



Barriers to Accessing Mental Health Care Under the Mental Health Services Act: A Qualitative Case Study in Orange County, California

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Abstract

Despite progress made under California's Mental Health Services Act, limited access to care for cultural and linguistic minority groups remains a serious issue in community mental health. In this qualitative study we report findings from a large-scale community-level assessment that explored barriers to accessing care from the perspectives of multiple stakeholders including county advisors, advocates, community members, and consumers representing a range of cultural and linguistic communities in Orange County, California. We conducted 14 focus groups with N = 112 participants. Qualitative analysis revealed that system fragmentation, limited availability of linguistically appropriate care, and stigma continue to undermine access to mental health care. Peer health navigation and culturally responsive peer support are potential ways to promote service engagement with persons from cultural and linguistic minority groups that encounter barriers when accessing mental health services.

Keywords Mental health equity · Qualitative · Community mental health · Cultural and linguistic diversity · Access to mental health services

Inadequate treatment of mental illness remains a serious public health problem, with national data indicating that as few as 11% of adults with mental illness in the United States receive care that is consistent with available evidence-based treatment recommendations (Park-Lee et al., 2012). While persons from many racial and ethnic minority groups report similar or lower prevalence of mental illness compared to non-Hispanic Whites (Coleman et al., 2016), reports from the Substance Abuse and Mental Health Services Administration indicate that members of these groups are less likely than non-Hispanic White persons to receive treatment for mental illness (Substance Abuse and Mental Health Services Administration, 2019). Another report highlighted significant inequities in access to and use of mental and behavioral health services among individuals from racial

and ethnic minority communities compared to non-Hispanic Whites (Substance Abuse and Mental Health Services Administration, 2015), with other national data showing that 50% of Latino persons with mental illness have engaged in services in the past year, compared to 70% of non-Hispanic Whites (Substance Abuse and Mental Health Services Administration, 2015). These inequities have been documented elsewhere more recently (Manuel, 2018), are particularly pronounced among foreign-born and undocumented persons (Derr, 2016), and persist after accounting for the Medicaid expansion under the Affordable Care Act (Buchmueller & Levy, 2020). A recent study of the California Health Interview Survey has reported that these trends persist in California, with state-level data indicating that Hispanic and Asian persons in need of care are less likely to use behavioral health services than non-Hispanic Whites (Villamel-Grest, Siantz, & Cederbaum, 2021). These inequities can lead to excess morbidity and disease burden for racial/ethnic minority persons and communities (Alegria et al., 2016).

Federal and state-level policy initiatives have made efforts to promote health equity among persons with mental illness and persons from historically underserved racial and ethnic minority populations. While the Affordable Care Act

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of 2010 aimed to improve availability of mental health services among underserved communities by supporting health systems in delivering coordinated, patient centered care (<http://innovations.cms.gov>), California's Mental Health Services Act (MHSA) began transforming the delivery of mental health care in 2004 by placing a 1% tax on personal incomes in excess of \$1 million to increase the state's mental health service budgets, and to promote equity in access to and use of mental health care among historically underserved groups (Starks et al., 2017). In addition to improving access to care among underserved racial and ethnic minority communities, MHSA funds were meant to fund services that aligned with the principals of recovery (Felton et al., 2010). The MHSA also sought to address over reliance on emergency services, homelessness, and incarceration (Starks et al., 2017). Planning guidelines specified that MHSA priorities were to be developed through a community stakeholder process. This process occurred at the county level with the involvement of consumers and family members, particularly those from groups that were previously unserved or underserved. Counties also were required to include representatives from relevant agencies, including law enforcement, education, and social services (County Funding Request for Mental Health Services Act (MHSA) Community Program Planning. Letter No. 05–01).

However, whether barriers to accessing care continue to undermine access in multicultural communities remains unclear. A multiple stakeholder perspective, which explores insights from consumers and community members, consumer advocates, county advisors, and service providers can provide insight on persistent barriers to accessing mental health services from different perspectives and levels of the community. Such perspectives can illustrate the care seeking experiences of consumers, can highlight service provider challenges and successes with service delivery and program implementation, and share experiences from those with longstanding involvement with the mental health system. Input from multiple stakeholders can also help ensure alignment between community priorities and those of a health system (Boivin et al., 2014), and is needed to assist planners in curating a mental health system that is tailored to meet the needs of its diverse citizenship (Sunderji et al. 2019).

There are many benefits to using multiple stakeholder perspective to understand barriers to access and engagement with mental health service in historically underserved communities, and previous MHSA evaluation studies have used this approach. One study used qualitative interviewing with multiple stakeholders to understand barriers to use of MHSA-funded services among older adults in San Diego county, and reported a need for improved access to culturally appropriate services (Palinkas et al., 2007). A mixed-method

study that compared experiences of providers and consumers of Full Service Partnership (FSP) programs, which are MHSA programs designed to do 'whatever it takes' to provide intensive, recovery-oriented team-based care, to those from 'usual care.' This study reported stronger provider-client relationships and increased provider stress among those working in FSP programs (Starks et al., 2017). Other studies have used administrative data to evaluate MHSA impact, with one reporting that use of FSPs and programs that focus on prevention and early intervention improved circumstances and functioning among racially and ethnically diverse children, transition age youth, and older adults (Ashwood et al., 2018). Importantly, these studies of MHSA impact have focused on Los Angeles County (Ashwood et al., 2018; Starks et al., 2017) and San Diego County (Palinkas et al., 2007). No studies that we know of have focused on the needs of specific cultural and linguistic communities in Orange County, CA, which is known for its proximity to the US Mexico Border and its culturally diverse communities. Orange County includes substantial Hispanic (34%), Asian (21%), and Iranian (10%) populations (U.S. Census, 2019). According to the US Census (2019), 108 languages are spoken within the Orange County region. The most common languages are Spanish, Korean, and Chinese (Mandarin and Cantonese), and 1.3 million (46%) residents who are older than 4 years speak a language in their home other than English. In addition to these cultural and linguistic complexities, Orange County also continues to experience mental health service delivery shortages. It has one of the state's largest shortages of mental health beds per capita (calhospital.org) and is a designated mental Health Professional Shortage Area (HPSA) according to the Health Resources Services Administration (HRSA.gov).

In this qualitative study we report findings from a large-scale community-level assessment that explored access to mental health services and specific barriers to care from the diverse perspectives of county advisors and advocates, community members, and mental health consumers representing a range of Orange County stakeholder groups and cultural and linguistic communities. Linguistic communities that are represented in this study include Spanish/Latino, Vietnamese, Chinese, Korean, Khmer/Cambodian, and Farsi/Persian. Findings can help service providers and policy makers identify current challenges to accessing mental health services within the context of the MHSA and to plan for future mental health programs for these target populations.

Methods

The qualitative data used for this analysis were collected under a larger effort to evaluate unmet mental health need in Orange County, CA in an evaluation funded by the Orange County Health Care Agency.

Study Sample and Recruitment

This study includes data from fourteen community-based focus groups. During the fall of 2017 we conducted four focus groups with individuals serving as county advisors and advocates who were either employed by organizations contracted with Orange County's Health Care Agency or were in a formal advisory role to the county. In the summer of 2018 we then conducted nine focus groups with consumers, family members, and other community members representing six cultural and linguistic minority communities. To recruit study participants we followed a snow-ball sampling approach to identify community-based organizations and mental health clinics to host focus groups and assist with study recruitment.

Study recruitment occurred as follows. For the county advisor/advocate focus groups, program leadership was contacted by the study team to recruit advocates, administrative, and support staff to participate. Focus groups were scheduled at a mutually agreeable time. Advisor and advocate focus groups typically occurred as an extension to a regularly scheduled meeting. For cultural and linguistic community focus groups, the Orange County Health Care Agency shared their priority mental health sub-populations with the study team. The study team then identified one organization and recruited them to participate in the research project. During a given organization's study involvement, we would then ask their project contact to nominate additional organizations that serve Orange County's priority mental health populations and might be interested in hosting a focus group and recruiting individual participants. Once an organization agreed to host a focus group, providers from that agency then recruited their current clients and their family members, and staff members for participation by word-of-mouth.

Individuals were eligible to participate in a county advisor/advocate focus group if they (a) were a member of a county-recognized coalition or organization that agreed to host a focus group or (b) identified as a provider or advocate for the population discussed in the focus group and (c) were 18 years or older. Individuals were eligible to participate in cultural and linguistic community focus group if they were 18 or older, identified as a member of the specific cultural or linguistic group of interest, and were a current client, caregiver, or staff member at a participating organization.

Focus Group Data Collection

To prepare for data collection, focus group facilitators, co-facilitators, and other members of the project team was trained by the principal investigator during a full-day project introduction retreat. This retreat involved an overview of the study objectives, relevant background information on special populations in Orange County, and a booster training on focus group facilitation. During the retreat, the study team also drafted the focus group questions. The county advisor and advocate focus group questions were focused on understanding past successes in engaging vulnerable populations into care, barriers to accessing mental health care and potential strategies to overcome these barriers. Questions focused on experiences serving cultural and linguistic minority communities and the population as a whole. Focus group questions were finalized at a later date. These focus groups were facilitated in English by E.S., a PhD-trained researcher with expertise in qualitative methods and culturally responsive community mental health services, while an MPH-trained researcher co-facilitated.

Cultural and linguistic community focus group explored community perceptions of mental illness, community familiarity with available resources, and challenges in accessing mental health services. Due to the logistical challenges locating focus group facilitators who were skilled in this diverse array of languages, focus groups were conducted by a PhD or Masters level qualitative researcher from the study team, who facilitated the groups with the assistance of an interpreter, who was typically a program director or social worker, employed by each participating community-based organization. Responses and comments made by focus group participants were interpreted in real time by the interpreter. While these focus groups occurred at human service facilities that offer mental health services to members of these cultural and linguistic communities, they were open to all community members and were not restricted to mental health consumers or family members. This open invitation also potentially reduced any power differential between participants and the interpreter. Focus group questions are listed in Table 1.

All focus groups occurred on-site at stakeholders' organization facilities and lasted approximately 60 min. Focus groups were audio-recorded and professionally transcribed. The Vietnamese, Mandarin/Cantonese, Korean, Cambodian, and Farsi focus groups were translated into English during transcription, while the Spanish language focus groups were transcribed and analyzed in Spanish. Study participants not employed by Orange County were offered a \$35 gift card. The University of California San Diego Human Research Protections Program approved all study protocols.

Table 1 Focus group questions

Focus group type	Focus group question
Mental health Service planner/advocate	What has worked or is working to get hard to reach and vulnerable persons into mental health services in Orange County?
	Are there particularly vulnerable or underserved groups that you think would benefit most from receiving emotional or mental health services in Orange County?
	What types of mental health services are most needed in Orange County
	What are barriers to accessing mental health services in Orange County
	Are there any geographical areas of Orange County that have a scarcity of mental health services for the community that you represent?
Cultural and linguistic community	What are some of the things that make an experience with a mental health provider a positive one?
	How is mental health talked about in your community?
	Can you describe some instances in which you think it would be a good idea for members of your community to get emotional or mental health support?
	Who or what kinds of resources do people turn to when support is needed for mental health?
	What are some of the challenges that people in your community face in finding and using the services they need?
	What are some of the things you think would make an experience with a mental health provider a positive one?

Table 2 Composition of focus groups

Stakeholders Represented	Population Represented	N*		
County Advisors and Advocates	Advocates for adults with mental illness in an advisory role to the Orange County	Total = 34		
	Advocates for adults with mental illness in an advisory role to Orange county			
	Representatives from an advocacy organization for persons with mental illness and their families			
	Community Coalition focused on Women			
	Organization serving culturally diverse persons who are lesbian, gay, bisexual, or transgender (LGBT) with mental illness			
	Cultural and linguistic community focus groups		Vietnamese community	8
			Latinx community 1	10
			Latinx community 2	12
			Latinx community 3	7
			Chinese community	7
Korean community 1		7		
Korean community 2		9		
Cultural and linguistic community focus groups	Cambodian community	9		
	Farsi community	9		
		Total = 78		
		Total participants = 112		

* Exact numbers of service planning stakeholders and advisors is redacted to protect anonymity

Qualitative Data Analysis

This study used case study analysis (Patton, 2005), which prioritizes depth over breadth, to understand differences and similarities in perspectives from different stakeholders. This approach enabled us to focus our analysis on barriers to accessing mental health services in the community, and how these barriers impact cultural and linguistic minority communities specifically. This involved initially coding the transcripts using a technique known as open coding, which is an inductive process in which meaningful segments of text are identified with a descriptive code. We then revised these codes to become themes that fit with the focus group data by identifying and comparing similar and related ideas across transcripts. Next, we determined the reliability of these codes including examples or qualifications to the codes. Examples of codes included “linguistic access,” and “mental illness stigma.” Once the codebook was finalized, two coders independently reviewed and then together discussed each transcript line by line to ensure 100% coder

agreement. Disagreements in assignments or description of codes were resolved through discussion and by refining code definition (Boyatzis, 1998). To facilitate comparisons between and across the two types of focus groups, quotes that were derived from our coded material and illustrated these codes were then entered into a case summary matrix (Miles & Huberman, 1994). This enabled a review of points of convergence or divergence regarding stakeholder experience in accessing care in Orange County from multiple perspectives.

Results

In total, 112 individuals participated in 14 focus groups. Of these 14 focus groups, five were ‘county advisor and advocate stakeholder’ focus groups, which included a total of 34 individual participants. Nine other focus groups were conducted with members of cultural and linguistic communities, and included a total of 78 individual participants. Study sample composition is detailed in Table 2. Qualitative

analysis revealed three common themes that impacted access to mental health care. Theme 1: ‘System fragmentation undermines access’ was primarily discussed by county advisors and advocates; Theme 2: ‘Limited availability of linguistically appropriate care’ was discussed by both county advisors and advocate focus groups and cultural and linguistic community groups; Theme 3: ‘Community stigma and self-stigma’ was discussed by both county advisors and advocates focus groups and cultural and linguistic community members.

Theme 1: System Fragmentation Undermines Access

Participants from county advisor/advocate focus groups described barriers to accessing care that resulted from a fragmented mental health system. One remarked: *‘It’s like a patchwork quilt. Every piece is beautiful and designed for a specific purpose and attractive by any measure. But, it’s never been quilted together.* Another advisor/advocate remarked: *“we don’t have a system, ...what we currently have is a very fragmented system. If you’re drug and alcohol, you go this way. If you are court involvement, well that’s a different department. If you also happen to have AIDS or an STD, well that’s public health. If you have cancer, that goes over there...and god forbid if you have dementia...”*

Participants also described Orange County’s limited number of hospital beds as a barrier to receiving care among those who need inpatient services. According to one advocate, the need for inpatient care can result from stress related to transferring mental health programs within this fragmented system. This individual remarked: *At a certain point, they transition to another program...and that’s always a spot where the chances of rehospitalization become very great because the stress that that transfer provokes.* According to county advocates from a group focused on the needs of older adults with mental illness, this lack of inpatient psychiatric bed was of particular concern to those with chronic health conditions: *Maybe they have COPD. In other words, they have a chronic health condition. Or they may have a complex medical condition. And they also need a psychiatric bed.* Many providers and advocates agreed that such beds were needed, but as one individual remarked *‘Those kinds of beds are just not available.’*

For those who have been admitted to inpatient psychiatric care, county advisor/advocate focus group participants also described the complexities of navigating fragmented mental health and social services after being released. One advisor/advocate acknowledged that consumers require support for navigating outpatient mental health and social service systems of care after discharge. This individual described

another county’s ‘Mentors on Discharge’ program as a potential solution for supporting consumers and families at this turning point, and remarked:

“They have a mentors on discharge program. Where, somebody who’s in the psyche unit develops a relationship with somebody living [in the community and in recovery] with mental illness. And, when they’re released, that mentor, if you will, maintains contact with them. And it also has a very high success rate in terms of reducing recidivism..”

This advocate also suggested a program to address the needs of families that do not have the skills to navigate the complexities of a fragmented system: *“Staff and volunteers in the lobby space of psychiatric care hospitals, where the first time a family member follows a loved one into psychiatric care, they meet them there and help to embrace them, to give them emotional support and to help them navigate the system. Here’s kind of what to expect. Here’s some things that you can do.”*

Theme 2: Limited Availability of Linguistically Appropriate Care

Participants across stakeholder groups described Orange County’s lack of bilingual providers as one of the main challenges to engaging linguistic and cultural communities in mental health services. One advisor/advocate remarked that this need for linguistically appropriate care exists across various cultural and linguistic communities: *“I’ve just been at (organization) for a couple months, we already had needs for Mandarin...and we do have a Cambodian population here, that right now that’s our biggest struggle, is learning how to engage that population. ...And bilingual psychiatrists. I think from what I understand, there’s only one in Orange County.”* Another advocate also described the limited availability of linguistically appropriate services, particularly with respect to the advocacy organization where he worked. As this individual remarked *“I’m particularly mindful of the fact that, while (advocacy organization name) does a great job with the English-speaking population, and a good job with the Spanish-speaking population, we continue to work hard to further be able to support the other threshold languages. So, Korean, Vietnamese, Chinese, which isn’t a threshold language, Farsi and one other. We have some very limited capability in those areas...”*

This general shortage of bilingual services, advocates, and providers limited the availability of MHSAs programs for some communities. One provider commented on how this specifically impacts Korean community members: *“How great is the adult [Full service partnership] program? But there isn’t one you can send Korean patients to. If the patient speaks only Korean, there is no place we can send*

them. *FSP is the best program available in MHSA but there isn't anything for Koreans.*"

Participants from cultural and linguistic community focus groups discussed a need for linguistically appropriate case management and navigation emerged as a need for navigating mental health services for families who are receiving care. A service provider who is Korean and serves the Korean community remarked: *The American system is too complicated...Us professionals find it difficult so don't you think it would be more difficult for people who go through mental illness? The parents are busy making a living, their child is sick, the paperwork is all in English. This leads to people just giving up half way. If I'm a patient, yes I need a medical professional, but I need a case manager that can give a detailed help by navigating me through the way. They tell me, 'this paper is for this, system is set up like this,' and even if it's not really part of the therapy, I would like them to have the heart to grab and hold my hand.*

Cultural and linguistic community focus group participants also described how limited availability of translation services in mental health settings also impacted their experience with care. A Spanish-speaking consumer recalled an instance when they were expecting translation services but none were available. This person remarked: *"It could be that they say that there will be a translator, but what happens is that we go to the appointment and there isn't one... or, at least not enough of these services."* Another Spanish speaking consumer described feeling embarrassed to ask for translation: *"I can't go to the psychologist, because he speaks English, and I feel ashamed to ask someone to translate into Spanish."* Other Spanish speaking participants reported translators often *'are not [professional] translators'* and provide low quality services.

Linguistic access was also discussed during the Farsi/Persian focus group. One participant described how members of their community might first approach their primary care provider for mental health support, yet these individuals are unable to make referrals to linguistically appropriate mental health services. According to this participant:

Often people visit their primary care doctors when they feel bad, and doctors say that we can't do something for you physically. Your spirit is smashed. And they refer to (mental health) centers, but most of the doctors and clinics don't know if there will be Farsi speakers.

While all stakeholder groups reported a dearth of linguistically concordant services, many noted that when such services are available, they are appreciated venues for community building. As one Cambodian community participant remarked: *The program is very important to me because the program is offered in my language and also program offer an approach that build on peer support. Peer support is people around here that I can mingle with and speak the same*

language and understand the culture. So the peer support is very important for me because I'm able to share my happiness, to share my concern, to share my challenges with all people in my language and those people understand my culture as well." Other participants agreed with this comment.

Theme 3: Community Stigma and Self-Stigma

Focus group participants across stakeholder types described the impact of stigma at the community level and at the individual level as a barrier to accessing mental health services. Study participants described how stigma in the community, which leads to internalized stigma of mental illness, was among the most difficult barriers to overcome in cultural and linguistic minority communities. As one advisor/advocate remarked: *"One of the other big gaps in service we have is ethnic. So, there's a lot of self-stigmatization. We have a huge Vietnamese community, the largest in the country. We have Cambodians. We have other groups that self-stigmatize, Latinos they don't want, you know, grandma is just acting out or whatever. They don't want to know, and the families don't want to know."*

Cultural and linguistic community focus group participants also commented on reluctance to discuss mental health issues within their families and cultural communities. According to one consumer from a Spanish language focus group: *"The Community...isn't really open to talk (about mental health), I think that just as 'Latinos,' we are not very prepared to talk about mental health, what it means..."* Similarly, a participant from the Farsi/Persian focus group noted that information about mental health *'hasn't reached out culture yet: As said before, mental issues are not discussed. They say "you're crazy." For example, when I had a conflict with my husband and I told him that we have to go to a therapist, and he responded "You're crazy and ... And I am wise."*

While Spanish and Farsi speaking participants described how mental health is simply not discussed in their communities, participants from the Cambodian community focus group described how the consequences of stigma and shame of mental illness in the community can influence an individual's intentions to access care. As one Cambodian participant remarked: *"There are many stigmas around talking about mental health in Cambodian communities. According to our culture, when you talk about mental health, it's called crazy. That is a crazy person if you talk about mental health. There are a lot of shames around it and people are willing to live in the shadow rather than coming out talking about mental health issue."* Members of the Chinese community focus group also described *'being treated differently'* as a

consequence of stigma. As one individual remarked: *You have a high blood pressure; you have low... you have Diabetes. People did not discriminate you, but if you have a mental health issue people will treat you differently. They're either afraid of you as there is something wrong with you mental, or your psyche or whatever. They have those judgment, you not see with the judgment perspective and that's really hurtful.*

Advisors and advocates also commented on how stigma related to the intersection of sexual and gender minority and racial and ethnic minority identities impacts access to mental health services. One advocate, who identified as transgender, described safety concerns that can occur among sexual and gender minority persons who are trying to access care:

A lot of people are afraid of like going to any LGBT center, it's like whoa I can't go there or I'll go there after hours or when it's dark or if there's no one around and from personal experience like dealing with men who have been attracted to me or attracted to trans women it's this fearful like 'oh is there anyone there? Are you by yourself?'...tracking and making sure no one is around like a safety thing...

Advisors and advocates also broadly described how stigma of mental illness impacts individual decisions to access care, while one outlined three main ways to address stigma at the community level. As this individual remarked: *First, there needs to be awareness that there is such a thing as stigma and there is such a thing as mental illness. And then, second, there needs to be education about mental illness... Education really involves some individual or group of individuals communicating information to others and their willingness to receive that information. And then, third, and this is critically important. There needs to be contact. It's not leprosy. 'I've been educated that it's a biological brain disease. It's a neurological disorder. And it's not a parenting issue or a character flaw.' The third is, I need to meet someone who has a mental illness and realize, because I've met them, they don't have three heads or whatever other assumption I might have irrationally made.*

Discussion

This study reports results from a qualitative evaluation of barriers to accessing mental health care within the context of the MHSA in Orange County, California. We analyzed qualitative data from 14 focus groups conducted with multiple local stakeholders from Orange County's advisor and advocacy community and members of several cultural and linguistic communities that were prioritized by the county at the time of data collection. Our study revealed that Orange County advisors and advocates view system fragmentation

as a major barrier to accessing addressing the multiple health and social service needs among Orange County residents. Despite efforts on the part of the MHSA to support the integration of mental health, behavioral health, and primary care services in some California county mental health systems (Gilmer et al., 2016) county advisors and advocates indicated that Orange County continues to be challenged by the historic separation of these services. However, potential solutions for alleviating the consequences of system fragmentation were also discussed in focus groups, which included a mentoring program for individuals who are discharged from inpatient care, and a navigation program that supports families in accessing services. To promote engagement engagement, and to support navigation of a fragmented mental health system among persons with mental health needs, the MHSA has provided funding to scale up peer-based mental health services throughout California (Ojeda et al., 2016). These services, which are delivered by persons who have lived experience with mental illness, have the potential to promote equity in access to and engagement with mental health care in Orange County. Researchers have demonstrated the effectiveness of peer-based mental health services in many settings (Chinman et al., 2014). Relevant to the present study, peer navigators have been implemented to support mental health consumers in accessing care within a fragmented mental health service system, and have decreased use of emergency services in Los Angeles (Kelly et al., 2014). Scaling up these services could alleviate challenges identified by Orange County advisors and advocates.

Whereas the challenges of service fragmentation were discussed primarily in advisor/advocate focus groups, cultural and linguistic community members reported on culturally nuanced examples of stigma, and challenges accessing culturally and linguistically appropriate care in a complex system. Limited availability of linguistically appropriate services within fragmented system is a longstanding challenge in the planning and delivery of services for persons with mental illness (Cabassa et al., 2014). Health navigation and interpersonal support from culturally responsive peer specialists can address these multiple challenges discussed across stakeholder groups, and especially challenges associated with culturally nuanced examples of stigma and linguistic access that were described in these groups. While previous work has described the importance of culturally concordant peer support for transition aged youth (Ojeda et al., 2021), and other work has described the process of implementing culturally responsive peer supporters and navigators within the context of the MHSA (Siantz, Henwood, & Baezcondi-Garbanati, 2018), fewer studies have examined the effectiveness of peer providers in promoting engagement among members of the specific cultural communities identified in the present study. Participants from

cultural and linguistic community focus groups identified language as a significant barrier to accessing care, which speaks to the importance of developing culturally and linguistically responsive peer-based models in conversation with communities they serve. Such support could be used to conduct targeted outreach in linguistic minority communities, and help community members and consumers navigate care in a fragmented system. The recent passage of the Peer Support Specialist Certification Act in California presents an important opportunity to initiate dialogue between cultural and linguistic mental health communities and those who train and certify peer specialists to make these services more culturally responsive.

Our study also indicates that the challenges identified by advisors/advocates and by community members overlapped in many ways. However, different priorities emerged from advisor/advocate and cultural and linguistic community focus groups. Whereas advisors and advocates focused on system fragmentation, challenges with inpatient care, and stigma at the broader societal level, participants from cultural and linguistic community focus groups described being excluded from using certain MHSA programs, the lack of information circulating in their communities surrounding mental health care, and feelings of humiliation associated with having mental illness in their specific cultural communities. Therefore, a final note of our discussion pertains to the importance of county advisors and advocates developing communication mechanisms to understand the experiences and challenges of Orange County's multicultural consumer population. Previous work has identified many challenges to involving community members in in county initiatives (Sunderji, Ion, Zhu, Perivolaris, Rodie, & Mulsant, 2019). A recent systematic review of patient engagement strategies to improve quality of care reported ways to strengthen community participation (Bombard et al., 2018). This review highlighted the importance of 'creating a receptive context' by using democratic dialogue, and dedicating time to share values and beliefs, which can facilitate consensus building between community members and those in a more formal advisory roles. Reaching consumer stakeholders at their homes, in their care facilities, or other environments where care is delivered (and paying them for their time) can increase participation, comfort and willingness to participate in service planning. External facilitation, or support from external consultants with expertise in community engagement, can also help a health system and community members create additional momentum towards a more participatory environment. Enthusiasm and commitment on the part of organizational leadership, which sets the tone for a health system, is also critical to enhancing community involvement in a meaningful way. Example actions that organizational leadership can undertake to promote an

environment that welcomes the insights and experiences of consumers and their families when planning mental health service delivery can include having managers and executive leadership recognize and advocate for the importance of patient involvement. Organizational leadership should also be cognizant of the timing with which consumer and family input is sought after, as it is important to ensure that engagement occurs prior to decision making, rather than providing input when funds are already committed (Bombard et al., 2018; Macdonell et al., 2013). These approaches could improve congruence between community need and MHSA priority, and could be helpful to other counties in California.

Limitations

The purpose of this study was to examine the views of two stakeholder types who have very different experiences with Orange County's public mental health system. Although we included a diverse array of stakeholder experiences, our sampling approach might have excluded consumer participants who were less engaged in care or who had even greater challenges in accessing care. Further, the qualitative nature of this study precludes us from generalizing the experiences of participants to all participants who are receiving care or have tried to receive care (or work in) Orange county mental health services.

Further, while our focus on the experiences of Orange County's cultural and linguistic communities is a major strength of this work, there were several challenges inherent to including such a diverse array of community voices. For example, hiring fluent speakers of Farsi, Khmer, Mandarin/Cantonese, Korean, and Vietnamese as members of our research team was not feasible within our study's constraints. Instead, we collaborated with the community-based organizations that serve these communities whose staff gladly served as interpreters between the facilitator and the group participants. Limitations of this approach include possible abbreviation of group responses and potential for missing nuances that occurred across group commentary. Translation of focus group transcripts was an additional challenges, as many transcription services lack the resources to translate these languages into English. As such, our focus group transcripts had occasional moments of awkward translation. Unfortunately, such logistical challenges have led to the exclusion of diverse community voices from research on mental health service planning and other topics that are of concern to communities. Therefore, we believe that the benefits of including the experiences of these community members outweighs any potential imperfections associated with the interpretation process.

Conclusion

While the MHSA has had a substantial impact on the landscape of mental health service delivery in California (Cashin et al., 2008; Gilmer et al., 2014), equitable access to mental health services remains a challenge. Additional efforts are needed at the policy, agency, and community levels to improve mental health equity among members of the historically underserved groups described in the present study.

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