA. We propose that this report, including the incorporation of public responses to the draft of this report, serves as part of an ongoing dialogue between administrators of mental health services and the people they serve.</i></p>
	<p>Comment (Advocate/Consumer): What was the criteria in this report? To what extent was blended stakeholder, i.e. consumer family member feedback used in the conclusions?</p> <p>With this much money going out shouldn't we be hearing some astounding results from thousands moving through recovery, served directly by programs that increase the wellness and the health of individuals and communities through taking action for social change...strategies to restructure mental health systems to be recovery-oriented and community-based; to protect our civil and human rights...to build more accepting, inclusive, and diverse organizations and communities...maximize our individual and collective strengths, potential, and creativity to make wellness and social justice a reality for all. Are following outcomes a result of or addressed in the report?</p> <p>Are outcome assessments offered by consumers about their reaction to health care a direct service?</p>	

	<p>Comment (Administrator): What about documentation on consumer/stakeholder level of involvement: sporadic vs on-going ; providing input, member of advisory, or involvement is on-going and participates in collaborative a decision making process?</p>	
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Deliverable 2c Report Sections	Comments/Feedback Received	Changes Adopted
II. Introduction	<p>Comment (Advocate): One of the important groups furthering the reduction of disparities is the California MHSA Multicultural Coalition (CMMC). This Coalition representing communities from under represented and underserved constituencies (i.e., Deaf/Hard of Hearing, Middle Eastern Arab communities, Armenian, Russian-Speaking, Islamic populations, aging and older adults, and other groups) plays a vital role in advocacy and in analysis of client, family member, and lived experience perspectives regarding impact of the MHSA on mental health disparities.</p> <p>Comment (Mental Health Organization): Omission of the California MHSA Multicultural Coalition (CMMC) in the section describing the California Reducing Disparities Project (CRDP). (Page 4) The CMMC is an integral part of the CRDP. In addition to the five groups selected for special population reports, the CMMC represents additional underserved communities in addition to these five groups (the Middle Eastern communities, the Deaf and Hard of Hearing community, the Muslim community, the Older Adult community, the Armenian community, etc.). The CMMC has produced reports and documents that include information on the needs of these</p>	<p>Response: Thank you for pointing this out. We have added a footnote to acknowledge these efforts.</p> <p><i>The CRDP is supported by the California MHSA Multicultural Coalition (CMMC). Formed on March 2011, the CMMC aims to identify challenges in access to care among underserved communities and to recommend solutions for the development of more culturally and linguistically appropriate mental health systems. Composed of representatives from various underserved communities throughout California, the CMMC offers the CRDP valuable insights from diverse multicultural perspectives, inclusive of consumers and family members, that have not been previously represented in mental health systems (Racial and Ethnic Mental Health Disparities Coalition (REMHDCO), 2013).</i></p>

	<p>communities and policy issues that impact reducing disparities under the MHSA for all underserved communities.</p>	
	<p>Comment (Commissioner): Previous efforts to engage stakeholders have not been met with active uptake of recommendations or have not made recommendations that have been, according to public comment, actionable policy measures for the most marginalized of these groups.</p>	<p>Response: We acknowledge these comments, which suggest that recommendations from the UCLA report related to stakeholder engagement were not translated into actionable items or have not been meaningfully honored. While we do not directly address this issue in the Introduction to our report, we provide a statement in the Conclusion to our report, which draws attention to this point raised by several of our public comments.</p> <p>In the conclusion to our report, we added the following:</p> <p><i>Diverse stakeholders who offered critiques and suggestions through interviews or comments on a draft of this report during a period of public feedback observed that they have not seen many calls for stakeholder engagement, as the UCLA report had recommended. To date, stakeholder engagement has not been translated into an “actionable item” or meaningfully honored. We view this report as a step toward increasing the involvement and feedback of stakeholders. As such, we encourage the continued integration of stakeholder perspectives, so that diversity in perspectives drives the conversation about community-informed access to care and treatment. The importance of eliciting and using stakeholder feedback emerged as a consistent theme throughout this report as a significant means to help MHSA continue transforming mental health services that mirror the composition of un(der)served groups in California.</i></p>
	<p>Comment (Advocate): Annual updates with stakeholder input is not reviewed carefully enough or, maybe minimally, by local Boards nor honored as meaningful input by leadership. Including it as written form with seemingly glib responses in the update discounts and often negates stakeholder involvement.</p>	
	<p>Comment (Administrator): What about documentation on consumer/stakeholder level of involvement: sporadic vs on-going ; providing input, member of advisory, or involvement is on-going and participates in collaborative a decision making process?</p>	
	<p>Comment (Mental Health Organization): Lack of analysis in regards to communities of color and other underserved communities in the section regarding Stakeholder Engagement. This section describes evaluation efforts by the MHSOAC in regards to stakeholder engagement but does not discuss that lack of attention given to obtaining information from people with knowledge and connection to racial and ethnic communities. For example, the most recent evaluation of the stakeholder process was planned by a collaboration of organizations, none of which primarily served racial, ethnic, and cultural</p>	<p>Response: Thank you for pointing out this oversight. We have added the following <i>italicized</i> statement to our discussion of stakeholder engagement by the MHOAC:</p> <p><i>Specifically, the MHSOAC-sponsored evaluation will assess counties’ local planning processes. This is a step in the right direction to adequately evaluate the degree to which counties involve stakeholders and to ensure the full participation of stakeholders in MHSA-funded mental health services. In spite of</i></p>

	<p>communities. A great number of focus groups were to be conducted (58), but none of the focus groups targeted specific racial, ethnic or cultural communities as this study on underserved communities.</p>	<p><i>this step, advocates for communities of color and underserved communities argue that attention and outreach to people who have sufficient knowledge of and connection to these communities remain inadequate.</i></p>
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Deliverable 2c Report Sections	Comments/Feedback Received	Changes Adopted
III. Research Methodology Section	<p>Comment (Advocate/Consumer): What was the criteria in this report? To what extent was blended stakeholder, i.e. consumer family member feedback used in the conclusions?</p>	<p>Response: Thank you for your question and the opportunity to clarify throughout our report. We have added various sentences to our Research Methodology section in order to clarify stakeholder involvement and the purpose of using qualitative methods. One of those specific comments is highlighted below:</p> <p><i>We engaged multiple stakeholders in this evaluation. Stakeholder involvement included participation in key informant or focus group interviews, engagement on our advisory panel, and critiquing a draft version of this report, which was circulated for public comment for a period of thirty days (see Appendix F for feedback and responses).</i></p>
	<p>Comment (Advocate/Consumer): What was the criteria in this report? To what extent was blended stakeholder, i.e. consumer family member feedback used in the conclusions?</p>	<p>Response: Thank you for your question and the opportunity to clarify throughout our report. Qualitative and quantitative analysis take different approaches to sampling and observation. This Deliverable reports the qualitative findings of our evaluation. Quantitative (population-based) findings and methods are reported in a separate deliverable,</p> <p>We have added various sentences to our Research Methodology section in order to clarify stakeholder involvement and the purpose of using qualitative methods. One of those specific comments is highlighted below:</p>
	<p>Comment (Advocate/Consumer): Offhand I believe qualitative statistics, not measuring the survey numbers, not quantitative methods were applied to conclude that Reducing Disparities targets were being met. It is helpful to know what other agency responses, (see Orange County) are to this report which appears to completely miss the point in its unbalanced conclusion.</p>	

	<p>Comment (Mental Health Organization): Even though the evidence to be acquired is largely qualitative in nature, it is important that the sampling strategies have some reasonable quantitative basis in order to be taken as evidence to support hypotheses or objectives.</p>	<p><i>The purpose of qualitative methods of research is to gain an understanding of the experiences of those engaged in mental health services. Qualitative methods consisted of interviews with key stakeholders, including mental health administrators, advocates, and providers associated with mental health service delivery, as well as individuals at risk of and living with serious mental illness, their family members, and personal caregivers, who were part of historically un(der)served groups. Interviews were employed in order to have an open-ended, directed conversation that could explore stakeholders' "firsthand knowledge and experience" with California mental health service systems and the impact of the MHSA.</i></p>
	<p>Comment (Advocate/Consumer): What were the criteria in this report? To what extent was blended stakeholder, i.e. consumer family member feedback used in the conclusions?</p>	<p>Response: Thank you for your question and the opportunity to clarify throughout our report. We have added various sentences to our Research Methodology section in order to clarify stakeholder involvement and the purpose of using qualitative methods. One of those specific comments is highlighted below:</p>
	<p>Comment (Advocate/Consumer): Offhand I believe qualitative statistics, not measuring the survey numbers, not quantitative methods were applied to conclude that Reducing Disparities targets were being met. It is helpful to know what other agency responses, (see Orange County) are to this report which appears to completely miss the point in its unbalanced conclusion.</p>	<p><i>We engaged various stakeholders at different levels—consideration of interview topics, identification of interviewees, review of drafted report findings for analytic clarity and gaps in responses.</i></p>
	<p>Comment (Administrator): What about documentation on consumer/stakeholder level of involvement: sporadic vs on-going; providing input, member of advisory, or involvement is on-going and participates in collaborative a decision making process?</p>	
	<p>Comment (Advocate): Among its strengths are the qualitative and CBPR methods used to gather data from different sources (consumers, family members, mental health providers, administrators, and members of LGBTQ groups). Advocates can be included in this list.</p>	<p>Response: Thank you for catching this oversight. We have included advocates among our list of sources.</p> <p><i>Our approach to understanding diverse stakeholder perspectives</i></p>

		<p><i>(including administrative, advocacy, service provider, consumer, and family perspectives) on the ability of the MHSA to reduce disparities in access, quality of services, and outcomes also involved a content review of current documents relevant to understanding mental health services, consumer needs, and disparities (Minkler & Wallerstein, 2010).</i></p>
	<p>Comment (Mental Health Organization): Lack of details and transparency with regard to the efforts of the CEAB (Community Expert Advisory Board). As the report states, “The CEAB met four times during an 8-month period and solicited frequent feedback Engagement with our CEAB assisted us in refining our initial list of Key Informants as well as our strategy for sampling informants and specific focus group participants based on the barriers they face to appropriate and effective care.” (Page 9) This appears to be a vital element in this report, but this process lacks transparency.</p> <p>What was the feedback? Can we learn more from this process that will help explain why certain key informants and focus groups were chosen?</p>	<p>Response: Thank you for allowing us the opportunity to clarify this process. We now realize that our attempt to explain the process as simply as possible has made the process less transparent. We hope that our attempt to clarify has assisted in making the process a bit more clear.</p> <p><i>Our research team met with the CEAB four times during an eight-month period, and solicited comments frequently during these meetings via telephone calls as well as by electronic mail. Our team sought advice from the CEAB regarding gaps in our list of key informants for interviews, including their informed understandings of the relationship of the potential key informant to the MHSA as well as the types of underserved populations, racial and ethnic communities, and geographic areas the key informants represented. CEAB members provided a critical eye that helped to inform the selection of a range of key informants who could speak to the need of diverse persons and communities. Engagement with our CEAB assisted us in refining our initial list of key informants, as well as our strategy for sampling informants and specific focus group participants, based on the barriers that impede their access to appropriate and effective care.</i></p>
	<p>Comment (Mental Health Organization): “I’m struck by the small size of the samples, and the use of an ESL class subsidized by MHSA funds to use as a focus group. It appears that they deliberately used groups that weren’t involved in MH services. Using a group of four gay and lesbian TAY as a focus group is too small to be meaningful. They don’t explain how they got the 21 key informants.”</p>	<p>.</p>

	<p>Comment (Advocate): The guiding questions for the focus groups are insightful; I'm wondering if they were clearly understood by all participants (e.g., is "assess" clear? does "engage" mean something different to cultural groups in their native language? are "interventions" understood or what does an intervention look like to an immigrant? Is "mental health services system" clear or is there awareness about a system even, esp. when there's no familiarity about MHSA?) and whether they can be simplified even though a facilitator will explain these terms well.</p>	<p>Response: Thank you for making this point. We have noted this in our discussion of interview methods.</p> <p><i>The moderator was skilled in using the interview script as well as in clarifying unclear concepts or terminology for diverse participants. Trained moderators have the capacity to respond to the needs of specific participants and to ensure that participants understand the kinds of questions being asked. In addition, the inclusion of community members helped to ensure clarity in the presentation of interview questions.</i></p>
	<p>Comment (Mental Health Organization): We are told that the CEAB “aimed to ensure a diversity of viewpoints . . . that represent and/or can speak to the experiences of un(der)served groups including, for example, Native Americans, the severely mentally ill, and LGBTQ communities.” (Page 9)</p> <p>However, the report gives no information as to what these aims produced and what populations the subsequent key informants primarily represent. Such answers would provide key insights into understanding the barriers and issues that informants identified.</p>	<p>Response: We appreciate the fact that this information would be useful and provide greater validation of our findings. However, our IRB protocol prohibits disclosure of any information that might disclose the identity of a key informant. For those serving certain vulnerable populations or in smaller communities, such information could potentially jeopardize the confidentiality of the interviewee. Therefore, we have withheld such information.</p>
	<p>Comment (Mental Health Organization): Lack of attention to gender and family issues. Key informants mention gender and family issues only once on page 25. Thus, it would be pivotal to know if key informants work primarily with women, men, families, etc.</p>	
	<p>Comment (Mental Health Organization): ...the report states that “Three populations were targeted for focus group interviews based on their experiences of multiple and significant barriers to appropriate mental health services” (Page 13) What does the term “significant” encompass in this context?</p>	<p>Response: Thank you for asking for clarification regarding the generalizability of our findings. We address these comments related to generalizability in two sections of our report. First, in describing our goals in selecting focus group participants, and second, in our discussion of limitations of our report. The additions we have made to these sections of the report are noted below.</p>

	<p>Comment (Administrator): this includes age, condition and culture/linguistic</p>	<p>To the methods discussion, we added:</p> <p><i>Our goal was to learn from these groups about the multiple and diverse barriers to appropriate and effective mental health services delivery and to use these data as starting points for exploring the barriers encountered by other un(der)served groups who face similar obstacles.</i></p> <p>To the limitations of our study, we added:</p> <p><i>Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.</i></p> <p><i>Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy</i></p>
<p>Comment (Advocate/Consumer): This could be compared to the number and demo characteristics of informants</p>		
<p>Comment (Provider): A big problem I see for this report is the credibility for readers across the state. The amount of people interviewed and the limited regions surveyed may cause those to not relate since it is based on such a small population. The interviewee amount was minimal and central to certain areas, not truly representative of the state and counties. If I were a reader I may say, "well that's nice to read 30 individuals views in 3 counties, but it doesn't help our area with the disparities here because of our populations, cultures, groups, etc... are different, unique, reached, etc.."</p>		
<p>Comment (Mental Health Organization): ...the choice of counties to sample seems non-representative. The three counties selected were all large, urban counties. No rural or medium-sized counties were included, which seems an insufficient sample size for a report of this type.</p>		
<p>Comment (Advocate/Consumer): Offhand I believe qualitative statistics, not measuring the survey numbers, not quantitative methods were applied to conclude that Reducing Disparities targets were being met. It is helpful to know what other agency responses, (see Orange County) are to this report which appears to completely miss the point in its unbalanced conclusion.</p>		

	<p>Comment (Administrator): You list three “un(der)served groups” in your report but left out the most important underserved group – those with a serious mental illness; schizophrenia, bipolar disorder or major depression.</p>	<p><i>maker, researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.</i></p>
	<p>Comment (Mental Health Organization): Lack of diversity in the LGBTQ focus group. Only four members were included in the LGBTQ focus group and “all identified as white, with two of the four reporting being Latina.”</p>	
	<p>Comment (Mental Health Organization): The choice of persons to speak for underserved groups seems not to have been large enough to be representative of those groups.</p>	
	<p>Comment (Administrator): Also, if the premise of holding a focus group for Older Adults was because they have little access to care then why wasn’t the focus group held with Older Adults themselves as opposed to the caregivers?</p>	<p>Response: Thank you for allowing us to clarify. We have added the following:</p> <p><i>We included both older adults and caregivers, because limitations of multiple comorbid conditions limited some older adults from participating in focus group discussions. Therefore, caregivers were encouraged to participate, so as to share the perspectives of these consumers.</i></p>
	<p>Comment (Advocate/Consumer): What were the criteria in this report? To what extent was blended stakeholder, i.e. consumer family member feedback used in the conclusions?</p>	<p>Response: Thank you for your question and the opportunity to clarify throughout our report. We have added various sentences to our Research Methodology section in order to clarify stakeholder</p>

	<p>Comment (Administrator): What about documentation on consumer/stakeholder level of involvement: sporadic vs on-going; providing input, member of advisory, or involvement is on-going and participates in collaborative a decision making process?</p>	<p>involvement and the purpose of using qualitative methods. One of those specific comments is highlighted below:</p> <p><i>Our data analysis included “fact checking” by our interviewees and by way of a 30-day public comment period, which were used to assess the relative accuracy of the data collected and our interpretation of these data. All persons who participated in an interview (key informant or focus group) or assisted in recruitment of focus group participants were sent our analysis of the interview data for review. Approximately 15% of persons who participated in a key informant or focus group interview or who assisted in participant recruitment provided feedback to our original report (Deliverable 2b). We have incorporated and responded to interviewee and public comments made on a draft of this report, which was circulated on February 15, 2014.</i></p>
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Deliverable 2c Report Sections	Comments/Feedback Received	Changes Adopted
IV. Findings Section	<p>Comment (Mental Health Organization): “I would like to state that I thought the inclusion of “actual comments” made by consumers and/or family members that were included in the report was especially meaningful. They were direct statements rather than “the family/and or consumer said” - it is nice to see the recognition of the speaker included in the quotes.”</p>	<p>Response: Thank you.</p>
	<p>Comment (Advocate/Consumer): I wanted to remind everyone that it’s far more complicated -- historically, emotionally and ethically. How do we maintain compassion for those of us charged with this kind of study and work to support the uncovering and goals by asking the right questions to gain more clarity or insight and see this as a collective community effort?</p>	<p>Response: Thank you for noting this. We have included a statement in our report that foreshadows our conclusions in this report and pending recommendations.</p> <p><i>None of our focus group participants had an awareness of the Mental Health Services Act (MHSA), its ability to respond to health disparities, or most common barriers to the effective delivery of</i></p>

	<p>Comment (Family Member/Advocate): An overarching theme that emerged was lack of general knowledge of MHSA-funded services, treatment options, and location was evident among most focus group participants. The lack of knowledge and awareness of services is concerning given the purpose and intent of the MHSA, to provide services that are not already covered by federally sponsored programs or insurance programs.</p>	<p><i>mental health care services in California (issues that pertain to questions 1 and 2 above). As a result, we offer information that our key informants offered to address the first two research questions. Our presentation of findings pertaining to our third research question is based on key informant viewpoints of consumer experiences and the actual experiences described by our focus group participants. The fact that none of our focus group participants had an awareness of the MHSA or its impact suggests that opportunities for increasing awareness and potential engagement of consumers that have not yet effectively been employed.</i></p>
	<p>Comment (Commissioner): One finding seems clear re: the lack of awareness of MHSA programs. That seems actionable and under our control.</p>	<p>In our limitations section we state:</p>
	<p>Comment (Advocate): Stigma experienced by individuals as they move within the system is a barrier that needs to be constantly addressed. Although FSPs have had an impact, it has not been well documented or reported -- and for underserved/under represented, how is public stigma reduction in the general community measured?</p>	<p><i>Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.</i></p> <p><i>Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy maker, researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history</i></p>

		<p><i>of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.</i></p>
	<p>Comment (Advocate): Stigma experienced by individuals as they move within the system is a barrier that needs to be constantly addressed. Although FSPs have had an impact, it has not been well documented or reported -- and for underserved/under represented, how is public stigma reduction in the general community measured?</p>	<p>Response (Research question 1): We appreciate your comments regarding the difficulty in identifying mental health issues as well as in being a family member attempting to engage a loved one in the mental health system. We also acknowledge comments related to stigma that may emerge (continually) as consumers and family members move through the system. We have included a statement in our report that foreshadows our conclusions in this report and pending recommendations.</p> <p><i>In particular, the stigma that individuals or family members experience while attempting to identify mental health issues, or that</i></p>
	<p>Comment (Mental Health Organization): Lack of attention to stigma and the diversity of stigma among the focus groups. The focus groups also had a limited frame of questions with regard to uncovering the diversity of stigma.</p>	

	<p>Comment (Advocate/Consumer): .I initially felt sad as I read the comments because it seemed people were looking down from the sky upon the MH system and assuming they knew the "best assessment method, use of funds or "fix" for this problem. I wanted to remind everyone that it's far more complicated -- historically, emotionally and ethically. How do we maintain compassion for those of us charged with this kind of study and work to support the uncovering and goals by asking the right questions to gain more clarity or insight and see this as a collective community effort? I am merely trying to give more context to why the study is important -- to hopefully capture the feelings behind the numbers and/or the depth/ contextual factors of disparities that exist.</p>	<p><i>consumers and their families might experience as they move within the mental health system, require acknowledgement and redress.</i></p> <p>In our limitations section we state:</p> <p><i>Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.</i></p> <p><i>Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy maker, researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of</i></p>
	<p>Comment (Administrator): I enjoyed reading your report and found that the findings seem to indicate that after the first years of MHSA, the funding is starting to achieve its goals, but that there is more needed to reach out and educate those on the services throughout the state and increase access for each group to receive services by designing specific teams for their populations.</p>	
	<p>Comment (Administrator): Person living with a serious mental illness</p>	
	<p>Comment (Administrator): Family member of a person living with a serious mental illness</p>	
	<p>Comment (Provider): The many secrets that exist in our lives often make us become ill it does not help when there are more secrets involved about our mental health. Our individual needs are often half met and the rest is often given a brief view and not taken into account.</p>	

		<p><i>those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.</i></p> <p><i>In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.</i></p> <p><i>Throughout our report, we have pointed to the impact of stigma on underserved communities, but we have yet to understand the full extent and scope of the role stigma plays in diverse communities on limiting access to care or diminishing quality of care or efficacy. Additional efforts must be made to assess the way in which stigma affects diverse underserved communities. Similarly, interviewees described the impact of multiple barriers to receipt of effective care or access to adequate treatment. While we have highlighted some of these intersections, future evaluations need to expand on the questions and issues we outline in this report in order to critically detail and clarify the impact of intersecting barriers and identify ways to remediate them. This report may serve as a point of clarification for some stakeholder perspectives and perhaps a point for framing questions about groups that this report may not have been adequately represented. This report also offers further opportunity for formulating informed questions about California mental health services and for establishing a benchmark against which to measure future initiatives and improvements.</i></p>
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	<p>Comment (Administrator): One barrier I typically find is that even with education to the community, it is difficult to deliver services to those with the most need with MHSA because of the limits on inpatient funding. The clients will come into inpatient service providers and then leave with no follow up or continued services within the MHSA continuum of care.</p>	<p>Response (Research question 1): Thank you for your comment. We have included a statement in our report that foreshadows our conclusions in this report and pending recommendations.</p>
	<p>Comment (Family Member/Advocate): You state in your report that “The Mental Health Services Act (MHSA or Act) provides an unparalleled opportunity to serve children, youth, adults, older adults, and families with mental health needs.” Unfortunately, this money, which was intended for the most seriously mentally ill somehow never seems to quite get to this population, probably because the money is being wasted on meaningless studies such as this one, along with programs for the worried well.</p>	<p><i>Key informants expressed concern that data collection activities do not document the diversity of participants who are served by FSPs and, therefore, suppress understanding of the scope and impact of services provided for un(der)served groups, most particularly those highly marginalized groups whom these services may not reach.</i></p> <p>In our limitations section we state:</p> <p><i>Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.</i></p>
	<p>Comment (Administrator): Person living with a serious mental illness</p>	<p><i>Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy maker,</i></p>

		<p>researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.</p> <p>In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.</p> <p>Throughout our report, we have pointed to the impact of stigma on underserved communities, but we have yet to understand the full</p>
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	<p>Comment (Provider): Our medical emergency department is impacted with psychiatric patients who are denied services supported by MHSA funds because they are on an involuntary hold. They are too acutely ill to receive psychiatric services from the Agencies that are the recipients of these funds. By default these acutely ill psychiatric patients become the responsibility of medical community, not psychiatrists or anyone with psychiatric experience. They are held without treatment in our medical emergency rooms. This is the story of the misuse of these resources and the lack of psychiatric services for the mentally ill in the majority of communities.</p>	<p>Response (Research question 2): Thank you for helping to clarify some of the issues described by our Key Informants regarding use of emergency services by those impacted by serious mental health issues or who are “in crisis.” We have added some detail to our report to clarify our discussion.</p> <p><i>Descriptions of “inappropriate care” were common for informants who discussed institutional settings as the primary locale for the delivery of mental health-related services. Mental health providers, consumers, and families of people who have serious mental illness noted that emergency departments, while not the best alternative for mental health care, are often the only type of service available to people with serious mental illness or in crisis.</i></p>
	<p>Comment (Provider): We are facing a very real crisis in California and that is a shortage of psychiatrists. Every day individuals come to our emergency departments in crisis. The only way that they will be able to see a psychiatrist within a reasonable period of time is to be placed on a 5150 hold. Once this happens they are no longer eligible for services funded by</p>	<p>Response (Research question 2): Thank you for helping to clarify some of the issues described by our Key Informants regarding use of emergency services by those impacted by serious mental health issues or who are “in crisis.” We have added some detail to our report to clarify our discussion.</p> <p><i>Many informants described the inappropriate use of services and untrained staff for some un(der)served groups, including those with</i></p>

	<p>the MHSA.</p>	<p><i>serious mental illness, older adults with comorbid conditions, and African Americans. Interviewees' examples related to the treatment of African Americans illustrates that although un(der)served groups, like African Americans, do receive mental health services, the treatment they receive is not entirely appropriate.</i></p>
	<p>Comment (Administrator): This holds also true for older adults...older adults tend to access mental health services in ER, hospital and or in Primary Care.</p>	
	<p>Comment (Administrator): What about workforce issues...wondering if these issues were discussed by the various informants? There is no way to deliver the type of services that will help reduce disparities without a well trained workforce.</p>	<p>Response (Research question 2): Thank you for bringing our attention to this very important point. We have added a brief section about workforce planning and development based on some of our interview data and the valuable public comments provided by stakeholders.</p>
	<p>Comment (Advocate/Consumer): This is why there was an MHSA audit on intent of purpose, misappropriation of funding, better outcomes of reducing disparities, integrating and blending consumers in the workforce as provided by MHSA design- this is how law was legislated. Surprising results when MHSA helps with housing, job, self-determination. With encouragement and tools even seriously ill population can integrate and recover.</p>	<p>Planning for and development of an adequate and well-trained workforce. <i>Key Informants and stakeholders all requested more proactive strategies for responding to the needs of people with serious mental illness, including planning for and development of a more adequate and well-trained workforce in settings where people "in crisis" or living with serious mental illness could best be served. Specific barriers to developing an adequate workforce to serve mental health needs in California is highlighted by this stakeholder comment:</i></p> <p><i>"The MHSA is assistive in many areas of administration [but] the problem persists in the hiring</i></p>

<p>Comment (Provider): The MHSA is assistive in many areas of administration the problem persists in the hiring of individuals with lived experience and although there are some positions available there is no end in sight for those of us working on the front lines with limited time to go to training, that is time consuming and often becomes obsolete. The reason for the funding is to assist the community with more alternatives than incarceration and other forms of restraint. Further obstacles are identified when the conferences and trainings are specified for doctors only. The many secrets that exist in our lives often make us become ill it does not help when there are more secrets involved about our mental health. Our individual needs are often half met and the rest is often given a brief view and not taken into account. More is better but not always quality with the overloading of our staff and colleagues. Sounds like I am ranting about the many areas of concern and it is just that a concern for the many lives it touches when we confront the well-being of our community. Would like to thank you for efforts in this and many other areas you have helped out.</p>	<p><i>of individuals with lived experience. Although there are some positions available, there is no end in sight for those of us working on the front lines with limited time to go to training that is time consuming and often becomes obsolete. The reason for the funding is to assist the community with more alternatives than incarceration and other forms of restraint.” (Public commentary, February 19, 2014)</i></p> <p><i>In addition, some stakeholders have noted that parameters for the use of MHSA funding and the availability of treatment for people living with serious mental illness highlight the lack of community-based psychiatric services, including adequate staffing or appropriate training for primary care and other providers who eventually care for patients who suffer with mental illness. Family members and mental health care providers noted the absence of training for personnel who are not licensed physicians or psychiatrists.</i></p>
<p>Comment (Provider): Funding from the MHSA would serve those in crisis most efficiently if it were to go to relieve our medical emergency departments from the burden of holding these individuals in an environment that is uniquely ill-suited for the initiation of treatment. If MHSA funds were accessible to serve patients in all phases of their illness I could support of those efforts.</p>	<p>Response (Research question 2): Thank you for making this important point. We have included a comment in our report regarding sensitivity to issue.</p> <p><i>The importance of a culturally competent workforce cannot be overstated, and should be informed with sensitivity to the fact that</i></p>

	<p>and sensitivity about generational values and roles.</p>	<p><i>individuals in some ethnic communities may choose to seek care outside of their communities due to the potential for stigmatization.</i></p>
	<p>Comment (Advocate): Another barrier is messaging, how the message about mental health is delivered to cultural, underserved communities (e.g., CHAA in Alameda County: Community Health for Asian Americans does not have "mental" in its name - this matters in how people view CHAA and its approach to community, so the name isn't laden with stigma). Vigilance around messaging about mental health is important, paying attention so that the language/terms do not alienate nor stigmatize.</p>	<p>Response (Research question 2): Thank you for this comment. We have noted in our report that messaging is an important component relating to awareness and potential engagement. We have added the following statement:</p> <p><i>Stakeholders offering public comment about the draft of this report suggested that specific strategies related to messaging, along with communication by health services providers, could yield potentially effective methods for increasing awareness of MHSA-funded services and engaging un(der)served communities.</i></p>
	<p>Comment (Advocate): If focus group participants had no awareness about MHSA principles and values, a provider receiving MHSA funding bears responsibility to inform and educate recipients about core values of wellness, resiliency, recovery and the power of hope to pave pathway to quality and dignity in life. This can do a lot for a person's engagement, success and motivation.</p>	<p><i>Some stakeholders suggested that providers and organizations who receive MHSA funding should be responsible for informing consumers about the source of funds for that care and the values that support its funding. Lack of awareness related to resources for mental health care can disempower communities. Greater awareness of available services and their funding sources not only provides community members with information about the availability of resources in their local community but may also allow them avenues for input in the type and delivery of services. In response to findings that focus group participants were not aware of MHSA principles and values, one stakeholder commented:</i></p> <p><i>“If focus group participants had no awareness about MHSA principles and values, a provider receiving MHSA funding bears responsibility to inform and educate recipients about core values of wellness, resiliency, recovery and the power of hope to pave [a] pathway to quality and dignity in life. This can do a lot for a person's engagement, success and motivation.” (Public commentary, March 6, 2014)</i></p>

	<p>Comment (Advocate/Provider): Well, as a senior peer counselor in Sonoma County our program (funded under Prevention and early intervention by MHSA) has doubled both in the number of seniors we see and in the number of volunteers who are trained for this important work. County and other social workers say that the impact we have helping seniors with the vicissitudes of aging including depression, drug and/or alcohol counseling, and knowledge of community resources makes our seniors more hopeful and positive and able to conduct their lives in a more hopeful manner with greater independence. We get extremely positive feedback from exit surveys. I can't give you names and numbers but I am sure even those would not satisfy your cynicism.</p>	<p>Response (Research question 2): We appreciate these comments. We note that they reinforce the value of PEI programs, <u>and</u> they also underscore problems related to inconsistent tracking of these types of programs. We added the following statement to our analysis:</p> <p><i>Stakeholders offering public comment have noted that some county programs have seen an increase in consumers served by the mental health system and the number of volunteers trained to assist older adults with comorbid conditions. The successes of some of these new programs under PEI, however, have been overshadowed by inconsistent efforts at tracking the success of the programs.</i></p>
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	<p><u>Comment (Administrator): A FEW EXAMPLES OF WHAT WE DO NOT KNOW AFTER STEINBERG REVIEW:</u></p> <ul style="list-style-type: none"> • Are any additional services in the core Systems of Care funded by MHSA, as intended by voters and explained by the Legislative Analyst in 2004 ballot? • Are counties funding MHSA PEI programs for people with serious mental illnesses to prevent illnesses from becoming more severe and disabling? • How much money are counties spending on Systems of Care and PEI direct services and how much on overhead, administrators, conferences, consultants, studies, and other products? • What Systems of Care services are most in demand by consumers and families, and what is county capacity to meet that need? • How has the county integrated MHSA components and core programs, funded improvements in cultural competency and co-occurring disorder services, reduced waiting lists for children’s wraparound programs? • Has the county developed self-help programs, reduced caseloads for service coordinators and physicians, added individual or group counseling options? 	
	<p>Comment (Administrator): this includes age, condition and culture/linguistic</p>	<p>Response (Research question 3): We appreciate concerns expressed related to the generalizability of our findings and have provided more specific rationale for our selection of focus group participants. In addition, we have added more detail to our discussion of the limitations of this report. We have added the following description to those selected for focus group participation:</p>
	<p>Comment (Administrator): This could be compared to the number and demo characteristics of informants</p>	

	<p>Comment (Administrator): A big problem I see for this report is the credibility for readers across the state. The amount of people interviewed and the limited regions surveyed may cause those to not relate since it is based on such a small population. The interviewee amount was minimal and central to certain areas, not truly representative of the state and counties. If I were a reader I may say, "well that's nice to read 30 individuals views in 3 counties, but it doesn't help our area with the disparities here because of our populations, cultures, groups, etc... are different, unique, reached, etc.."</p>	<p><i>Our goal in conducting focus groups was to understand the ways in which specific barriers prevent access to diverse un(der)served groups. To accomplish this, we focused the viewpoints of key informants on the major barriers to service for un(der)served groups. We then examined these barriers, focusing on those that were described as affecting the greatest number of persons, and cut across diverse groups. The obstacles we found to be most significant, based on our interviews with key informants and review of existing documents, were barriers due to the degree of perceived stigma in accessing mental health services, immigrant status, linguistic and cultural barriers, age-related difficulty in accessing appropriate care or shortcomings in mechanisms for engaging appropriate care, and geographic availability of resources for mental health care (see Table 3). Next, we identified three specific un(der)served groups, whose experiences reflected a combination of these barriers.</i></p>
	<p>Comment (Advocate/Consumer): Offhand I believe qualitative statistics, not measuring the survey numbers, not quantitative methods were applied to conclude that Reducing Disparities targets were being met. It is helpful to know what other agency responses, (see Orange County) are to this report which appears to completely miss the point in its unbalanced conclusion.</p>	
	<p>Comment (Administrator): You list three "un(der)served groups" in your report but left out the most important underserved group – those with a serious mental illness; schizophrenia, bipolar disorder or major depression.</p>	
	<p>Comment (Advocate): Another barrier is messaging, how the message about mental health is delivered to cultural, underserved communities (e.g., CHAA in Alameda County: Community Health for Asian Americans does not have "mental" in its name - this matters in how people view CHAA and its approach to community, so the name isn't laden with stigma). Vigilance around messaging about mental health is important, paying attention so that the language/terms do not alienate nor stigmatize.</p>	<p>Response (Research question 3): Thank you for this comment. We have added the following statement to draw attention to the importance of messaging in awareness and engagement:</p> <p><i>Adequate attention and sensitivity to stigma in public policy and messaging related to issues of mental health and serious mental illness may, in fact, provide a starting point for enhancing awareness and engaging relevant persons in appropriate mental health services and treatment.</i></p>

	<p>Comment (Administrator): there is almost no acknowledgement of disabilities apart from mental health or drug and alcohol abuse disabilities. You and I both know that co-morbidity when someone has a disability is high – it’s more common to have mental health *and* physical, sensory, etc. than not. Access to services is critical and hard to come by. One of my early work assignments in 1996 was facilitating a support group for heroin addicts who were persons living with spinal cord injuries. Most of them had high level injuries limiting the use even of their hands. These people had a hard time finding treatment programs that could accommodate their needs, increasing their relapses. People with physical disabilities are statistically more likely to experience clinical depression than those without disabilities. People who are Deaf have trouble getting sign language interpreters in any kind of medical or treatment setting. In the evaluation’s discussion of language and access issues, this conversation was glaringly absent and reflects a narrow perspective that does not serve the public well.</p>	<p>Response (Research question 3): Thank you for bringing up this issue. There were some discussions regarding co-morbid conditions in our Older Adult group, and we have added a statement related to transportation and these issues, to draw attention to the importance of this barrier and access to care for those facing multiple conditions (the statement we added is provided below). In addition, we will consider this in our discussion of recommendations (currently under development).</p> <p><i>Stakeholders offering public comments underscored that counteracting limitations in transportation is not a simple matter but would go a long way to remediate access impediments for un(der)served populations, particularly the most marginalized groups, such as people living in rural areas, those with a serious mental illness, and older adults.</i></p>
	<p>Comment (Advocate): Effectiveness of a progressive public mental health system depends on stakeholder involvement and the importance of representation from un(der)served groups - this calls for awareness of and respect for a community/culture's history (i.e., historical trauma, displacement, etc.) and values, including gender/generational roles.</p>	<p>Response (Research question 3): Thank you for this comment; it has helped us to frame some of the issues expressed in our immigrant group and older adult group. In addition, it is an important issue that merits consideration for our pending recommendations. The statement we added to elaborate on the experiences described by our focus group participants is as follows:</p> <p><i>Other populations who might experience vicarious or other trauma that could create barriers to receiving adequate mental health care include immigrant groups, many of whom have experienced historical trauma.</i></p>
	<p>Comments (Provider): More is better but not always quality with the overloading of our staff and colleagues.</p>	<p>Response (Research question 3): We have included the following comment as part of our attention to the workforce and competency issue:</p> <p><i>Stakeholders who commented on the “fit” between consumers and their providers suggested that adequate training of diverse community professionals could enhance the quality of service for</i></p>

		<i>the most un(der)served groups, including marginalized ethnic groups and those with serious mental illness, in addition to persons who participated in our focus group discussions.</i>
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Deliverable 2c Report Sections	Comments/Feedback Received	Changes Adopted
V. Conclusion Section	Comment (Family Member/Advocate): Emphasize the overall lack of effort so far to develop either community-based or evidence-based standards for evaluation of the implementation of these strategies. How will we ever know if the strategies work, or under what conditions they work, if no efforts are made to develop standards and evaluate the programs utilizing the strategies? You address the issue of poor data collection on WHO receives FSP services, but it may be even more critical to understand WHAT these FSP programs consist of, and how effective they are at providing those services to a given audience	<p>Response: Thank you for your insights. We have added two sentences to underscore these points, and will aim toward making recommendations in a later report that draw attention to this suggestion.</p> <p><i>Confusion remains, however, about the specific contents of some MHSA programs and a lack of systematic and sustained activities to evaluate their impact. We will not fully understand which types of strategies work, or under what conditions they work, if no efforts are made to develop community-based or evidence-based standards for evaluation of the implementation of these strategies.</i></p>
	Comment (Commissioner): Previous efforts to engage stakeholders have not been met with active uptake of recommendations or have not made recommendations that have been, according to public comment, actionable policy measures for the most marginalized of these groups.	<p>Response: Thank you for these comments, we have attempted to acknowledge them in our conclusions by adding the following:</p> <p><i>The findings of this report suggest that MHSA has and continues to have an impact on reducing disparities among un(der)served groups. The findings indicate that key informants recognize MHSA’s commitment to invest in resources that build the capacity of un(der)served communities. For example, informants acknowledged Prevention and Early Intervention (PEI) and Full Service Partnerships (FSPs) as two major examples that strengthen the linkages between un(der)served groups and access to care. Furthermore, we have learned through this study that MHSA must do more to increase culturally competent programs and community outreach and engagement in order to ensure that services are adequate and appropriate for targeted un(der)served groups.</i></p>
	Comment (Advocate): Annual updates with stakeholder input is not reviewed carefully enough or, maybe minimally, by local Boards nor honored as meaningful input by leadership. Including it as written form with seemingly glib responses in the update discounts and often negates stakeholder involvement.	

	<p>Comment (Provider): The MHSA is assistive in many areas of administration the problem persists in the hiring of individuals with lived experience and although there are some positions available there is no end in sight for those of us working on the front lines with limited time to go to training that is time consuming and often becomes obsolete. The reason for the funding is to assist the community with more alternatives than incarceration and other forms of restraint. Further obstacles are identified when the conferences and trainings are specified for doctors only. The many secrets that exist in our lives often make us become ill it does not help when there are more secrets involved about our mental health. Our individual needs are often half met and the rest is often given a brief view and not taken into account. More is better but not always quality with the overloading of our staff and colleagues. Sounds like I am ranting about the many areas of concern and it is just that a concern for the many lives it touches when we confront the well-being of our community. Would like to thank you for efforts in this and many other areas you have helped out.</p>	<p>Response: Thank you for these comments, we have attempted to acknowledge them in our conclusions by adding the following:</p> <p><i>MHSA also promotes the transformation to a recovery-focused system of care, which is targeted to individuals living with serious mental illness who are not receiving enough support to alleviate their risk of homelessness, incarceration, or hospitalization.</i></p>
	<p>Comment (Provider): Funding from the MHSA would serve those in crisis most efficiently if it were to go to relieve our medical emergency departments from the burden of holding these individuals in an environment that is uniquely ill-suited for the initiation of treatment. If MHSA funds were accessible to serve patients in all phases of their illness I could support of those efforts.</p>	
	<p>Comment (Advocate/Consumer): This is why there was an MHSA audit on intent of purpose, misappropriation of funding, better outcomes of reducing disparities, integrating and blending consumers in the workforce as provided by MHSA design- this is how law was legislated. Surprising results when MHSA helps with housing, job, self-determination. With encouragement and tools even seriously ill population can integrate and recover.</p>	

	<p>Comment (Administrator): ...given the qualitative nature of this study carving out a significant amount of time to build relationships, community, and trust is essential and critical in working with un(der)served populations. This is especially true if they have a historical mistrust of others that may come from government and academia due to racism and discrimination. Not taking the time to build relationships and trust with the community may explain why there were only four LGBTQ TAY participants who all identified as white (pg. 14). Perhaps I would suggest making mention of the need to build relationships and trust in the discussion part of the report...pages 45-46</p>	<p>Response: We appreciate your comments. We have added a sentence to clarify the generalizability of our findings and to make note of this.</p> <p><i>Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report ... In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.</i></p>
	<p>Comment (Administrator): I'll like to note that the Asian/Pacific Islander (API) population are underserved in many counties across the State and it is very critical they should have been included in informing the report. Also, if the premise of holding a focus group for Older Adults was because they have little access to care then why wasn't the focus group held with Older Adults themselves as opposed to the caregivers?</p>	

	<p>Comment (Administrator): This report is very valuable considering the current political climate around MHSA services. Overall, this report does an impressive good job of highlighting the good work that MHSA does in reducing disparities.</p> <p>My first comments are about the emphasis placed on CBPR as an evaluation method in this report. My understanding of CBPR methods may differ than the authors of the report. As I understand it, community members have a very active and leading role throughout the evaluation process, including inception, design, implementation, evaluation, & dissemination. Therefore, CBPR would have to be much more than interviewing community members and having them provide input on the selection of key stakeholders and content of the interview guide. Accordingly, a CBPR evaluation project would hire and train consumers from the target population and have them lead, to the fullest extent possible, the evaluation process. Consumers have a much more significant role in the research process.</p>	<p>Response: Thank you for your valuable and insightful comments. We have added the following sentence to clarify:</p> <p><i>Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report ... In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.</i></p>
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	<p>Comment (Commissioner): Previous efforts to engage stakeholders have not been met with active uptake of recommendations or have not made recommendations that have been, according to public comment, actionable policy measures for the most marginalized of these groups.</p>	<p>Response: We acknowledge these comments, which suggest that recommendations from the UCLA report related to stakeholder engagement were not translated into actionable items or have not been meaningfully honored. In the conclusion to our report, we added the following:</p> <p><i>Diverse stakeholders who offered critiques and suggestions through interviews or comments on a draft of this report during a period of public feedback observed that they have not seen many calls for stakeholder engagement, as the UCLA report had recommended. To date, stakeholder engagement has not been translated into an “actionable item” or meaningfully honored. We view this report as a step toward increasing the involvement and feedback of stakeholders. As such, we encourage the continued integration of stakeholder perspectives, so that diversity in perspectives drives the conversation about community-informed access to care and treatment. The importance of eliciting and using stakeholder feedback emerged as a consistent theme throughout this report as a significant means to help MHSA continue transforming mental health services that mirror the composition of un(der)served groups in California.</i></p>
<p>Comment (Advocate): Annual updates with stakeholder input is not reviewed carefully enough or, maybe minimally, by local Boards nor honored as meaningful input by leadership. Including it as written form with seemingly glib responses in the update discounts and often negates stakeholder involvement.</p>		
<p>Comment (Administrator): What about documentation on consumer/stakeholder level of involvement: sporadic vs on-going ; providing input, member of advisory, or involvement is on-going and participates in collaborative a decision making process?</p>		

	<p>Comment (Administrator): What about workforce issues...wondering if these issues were discussed by the various informants? There is no way to deliver the type of services that will help reduce disparities without a well trained workforce.</p>	<p>Response: Thank you for these comments, we have attempted to acknowledge them in our conclusions by adding the following:</p> <p><i>At the system level, improvements must be made in culturally competent treatment, outreach for underserved groups, and provision of care in appropriate settings through planning and development of a well-trained mental health services workforce, encompassing a range of mental health service providers. Large county mental health programs as well as smaller community-based organizations continue to experience difficulty in obtaining adequate funding to respond to these needs and to systematically monitor expenditures.</i></p>
	<p>Comment (Advocate): Stigma experienced by individuals as they move within the system is a barrier that needs to be constantly addressed. Although FSPs have had an impact, it has not been well documented or reported -- and for underserved/under represented, how is public stigma reduction in the general community measured?</p>	<p>Response: Thank you for these comments, we have attempted to acknowledge them in our conclusions by adding the following:</p> <p><i>Strategies for response need to also include appropriate evaluation and monitoring of existing programs, such as PEI and FSPs, proposed to expand their services to un(der)served populations.</i></p>
	<p>Comment (Administrator): A big problem I see for this report is the credibility for readers across the state. The amount of people interviewed and the limited regions surveyed may cause those to not relate since it is based on such a small population. The interviewee amount was minimal and central to certain areas, not truly representative of the state and counties. If I were a reader I may say, "well that's nice to read 30 individuals views in 3 counties, but it doesn't help our area with the disparities here because of our populations, cultures, groups, etc... are different, unique, reached, etc.."</p>	<p>Response: Thank you for these comments, we have attempted to acknowledge them in our conclusions by adding the following:</p> <p><i>Because this report used qualitative methods and a small sample, it cannot be generalized by extension to other populations. Specifically, its reliance on volunteers and recruiting participants using the snowball sampling or word-of-mouth method may have limited the variability of participants. Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report.</i></p>
	<p>Comment (Administrator): Facilitating three (3) focus groups with a total of forty (40) individuals to inform the impact of a Statewide policy/act is not sufficient enough to adequately depict the true impact of MHSA on the un(der)served population.</p>	

	<p>Comment (Administrator): I'll like to note that the Asian/Pacific Islander (API) population are underserved in many counties across the State and it is very critical they should have been included in informing the report.</p>	
<ul style="list-style-type: none"> • 	<p>Comment (Mental Health Organization): A surprisingly small N = 4 for the LGBT/Q group, all of whom were female, seems non-representative. Also, numbers for persons of African-American, American Native, or Asian/Pacific Islander race/ethnicity seem to be insufficient for a well-designed study. Although there were some persons of Hispanic ethnicity, we question whether there were adequate numbers to be representative of this group, as the total persons interviewed in the study for Objective #3 remains quite small. Numbers of persons in each age category of interviewees seems to be not adequate.</p>	<p><i>Another limitation was the fact that although a small number of key informants reported also being consumers of mental health services for themselves or a family member, we did not report their perspective as a consumer of mental health services; we rather defined them in terms of the primary stakeholder status with which they identified (e.g., administrator, advocate, policy maker, researcher). Because we did not specifically ask key informants to self-report, whether or not they were the family member of a person living with a serious mental illness or if they had a personal history of receiving mental health services, we cannot provide precise counts of the number of family members interviewed. In addition, several focus group participants described experiences related to care seeking for relatives living with a serious mental illness; some of these experiences were reported in the findings above. While we were able to reach theoretical saturation (and redundancy in themes) related to common barriers to receiving appropriate mental health services for un(der)served populations, a major finding of from our focus group interviews was that the unique intersection of those barriers magnify the impact of the barriers in a manner which may be specific to distinctive populations. For example, although un(der)served subgroups may experience some of the same persistent barriers, the junction of those barriers (e.g., lack of insurance coupled with the stigma of sexuality (LGTBQI); insurance barriers and the physical disabilities of aging (Older Adults); insurance and linguistic barriers (Latino immigrants), augment the impact of the barriers for the affected groups.</i></p>
<ul style="list-style-type: none"> • 	<p>Comment (Mental Health Organization): The intersection of multiple barriers. The LGBTQ focus group is described as identifying issues that represent the “complex intersection of their age and sexuality in addition to other factors.” But what about the intersection of age, race, gender and other factors with regard to the other focus groups? Barriers specific to Latino men are mentioned briefly on page forty. Moreover, the older adult focus group is the most racially diverse of all the groups, but this diversity is not represented in this report. There is only one mention of low-English proficiency in the older adult focus</p>	<p>Response: Thank you for your insight. We want to be careful not to over generalize our findings, yet we acknowledge the significance of this finding for each of three groups we interviewed. We have added the following to our discussion of limitations:</p> <p><i>Although CBPR strategies are currently among the best methods for eliciting the viewpoints of diverse and marginalized communities, it is difficult to estimate the amount of time needed to obtain the level of trust and rapport necessary to enlist specific groups who experience high levels of mental health stigma (e.g., LGBTQ, those who suffer from serious mental illness, or those whose trust may have been betrayed in previous research or by</i></p>

	<p>group.</p>	<p><i>government interventions, such as African Americans or ethnically marginalized communities who have immigrated to the U.S.) in research-related endeavors similar to this report ... In future research efforts using CBPR, more flexible time parameters, added funding, and expanded community-based support may result in increased representation from hard-to-reach and highly-stigmatized communities, such as those persons living with severe mental illness, LGBTQ, African American communities, and those persons who identify as “non-Hispanic White” with distinct ethnicity or heritage, whose perspectives and specific barriers may not have been adequately represented in this report but provide for investigation of how the intersection of barriers that shared across diverse populations might differently impact particular groups.</i></p>
	<p>Comment (Mental Health Organization): “Another thought: Will (the authors) come up with a separate section on recommendations?”</p> <p>The report suggests that both these statements are true: that MHSA funded programs are successful in reducing disparities through increased access of un(der)served communities to Full Service Partnerships and expanded Prevention services; and that disparities in access persist because of unaddressed barriers such as language/cultural issues, costs, transportation, and other difficulties. The report does not outline a strategy to use MHSA program funds to mitigate these difficulties.</p>	<p>Response: Thank you for your inquiry into our recommendations. Our deliverables for the contract are presented in separate documents, so that the quantitative (population-based) analyses and final recommendations, which are based on both quantitative (population-based evaluation) and qualitative (stakeholder viewpoints and feedback) assessments, are presented as separate deliverables in separate documents. Our recommendations are forthcoming and will be reported in Deliverable 3.</p>
	<p>Comment (Mental Health Organization): We observe that the State of California invested years of effort and millions of dollars of Prevention and Early Intervention funds in the Reducing Disparities Project (CRDP). Working with community groups throughout the State, the CRDP produced population reports that provided an exhaustive discussion of the challenges facing 5 racial and cultural communities. Each of these reports provided community defined solutions that would address the many barriers to full access by these underserved communities</p>	<p>Response: We thank you for this comment and your insight. We also view this report as a starting point for formulating better questions about California mental health services and as a benchmark against which to measure future initiatives and improvements.</p>

	<p>to public mental health services. The State will not have an opportunity to implement any of these recommendations until the full Strategic Plan to Reduce Disparities is finalized. So while this evaluation is not as comprehensive as needed, the Council recommends that it could be used as a benchmark to measure future improvements resulting from the implementation of CRDP strategies to reduce disparities in these underserved communities.</p>	
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Deliverable 2c	General Comments/Feedback Received	Changes Adopted
	<p>Comment (Mental Health Organization): “I briefly looked at the report and began to wonder if this report is for legislators and professionals who are pretty savvy [about] the mental health system. I understand that this report was asked by OAC in 2012 and that before it is sent to OAC, it is to go through a “public review”. Is this “public” intended to be a professional group that is knowledgeable on mental health systems? My point is this: what is the grade level of this report? Will the “public” be able to understand it? I find it scholarly, thanks to the authors, but I fear that comprehension might be minimal.” “This is a HUGE issue and complaint - this is written in academic language and folks need an interpreter to understand what is being said and/or written.”</p>	<p>Response: Thank you for these comments. We utilized the services of a professional editor and shared these concerns with him. The editor has made the following changes:</p> <ul style="list-style-type: none"> • Revised technical jargon, when appropriate. • Has used the suggested terms (serious mental illness, person living with a serious mental illness, consumer, and family member of a person living with a mental illness) throughout the document. • He also distinguished between consumers and family members where appropriate.
	<p>Comment (Administrator): Are you anticipating “consumers of mental health services” to read the report and respond? If so, can it be translated into simple, everyday language in a shorter number of pages?</p>	
	<p>Comment (Administrator): Would like to see a more proactive word used than “effort” in providing a diverse workforce.</p>	

	Comment (Administrator): Please do not join the terms consumers and family member by saying that you interviewed clients and/or family members, would like to see this separated as consumers AND family member.	
	Comment (Administrator): Want to make sure the same verbiage is being used throughout the document: either client or consumer.	
	Comment (Administrator): Please use Person living with a serious mental illness rather than (Severe mental illness when appropriate) and Family member of a person living with a serious mental illness.	