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Supporting the mental health needs of underserved communities:

A qualitative study of barriers to accessing community resources

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Abstract

This study examined the accessibility of community resources (e.g., welfare programs, afterschool programs) for underserved youth and families with mental health needs. Mental health professionals ($n = 52$) from a large community mental health and welfare agency serving predominantly low-income, Latinx families completed a semi-structured interview that asked about the accessibility of community resources. Participant responses were coded using an inductive thematic analysis. Results showed that 71% of participants endorsed availability barriers (e.g., limited local programs), 37% endorsed logistical barriers (e.g., waitlists), 27% endorsed attitudinal barriers (e.g., stigmatized beliefs about help-seeking), and 23% endorsed knowledge barriers (e.g., lacking awareness about local programs). Professionals' perceived availability barriers were mostly consistent with the actual availability of community resources. Findings highlight the compounding challenges that underserved communities face and point to opportunities for promoting enhanced well-being and functioning for youth and families with mental health needs.

Keywords: Community mental health services; allocation of resources; underserved populations; qualitative research; health and welfare planning; child well-being; community services

Supporting the mental health needs of underserved communities:**A qualitative study of barriers to accessing community resources**

The United States spends more than \$1.3 trillion annually on programs that promote human well-being and functioning (U.S. Department of Health and Human Services, 2020). Medicaid and the Children's Health Insurance Program (CHIP) connect more than 72 million individuals, including 35 million youth, with healthcare for maintaining their physical and psychological well-being (Centers for Medicare and Medicaid Services, 2020). Nearly 43 million individuals are granted enhanced food security through the Supplemental Nutrition Assistance Program (SNAP; U.S. Department of Agriculture, 2020), and 5 million American households receive rental assistance to alleviate housing rental costs (Center on Budget and Policy Priorities, 2019). An estimated 10 million youth participate in afterschool programs (Interagency Working Group on Youth Programs, 2020), which have been found to improve internalizing and externalizing symptoms, social skills, and academic functioning and performance (Durlak et al., 2010; Frazier et al., 2013). Additionally, thousands of school, neighborhood, and community organizations (e.g., Boys and Girls Clubs of America, religious institutions, LGBTQ+ support groups) across the county help reduce youth's risk for engaging in alcohol and substance use, risky sexual behaviors, and involvement in the juvenile justice system (Eisenberg et al., 2020; Kegler et al., 2005).

Community resources such as these may be particularly beneficial for youth with existing mental health needs who are vulnerable for impaired functioning. Youth living in poverty are likely to encounter many psychosocial stressors such as family conflict, financial struggles, unsafe living conditions, and exposure to violence (Evans & Kim, 2012; Santiago et al., 2013) – making them susceptible to social, emotional, and behavioral problems and, subsequently, good

candidates for mental health treatment. Notably, chronic stress influences not only who could benefit from psychotherapy but also what happens in the psychotherapy room. That is, multiple stressors occurring throughout a psychotherapy episode have been shown to impact both treatment fidelity and treatment effectiveness (Guan et al., 2019). Accordingly, community resources can help underserved youth and families meet their basic needs (e.g., food, shelter, safety) – thereby mitigating the prevalence and impact of external stressors and allowing for increased time and attention toward promoting their mental health.

That said, numerous barriers often prevent youth and families in need from accessing community resources. For example, many individuals, particularly persons of color and persons from low-income households, hold stigmatized beliefs that they will be judged or discriminated against for seeking public assistance or that accessing community resources makes them of lesser value (Wong et al., 2017). Underserved individuals with mental health concerns may also experience intense shame about their emotional or behavioral problems and, consequently, may feel the need to prove their worth to themselves and others by avoiding or rejecting support from mental health and public health programs (Corrigan, 2004). Additionally, underserved youth and families who have had past negative experiences with social services may feel reluctant about pursuing community resources and distrustful of individuals in helping professions.

Practical barriers may also limit youth and families' access to community resources. For instance, it can be difficult for many families, particularly those living in rural or under-resourced areas, to access community resources that are located far from their homes, given challenges with reliable transportation and childcare (Damian et al., 2018). Language barriers may also prevent families with limited English proficiency from capitalizing on available community resources, as there may be miscommunications about the presence of potential

supports, eligibility requirements, and expectations for program participation (Jacobs et al., 2004). Additionally, some community resources may have a lengthy application process or waitlist, which may deter youth and families in need from enrolling (Stalker et al., 2016).

Furthermore, to access community resources, youth and families must be aware that such resources exist, and this knowledge is often not widely disseminated (Yu et al., 2005). Relatedly, millions of underserved youth and families are not connected with a social worker or other related professional who could help them navigate the welfare system (U.S. Bureau of Labor Statistics, 2018). Within public sector mental health agencies, some professionals are well positioned to engage and support high-need, low-resource families. For example, paraprofessionals are equipped with contextual knowledge that can greatly facilitate their ability to link families with acceptable and appropriate community resources (e.g., Mehta et al., 2019). That said, many mental health professionals may have limited knowledge of the objectives, eligibility requirements, or availability of local community programs. Given the promise of community resources to promote well-being and functioning and the wide array of potential barriers to accessing community resources, determining which barriers are most prominent for youth and families with mental health needs may serve as an initial step toward enhancing health equity.

The present study explored mental health professionals' perceptions about the accessibility of community resources. Specifically, this study aimed to: (1) identify perceived barriers to accessing community resources for youth and families with mental health needs; and (2) compare mental health professionals' perceived availability of community resources with the actual availability of community resources. Given well-documented barriers to help-seeking (Santiago et al., 2013; Smokowski et al., 2018), it was hypothesized that challenges related to

attitudes, logistics, and knowledge would be identified as impeding accessibility to community resources for youth and families with mental health needs. It was also hypothesized that mental health professionals' awareness of local community resources may be relatively limited, as case management tends to be a substantial but often unsupported aspect of their work (Dorsey et al., 2017). Through better understanding barriers to accessing community resources, findings from this study can point to opportunities for connecting more youth and families with appropriate mental health and public health programming.

Methods

All study procedures were approved by the Institutional Review Board of the University of California, Los Angeles.

Participants

Mental health professionals who were employed by one of the largest mental health and welfare agencies for youth and families in Southern California were invited to participate in this study during monthly staff meetings in June and July 2017. Those who expressed interest in participating were contacted by the Principal Investigator to schedule independent semi-structured interviews that asked about their experiences working with historically underserved youth and families. Mental health professionals received a \$10 gift card for participating in the semi-structured interview.

Participating mental health professionals included 21 clinicians, 9 supervisors, 6 case managers, 5 community wellness specialists (i.e., bachelor's level professionals who help clients develop coping and problem solving skills), 4 directors or assistant directors, 4 referral managers (i.e., bachelor's or master's level professionals who assist with managing and processing referrals), 2 parent partners (i.e., caregivers who have successfully navigated youth mental health

or related services and who provide peer support to other caregivers on a similar journey), and 1 evidence-based treatment trainer. Professionals identified as 44% Latinx, 31% non-Hispanic White, 12% Asian or Asian-American, 8% Black or African American, and 4% of mixed ethnicity. Most professionals identified as female (90%), and their average age was 37.5 years ($SD = 8.80$). Professionals were predominantly Master's level (75%). Professionals reported an average of 5.29 years ($SD = 5.06$) working at their current agency.

For context, the participating mental health and welfare agency provides outpatient and school-based mental health services, wraparound and in-home services, psychiatric services, psychological testing, educational support services, after-school tutoring and enrichment, residential treatment, and transitional shelter care and living assistance to more than 15,000 youth and families annually across 3,500 square miles. The agency serves youth and families living in six of Los Angeles County's eight service areas (SA), or geographic regions that are divided to facilitate the development of public health and clinical services that are most relevant to residents (Table 1). The agency serves predominantly low-income, Latinx youth and families. The top problems treated by mental health professionals at the agency include depression, traumatic stress, disruptive behavior, and anxiety.

Semi-Structured Interview

Mental health professionals' perceptions of the accessibility of community resources were gathered through semi-structured interviews conducted by four graduate students and one postdoctoral scholar. Specifically, participants were asked, "Do you feel there are adequate resources in the community to support the mental health needs of underserved consumers and families? Please tell me more about that." All interviewers participated in a training on how to conduct semi-structured interviews, including instruction on asking follow-up questions to gather

more detailed or clarifying information and role-plays with the Principal Investigator.

Interviewers also met biweekly with the Principal Investigator to review interviewing procedures and to troubleshoot any issues that had arisen during interviews. Semi-structured interviews were transcribed by members of the research team prior to coding.

Coding Procedure

An inductive thematic analysis was used to identify themes in mental health professionals' responses about the accessibility of community resources. First, the first, third, and ninth authors reviewed all semi-structured interview transcripts and generated an initial list of semantic content codes. These codes were then collated and combined into a pool of 16 candidate themes. Next, the first and third authors independently coded data from transcripts within the candidate themes. At least one barrier to accessing community resources theme (see Table 2) and at least one type of community resource theme (see Table 3) was applied to each transcript; additional themes were applied if multiple barriers or multiple community resources were mentioned. Given that transcripts were relatively concise (*range* = 93-1256 words, $M = 406.80$, $SD = 282.13$), themes were applied to the entire transcript, consistent with Braun and Clarke's (2006) advice to code inclusively. Raters and the Principal Investigator met monthly to resolve discrepancies through consensus (e.g., Hill et al., 2005). These discussions also led to the refinement of themes (e.g., barriers related to the cost of resources or lack of reliable transportation were collapsed into a theme of logistical barriers; barriers related to social and cultural norms were separated into themes of attitudinal barriers and knowledge barriers) for more parsimonious coding over time.

Data Analyses

Although conventions for representing the prevalence of themes are debated (e.g., Braun & Clarke, 2006), we report the frequency with which mental health professionals endorsed barriers to accessing various community resources to illuminate where efforts to promote public health and mental health may be best invested. For instance, mental health professionals' more frequent endorsement of availability barriers compared with knowledge barriers may suggest a relatively more pressing need for communities to develop additional welfare and social resources than to improve consumers' knowledge or attitudes. The prevalence of various barriers to accessing community resources was calculated by dividing the number of professionals who identified an accessibility barrier by the total number of participating professionals. Mental health professionals' perceived availability of community resources and the actual availability of community resources was compared by first identifying the participating professionals working within each service area (SA) who endorsed an availability barrier in the semi-structured interview. Then, community resources within each SA were identified using data from the Los Angeles GeoHub (City of Los Angeles Hub, 2018), which features information about community resources including name of resource, type of resource, description of resource, and zip code where resource is located. The first and second authors coded descriptions of 3,013 community resources listed in the Los Angeles GeoHub using the semantic themes from the interview transcripts regarding types of community resources: (a) outpatient mental health services, (b) specialty health or mental health services, (c) welfare services, or (d) youth services. Coders met monthly to review final codes, resolve discrepancies through consensus, and refine definitions of themes to improve parsimony of coding See Table 4 for the number of community resources within each SA.

Results

Perceived Barriers to Accessing Community Resources

Two overarching themes in mental health professionals' responses about the accessibility of community resources were identified: (1) perceived barriers to accessing community resources, and (2) types of community resources. The theme of perceived barriers to accessing community resources contained five sub-themes: (a) attitudes, (b) availability, (c) knowledge, (d) logistics, and (e) other. The theme of types of community resources contained six sub-themes: (a) outpatient mental health services, (b) specialty health or mental health services, (c) welfare services, (d) youth services, (e) other services (e.g., emergency services, child protective services), and (f) unspecified services (see Tables 2 and 3 for theme definitions).

All but one participant (98%; $n = 51$) endorsed barriers to accessing community resources for youth and families with mental health needs. The majority of participants (69%) identified availability barriers. As noted by a supervisor from SA 1, "I think that the issue is that there is not enough. There may be one of this, one of that, and what we're dealing with is, at least for this area, wait lists." Logistical barriers were identified by 37% of participants. One clinician from SA 1 mentioned, "I know transportation is a big issue for families out here because everything is kind of spread out. It's not like down in [suburban region] or in [urban metropolitan city] where there are kind of like cities just really close, so I know that's a big issue." Attitudinal barriers were endorsed by 27% of participants. A supervisor commented, "There's bias too, cultural bias around mental health. Like, 'Only crazy people get it.' I've heard that from a lot of families. Like 'Oh my child doesn't need that. That's weak.' Or it doesn't go in line with their religious belief, so sometimes there's barriers from culture." Knowledge barriers were identified by 23% of participants. As stated by a clinician, "They didn't even know [these resources] existed until I

told them about it, and it took me a while to find out they existed. I think there's a lot of resources that could be beneficial, but they just don't know about them." Lastly, "other" barriers were identified by 21% of participants. An assistant vice president reported, "It's also really challenging to get other system stakeholders to have more of an open approach to working with diverse populations. There's just a lot of barriers for them. It's not always their fault. They have like incredible caseloads and stuff, but they're just not able to pay attention to some of the needs, and so a lot of crises happen that they expect the families to call the police when that is so radically different from what their culture and community would accept." As shown in Figure 1, most participants discussed community resources in general rather than identifying accessibility barriers related to specific types of resources.

Perceived Availability Compared with Actual Availability

More participants tended to endorse availability barriers in SAs with fewer community resources than in SAs with more community resources (see Table 4). For instance, 72 community resources were identified in SA 1, and 73% of participating mental health professionals working in this area endorsed availability barriers; whereas, 325 community resources were identified in SA 3, and 60% of participating mental health professionals working in this area endorsed availability barriers. An exception to this trend is SA 4 where 397 community resources were identified, and 100% of participants endorsed availability barriers.

Discussion

This study aimed to explore the accessibility of community resources for youth and families with mental health needs. Specifically, this study investigated perceived barriers to accessing community resources among community mental health professionals working with historically underserved youth and families. To differentiate between potential knowledge

barriers or availability barriers, this study also compared mental health professionals' perceived availability of community resources with the actual availability of community resources.

Understanding the barriers that vulnerable populations, such as those with mental health concerns, encounter when trying to access welfare and social resources is an essential first step to generating solutions for promoting well-being and functioning among individuals with some of the greatest need.

As hypothesized, findings from this study showed that the vast majority of participating mental health professionals endorsed barriers to accessing community resources – most commonly, limited availability of local programs and supports. These results are consistent with documented barriers to help-seeking (Castañeda & Melo, 2014; Gulliford et al., 2002; Thornicroft, 2008) and present a considerable impediment to helping underserved youth and families meet their basic needs. That is, even if no other practical barriers (e.g., unreliable transportation, waitlists), attitudinal barriers (e.g., stigmatized beliefs about help-seeking), or knowledge barriers (e.g., limited awareness of resources, uncertainty about how to enroll in resources) existed, the lacking presence of community resources means that underserved youth and families would still be unable to receive these supports. Accordingly, these findings suggest the need for solutions that address accessibility barriers at various levels of the mental health service system ecology (e.g., Southam-Gerow et al., 2012). For instance, within the broad sociopolitical system, there is a need for increased funding toward mental health and public health programs, as well as large-scale campaigns that disseminate information about such services (Corrigan, 2004). With government officials reimagining public safety following the killings of Ahmaud Arbery, Breonna Taylor, and George Floyd, there is a timely opportunity to shift funding from police to much-needed public health and clinical services (e.g., Bickman,

2020). Additionally, mental health organizations, particularly those serving underserved youth and families, can better facilitate the coordination between mental health and welfare services by leveraging the knowledge of mental health professionals who may be familiar with local community programs and resources (e.g., social workers, case managers, paraprofessionals), providing accessibility supports (e.g., bus tokens, childcare, free meals), and employing peer supports to destigmatize help-seeking (Barnett et al., 2018; Hoffman et al., 2016; Lau et al., 2010; Planey et al., 2019). Additionally, in the psychotherapy room, mental health professionals may consider incorporating cultural and contextual factors (e.g., client identity and intersectionality; community norms and values) into their conceptualization and treatment plans, as well as validating, normalizing, and challenging clients' shame-inducing thoughts about using community resources.

Findings from this study also suggest that mental health professionals may be generally aware of local community resources. Results showed that mental health professionals working in areas with relatively few community resources tended to endorse availability barriers at higher rates than those working in areas with more community resources. These findings support the notion that accessibility barriers may be more related to limited availability of community resources than to knowledge deficits, which has implications for potential solutions. For instance, although a multifaceted approach is critical for improving the accessibility of community resources, there is an urgent need to increase the number of community resources in under-resourced areas. Despite the fact that underserved communities may benefit from any additional welfare or social supports, there is likely to be utility and value in conducting a needs assessment and developing specific programs that will be of the greatest relevance to residents. As an example, residents of SA 4 in Los Angeles County, CA are likely to benefit from a wide

variety of community resources but may especially appreciate increased housing assistance, as significantly more SA 4 residents are unhoused than families from other SAs (Los Angeles Homeless Services Authority, 2020).

Although this study has several strengths, including its relatively large sample of semi-structured interviews, inclusion of diverse mental health professionals, and comparison of perceived availability with actual availability of community resources, some caveats are in order. First, all participants were employed by a single mental health and welfare agency in Southern California and, thus, findings may not reflect perspectives of mental health professionals working in other settings or other areas of the country. Notably, the participating mental health and welfare agency serves more than 15,000 youth and families annually in communities covering 3,500 square miles, including urban metropolitan and suburban neighborhoods. Additionally, the participating mental health and welfare agency and, more generally, Los Angeles County are relatively well-resourced – making it likely that the accessibility of community resources described in this study may be a general overrepresentation and that there may be increased accessibility barriers in other public sector mental health agencies, counties and states. Relatedly, this study focused on understanding the perspectives of mental health professionals who may play an integral role in connecting youth and families with community resources but who may not access community resources themselves. A valuable future direction would be to investigate consumer perspectives about the accessibility of community resources and strategies for improving the public health and mental health of youth and families in need. A second study limitation is that these findings reflect the accessibility of community resources at a single point in time, when resource availability and capacity may ebb and flow due to a variety of factors including new clinicians entering the workforce, clinician turnover, agency caseload

requirements, and agency sites closing down or relocating. Another study limitation is that mental health professionals tended to discuss community resources in general rather than speak about the accessibility of specific types of community resources (e.g., welfare programs, youth programs). One possibility is that community resources may be indiscriminately impacted by practical, attitudinal, and knowledge barriers. Another possibility is that underserved youth and families may benefit from multiple community resources, making it difficult for mental health professionals to speak about the barriers to accessing a specific type of support. Future research investigating ways of effectively coordinating mental health and public health services should consider whether different types of community resources have different accessibility barriers and facilitators. A final study limitation is that two of the raters who created the initial list of semantic content codes were later involved in applying those codes to interview transcripts. Final codes were reviewed, discrepancies were resolved through consensus, and themes were iteratively refined by the raters, with the Principal Investigator serving as auditor, to address possible code subjectivity bias and to promote increasingly parsimonious coding.

Conclusion

This study found that the limited availability of community resources, such as welfare programs and afterschool programs, represents a major barrier to helping youth and families with mental health concerns meet their basic needs. These findings point to opportunities for improving well-being and functioning among particularly vulnerable populations – for example, though conducting a needs assessment to determine which community resources may be most dire, dedicating funding to developing these resources, and increasing awareness of these resources among helping professionals regularly interacting with underserved youth and families. Although many concerted and multifaceted efforts are needed to address individual,

social, and systemic barriers to help-seeking, identifying the urgent need to increase the number of local community resources is a start.

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Table 1

Demographics of all individuals living in each service area

SA	Population ^a	Square Miles	% non-Hispanic White ^b	% English-speaking households ^b	% households living in poverty ^b	% households that are food insecure ^b	Number unsheltered ^c
1	397,583	1,517	35%	78%	21%	34%	3,918
2	2,262,277	988	45%	69%	15%	27%	6,615
3	1,808,263	717	21%	50%	13%	22%	3,027
4	1,185,794	91	25%	54%	24%	32%	12,454
5*	667,863	189	64%	87%	12%	31%	5,042
6	1,057,694	71	2%	50%	34%	32%	7,891
7	1,321,304	157	14%	55%	17%	32%	3,631
8*	1,578,056	331	28%	76%	17%	30%	3,512

Note. SA = Service area. Service area numbers designated by the County of Los Angeles Department of Public Health. *Service area is not served by participating agency. ^aBased on data from 2019 (Los Angeles County Office of Health Assessment and Epidemiology, 2020). ^bBased on data from 2015 (Los Angeles County Department of Public Health, 2017). ^cBased on data from 2020 (Los Angeles Homeless Services Authority, 2020)

Table 2

Barriers to accessing community resources themes

Sub-theme	Definition
Attitudes	Barriers related to youth or families' attitudes about using a community resource (e.g., stigmatized beliefs, ambivalence about service use, distrust of professionals or organizations).
Availability	Barriers related to the availability of a community resource (e.g., long waitlists, insufficient staffing, limited hours, no services offered in family's preferred language).
Knowledge	Barriers related to lacking awareness or knowledge about a community resource (e.g., uncertainty around presence of community resource, eligibility requirements, and/or enrollment process).
Logistics	Barriers related to logistical challenges in accessing a community resource (e.g., lack of reliable transportation, burdensome application process, costly to access).
Other	Barriers that do not reflect any of the above codes (e.g., systemic challenges, uncertainty around needs of family).

Table 3

Types of community resources themes

Sub-theme	Definition	Exemplar Quote
Outpatient mental health services	Resources related to outpatient mental health services (e.g., individual or group psychotherapy, case management, crisis management, psychiatric services).	“I really don’t think there’s enough resources here in this community for the mental health service needs for everybody, and I think that is why we are so inundated here with families who need those supports and services.”
Specialty health or mental health services	Resources related to specialty health or mental health services (e.g., inpatient services, partial hospitalization programs, residential services, rehabilitation services, regional centers, neuropsychological assessment).	“For example, the youth that’s transgender. I already know there’s only one place in [suburban region] that provides that service. I know the person that runs the program is amazing. They go out in the community and provide tools and information and fliers, but if that youth can’t get there, then...”
Welfare services	Resources related to assistance with food, shelter, clothing, and other basic living expenses (e.g., Supplemental Nutrition Assistance Programs, section-8 housing, rental assistance).	“We’re looking at low-cost, no cost resources for these families. Housing is always a big thing that comes up. For a lot of our families that’s really tough just because of the financial situation, and I know there’s a waitlist for Section 8.”
Youth services	Resources related to academic achievement programs, extracurricular activities, social skills programs, or emotional support programs (e.g., afterschool programs, Boys and Girls Club of America, daycare).	“There are a couple of anti-gang, anti-crime, at risk youth programs here, but I don’t think it’s enough - those kinds of neighborhood and community resources for after school activities, safe activities. I know there is a Boys and Girls Club. I don’t know if that’s enough.”

Other services	Resources that do not reflect any of the above codes (e.g., emergency services, child protection services, interpretation services).	“I think there’s not enough support for parenting groups or the different types of specific needs that their children have.”
Unspecified services	Resources that do not refer to a specific community resource (e.g., “community resources”).	“A lot of the times when we have to do linkages, either a lot of the resources are down in [suburban region] or further out. The issue with that of course is that a lot of the families we do serve do not have transportation.”

Table 4

Availability of community resources within each service area

SA	% Participants who endorsed availability barrier	# Outpatient mental health resources	# Specialty health or mental health resources	# Welfare resources	# Youth resources	Total # community resources
1	73%	15	18	33	6	72
2	64%	65	38	134	53	290
3	60%	54	67	130	74	325
4	100%	57	38	221	81	397
6	67%	54	27	111	72	264
7	83%	31	31	96	54	212

Note. SA = Service Area. Service area numbers designated by the County of Los Angeles Department of Public Health.

Figure 1

Perceived barriers to accessing various community resources