Focus Groups as a Method for Accessing Stakeholder Voice in Public Sector Community Mental Health

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Abstract

Focus Groups as a Method for Accessing Stakeholder Voice in Public Sector Community Mental Health

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This research represents a secondary analysis of a series of thirty focus groups addressing the topic of public sector community mental health services. These groups were conducted with four designated constituency groups (Consumers and Advocates, Children's Service Providers, Health and Social Service Providers, and Justice Service Providers) in three geographic locations in Washington state.

The purpose of this secondary analysis was to explore the potential for using focus groups as a method for gathering information from the public stakeholders in the community mental health delivery system. The significance of this hinges on the reality that the citizenry funds public sector community mental health services yet few citizen stakeholders participate in the determination of service need, planning or evaluation. Professional expertise and voice has historically been privileged thereby diminishing community ownership of public mental health services and jeopardizing funding allocations. A trustworthy, cost-effective method is needed if a broad range of stakeholders are to be included in the processes noted above, even if only to educate those who have the authority to make public mental health policy. Focus groups hold potential to be this method.

This research developed a model for planning and conducting focus groups that was shown to yield trustworthy data that was generalizable to similar constituencies or regions. Transcripts of focus groups were analyzed using ATLAS.ti and Excel. Patterns of consistencies were found in transcript themes among and across constituency clusters; these supported the validity and usefulness of focus groups for accessing stakeholder voice and public opinion. Limitations of the research include transcription quality, coding issues, and most importantly the lack of ethnic diversity of participants. Further study is recommended to evaluate the application of focus groups in other public service arenas and to explore ways in which this method might be more effective with regard to involving a diverse and representative population in the public discourse.

TABLE OF CONTENTS

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Finally, without the assistance and the participation of members of the community no focus group would have been convened; I would have missed this opportunity to understand the importance of public discourse and the potential of the focus group method.

Dedication

To my parents, Elizabeth and Thomas Caverly, who instilled in me the desire to learn.

To my husband, Edward Silva, who has supported me in this journey.

To my daughters, Kirsten and Catherine Silva, who have taught me what is really important in life.

To clients, colleagues and friends who have cheered me on and helped me to understand that each of us has the potential to impact our world.

Focus Groups as a Method for Accessing Stakeholder Voice in Public Sector Community Mental Health

Chapter I

Introduction

This work is a descriptive study exploring the use of focus groups as a method for gathering information regarding public opinion of public sector community mental health services. The interest in public opinion reflects concern that the voices of multiple constituencies of stakeholders are not included in the process of mental health service planning, policy development or evaluation. This circumstance limits the capacity for community services to truly meet the needs of community members, causes those who have accountability for designing and providing care to have inadequate information on which to base decisions and presses for consideration of social justice issues as related to the development and provision of public sector community mental health services. The intersect of public mental health policy development and implementation with social justice is both unavoidable and critical as the population served by community mental health programs is one traditionally without voice. However, it is also worth noting that the public at large is commonly left without voice in the discourse of mental health policy, and that this too has a limiting impact on policy. Common rationale for failing to include multiple stakeholder voices in development of policy includes concerns about the cost of extensive research and a reluctance to encourage interest-group politics. The challenge, then, is to find ways of gathering information from a broad range of stakeholder groups in a cost-effective manner that gives access to the public discourse without derailing the process on the basis of special interests.

The role of the community as funder for public sector community mental health care services has been a neglected aspect of community mental health services research. In times of fiscal constraint it becomes imperative that efforts to evaluate the effectiveness and impact of public sector services consider the full spectrum of system stakeholders. State legislators and administrative policy makers are pressed to make decisions regarding the allocation of ever scarce service dollars, and to do so in a manner that attends to the needs of the community. The public sector community mental health system has a responsibility to engage with stakeholder groups since the ability to capture necessary public dollars increasingly relies on evidence that public services are effective and responsive to community need.

Statement of Problem

There is a need for a cost-effective process through which those in the position of implementing or evaluating public sector community mental health care services can gather information from a broad range of stakeholders. In the absence of such data, policy makers rely on partial information to make decisions. This circumstance reifies the tendency for determination of service need to be made by those individuals and groups that have historically had access to public voice rather than those who rely on or perhaps support such services. Focus groups represent one possible method for accomplishing this task; however, the perception has been that the use of focus groups is unlikely to result in data that can be generalized beyond a particular group to the public community. Research to explore the content validity and generalizability of focus group research is needed if this method is to gain acceptance as an effective tool.

Purpose

The general purpose of this study is to explore the potential for using focus groups as a method for gathering information from the public stakeholders in the community mental health service delivery system. As such, the voices of stakeholder constituencies from whom information is not commonly solicited will be given venue and the use of focus groups will be analyzed as a method for accomplishing this. Consideration of stakeholder voice permits those who are responsible for determining and implementing public policy to do so in a manner that attends to issues of community need and social justice.

The Specific Aims are:

1. To explore the potential for focus groups to be used as a means for accessing the voice of stakeholders in the public sector community mental health system.

2. To compare like and unlike constituency focus group data to determine whether the information obtained by means of focus group research can be used as a valid indicator of public opinion with regard to public sector community mental health services.
3. To describe data obtained through the use of focus groups and in so doing to illustrate that facilitating the public voice of stakeholders enhances the potential for public mental health policy to respond to a determination of need that is reflective of and in context with the characteristics and priorities of the community and service users.

Significance

The chief importance of this research is to provide information as to whether focus groups represent a valid method for accomplishing the task of gathering information about the public stakeholder perceptions, priorities and expectations of public sector community mental health services. If focus group data can be generalized beyond the convened group to like constituencies in the same community, then this method allows for a cost-effective means of including multiple voices in the evaluation of public mental health programs. A chief criticism of the use of focus groups for this purpose has been the lack of established external validity; focus group data has long been believed to reflect the opinions and interaction of only the specified collective of individuals. Little has been done to establish that with iterative use of focus groups, there is a likelihood that data obtained begins to be reflective of the broader opinion of community members within a constituency, and perhaps within a collective of constituencies in a given community. Concerns that multiple voices can degenerate to a politics of special interests are one aspect of inherent distrust of focus group data. However, there is a reciprocal concern that to exclude a variety of discrepant voices from public discourse creates a singular voice reflective of an entitled few who do not necessarily represent the public views. If a cost-effective and time-contained method for broadening access to multiple voices can be shown to be a genuine reflection of the greater public opinion or that of a single salient constituency, then the method would be of value.

The implications for policy makers, program planners and evaluators is relatively transparent. More information is made available about what community mental health services the public wants, expects and will fund, and as the public citizenry is the ultimate customer of public services of all sorts, it is extremely useful to have access to this information. The implications for the broad range of public constituencies, including those in need of community mental health care, are also clear. The services available in a given locale would potentially be more responsive to the needs of the members of that community rather than to needs extrapolated from the beliefs of those providing services in another part of the country where more research has been done.

In a different way, this project has significance because it provides a method for encouraging open discussion about these issues and creates a situation close to that of

Habermas' "ideal speech" circumstance through which historically invisible factors affecting public sector community mental health care services can be considered (Rasmussen, 1990). The use of focus group methods rather than individual interviews or surveys and the recruitment of community stakeholders who have commonly been excluded from comment represents a means of gathering data about the topic that is both rich and diverse. This method of gathering information relies less on preconceived ideas of what is important to ask and instead allows the group to address aspects of the topic that the researcher/evaluator may not be knowledgeable about. It permits a diminishing of the power discrepancy between the program planner/evaluator and the identified stakeholders, and by so doing has the potential for learning about stakeholder beliefs and needs in a manner not otherwise possible. By creating a forum for public discourse open to individuals and constituencies not commonly given venue to participate in public policy decisions, focus groups provide one means for promoting social justice in the public sector community mental health system's process and service delivery.

Theoretical Framework

This research reflects a desire to meld the concepts of social justice and public mental health policy in a manner that is pragmatic and applicable. Both Fraser (1989, 1997) and Forester (1993) have addressed issues of social justice in public policy. Each contends that the value of multiple voices in the public discourse is necessary for public services to meet community need. Frazer and Lacey (1993) have considered similar issues but do so in the environment of a feminist critique of the liberal-communitarian debate, the relevance of which for this project hinges on a concern for citizen participation and voice as crucial components in a just society. Habermas' work in communicative action is a common thread in these writings and the concept of voice while not always stated as such is pivotal. A myriad of distinct (and perhaps discrepant) implications and interpretations can extend from Habermas' Theory of Communicative Action; therefore, it is necessary to identify that the central theoretical aspects essential to this work relate to his conceptualization of an "ideal speech" situation that assumes both symmetry and reciprocity (Rasmussen, 1990, p. 64).

Forester frames his arguments with regard to critical public policy in terms of Habermas' theory of communicative action and reformulates his understanding of planning practice from one that is instrumental to one that is termed practical-communicative action (Forester, 1993, p. 28). He commits to the value of the "ideal speech" circumstance described by Habermas and finds practical applications for this in the realm of planning and policy. He also specifies that the role of the planner includes responsibility for assuring that all available salient information is considered in pubic decision making. He refers to the importance of legitimate public policy redressing any structural communication distortions or deliberate exclusion of affected publics. It is in relation to these values that Forester bridges "cognition to action," moving from a theoretical consideration of public planning and policy to practice that is bounded in ethical discourse. While he does not attend directly to the use of focus groups as a mechanism for attaining these goals, the fit is readily made so long as the design of the focus group is in keeping with the ethical mandates of a critical theory.

Habermas has been included by Frazer in her communitarian critique of liberalism. She highlights Habermas' communicative ethics, associating these with a conception of active citizenship only possible when citizens have an opportunity to speak in a forum that is respectful and when the content is intentionally truthful and not manipulative. The importance of such a situation is evident when placed in context with her contentions that absent citizens who are involved and empowered, there is potential for democratic society to disintegrate into an authoritarian regime (Frazer and Lacey, 1993, p. 105-107).

Fraser references Habermas in her work, but not without critique. Her view seems to be that he does not take his theory far enough for social justice to be served. Fraser is pragmatic and presses for the public discourse to be inclusive of multiple voices and in fact multiple public spheres when policy decisions are in process. She problematizes the view of a single public sphere as neglecting the multiple counter-public spheres and as being inherently "bourgeois, masculinist, white-supremacist" (Fraser, 1997, p. 76). She contends, among other things, that it is necessary to acknowledge the unequal nature of individuals even in an open space of communication and she refutes the importance of focus on public versus private interests as a focus for discourse.

This project has drawn primarily on Fraser's efforts to examine and expose methods of need determination (and voice in the discourse) as related to public policy and in particular social welfare policy. Fraser's analysis of the determination of need closely relates to common practice in the arena of public sector community mental health policy and service. In many instances, an entitled few who are either considered experts or who have the capacity to provide or withhold funding determine the needs that will be recognized and provided for. In addition, there tends to be an ideology that is favored in the determination of need and which ascribes a privileged definition of "deserving." This is reflected as a distinction between those who are considered to be "deserving" of public services and those who are perhaps in need but are not adequately "deserving." The distinction, while not articulated in law, represents a fact of the culture and an aspect of context for provision of public sector services to those in need. On the surface (and this alone is significant), worthiness relates to receiving dollars or services at a cost to society, but the notion of worthiness is also linked to having a voice in the public discourse that determines what dollars or services are even available to those in need (Fraser, 1989, 1997; Phillips, 1993). The presence of voice can then be considered to be a political artifact of power, worthiness and privilege.

Focus groups as a method hold potential for enacting the "ideal speech" situation described by Habermas and which is consistent with the normative concerns related to public policy and publicly funded services expressed in various ways by Fraser, Forester, Frazer and Lacey, and Phillips. While early focus group research was conducted in the private sector and the military, academic researchers have recently begun to recognize the value of applying this method to program evaluation and clinical evaluation research. Basche (1987) is responsible for introduction of the focus group as a research tool in health education research, program planning and evaluation research. He framed the use of focus groups in Calder's theoretical model of inductive and deductive hypothesis testing and for purposes of exploratory, clinical and phenomenological research. As one reviews the importance of group interaction and moderator role, it becomes evident that, when carefully constructed, the focus group is a fitting method for exploiting the possibilities of Habermas' "ideal speech" circumstance to access multiple voices that might otherwise be stilled, hence the intersect of the focus group method of research with the social justice considerations that press for inclusion of stakeholder voice in the determination of need and the evaluation of public sector community mental health services.

Definition of Terms

The terms selected for definition reflect those that hold the most import in determining the meaning of this research and the context in which it is to be understood. These definitions are intended to be focused constructs rather than full elaborations of possible meaning. In some instances, the definitions used in this work may differ from everyday usage or be a restricted version of such.

Community

Community, as understood in the context for this research, is defined as a locality rather than on the basis of other criteria. This definition is consistent with that proposed by Peterson and Lupton (1996, p. 147). The use of geographic boundaries to distinguish one community from another fits with the reality of collective public funding for services and joins very different groups of individuals into a collective with a common focus. The recognition and convening of stakeholder groups in some ways reinforces formation of identity group agendas and perhaps politics. However, the use of a funding and geography based definition of community is important, as it allows for a common vantage from which beliefs about the public sector community mental heath care system can be voiced and understood across special interests.

Determination of Need

For the purposes of this dissertation, the determination of need refers specifically to the need for community mental health services. However, the concept of need determination is a socio-economic-political construct that attends to the process of how public sector services are established, funded and distributed. The process is one fraught with dynamics of power, authority and designated worthiness as well as specifically public voice. The determination of need for public sector services is made by those who have public voice and therefore have power to influence policy decisions. Most commonly, it is not all those who have a stake who have access to public voice; therefore, an elite few, frequently professionals and administrators, are engaged in the public discourse that is the precursor to need determination. In the context of the current work, it is proposed that the determination of need is best accomplished through inclusion of a multiplicity of stakeholder voices rather than the entitlement of only those historically participating in the public discourse. This understanding of determination of need is consistent with the work of Fraser (1989, 1997).

Focus Group

Focus groups can be defined as groups convened for the express reason of collecting data through the process of group interaction. Focus group research is usually considered exploratory research and the data is qualitative in nature. Usually focus groups consist of a moderator, an assistant, and 6-12 participants. Ideally, the groups are audio-taped and the tapes are transcribed for analysis of content. The participants in a focus group commonly have some characteristic or interest in common so as to facilitate meaningful discussion. The moderator introduces the topic for the focus group. The moderator is responsible for maintaining attention to this topic while at the same time encouraging participant interaction that provides for breadth and depth of data that would not be elicited by other, less interactive methods. Each focus group is considered to be a single informant source since the data obtained is reflective of the interaction and would not be likely obtained in the same form from any individual participant.

Focus groups were the method selected for this research both because of the potential for gathering information from stakeholders in an economical fashion and because of the fit with the "ideal speech" environment described by Habermas. In the situation of ideal speech, individuals are in a position to be free to speak in a public space without concern for censorship or retaliation. This circumstance can be considered as requisite for activation of the notions of social justice, public voice and recognition. In turn, these factors are linked with the reasonable and efficacious determination of need for public sector community mental health services.

Public Community Mental Health Policy

Public mental health policy is the product of legislative and administrative work to determine and prioritize need for public community mental health services, as well as the funding, implementation, and evaluation of such services.

Public Sector Community Mental Health Services

Mental health services are defined as services provided in the state of Washington, funded by public monies, to persons who meet state and local criteria for care. In general, these criteria are based on need as defined by psychiatric diagnosis, documentation of disability and income eligibility. The services differ to some extent by locality, but the intention is to provide community services necessary for maintaining the independence and stability of individuals who are deemed eligible.

Public Sector Community Mental Health System

For the context of this research, the public sector community mental health system refers to the Washington State funded Community Mental Health System. This is a publicly funded and managed system of determining need for, providing and evaluating public sector community mental health services.

Social Justice in Public Sector Community Mental Health Services

The notion of social justice is extremely broad, far too broad to be adequately considered here. However, aspects of social justice as applied to this work, the public sector community mental health system and the services thereby provided can be more reasonable managed. The frame for this conceptualization hinges on the work of Rawls (1971, 1993), Daniels (1996) and Fraser (1989, 1997), among others. In this context, public sector community mental health services are viewed as a social good; therefore, Rawls would require that principles governing the distribution of this good meet mandates of fairness and, in this regard, that the needs of those least well off are prioritized. Daniels follows in this tradition, but Fraser constructs a dynamic of justice that incorporates not only redistribution to meet need, but also factors of recognition.

The contention is that for social justice to be enacted in the public sector community mental health system and incorporated in the services provided by this system, there must be not only access to the resources, but also freedom from cultural domination, non-recognition and disrespect (Fraser, 1997, p. 13-14). This notion connects with the concern that stakeholders are given access to public voice. Public voice effects not only recognition, but provides opportunity for those who have authority to determine need for community mental health services to understand what the redistribution needs are from the standpoint of the stakeholders. Historically, this has not been the usual course of affairs. Routinely, those viewed as having professional expertise or who have had longstanding access to the public discourse have enjoyed recognition and had the power to influence the decisions made regarding redistribution of goods or services.

Stakeholder

Stakeholders are all the individuals or groups of individuals who are affected by or have vested interest in affecting the public sector community mental health care services planned and provided in a given community. For the purposes of this research, stakeholders have been assigned to one of four constructed categories. These categories are functional, intended to cluster together those expected to have similar interests or experiences related to public sector community mental health services in a given locale and to facilitate open participation in public discourse regarding these services. Stakeholder groups have been categorized as follows:

1. People who need public sector community mental health care services, their significant others and those who self define as advocates for persons suffering from mental illness.
2. Persons or organizations that provide public sector services other than mental health services to children in the community.
3. Persons or organizations that provide public sector health and social services to individuals in the community.
4. Persons or organizations that provide community justice services.

Stakeholder Voice

Stakeholder voice refers to the public expression of opinion and the ability to be heard in a manner that has the potential for influencing public decision-making. In the instance of this research, the public decision-making of focus is that of the public sector community mental health system. The reality of limited resources requires that service decisions attend to the most significant needs of the community in the most efficacious manner. This is a difficult undertaking and without full information about the needs of those who use the services it is less likely to be successful. Public opinion is a product of stakeholder voice that enhances the capacity of public sector community mental health policy makers to determine the need for services.

Citizen

Individuals who have full capability to participate in the public sphere. Citizens operate with full rights available in the society and also have obligations (responsibility and accountability) to contribute to society in a manner consistent with established expectations. These expectations generally include the payment of taxes to support public services. The citizenry is essentially the public, and as such the customer of public services. Those who are unable to meet the responsibilities required for true enactment of the citizen role are sometimes not considered in the equation of distribution of social goods. Commonly, those who are mentally ill, and as such unable to contribute fully to society or to financially support themselves without public funds, are disenfranchised from some aspects of citizenship.

Customer

In common usage, the term customer refers to an individual or entity that purchases a commodity or service. As such, it is problematic to use this word to refer to individuals who use public sector community mental health, since in general the services are not purchased by those receiving them. Therefore, unless used by a cited author or a focus group participant, the term customer in the context of this work is used in reference to the citizens and the community that provides funding for public sector community mental health services to the community.

Consumer

The historical context of the term consumer is more in keeping with the private sector than the public sector. A consumer is an individual who possesses rights as a citizen and who has the ability to choose services or goods to consume or purchase. In a private sector environment, the consumer holds both positive and negative rights, whereas in the public sector, those identified as consumers commonly do not possess these rights and do not have the ability to purchase the services they receive. Therefore, in an effort to prevent confusion and to promote clarity, this term will be avoided except as used by a cited author and as the politically correct label for the "consumer/advocate" focus group.

Professional

The term professional for the purposes of this work refers to those individuals or groups of individuals who have achieved training and education in an area of mental health care, health administration or evaluation, health education and research or public service. The expertise of the professional with regard to public sector community mental health care conveys an authority for enhanced ability to exercise voice and influence the development and implementation of mental health policy and services. Citizens who have professional expertise in a field unrelated to public sector community mental health services do not meet the operational definition of professional.

Summary

This research represents an attempt to explore the potential for focus groups to be used as a means for accessing the voice of the broad range of stakeholders in the public sector community mental health system. In the event that the results of focus group research can be considered to be valid indicators of public opinion rather than merely special interest opinion in this arena, focus groups represent an efficient and cost-effective method for advising those in policy making positions. As the public citizenry is the ultimate customer of the public sector community mental health system, it is salient for decision makers to understand what this same local public wants, expects and is willing to fund with regard to mental health care in a given community. The construction of this project to provide circumstances akin to the "ideal speech" situation described by Habermas also fosters an effort to make issues of social justice overt in the process of gathering data to inform the policy process.

Chapter II

Literature Review

Introduction

This review of the literature is directed toward domains key to understanding the use of focus groups to access stakeholder voice in public sector community mental health. These domains include: focus groups as a qualitative research method, historical impact of public policy on the public sector community mental health system, social justice as it applies to public sector community mental health services, public sector community mental health service evaluation, stakeholder voice and the determination of need for public sector community mental health services. The review is not exhaustive, but instead is intended to support the need for this research and to provide the context necessary for understanding its importance.

Focus Groups

> *"Reaching intelligent decisions about when to use focus groups requires that we go beyond the mythology that has guided too much of past practice. There are myths about both the advantages and disadvantages of focus groups. We have been too hasty in assuming that focus groups are appropriate for some purposes and too slow in applying them to other purposes…" (Morgan and Krueger, 1993, p. 4.)*

Focus groups are a form of group interview originally used in business marketing research, but which has been adapted for use in qualitative research for purposes of gathering exploratory data. In general, the setting for the focus group is a formal/preset environment, the interviewer assumes a directive role, the questions are structured and the purpose as noted above is usually exploratory in nature. Fontana and Frey have distinguished the focus group interview from brainstorming, nominal/delphi groups, field/natural group interviews and field/formal group interviews. The latter was described as having characteristics of a preset field setting, a somewhat directive interviewer role, a semi-structured question format and a phenomenological purpose (Frey and Fontana, 2000, p. 652). Evolution of the focus group as a means of gathering phenomenological data for qualitative research has in some ways required that the form of the focus group become a hybrid between the formal focus group and the field/formal group interview. This becomes a significant distinction because the flexibility of the less structured format permits greater understanding without a priori categorization that can limit the depth and breadth of the information gathered. As such, the focus groups used in social science research tend to be most useful when designed in a similar hybrid format.

Interestingly, Krueger has described the focus group as an invention of necessity born in the 1930's and developed by social scientists. The intention was to find a means for interviewing subjects that allowed for a shift of attention from the interviewer (replete with directive questions) to the respondent. Merton, Fiske, and Kendall published "The Focused Interview" in 1956 and in the intervening years the method has been adopted for a variety of purposes. Social program evaluators have become interested in the use of focus groups as there has been increased scrutiny of resource utilization and the impact programs have on service recipients. Focus groups have been considered to be an especially useful means for gathering information about the attitudes and perceptions of participants. During the focus group interaction, individuals are believed to influence each other in thinking and opinion, and when comfortable the dynamic is viewed as encouraging participants to divulge more about what they believe or feel than they might be inclined to do in a private and more structured interview (Krueger, 1994, p. 7-12).

The use of interaction to generate data was cited by Kitzinger and Barbour (1999) as the distinguishing characteristic of the focus group. Participants were encouraged to talk with one another rather than respond to the moderator in a direct manner. However, they also noted that hybridization of focus groups with other group interview methods was at times not only appropriate but perhaps necessary for a certain project or group of respondents. Waterton and Wynne (1999) have specifically considered the use of focus groups as an alternative to attitude polls as a way to understand community attitudes toward risks. They found that while focus groups tended to uncover more rich information about community views, opinion polls were inclined to reveal a “misleadingly simple and impoverished view…” (Waterton and Wynne, 1999, p. 127). In addition, they have speculated that the process of polling as opposed to that of the focus group limited the opportunity or capacity to consider the impact of contextual factors on the information provided in response to questions, and the data gathered was therefore a somewhat superficial construction that failed to attend to how the research circumstance affected the data obtained.

The application of focus groups as a research method for understanding the views of clients or consumers has not been not unproblematic. Cunningham-Burley, Kerr and Pavis (1999) have questioned the role of the social science researcher in the power relationships between funders, consumers and citizens, and expressed concern about the limitations imposed by the current constraints of market ideology. The potential for the research situation to be misrepresented to participants or for the researcher to wittingly or unwittingly be co-opted into supporting a particular policy agenda rather than to faithfully interpret and represent the voices of respondents is present and cannot be ignored if data is to be truly useful in the evaluation of social programs. These concerns cannot be attributed or limited to focus group or other qualitative research. In any evaluation, the researcher must consider the impact of the stories chosen to be told, of the conclusions that are drawn and the possibility for change to be enacted on the basis of recommendations (Greene, 2000, p. 990). The position of the research and the researcher in relationship to stakeholders of all levels and investment cannot be ignored. The aspect of focus groups that makes this somewhat more critical may be the impression held by participants that what they say will influence policy and that they are engaging in a participatory process wit the researcher. If this is the case, then the experience can be empowering as well as informative; but if the intent is to take only what information is sought and to ignore other stories, then the voice of the participants is not fully interpreted and the participation is partial at best. The ethical aspects of such a situation are many.

Historical Foundation for the Use of Focus Groups in Social Science Research

"Focus groups have become an important technique because they offer a way for researchers to listen to the plural voices of others. They are especially important for making audible the voices of oppressed people who are demanding to be heard..." (Madriz, 2000, p. 848.)

The first mention in the literature regarding focus groups was the group interview described by Bogardus in 1926, but there was little reference to this in the following decades (Basche, 1987; Dilorio, 1994). In 1941, the focused interview was again discovered when Lazerfield and Merton began to use it to evaluate audience response to radio programs. Merton later used the method in his work with the Research Branch of the United States Army Information and Education Division during World War II. In 1946, he co-authored an article describing the method, and in 1956 he co-authored a book on the topic (Merton, Fiske and Kendall, 1956; 1990; Merton and Kendall, 1946). The area of Merton's expertise was public opinion research and the influence of mass media. G. H. Smith (1954) contributed to the refinement of the method by defining the term group as it applies to the group interview. Smith's description clarified that group interviewing could only be accomplished when the group assembled was "small enough to permit genuine discussion among all its members." It is important to note that the early research using focus groups as a method was conducted in either the military or the private sector and the core intent was to market a product. It is only in recent years that academic researchers have recognized the value of the method and have begun to find applications for it in clinical and program evaluation research. It is more than coincidental that the increased academic interest in focus groups has occurred at the same time there has been greater application and refinement of qualitative research methodologies and methods.

In 1987, Basche contributed to the use of focus groups in health education research, program planning and formative or summative evaluation. He applied a theoretical framework adapted from Calder's philosophy of science perspective. This model highlighted the belief that "hypothesis testing occurs both inductively and deductively." It also describes the methodological profiles crafted by Calder to show the use of focus groups in exploratory, clinical and phenomenological research. Eight factors were considered in the matrix developed by Calder. These included: the primary use of the research approach, the simple generalizablility, the determination of sample size, the nature and extent of group interaction and interaction between the moderator and group members, the requirement of homogeneous group membership, the importance of the moderator's interviewing technique, the expertise required for the moderator, and the rationale for analysis and reporting results (Basche, 1987). This paradigm supports the notion that focus group research must be carefully planned and based in a theoretical framework or the results will be difficult to interpret and understand.

Stewart and Shamdasani (1990) made an effort to produce a guide to the conduct and application of focus groups and to place the use of the method in a theoretical context.

This required that group dynamics be seriously considered, that moderator effects be fully evaluated and that the use of content analysis be explicated as a common analysis tool applied to the textual data obtained through the use of focus groups. They considered the emic and etic nature of focus group data and acknowledged that even in the most natural of settings, there was researcher effect. Still, they encouraged that during the design phase the researcher consider whether the intent was to lean toward etic or emic data. One factor that influences this decision is the degree of knowledge that exists about the phenomenon being studied. As more is known, the research may become more etic; but in some instances it will be come increasingly clear with more knowledge that the underlying constructs are not completely understood. In the latter case, a more emic approach may be chosen. The flexible nature of the focus group allows the researcher to adapt the tool to the needs of the research design. The two uses defined by Stewart and Shamdasani were exploratory and confirmatory applications. The common uses they distilled from the literature included (Stewart and Shamdasani, 1990):

1. to obtain general background information;
2. to generate research hypotheses;
3. to stimulate new ideas and creative concepts;
4. to diagnose potential problems for a new program, service or product;
5. to generate impressions of products, programs, services, institutions or other objects of interest;
6. to learn how respondents talk about the phenomenon of interest to improve future research techniques; and

7. to interpret previously obtained quantitative results.

Krueger attributed the resurgence of interest in focus groups by social scientists to both the environmental need for program evaluation that takes the consumer view into account, and the recognition that all too often the assumptions on which quantitative research has been based are not warranted. In addition, the public sector service industry has begun to embrace the lessons learned by the private sector. This is clear in the preoccupation with the quality improvement techniques of program management and that marketing the product of an agency requires understanding the target population of customers. The historic use of focus groups for this purpose appears to make them a natural fit with the needs of those who are evaluating existing programs or developing new services (Krueger, 1994). Folch-Lyon and Trost have highlighted the reality that exclusive reliance on statistical information has been less than sufficient for managing successful public sector organizations. They have conceptualized qualitative research methods, including focus groups, to be in a relationship with quantitative methods as a "parallel source of distinct, rich, and pertinent information." In essence, they have supported the use of multiple methods as a means of controlling for the limitations inherent in all singular approaches (Folch-Lyon and Trost, 1981, p. 444).

Morgan has significantly contributed to the use and development of focus groups in social science research. In an edited volume, Morgan (1993) presented the work of multiple authors addressing a broad range of issues related to the use of focus groups.

Morgan and Krueger co-authored the first chapter, a description of the pitfalls, myths and advantages of using focus groups. They described potential uses of this method in exploratory research, as pretest research for larger scale survey or questionnaire studies, as a dimension of triangulation study and as a way to understand phenomena. Among the triangulation uses, they considered focus groups to be a valuable means for enhancing the rigor of one-on-one interpretative field interviews and ethnographic reports (Morgan and Krueger, 1993, p. 24).

Albrecht, Johnson, and Walther (1993) have reviewed the relationship of communication theory with the use of focus groups and in so doing have drawn attention to the fact that the group itself represents a communication event which must be considered to be somewhat unique in its features and outcome. As such, they offered the following four recommendations regarding the use of focus groups:

1. The role of the moderator must be given critical consideration, with particular emphasis on the selection, experience, communication competence, and style of the individual selected;
2. Consider the potential of the focus group for generation of quantitative as well as qualitative data (note that this is a point that many authors would challenge) (Folch-Lyon and Trost, 1981, p. 445);
3. Social desirability, low levels of trust, face-politeness needs, researcher bias and deception are some of the potential threats to the validity of focus group data that must be considered; and

4. Differences in group size and demographic composition (including status, ethnicity and gender) will have implications for the language choice, cultural way of speaking and the disclosure that occurs in the group (Albrecht et al., 1993).

Morgan used focus groups to learn more about the use of the method itself. He convened four focus groups of 15 members who were experts in the method and sequentially addressed four issues he deemed important to the future direction of focus group research. The issues were: 1) do more research on focus groups, 2) create more links to other disciplines, 3) develop focus groups for various purposes, and 4) work on technology issues. The groups led to a clarification of the need for methodological research in the use of focus groups, to develop standardized procedures and in general to respond to criticisms of the method. Participants expressed interest in increasing the interdisciplinary nature of focus group research to enrich the pool of contributors. However, they had reservations about bridging the interests and differences of those who have been trained in a positivist paradigm with those who are vested in qualitative research methodologies, as well as grappling with the ethical gap between those pursuing pure marketing research and those engaged in academic research. The purposes identified by expert informants as appropriate for focus group research included basic research, evaluation research, change-oriented research and policy research. Cross-cultural research was highlighted as an arena in which focus groups can be useful. These experts expressed concerns about ethical considerations – including the impact and power inherent in the relationship between the researcher and the researched. Technological advances were discussed in this forum with interest and skepticism. The effect of technology on researcher intimacy with the data or the potential for analysis shortcuts diminishing research results were among the concerns expressed. Simultaneously, there was recognition that word processing and text analysis programs opened possibilities for analysis of large data sets in a more efficacious manner than in the past (Morgan, 1993). These conclusions drawn from Morgan's focus group research tend to be consistent with the information found throughout the literature.

Focus Group Method and Mental Health Program Research

Richter and co-authors (1991) have described the use of focus groups as an affordable qualitative method that holds promise specifically for mental health program planning and evaluation research. They contracted with a regional medical center to conduct four focus groups exploring physical and mental health care needs or opportunities that were not addressed by the center. They solicited participants who were representative of the community members who used health services, and the groups were divided on the basis of age. The results were found to be helpful in providing direction for future services (Richter et al., 1991).

Schearer (1981) articulated the process through which focus groups can assist in the development of social action programs and Mitra proposed the focus group method as a means both for developing needs assessment instruments and obtaining community input into service planning (Mitra, 1994). Other authors, including Smith, have applied this method to gather information from customers to help guide service planning and better meet customer needs in a manner consistent with health care organization quality improvement processes. Specifically, Smith and co-researchers found focus groups to be a way for an organization to learn "to speak the patient's language." They demonstrated the use of focus groups for the purpose of interactive planning, concept testing, ongoing evaluation and to generally inform health care managers (Smith, J. A., et al., 1995). The potential for using focus groups in a wide range of qualitative methodologies including grounded theory, ethnography, phenomenology and critical social methodology, and focus group adaptability for construct and model generation, instrument evaluation and program or service evaluation form a strong basis for qualitative social science researchers finding them attractive (Gray-Vickrey, 1993, p. 21).

The literature references the use of focus groups as a way to learn about perceptions regarding the process of institutional placements; the effects of system change on consumers, families and providers; service coordination in mental health systems for children, youth and families; patterns of preference for mental health outcomes among consumers, families and providers; and a myriad of other specific inquiries. In some instances, studies have been conducted using focus groups as the sole method, and in others, focus groups represented one method in a triangulation study or were a means for gathering data intended to be used to develop questionnaire research in a given area or population.

Focus groups were used by Teague to determine items for a Q-sort methodology study to determine priorities and preferences for mental health outcomes among consumers, families and providers. Ultimately, comparisons were made across the three stakeholder groups and highlighted the possibility that patterns of preferences might be related to factors other than stakeholder group (Teague, 1995). Illback and Neill (1995) included focus groups with service coordinators and their supervisors along with a review of evaluative data and administrator experience to develop recommendations for child, youth and family mental health service coordination.

Focus groups were the chief method used in an effort to gather information from administrators, staff and youth residing with the child welfare, juvenile justice and child mental health systems to better understand the factors driving these placements from the point of view of the individuals involved in the process. The hope expressed by Mulvey and Pieffer (1993) was that such information would be helpful in developing regulations that make sense to the people involved in the system and provide useful information for strategic planning and development of effective policies related to child residential placement. The authors concluded that the information gathered was rich, but not necessarily generalizable. They did report a number of areas for further research, and acknowledged that the failure to convene groups of family members represented a shortcoming in this study.

In a study of the perceptions of mental health consumers, family members and providers with regard to the 1988 mental health reforms implemented in Vermont, researchers convened eleven focus groups of 94 individual participants. The rationale for use of focus groups was based in the desire to capture data about factors that affect individuals on a personal level and which is often missed by quantitative research, an interest in incorporating an empowerment model and the hope that qualitative data would guide development of a larger quantitative study of the policy. The results were presented to participants for comment and feedback was added to the analysis used to develop the subsequent quantitative evaluation of the targeted policy (Pulice et al., 1995).

Strickland explored the impact of culture on the use of focus groups and described strategies for use in cross-cultural focus group work. The potential for difficulties arising due to cultural norms and patterns of communication had not been adequately addressed prior to Strickland's study of data gathered in the course of fifteen focus groups with Native Americans from two Washington state American Indian tribes. In the original work, she used focus groups to expand on codes developed from interview data, validate interpretations, better understand hypotheses drawn from grounded theory and participant observation methods and to revise an instrument to make it more culturally appropriate. She then analyzed the focus group data and experience for factors considered dimensions of focus groups that required adjustment for cultural variation. Group goals, participant characteristics, length of each group, incentives for participation, physical environment and moderator role were specifically considered as dimensions of focus groups that needed to be adjusted for cultural variation. In tribal community research, it was further noted that it was essential to attend to community partnerships and collaboration (Strickland, 1999). In reality, there is a need for these dimensions to be considered in any focus group research, since culture cannot be assumed and each community has its own culture.

The importance of accessing and explicating stakeholder voice with regard to publicly funded community mental health services is consistent with the use of focus groups as a research method. For public mental health policy to be relevant to public need, it is critical that factors of social justice are not obfuscated and that those in policy making positions have an understanding of stakeholder needs and expectations. The focus group has potential as an efficacious method to create a circumstance in which those who have been traditionally excluded from the public discourse and policy process are given venue for voice in a manner similar to the "ideal speech" situation proposed by Habermas. Historically, the public sector community mental health care system has been directed by public policy decisions driven by external forces that have often lacked insight regarding the public mental health care needs of local communities. Understanding the history of the public sector community mental health system and the policies that have framed it is requisite for discerning alternative policies compatible with a social justice model.

Impact of Public Policy on the Public Sector Community Mental Health Care System

> *"For the historians of American mentally health, the crucial legacy of Reagan will not be the official policies towards the mentally ill, but the creation of an environment in which large-scale innovation for the socially disfavored is practically unthinkable...." (Marmor and Gill, 1989, p. 473-474.)*

The historical underpinnings of the public sector community mental health system date to the time of the American Revolution when states and local governments were given both authority and accountability for matters related to the health and welfare of the citizenry. It was the belief of the time that society had a moral and ethical obligation to provide for those who were "not capable of independent survival..." (Grob, 1994, p. 472). The 1820's and 1830's brought the asylum movement, when the insane and dangerous were housed in public psychiatric facilities funded by state and local municipalities. At first, the states assumed the cost of physical facility management and the local governments financed care. Problems arose and inconsistent patterns of care resulted. The states and localities each took steps to shift costs to the other. By the 1900's, the states were the principal funders of care for the insane. As this transition occurred, public dependents such as the elderly tended to be re-diagnosed, for economic reasons, as suffering from mental illness.

Prior to World War II, there was little public awareness that between 61% and 72% of those treated for mental illness were released from asylums in less than one year. Rather, the belief was that mentally ill individuals were warehoused in state hospitals and deprived of state-of-the-art therapies. The psychiatric disorders experienced by soldiers during and after World War II brought renewed attention to psychiatric treatment. The philosophy of this new psychiatry was grounded in a public health model of community care, and psychiatric care began to be viewed as a "personal right" similar to other health care (Grob, 1994, p. 480).

The National Mental Health Act of 1946 both created the National Institute of Mental Health and allocated federal dollars to research and demonstration projects, training and the establishment of community mental health clinics and treatment centers. This act has been cited as being the single most important force leading to the legitimization of psychiatric services in a community setting (Grob, 1994, p. 481).

Marmor and Gill (1989) have offered an analysis of the political and economic factors that were inseparable from the historical work of Grob. The movement of the mentally ill from institutional care to the community was accomplished without a concordant change in incentive to shift monies from the institution to the community. Funding structures were fragmented and not managed with the needs of the patient in mind. As a result, on the individual and the collective level, there was inadequate financing available for the services necessary to meet the proposed community mental health care agenda. Critique goes beyond mere funding issues, as the realities of need faced by patients discharged from the state psychiatric hospitals were not addressed; individuals and communities were left to either suffer or make do. The impact of such policies is now more accurately viewed, but the present reality has not escaped the historical inadequacy of funding and care.

Those advocating for funds to serve the severely and persistently mentally ill in the community are in constant and often direct competition with more favored constituencies for rare public dollars. Policy makers are pressed to stretch limited resources to meet a plethora of public needs. Designating public funds for community mental health services is balanced against directing the same funds to children's services, health care for the elderly or community safety. Even among those who vie directly for public sector community mental health dollars, there is a discrepancy of interests and a struggle to attain prioritization for each of the plurality of populations requiring public sector community mental health care. The constituencies might reflect those who require intensive case management services versus those who require infrequent medication management, and adults versus children and adolescents or any of a number of similar special interest groups (Mechanic, 1994, p. 502). In reality there is little agreement about which values and priorities "should apply" with regard to community mental health spending, and the funding remains both limited and fragmented. The population that relies on publicly funded community mental health care is not heterogeneous and the research related to mental health treatment modalities remains incomplete. In addition, it cannot be ignored that the mentally ill in need of public sector services are a marginalized constituency. Young (1990) has included the disabled (along with the racially marked underclass, the old, youth, and single mothers and their children) as marginalized and as such suffering loss of opportunity and citizenship rights, in addition to material deprivation.

Political Theory and Social Justice as Related to Public Sector Community Mental Health Services

> *"...Problems of mental illness pose a number of fundamental questions of social justice in response to which the American political system has always hedged. Is the receipt of health care, including mental health services, a right? Do mentally ill persons have a guarantee to adequate community care, including needed housing arrangements and social support? Is a two-tiered system of public and private mental health services acceptable public policy? Is it appropriate for mentally ill persons to receive care of widely disparate quality simply as a function of where they happen to live? ...These ever-unsettled intergovernmental questions reflect the special politics of a marginal and unempowered social group..." (Rochefort, 1999, p. 483.)*

Issues of social justice are integral to understanding the public sector community mental health system or the services. Those who suffer from mental illness are often relegated to status below that of full citizen because they possess a limited capability to meet the full obligation of citizenship. As such, rights claims of mentally ill individuals to equality of opportunity or pubic goods (let alone publicly funded services) are sometimes viewed as less legitimate than are the rights claims of others, for example, those retired after having earned a right to public goods. However, if the notion of equal opportunity and access to social goods is amended to include access to health care, as has been suggested by Daniels, it becomes more possible to consider the legitimacy of such rights claims. These issues are variously attended to by liberal, communitarian, distributive and civic republican frameworks. For each, the notion of rights for those who for whatever reason are unable to participate fully as citizens remains problematic. Some theories of political justice explicitly favor the needs of those most in need, yet these remain unprepared for those who are not fully vested citizens.

Even if such difficulties did not exist, equality of opportunity or even access to social goods does not necessitate that there is a clear right to choice of care or services. It is also not uncommon for questions to arise with regard to whether persons suffering from mental illness (or others who are unable to participate as full citizens) have access to the public sphere as actors with voice. A realistic representation of public sector community mental health services as they currently exist in the United States must acknowledge these difficulties. Decisions are made by public policy makers as to what services will be made available in designated situations in which eligibility criteria are met. This may reflect some semblance of equality when overall resources are defined, but it does not provide a means for determining why only some individuals have a voice in designing, implementing or even evaluating the services to which the resources are allocated.

The liberal framework for justice in the public sector community mental health care system sets the stage for considering voice as fundamental if equality of opportunity is to be embraced as a basic social good. It also forces reflection as to whom the rights to social goods apply and under what circumstances. The liberal approach to these issues has at its base an individual focus. Alternatively, the communitarian approach views the good of the individual as it affects the good of the community. In either framework it is possible to find support for the public to provide mental health services, but the scope or priority of these services would differ. The community neutrality of the liberal approach to justice is in conflict with the communitarian concern for the common good. However, both are inclined to view policies related to opportunity, wealth and common good as being justified only in terms of some conception of good; to consider citizens to be independent and responsible; and to support or provide for the opportunity for citizens to enter public discourse on social policies (Emanuel, 1996).

The communitarian concern for the common good and the liberal priority for individual freedoms and rights both focus on the citizenry, and this is problematic for populations such as those who suffer from severe mental illness, in that any guarantee of services (in this case mental health care) is made to the citizens. There is no guarantee of social goods or services to "individuals who are irreversibly prevented from being or becoming participating citizens..." because these are not basic rights (Emanuel, 1996, p. 13). In essence, even as liberal and communitarian philosophies begin to find common ground, the nature of citizenship and the rights associated with it continue to be at odds with equity for those who are disadvantaged or disabled.

Distributive justice has frequently been a liberal means for assessing the allocation of public sector services. However, distributive justice does not adequately provide a foundation for grappling with decisions about how to allocate resources for public community mental health care. This is in part because mental health is not amenable to being distributed. Also, the service of mental health care might be distributed in a liberal, individually focused manner, or in a communitarian (or civic republican) manner that attends to community good rather than individual good. Jennings distinguished between distributive justice and civic reconstruction in terms of liberal and civic republican traditions in the American political culture. The line he drew was that liberalism "…centers on the protection of individual rights and interests and on the pursuit of personal conceptions of the good…" while civic republicanism "…focuses on the problem of creating a self-governing community that makes possible the pursuit of a good in common that no individual member of the community can realize or appropriate alone…" Hence, health care (and mental health care) can be viewed as public rather than personal problems (Jennings, 1996). This seems important since in a liberal context that prioritizes individual freedoms; only the prevention of harm to others represents a legitimate rationale for coercing citizen conduct and forms one basis for the structuring of services as well as lack of services made available to those suffering from mental illness. This might be viewed from both the situation of the well citizen being free from coercion to fund such services and the position of the mentally ill individual who may choose to defer accessing such services.

Rawls, in his Theory of Justice as Fairness, developed ideas of obligation to the least well off in society and conceptualized the original position in which decisions are made without knowledge of how one might personally be affected by those decisions. To accomplish this, he relied on the notion of the veil of ignorance as a means for diminishing the potential for policy decisions to be made in a self-serving manner. He theorized that, given an equal opportunity for position in society, decision makers would be inclined to assure that those with the fewest resources and the least power are not diminished by token of policy decisions (Rawls, 1971).

Rawls has made a point of acknowledging the incomplete nature of his theory, and reflected that no moral theory can attend to every possible special circumstance (Rawls, 1996). In fact, there have been criticisms that Rawls' original position did not accommodate for someone who was unable to meet the obligations of citizenship, that everyone was well, and that the position seemed to be inherently entitled as a masculine position. He proposed an index of primary social goods that included five forms of social goods. These were defined in relation to the healthy citizen and included a set of basic liberties, freedom of movement and choice of occupation, powers and prerogatives of office, income and wealth, and social bases of self-respect. Daniels (1996a) has elaborated on this theory, noting that there must first be a guarantee of equality of opportunity in order to propose that health care be considered as an element of justice that is related to the guarantee of equality of opportunity. Even so, there is a question as to whether health care represents a special category of good to which there is a right, and if so to whom it applies and what it includes. If, indeed, the notion of equal opportunity and access to social goods includes health care and mental health care, then this would seem to indicate an entitlement to the care and services necessary to enhance (if not to assure) access to opportunity for those who require publicly funded mental health care services.

While Daniels has adopted many of the principles of Rawls' work, he has adapted or applied these to the realm of health care services and the allocation of scarce health care resources. Daniels endorsed Rawls commitment to the equal access to opportunity and social goods, and he did not object to the grounding of these ideas in a frame of basic liberties (Daniels, 1996a, p. xi). However, he has asserted that the veil of ignorance espoused by Rawls is problematic in that unless it is a "thin veil" it may obstruct a realistic context within which decisions about allocating scarce resources must be made. Also, as noted above, Rawls' theory failed to account for those who suffer from impaired health or mental health, and Daniels (1996a) in turn has proposed that health care services are considered as a social good. Callahan has gone further by stating a bias that "The first goal of a health care system should be the relief of suffering, and the greater the suffering the greater the claim upon the rest of us to respond" (Callahan, 1994, p. 463). He also acknowledged that there is a need for the exercise of judgment and that there may be factors that require the initial bias to be overcome.

Others have critiqued Rawls' Theory of Justice as Fairness from a feminist standpoint. Frazer and Lacey objected to the assumptions of the original position in that it inferred equality of bargaining power among the participating parties (1993, p. 66-67). Along with Fraser, they also remarked on the fact of an inherently masculine, empowered standing having been adopted as the original position by Rawls, hence rendering it unlikely for decisions or choices to be truly based in equity. In large measure, these criticisms related to the liberal grounding implicit in Rawls' Theory of Justice as Fairness. They noted that liberal philosophy diverges with regard to emphasizing "the state's positive role for good (in the theory and practice of welfare liberalism) and...the emphasis on individual freedom and suspicion of state power..." (Frazer and Lacey, 1993, p. 47). They alleged that just as Rawls did not attend to the special needs of those who are disabled and thus unable to fully assume the role of citizen, the social theories in which liberal and communitarian politics are often based were not adequate when applied to individuals or groups who are not fully endowed as citizens (Frazer and Lacey, 1993, p. 213).

Stakeholder Voice and Need Determination

> *"...It is not possible to insulate special discursive arenas from the effects of societal inequality; and that where societal inequality persists, deliberative processes in public spheres will tend to operate to the advantage of dominant groups and to the disadvantage of subordinates..." (Fraser, 1997, p. 81.)*

Determination of need in public sector community mental health is an area in which the historical underpinnings, issues of rights, obligations, social justice and voice play a significant role. Fraser (1989) has been eloquent in laying grounds for understanding the ways in which some are afforded greater privilege than others on the basis of expertise, and the reality that some needs are then ascribed to be worthier than others. She described these differences as hinging on the individual's ability to assume the full role of citizen. In essence, individuals or groups of individuals capable of fully participating as citizens tend to be categorized as having needs that are deserving of public support; while those who are less capable of completely participating as citizens tend to become the subject of welfare services and are deemed less rightly deserving of dedicated public resources.

Those who are construed to be worthy commonly have greater access to public voice than do those construed to be defective or otherwise less worthy recipients of public support. Therefore, those who may be best aware of societal needs related to community mental health are commonly not given a venue for engaging in meaningful discourse with the privileged actors. They are in effect silenced in the public forum at the same moment in which they are given descriptive titles, such as "consumer," that serve to obfuscate this reality. In this way, Fraser's concerns about the importance of recognition as well as redistribution take on importance (Fraser, 1997).

Interestingly, while the less deserving recipients of services (in this case community mental health care as well as supportive income and housing) are prevented from participating with an active voice in the discourse driving these very services; the citizens at large are also given little access to the decision-making arena. Although the legislative representatives of the citizenry allocate funds and set policy direction, the professionals and administrators are routinely given authority to develop the policy that determines need and designs services. When citizens are afforded the opportunity for direct participation in community or system decision and policy making, there is commonly a self-selection process that occurs. It is important to question whether the activist individuals who are public participants are also representative of those who do not participate. This concern reflects the compelling liberal rationale for representative democracy rather than a more direct participatory democracy; voting is commonly regarded as the only truly egalitarian form of political participation because the effort and cost of engaging in the process is not such that it excludes those who lack the resources necessary to participate at a more involved, active level (Phillips, 1993, p. 15). While the potential for a politically active elite to exercise more power in decision making than the remaining populace must be acknowledged, such concerns must be balanced by awareness that failure to provide a forum and opportunity for stakeholders to exercise voice merely reifies an alternative elitism in which constituency groups are excluded and those in policy making roles have the venue to make decisions that affect the populace. Fraser's work elucidated the ways in which needs determination and interpretation for social welfare issues and constituencies occurs in an institutional dynamic that commonly excludes input from those who have needs because there are assumptions that the "definition of the need in question is self-evident and beyond dispute" (Fraser, 1989, p. 145).

The fact of constituencies led Daniels to recognize that when "...fundamental interests (such as health or mental health care) are at stake, we at least should seek to base our decisions on reasons that all 'free and equal' citizens can accept..." (Daniels, 1996b, p. 11). He endorsed a deliberative democratic process for "...making decisions about how to protect the normal functioning for a defined population under budget constraints...."

(Daniels, 1996b, p. 11). He suggested a social conversation about the goals of medicine. Certainly, this might be defined to include public sector community mental health services and such a conversation would seem to be in keeping with Habermas' ideal speech circumstance. Again, at issue might be the designation of who would have access to this discourse.

Habermas' theory of communicative action has been frequently referred to when the issue of access to public discourse has been under consideration. Specifically, his emphasis on the ideal speech situation has relevance as the issue of stakeholder voice is addressed. However, not unlike Rawls, Habermas has come under scrutiny and criticism by feminist theorists who objected to the inherent masculine premise for the assumptions on which he based the ideal speech situation. Yet, even so, Fraser has recognized that his ideal of the public sphere is "indispensable to critical social theory and to democratic political practice" (Fraser, 1997, p. 71). She further defined this public sphere as a place where public opinion, the rational consensus of the common good, could be formed "through unrestricted rational discussion of public matters" (Fraser, 1997, p. 72). Still, she found it impossible to accept the bracketing of such differences in social equality as this denial permits the ongoing scenario for practice as if these do not exist. It follows that to construct a single public opinion or pretend to a single public constituency is to deny the voice and participation of the plurality of publics. The strength of the plurality of public opinions remains in dispute, however, since without a venue for influencing decision making, there is little practical force.

Others such as Rasmussen focused instead on the intentions for allowing access to public discourse. Rasmussen has noted that symmetry and reciprocity were essential for rationally motivated consensus generated by discourse. "The symmetry is associated with an equal chance both to initiate communication and to make assertions, while the reciprocity refers to an equal opportunity to make wishes and feelings known, and to provide an assurance that the chances will be equally distributed..." (Rasmussen, 1990, p. 64). Habermas' model provides for the analysis of communicative distortions derived in relation to power, ideology and organization while the "argumentative style" of Weber does not attend to the factors of wealth, power or status and how these factors affect an individual's capacity for participation in an equal and free manner. Therefore, Habermas' perspective provided a functional frame for accessing the voices of both the entitled and the marginalized stakeholders.

Community Mental Health Services Evaluation

"Social program evaluation is a field of applied social inquiry uniquely distinguished by the explicit value dimensions of its knowledge claims, by the overt political character of its contexts, and by the inevitable pluralism and polyvocality of its actors..." (Greene, 2000, p. 981.)

The issue of who evaluates public sector community mental health services, and who pays for these evaluations must be made explicit if there is to be a clear understanding of any data obtained or conclusions reached. The vantage point of those who write for publication in the traditional community mental health literature is likely to represent the academic, professional or administrative view. There have been efforts to seek input from service recipients and to connect with family members, but evaluations described in the literature remain largely reflective of those who are insiders of the public sector community mental health system. A cursory review of the 1999 issues of the American Journal of Psychiatry failed to identify any articles written from a perspective apart from the psychiatric and mental health professions. This does not mean that there is no effort within these professions to understand other viewpoints, but that in practice the content of the psychiatric professional literature remains parochial to the profession.

The following studies are cited as representative of the literature, but are not to be construed to synthesize all that has been written with regard to community mental health evaluation. It is important to distinguish between studies and articles that acknowledge the necessity of seeking input from the community or the citizenry in some manner as opposed to those that are constraining the feedback regarding programs to those who are somehow a part of the system. In general, the latter are far more common, but of more limited use for policy development.

It is not uncommon for articles to be written by mental health professionals, administrators or academicians about others who are not directly consulted. For example, in one study of service needs, receipt and outcomes for clients with mental illness, the data were derived from clinicians rather than individuals receiving the services (Bartsch et al., 1995, p. 388-402). Among studies conducted to better understand perceived effects of a system change was one consisting of a series of 11 focus groups with consumers, family members and providers (Pulice et al., 1994, p. 575-579). Another study used focus groups to gather information about perceptions from administrators, staff and youth (Mulvey and Pieffer, 1993). There have been a few studies that identify more diverse groups of stakeholders or constituencies. Fried and Worthington surveyed psychiatric unit staff, directors and hospital administrators in 1995, and still they concluded there was a need to recognize the number of constituency groups that had been omitted from the assessment (Fried and Worthington, 1995, p. 11-24).

Certainly, some studies attempt to identify the stakeholders or constituencies who may not all be insiders of the mental health program or service under evaluation. Thomas and Palfrey (1996, p. 125-142) constructed five stakeholder groups in an effort to learn what evaluation criteria stakeholders considered important. The groups they defined were "those who pay," the "intended beneficiaries" of services, "professionals," "managers" and "politicians." Similarly, Papineau and Kiely (1996, p. 79-92) designed a participatory evaluation of a community organization. They included staff members, program funders, community agencies and institutions, service users and students as key informants. Individual interviews and participant observation were used in the "context of a formative evaluation within a grass-roots community economic development organization" (Papineau and Kiely, 1996, p. 79). Studies such as these widen the lens of program evaluation beyond the myopic vision routine in the evaluation of public services. They begin to acknowledge constituencies with a vested stake who are commonly not afforded avenues for explicit voice or engagement with the public service system.

Summary

Understanding stakeholder voice in the public sector community mental health care system is a multi-faceted process. The history of the mental health care system in the United States must be considered as a backdrop, but the issue of the public nature of the care and the related political aspects are necessary components of the equation. Review of liberal and communitarian philosophies and the creation of the citizen identity structure a vision of the public community mental health system that is very different from that ordinarily constructed. These fundamental issues set the stage for understanding the necessity of including a broad spectrum of stakeholders in any effort to evaluate the quality, acceptability or effectiveness of any publicly funded community mental health service or system. It also becomes apparent that not all stakeholders have the opportunity to exercise voice in this or any other public system. Finding ways to enhance stakeholder access to public discourse while attending to concerns about interest group politics and emphasizing the good of the community is a task that fits with the use of focus groups as a method embedded in a qualitative methodology grounded in social justice theory that addresses the politics of need determination.

Chapter III

Methods

Introduction

This study was a secondary analysis of data obtained in the course of a Washington State funded project to evaluate the impact of regulatory change on the quality of public sector community mental health services. The original data collection was conducted with awareness that a secondary analysis might be performed. The processes described for the focus groups reflect the method as designed and used for the original research. The purpose and specific aims of the secondary analysis were as follows.

Purpose

The general purpose of this study was to explore the potential for using focus groups as a method for gathering information from the public stakeholders in the community mental health service delivery system. As such, the voices of stakeholder constituencies from whom information is not commonly solicited were given venue and the use of focus groups was analyzed as a method for accomplishing this. Consideration of stakeholder voice permits those who are responsible for determining and implementing public policy to do so in a manner that attends to issues of community need and social justice.

The Specific Aims are:

1. To explore the potential for focus groups to be used as a means for accessing the voice of stakeholders in the public sector community mental health system.
2. To compare like and unlike constituency focus group data to determine whether the information obtained by means of focus group research can be used as a valid indicator of public opinion with regard to public sector community mental health services.
3. To describe data obtained through the use of focus groups and in so doing to illustrate that facilitating the public voice of stakeholders enhances the potential for public mental health policy to respond to a determination of need that is reflective of and in context with the characteristics and priorities of the community and service users.

Use of Focus Groups to Access Stakeholder Voice

> ***"…the work of social program evaluators is steered by the interests of selected members of the setting being evaluated. (Interests here are value-based claims on resources.) In all evaluation contexts there are multiple, often competing, potential audiences for evaluation – groups and individuals who have vested interests in the programs being evaluated, called stakeholders in evaluation jargon. These range from the powerful to the powerless, from policy makers and funders…and program staff members…to advocates…and to the citizenry at large." (Greene, 2000, p. 982.)***

The process of accessing stakeholder voice required first that there be some understanding of who stakeholders in a given environment and circumstance were, and then finding a means of effective inquiry. The requisite method needed to be flexible in order to manage a breadth of possibilities and to allow evolution of the inquiry process to encourage understanding. The interactive process integral to the focus group was key as a consideration for selection as the method for this purpose.

In the course of the focus group, participants respond to points made by other group members, and the group determines the direction and level of response to a given question or comment. The moderator is responsible for seeing that the group stays on topic and that all topical areas are addressed during the allotted time. The synergism of thought and expression that occurs in focus groups enriches the breadth of the data collected. Depth of individual participant information may be less than that achieved by multiple individual interviews; however, the opportunity for multiple views, member checking and on-the-spot corroboration or disagreement allows for development of inter-subjective meanings and a plurality of opinion on issues participants consider important. The extent of participant engagement in the focus group is to a great degree influenced by their emotional stake in the topic; however, spontaneity of discussion can be affected by moderator experience and style. The focus group discourse can be viewed as having characteristics of both a meeting and a conversation (Kidd and Parshall, 2000, p. 294).

The focus group serves not only as a vehicle for the gathering of data, but potentially as a means of consciousness raising and information sharing among participants. The focus groups analyzed in this project were representative of constituencies related to public sector community mental health services and were located in discrete communities. Thus, in fact, participants experienced not only an opportunity for exercising voice with regard to these services, but had an opportunity for coalition building and networking as a result of group participation. However, it is important to be clear that the focus groups were convened for the purpose of obtaining stakeholder opinion data for the Washington State Mental Health Division.

King and Appleton (1999) have stressed the need for health services evaluation to offer equal voice to consumers and professional stakeholders. The ethical and legal mandate for assessing quality of services in the practice disciplines has been one factor driving the need for evaluation research. The dynamics of power and influence need to be understood in the process of gathering stakeholder views, and health services evaluation must be framed in a methodology that permits the researcher to do so. In general they support the use of a constructivist research model consistent with an interpretist philosophy. Guba and Lincoln (1989) have termed this "fourth generation evaluation," in which the researcher focuses on the concerns and issues stakeholder participants consider important. The relativist standpoint accommodates multiple truths and realities, and as such supports the need for inclusion of diverse stakeholder perspectives in the evaluation process (King and Appleton, 1999, p. 704). The focus group method was identified as one of the qualitative methods along with in-depth interviews, participant observation and documentary evidence (King and Appleton, 1999, p. 707).

Morgan and Krueger have contended that the "basic goal in conducting focus groups is to hear from the participants about the topics of interest to the researcher" (Morgan and Krueger, 1993, p. 11). However, for the method to be effective, there is a necessity to select topics that lend themselves to group discussion, to configure groups with adequate homogeneity to encourage discussion and to provide a good match between researcher and participant interest (Morgan and Krueger, 1993, p. 13). When crafted with these considerations in mind, "the interactions in focus groups provide a clear view of how others think and talk, they are a powerful means of exposing professionals to the reality of the customer, student, or client" (Morgan and Krueger, 1993, p. 16).

In particular, focus groups may be helpful in "determining the reaction and perception of an affected population to a policy change" (Frey and Fontana, 1993, p. 21). Frey and Fontana (1993, p. 23-24) have described focus groups as effective data gathering mechanisms for exploratory, pretest, triangulation or phenomenological research. In triangulation studies, this method adds the "human element of the voices of multiple subjects." The technique also lends rigor through the group process, the cross-referencing and the elaboration of multiple opinions. Phenomenological use of focus groups has been described as a means to gain validation, and of "bring(ing) the researcher closer to the truth." The group process encourages inter-subjectivity, and it allows the researcher to experience a semblance of the participants' reality through the interaction. The focus group interview also permits there to be a means of controlling for the authority and influence of the researcher (through the use of environment and moderator style), thereby reducing the subjectivity of the accounts and the bias in reporting through the "polyphonic" nature of the technique (Frey and Fontana, 1993, p. 23-26).

The design of an environment and protocol in keeping with the ideal speech circumstances described by Habermas represents an innovative use of focus groups and supports a research program concerned with evaluation in a normative framework. Focus groups as a data collection method are easily adapted for linkage with moral theoretical underpinnings. Justice is at issue due to the context of evaluating publicly funded services to a population that is historically both stigmatized and disenfranchised, but it also has relevance for the process of research, the position and power differential inherent in the research and the act of preparing a manuscript. Autonomy and justice, beneficence and maleficence cannot be disengaged from consideration of the use or outcome of a social sciences research project (Miles and Huberman, 1994, p. 288-97). The concern with situating the focus group as a method useful for normative inquiry reflects the explication of issues of power and value. The researcher has the responsibility for creating a space in which participants are comfortable speaking freely with regard to the specific topic, and in which no one individual or stand is privileged in opportunity or implied safety with regard to exercising authority to speak (Allen et al., 1986, p. 33). This environment enhances the potential for eliciting stakeholder participant opinion. To foster such a circumstance, those who plan focus groups must consciously grapple with factors of group size, process of recruitment, constituency (of individual and collective groups), language, question selection and framing, and moderator style.

Focus Group Research as a Valid Indicator of Public Opinion

"Focus groups offer a practical way of eliciting such complex talk, and in analyzing the conversation we acknowledge the situatedness of opinion, and recover some of the richness and complexity with which people express, explore and use opinions." (Myers and Macnaghten, 1999, p. 174.)

Cunningham-Burley et al. purported that there is not an uncontaminated version of public opinion since all publics exist in relationship to an arena of policy, and social or health science research is "not a disinterested vector of knowledge, but itself positional" (1999, p. 198). Focus groups must be situated along with all other methods of social inquiry and as such require critical consideration as opposed to acceptance simply because the interpreted data is expressed as being the words of the participants. It is not the sole territory of the focus group, or for that matter qualitative research, to require some degree of skepticism. Without critical assessment, any measure or report of public opinion can be used as data to "manage public disquiet" (Cunningham-Burley et al., 1999, p. 198-9).

Context is important when the use of focus groups is weighed against the use of traditional opinion polls as a means for accessing community or stakeholder views. Surveys and polls intrinsically lack venue for participants to struggle with contextual issues that affect responses. In addition, there have been claims made by Billig (1987) that individuals tend to best express views through argumentation, an opportunity inherently lacking in an individual polling situation, but present as characteristic of the focus group interaction. Waterton and Wynne have described the use of focus groups in contrast with opinion polls to ascertain community views regarding nuclear risk. They reported that opinion poll data tends to construct "a misleadingly simple and impoverished view of locals' feelings…" (1999, p. 127). In contrast, data generated through the use of focus groups accommodates the social dimensions necessary for negotiating beliefs and narrative in an iterative manner that may achieve a more credible view of community or stakeholder opinion. The personal interaction inherent in the focus group coupled with the direct relationship between participants and the researcher/moderator is quite powerful. Participants have the opportunity to ask questions about the research and receive answers in a manner that allows for trust of the research intent to develop. This aspect of the focus group improves the potential that respondents will participate in a manner that is less guarded and more thoughtful than would be likely to occur in less personal forms of inquiry such as surveys and opinion polls (Morgan and Krueger, 1993, p. 16-18).

Focus Groups as Means for Enhancing Policy Response to Community Need

> *"To practice evaluation practically means to shift radically from a methodological to a political-ethical frame, and to be less concerned about perfecting and warranting our knowledge claims (Schwandt, 1996) and more concerned about helping practitioners to deliberate well and to develop their own wise practice." (Greene, 2000, p. 987.)*

The involvement of health care users and the general public citizenry in health care decision making has been increasingly expected since the 1980's. There has been debate about whether such inclusion relates to the taxpayers and citizens as well as those who actively use services. Rationale for inclusion of the broad public has been based in the realities that all citizens are potential service users, the services do in fact impact the community at large and inclusion of the public enhances public accountability and support for services in a given community. However, the manner in which this involvement is to be achieved has been described as "a bewildering array" of quantitative and qualitative research methods including "focus groups, patients' advocates and representatives, patient participation groups, health forums, stakeholder conferences, rapid appraisal, [and] citizens' juries…" (McIver and Brocklehurst, 1999, p. 48). Focus groups were the qualitative method noted by McIver and Brocklehurst to be most commonly used for gathering information about public views. However, they warned that an inexperienced moderator or researcher can greatly diminish the value of focus group data (p. 50).

Social program evaluation is fraught with the intrusion of political agendas and investment. The responsibility of the researcher is divided amongst multiple audiences and constituencies, each with a stake in the services, and the outcome of the evaluation project can be ignored, but stakeholder groups cannot be escaped. Greene suggested that balance can be attained through inclusiveness and pluralism that encourages and ensures all stakeholder voices are engaged in the public dialogue (Greene, 2000, p. 995). Focus groups represent one method that is suited to such participation if so constructed. However, Peck and Secker have expressed the opinion that the impact of qualitative research for assessing effectiveness of health services has been somewhat negligible in spite of the richness of the information obtained. They suggested that with enhanced and clarified criteria for evaluating the quality and integrity of qualitative research, this circumstance may be changed such that qualitative data will be viewed more credibly as a basis for health care decision making (Peck and Secker, 1999, p. 552). Furthermore, they raised pragmatic questions about the possibility of abbreviating the process of qualitative research to permit research results to be more timely and accessible to those needing information on which to base health policy decisions.

Cunningham-Burley et al. have addressed the issues related to the client being transformed into the consumer and the citizen rights translated to consumer rights. This trend has been problematic in that it erodes social benefit entitlement at the same time that it emphasizes the attention paid to consumer views or health service user needs. They characterized the situation as one in which the consumer is framed as having power, while being manipulated by those with expertise or authority and simultaneously left with only insignificant ability to effect change of importance (1999, p. 187-9). It is crucial both for reasons of social justice and credibility of research that focus groups and any research intended to gather data based in public opinion or stakeholder voice be mindful of potential pitfalls.

Selection of Focus Groups

The focus group population of interest was selected to meet the needs of the original research project. It consisted of stakeholders in the public sector community mental health system. Specifically, persons who had knowledge of and a vested interest in the public sector community mental health system, but who were not traditionally included in mental health service evaluations. The use of focus groups was considered to be a means for gathering information about values, priorities and the criteria by which these stakeholders evaluate the success or failing of the public sector community mental health services available in their community.

Social and political context could not but influence the views of focus group participants. However, contextual factors were acknowledged as unstable variables intrinsic to all community-based research whether acknowledged or not. Contextual information when included as an aspect of the data was understood to both enrich and situate the research. Rather than control for such events, this research recognized that each focus group was an experiential unit replete with individual characteristics that would not likely be perfectly replicated, as no single in-depth interview can be fully reproducible. The strength of the use of multiple focus groups with similar and different constituencies in different geographic sites was that comparisons could be made of similarities and differences in themes expressed across categories of groups. Multiple focus groups with like and different stakeholder constituencies allowed for an interpretation of stakeholder views collectively and categorically, and also provided an opportunity for the focus group to be assessed as a method for gathering such data. Kidd and Parshall have stated that content validity is supported when consistent viewpoints are uncovered in a set of multiple focus groups, and that when the groups differ geographically the strength of the validity is greater (2000, p. 303).

Selection of Geographic Sites

Geographic location was one of the decisions that needed to be made when planning this focus group research. The benefit of using multiple sites has been purported as helpful for ascertaining content validity. Fortunately, the original research project required focus groups to be convened in multiple geographic locations. Three geographical sites within the state of Washington were representative of State-designated Regional Support Networks (RSN) for the provision of public sector community mental health care to local residents meeting established eligibility criteria. Two of the RSNs had volunteered to participate in a State-sponsored pilot project to evaluate the impact of mental health regulatory change. The third RSN was selected by convenience since many of the quantitative study outcomes were in routine use. That RSN not only agreed to provide such data for comparison, but also allowed focus groups to be convened for comparison with the pilot site focus group data.

All three of the RSNs supported the inclusion of focus groups in the original study and assisted in the process of identifying means for participant recruitment. The geography of two if the RSNs made it possible to conduct focus groups in a single central location within each RSN. The other RSN encompassed a large land area with a population distributed in four distant and major locations. The latter RSN represented a challenge for focus group scheduling and recruitment. One interesting dimension of that RSN was a widely held perception that a local bridge represented a significant and almost insurmountable barrier to participation in almost any activity. As such, in the one RSN, a more complex set of focus groups was convened to attend to distance and population distribution. The locations of the RSNs represented two semi-rural sites in western Washington and one relatively urbanized RSN in the central part of the state.

Stakeholder Constituencies, Control and Break Characteristics for Focus Groups

One paradigm for differentiating stakeholder groups was developed by Guba and Lincoln and later elaborated by King and Appleton to distinguish agents, beneficiaries (including disadvantaged stakeholders), indirect beneficiaries (including a range of support organizations for the health services and the research process), victims (those disadvantaged by the research or excluded on the basis of characteristics or disabilities), the invulnerable stakeholders and the temporarily immune (who in the future may need services and either become beneficiaries or victims at that time) (King and Appleton, 1999, p. 706). This clearly articulated a discrepancy of power and autonomy among stakeholder groups, and the groups selected for the original study were in many ways consistent with these categories. The stakeholder constituencies constructed for the original research could be fit into these categories. However, those in the position of agent were specifically not invited to participate, as these individuals and groups were construed to have other venues for having active voice regarding the public sector community mental health system and the services thereby provided.

Control characteristics were defined as characteristics common to members in a set of focus groups. In this research, the primary control characteristic was identification as a stakeholder in the public sector community mental health care delivery system for one of three RSNs in Washington state. Secondary control characteristics required that participants were adult and competent in the English language.

Break characteristics were based in role relationships with the public sector community mental health care system. Role relationship was defined as the role enactment by which the individual respondent was knowledgeable about this system, the manner in which it functions and the related success or limitation of services delivered (Knoedel, 1993, p. 39). Within the defined geographic regions, a number of competing characteristics vied for designation as a break characteristic for which a category of group would be convened. The four break characteristics ultimately chosen represented a compromise based on the realities of project resources and the relatively small population pool from which participants were drawn.

Thus, in addition to geographic considerations, break characteristics were used as a means of creating focus groups that were somewhat homogenous in composition. Homogeneity promoted productive interaction among and between group members, who then had a common frame of reference. It was important to avoid creating, by token of group membership, an environment in which heated argument or lack of discussion would occur. Homogeneity was one means of controlling for those unwanted occurrences. It minimized the potential for extreme power or agenda differentials within a single group.

Gender, race, ethnicity, physical challenges or disabilities, and socioeconomic class were each considered as potential break characteristics. These factors were not selected, as they were not the central concern of this project; project resources and logistics required that break characteristics be limited to the extent possible. Gender representation was varied in each group. Ethnicity and race were less varied. In part this was because the population base was primarily Caucasian. Efforts were made to recruit participants from local Native American reservations, but response was less than hoped for. The majority of participants in all focus groups included in this project were Caucasian and spoke English as a primary language. Efforts were made to solicit participation from under-represented sub-populations, but met with minimal success. Sign language interpreters facilitated the successful participation of one individual with hearing impairment.

Individuals receiving public mental health care, those in need of such care but not receiving it and advocates or family members were combined into one group constituency. The first of these groups served as a pilot for whether the configuration was workable, whether it silenced some participants or allowed equity in participation. In general, group members indicated that they found this group consolidation acceptable. However, the last such group was an exception and exemplified concerns about combining two constituencies in one group for the sake of convenience and efficiency.

The remaining individuals recruited for participation in focus groups were selected because of a primary association with the justice system (inclusive of corrections officers, police, sheriff department employees and jail employees), the children's service system (inclusive of teachers, school counselors, Child and Family Service workers and juvenile justice workers), or the public health and social service systems (inclusive of community health care providers, shelter workers and drug and alcohol workers). In addition, only those who engaged in regular interactions with the public sector mental health care system on behalf of, or relative to, those needing or receiving public sector community mental health care services were invited to participate. Primary association formed the basis for the focus group category to which participants were invited. The four categories of constituencies were:

- "consumers and advocates,"
- justice system workers,
- children's service workers, and
- health or social service workers.

Geography and participant time constraints resulted in the compromise of group composition. The residents of one community refused to drive to the regional focus group to which they were recruited. These individuals pressed for a local group that was representative of the full (four-category) constituency base. In the interest of including the full set of regional stakeholder voices, a multi-constituent group was convened in this one community. During the follow-up phase of the original study, another outlying community made the same request and this was honored. In addition, participants were given the opportunity to attend an alternative group with similar constituency in the event that an individual's schedule did not permit attending the group to which the invitation was made.

Human Subjects Review

An expedited review was requested of the University of Washington Human Subjects Review Committee, as this study represents secondary analysis of data previously collected by this researcher. Participant protection remained important, but as this secondary analysis required no additional contact with focus group participants, the potential for harm was minimal. The protection of the privacy of focus group participants remained significant; therefore, all focus group participants were unidentifiable in the transcript material and individual statements could not reliably be traced to specific individual participants. The lists of focus group participants were not accessed for this secondary analysis. Additional consents from participants were not obtained for the secondary analysis. However, because this researcher moderated the entire set of original focus groups, the confidentiality agreements formally made in the original project stood.

For reference, the overall triangulation study was approved by both the Washington State Human Subjects Review Board and the University of Washington Human Subjects Review Committee. The first process required a full application process and attendance at a meeting of the Review Board. The University process was less cumbersome since the project had already received approval at the State level. The duplicate reviews were required because the larger study necessitated inclusion of individuals receiving state-funded community mental health services. The university affiliation of the overall research team demanded that the University Human Subjects Review Committee also approve the research.

Human Subjects Review Committee concerns regarding the original focus group research included the potential for harm to participants, threats to participant confidentiality and whether appropriate safeguards were in place. Since individuals suffering from mental illness (considered to be a vulnerable population) were among the focus group subjects, the review committees very carefully evaluated assurances against harm. Commitment was made for confidentiality protection as is noted below. Also, it was planned that any individuals who experienced distress as a function of having participated in a focus group would be referred to an appropriate local service. The participants were given information regarding how to contact the focus group moderator should there be a need. The moderator was an experienced mental health practitioner and capable of triaging in the event that an individual required assistance subsequent to having participated in a focus group.

Confidentiality

The original study plan for maintaining participant confidentiality included the assurance that focus group participants would not be identified in any way and that contributions would not be attributed to any individual. Procedures for safeguarding audiotapes, transcripts, attendance rosters and recruitment lists included maintaining these in a locked file cabinet until completion of the original research. Volunteers on the project and transcriptionists were educated regarding the necessity of protecting the confidentiality of participant information. For the purpose of this secondary analysis, the transcripts were edited to assure removal of any remaining individual names. The audio-tapes and lists of participant names had been destroyed after completion of the original research project so were not available for this secondary analysis.

The small, sometimes close-knit nature of the cities in which these focus groups were convened made it difficult to assure confidentiality and to structure an environment in which participants felt safe in speaking their minds. It was deemed unlikely that participants would leave the group and maintain silence about the content or process. Therefore, participants were asked not to take information from the focus group for use in their work or personal lives without first asking the permission of the individual who contributed that information to the group. Participants indicated that they understood the rationale for this request, found it reasonable and agreed to be respectful of other group members.

Sample Selection and Recruitment

"It is important to reiterate that randomized sampling does not facilitate the collection of the viewpoints of marginalized stakeholders...For example, certainly in terms of consumer stakeholders, it is often those who are most articulate or who have the ability to access health services whose views will be represented. Difficulties also surround fears of repercussions about the outcome of the evaluation process, and stakeholders may not feel that they are able to be honest or to give a full account of their views." (King and Appleton, 1999, p. 708.)

MacDougall and Fudge (2000) have provided a comprehensive three-stage description of processes for sampling and recruitment of participants for focus groups or in-depth interviews in a real world situation fraught with expected and unanticipated problems and politics. They found that while there were a multitude of means for advertising opportunities for participation in focus groups or in-depth interviews, some means were more productive than others. For example, they cited use of public service announcements on local radio, poster displays, pamphlet distribution and advertisements as being less effective for locating appropriate participants. Instead, they found success greater when personal contact was made with prospective participants or with those who had access to community networks or organizations with which prospective participants might be associated. In part they conjectured this to be the case because

> "In areas such as community needs determination, it is often the people who do not have a formal lobbying voice that the researcher finds most difficult to reach, and yet their views are vital to the assessment. They do not readily approach the researcher in response to advertising, however well targeted that may be, and therefore the researcher must seek alternative pathways to them." (MacDougall and Fudge, 2000, p. 119.)

Distinctly different from the standard random selection techniques used in quantitative research, the methods for selecting qualitative research samples is more purposive with an aim toward selection of participants likely to provide rich data. The research sample also is more likely to evolve over the course of the project as greater understanding about important key informants occurs. The need to accommodate schedules of potential participants requires knowledge about routines common to stakeholder groups, informal and formal networks, and formal or informal gatekeepers who might facilitate or obstruct recruitment. The use of individual letters of invitation followed by telephone calls to confirm participation may be among the most successful recruitment strategies (MacDougall and Fudge, 2000, p. 120).

The secondary analysis that represents this research was performed on the complete set of transcripts from the focus group sample obtained for the original research project. Therefore, the sampling method developed for that study requires description to permit the current analysis to be understood in full context.

The process for sample selection for the original research was a combination of purposive, convenience and snowball methods. The constituency groups were defined prior to attempts to identify and locate potential participants. Resource manuals, telephone books and mailing lists from RSNs were used to gather information about local social or health service agencies, advocacy organizations, schools and justice organizations. RSN staff were interviewed by telephone, as were key individuals in community organizations, to further expand the list of individuals to be invited for each constituency category in each geographic region. During the first set of focus groups, participants were asked if they would like to receive further information about the focus group findings, and if they would like to be invited to a follow-up focus group the next year. Those who expressed interest in further participation provided their names and addresses. These lists were used as mailing lists for the second set of groups.

Once names of prospective participants were identified, letters of invitation were sent by mail or facsimile. An RSVP was requested within five working days of receiving the invitation. If no response was received, a follow-up reminder letter was sent. Invitations did not include the location of the focus group; this information was withheld until participation was confirmed. This process provided an element of predictability regarding the attendance for each group and prevented participant inconvenience in the event that circumstance demanded that a scheduled focus group be canceled or rescheduled. In fact, two groups were canceled due to severe weather conditions and it was useful to have a discrete list of participants to call and inform of the cancellation. When recruitment for a given focus group was either slow or inadequate in number of confirmations, personal telephone calls were made to encourage those invited to consider participating. This made it possible to clarify the purpose for convening the focus group and to respond to questions about what the expectations of participants would be.

Members of the local chapters of the Washington Advocates for the Mentally Ill (WAMI) assisted in recruiting participants for the consumer and advocate focus groups. Information about the focus groups was placed in local WAMI newsletters and taken by WAMI members to local mental health support group meetings for the purpose of recruiting participants. Announcements regarding the focus groups were also posted at local mental health centers.

Participant selection occurred at the recruitment phase. Every individual who expressed interest and ability in participating, and who was eligible for one of the constituency groups, was invited to attend a focus group. It must be noted that the single exclusion criterion was direct conflict of interest such as employment with one of the local public sector community mental health agencies or administrations. Thus, the size of groups varied. No limit was established on the number of participants in any group. More often than not, the groups were smaller than expected in spite of the request for an RSVP from recruited participants.

The only inducement to participate was desire for or interest in the opportunity to provide opinions or to state views about the local public sector community mental health system and the care available in the community. It was important that the State Division of Mental Health would be receiving the information obtained from the focus groups. No remuneration was offered or available to participants; however, consumers and advocates were reimbursed by the State for their transportation costs. Non-alcoholic beverages and cookies or pastries were provided as refreshments at each focus group

Focus Group Questions

A set of questions was drafted for the original evaluation study on the basis of experience in association with the public sector community mental health care system. These were then tailored to fit each constituency group. People who had familiarity with the public sector community mental health care system were asked to review the master list of questions. Comments on content and topic importance for each question resulted in minor changes in question phrasing in response to this review. The first two focus groups were pilots for the clarity and usefulness of the questions. The only area consistently addressed, in spite of not being a designated topic, was the issue of respectfulness. Therefore, a question regarding respectfulness was added to the question framework. The questions were as follows.

- Describe the relationship between (constituency) and the public community mental health system in your region. (Is there a mechanism, formal or informal, for the coordination of treatment and referrals?)

- Approximately what percentage of (constituency) time is spent with public sector psychiatric patients or obtaining services for them?

- What aspects of the public community mental health system most affect the work you do, the consumers you serve, yourself or your family?

- What do you perceive to be the strengths of the public community mental health system?

- What do you perceive to be the weaknesses of the public community mental health system?

- Describe the responsiveness of the public community mental health system in terms of time and the adequacy of the services provided.

- Does the public community mental health system respond better for some consumers than for others? Are there any consumer characteristics that predict this?

- What outcome measures would you recommend that might reflect the quality of services provided by the public community mental health system?

- Please comment on your perception of the respectfulness of the community mental health system and the services you access.

Consistent with recommendations for focus group moderation, questions were used as a discussion guide rather than discreet queries directed at individual participants. Questions were posed as open-ended comments inviting clarification or response. The rules articulated at the start of each group encouraged that participants interact with each other about the specified topic. Often, the group discussion covered questions out of order and without prompting. Other groups were less spontaneous or more inclined to ramble off topic. In the latter events, questions were more directly adhered to and used more clearly as a base for the discussion. Kidd and Parshall stressed the importance of using non-directive questions to attain spontaneous responses among participants; they further emphasized the significance of attending to both expected and unanticipated responses, including reactions to the focal situation itself (2000, p. 296).

Focus Group Setting

In selecting a site at which to convene a given focus group, considerations included convenience for invited participants, comfort of the surroundings, minimal environmental distractions and non-affiliation with the public sector community mental health care system. Facilities were found in much the same manner as were participants. Each region had traditional locations where meetings were held. These sites were the first choices for use. Facilities associated with local colleges, shopping malls, school systems, court jurisdictions, fire stations and local hospitals were used. The majority of these sites were available without cost, but two sites required a nominal fee for use. Only one group, organized by a member of WAMI, was held on site at a community mental health center. Participants were very clear that they were comfortable speaking freely at that site, and the mental health center staff were very careful to remain at a distance before, during and after the focus group. In another region, WAMI members regularly held their meetings at a local hospital, and they chose to designate a portion of their meeting time for use as a focus group rather than scheduling a second meeting in a given month. Therefore, that focus group occurred at the hospital, which was affiliated with one of the community mental health centers.

The rooms differed in degree of comfort, but were large enough for the groups. Chairs were reasonably comfortable. All but one room was equipped with a table that could be used to structure the seating of participants. The moderator arranged the rooms prior to the arrival of participants. Light refreshments were served to enhance participant comfort and to encourage participation in discussion.

Moderator Style

Moderator experience and style have been commonly cited as crucial for the success of focus groups. These focus groups were staffed with a moderator and a co-moderator. A single moderator conducted all of the groups to add an element of consistency across the groups. The co-moderator acted as a host to the focus group, managed organizational aspects such as attendance sheets and collection of consent forms as well as note taking and assuring that tape recording devices were functioning.

The moderator style used was one of low intervention. The role of the moderator was to guide the discussion and assure that all participants were afforded the opportunity to speak. This required active listening, clarification and reflective summation. Occasional intervention was necessary when the discussion veered off topic, the subject matter became too personally disclosing for the context of the group or a participant monopolized the group and prevented others from expressing their ideas. The moderator was responsible for pacing the group and reserved the authority to move the discussion on to the next topical area when the need arose. This was important since groups were limited in time and the goal was to address all question domains. The moderator was an experienced therapist familiar with the public sector community mental health system, and was situated as a non-expert who understood the language related to mental health services, but otherwise needed to have meanings made explicit. This moderator role protected against silencing participants by virtue of expertise, and encouraged that meanings were clearly articulated and described rather than alluded to through the use of jargon or mental health related terminology.

Focus Group Administrative Process

Participants were greeted as they arrived for focus groups. Refreshments were offered and they were assisted in finding a seat if help was indicated. Each table setting was provided with a name tag, a consent form for participation and a business card or a self-addressed envelope to allow a means for future feedback or to ask questions that might arise after the close of the group. The table also held two tape recorders (and for the second set of groups a conference microphone) used to audio-tape the focus group discussion. The co-moderator assumed responsibility for managing these aspects of the focus group process.

Prior to beginning each focus group, participants were asked to sign an attendance sheet. Participant addresses and telephone numbers were obtained for use in the event of a need to clarify transcript data, send group summaries to participants or to send invitations to follow-up groups. Participants were provided information regarding the purpose and format for the group, as well as an explanation regarding the audio-taping process. Consent forms were signed by participants and submitted to the co-moderator before the groups began.

Focus Group Data Collection Process

The data used for this secondary analysis was obtained by this researcher for the original evaluation project. The following describes the process used to collect the original data. Each group began with a statement of the purpose of the focus group and a description of the plan to evaluate the impact of regulatory waivers on the quality and efficiency of public community mental health services. Brief information was provided regarding the research project as a whole, as well as the role of the University of Washington and

Western State University Evaluation Team. The roles of the moderator and co-moderator were explained as introductions were made.

Only the initial question posed to participants required a direct individual response. Participants were asked to introduce themselves and to state their relationship to or interaction with the public sector community mental health system. Discussion evolved during the course of introductions. At times participants knew each other and at times they did not. The process varied with the configuration of the group.

The moderator was responsible for assuring that each topical area was addressed; however, the flow from topic to topic differed in different groups. Reflection and probing techniques were used to clarify participant comments. Participants were encouraged to talk with each other rather than to address the moderator. At the close of each group, a question was posed as to whether anything important had been missed by the questions, and the moderator provided a brief summation for the group. Participants were given the opportunity to provide closing comments, and were thanked for their time and thoughts.

Following each focus group, the moderator and co-moderator processed the content and the interaction style of the group. At times notes were taken during this debriefing, and at others they were not felt to be significant. Co-moderator notes were maintained in a locked file along with group attendance rosters. Audio-tapes were transcribed, and transcripts, once obtained, were also kept in a locked file.

Plan for Analysis

Data Management

Key to approaching focus group data is understanding that the respondent, or unit of analysis, is the group rather than the individual participant. Therefore, counting the number of individuals who might have made a certain statement is not in keeping with this method. However, if every participant in a given focus group, or in all of a series of focus groups, stated agreement with a statement this might be worthy of inclusion in the analysis.

Management and analysis of focus group data is cumbersome because of the great volume of written transcripts. The process of working through this data requires a plan that precedes the research and one that is practical (Krueger, 1993, p. 132). Transcription importance depends on the purpose of the focus group and the intended use of the data. In general, for research purposes, transcripts are essential. Whether to edit transcripts is a question that must be considered, as this will perhaps clarify the data, but will also alter it. For the original project, the decision was made to edit only with regard to clear typographical errors, but not to revise transcripts on the basis of memory or reviewing tapes. For this secondary analysis, transcripts were edited only to remove any remaining information regarding participant identity.

Stewart and Shamdasani (1990, p. 102-121) described both cut and paste and content analysis as traditional analysis methods for focus group data. They noted that the use of content analysis requires the unit of analysis to be defined, and cited physical, syntactical, referential, propositional and thematic units as examples of those commonly used. They distinguished thematic units as being more global, interpretive and explanatory in nature (Stewart and Shamdasani, 1990, p. 110).

In the case of the original research, the intention was to both describe and interpret the perceptions voiced by stakeholders in the public sector community mental health care system. As the questions for the focus groups were developed and ordered, the beginning of analysis occurred. The process of creating constituency groups on the basis of break characteristics provided an initial categorization of the data, and situated the thirty-two focus groups in relation to one another. The groups were also categorized by geographic location, thus providing a second means of dividing the data to be analyzed. The division of groups into categories for purposes of analysis made it possible to read the transcripts for themes in each category of group and then to compare themes across groups both within and between categories. This process was useful for understanding what was important to which groups of people. The ability to analyze across group categories provided opportunity for constructing explanations as well as for describing the data.

A thematic content analysis process was planned with the purpose of identifying themes, and interpreting the recurrent themes as they occurred in the focus groups. Points of seeming importance to participants were considered themes. Themes were then clustered and patterns or relationships between themes were explored to gain insight, to hypothesize with regard to meanings expressed and to evaluate the usefulness of focus groups in accessing stakeholder voice and public opinion regarding the public sector community mental health system. ATLAS.ti, Version 4.2, was selected as the best qualitative data software package to meet the needs of this project.

Unitizing, sampling, and recording were the steps described by Stewart and Shamdasani (1990, p. 110-111) for transforming raw transcript into useable data for analysis. Themes were the primary unit selected for this project, and the thematic sampling procedure was designed to be intentionally broad in that all the themes identified as relevant to this work were coded for all of the focus group transcripts as a precaution against drawing conclusions not supported by the data.

Computer Software

The computer software program selected for management and analysis of data for this project was ATLAS.ti, Version 4.2, a proprietary program developed and copyrighted by Thomas Muhr and Scientific Software Development (Berlin, 1997). This program has been described as having the capacity to manage data at the textual level, the conceptual level and the organizational level. While one purpose of this software has been specifically noted to be theory and model development, such work would have extended beyond the scope of the current research. The software was also designed to manage graphical and audio data, but these aspects of the program were not exploited for the current project.

ATLAS.ti required that textual data be converted to an ASCIII or ANSI character code table. Therefore, the original Word transcripts were so converted at the time they were cleaned of any residual participant identifiers. A consultant was engaged to assist in preparing the data for use with ATLAS.ti. This consultant signed a confidentiality agreement consistent with the agreements signed by the research assistants and interviewers who participated in the original data gathering process.

All of the data from focus groups intended for use in this study was considered as a single hermeneutic unit by the ATLAS.ti program. Within this hermeneutic unit, there existed multiple primary documents consisting of the individual focus group transcripts. The program allowed for maintenance of the original data file without alteration as the processes of quotation identification, coding (indexing or assigning keywords), memo notation, super-coding (the combination of codes in a query) and identified multiple author work were conducted. As such, work on a specific part of the original file could be viewed as an overlay to the original file data without distorting the original.

The aspects of ATLAS.ti that were crucial to meeting the data management needs for this project included the ability to designate quotations or segmented units of text data from focus group transcripts and assign multiple codes with or without clarification memos associated with each, the capacity for construction of queries using clusters of codes and categories of codes and the ability to compare work by different authors conducted using the same data sources. These capabilities allowed for exploring the similarities and differences between and among individual focus groups with regard to specific themes and with consideration of the coding author.

The ATLAS.ti program provided a means for constructing lists of quotations and codes. This function was utilized in this project. The full variety of coding mechanisms offered by this software were accessed in the course of data analysis. These included free-coding (the creation of a stock of predefined codes for later use) (Muhr, 1997, p. 44), open-coding (simultaneously creating a quotation and assigning a code to it) (Muhr, 1997, p. 25), coding by list (Muhr, 1997, p. 19), and in-vivo coding which uses words contained in the textual quotation as the keyword or code (Muhr, 1997, p. 26). Once the full hermeneutic unit had been coded, queries were defined to explore associations between and among coded thematic content of focus groups that were of similar constituency and geography and those of differing constituency and geography.

Rigor and Trustworthiness

Social policy or service evaluation research is of no use unless it is perceived as credible by those who would use the results (Greene, 1994, p. 536). Therefore, issues of rigor and assurances of the quality of the research and the analysis, as well as the interpretation of results, is crucial for this work. To build audience credibility, the criteria for trustworthiness adopted for this project combined critical and constructivist models.

In critical terms, the quality of this research endeavor was judged on the basis of historical situatedness, action to erode ignorance, and for transforming existing structures (Guba and Lincoln, 1994, p. 114). The issue of credibility of research product was determined by whether "constructions are plausible to those who constructed them, and even then there may be disagreement, for the researcher may see the effects of oppression in the constructs of those researched - effects that those researched may not see" (Kincheloe and McLaren, 1994, p. 151).

These critical criteria were not likely to provide acceptable assurances of quality for policy makers, whereas constructivist criteria in part permitted assessment of research trustworthiness in a frame that had familiarity for those who would use the research. Credibility has been described as a constructivist standard that parallels the concept of internal validity; similarly, transferability parallels the concept external validity, dependability parallels reliability, and confirmability is comparable to replicability (Guba and Lincoln, 1994, p. 114).

The design structure of this research allowed for inherent ability to attend to these criteria. For example, the multiple focus groups within each category of constituency group and geographic region allowed for comparison of themes among and between these categories of groups; this attended in part to the trustworthiness factors of credibility, transferability, dependability and confirmability. In addition, the credibility, dependability, transferability and confirmability of this work were enhanced by providing participants, on their request, the opportunity to provide feedback regarding the focus group report prepared for the Division of Mental Health. One focus group, encompassing the full spectrum of constituencies within one sub-region, reviewed and commented on the report prepared specifically in relation to that region. The research staff, who acted as co-moderators, reviewed the focus group analysis prepared for the Division of Mental Health and provided feedback regarding the themes they experienced as important to participants. None of the participants or staff who reviewed the state report countered the content. While the comment and corroboration pertained to the original study rather than the secondary analysis, validation supports the original data and the analytic process in which the current project is based.

General Threats to Validity

> *"...Several threats to the validity of focus group data exist related to communication phenomena. These include social desirability, low levels of trust, face politedness needs, researcher bias, and deception.... (Albrecht et al., 1993, p. 63.)*

Risk existed with regard to generalizing focus group data to the full population since focus group sampling was not necessarily intended to be reflective of the entire population (Krueger, 1994, p. 33). Krueger (1994, p. 66-85) defined Ten Quality Factors in Focus Group Research as follows: clarity of purpose, appropriate environment, sufficient resources, appropriate participants, skillful moderator, effective questions, careful data handling, systematic and verifiable analysis, appropriate presentation, and honoring the participant, client and method. Each of these areas carried related threats to quality, and therefore to validity or trustworthiness. Applying Krueger's factors with regard to this project highlights several potential threats to quality that were attended to; however, other areas remained problematic. The areas of vulnerability included those related to moderator issues, recruitment and participation issues, and those specific to the transcript quality and plan for analysis.

Focus groups were held at sites distant to the operation base of the moderator; therefore, multiple groups needed to be "piggy-backed" into single days. Thus, both travel time and the reality of multiple focus groups on a single day led to the potential for moderator fatigue. As the moderator of these groups was an experienced psychotherapist, there was some protection against the intrusion of bias related to this fatigue. Similarly, the moderator was well trained in the art of interviewing without influencing group opinion. At times, it was evident that off-topic discussion was fruitful. When this circumstance arose, the experience of the moderator permitted the group to proceed as time allowed in the hope that new insights with regard to the research area might be revealed. The moderator summarized content during and at the close of each group, and silent members were drawn into the discussion. Reframed questions, reflection and moderator silence acted to prod the discussion. At the close of each group, the moderator checked with participants to see if there were any areas that were neglected and needed consideration by the group. The same moderator conducted all groups; however, the need for a variety of research assistants contributed to variation in consistency of the tape-recording and other administrative processes, hence the quality of original data and transcripts was not entirely uniform.

Segmenting the focus group constituencies by break characteristics was accomplished in a manner that proved useful and acceptable for the original research. However, participant recruitment required the use of multiple lists and recruitment contacts. At times, addresses for potential participants were not accurate or changes in employment had occurred. The result was that some initially identified individuals were never contacted, but alternative individuals received the invitation to participate by default. Multiple prongs were used to find participants and to compensate for the lack of controlled randomness in the recruitment process. In some regards the recruitment was a full blanket of eligible participants as well as the outgrowth of a snowball sampling method.

The individuals who did participate seemed to be genuinely invested in the process, although they were at times directed to attend by a superior in the organization in which they worked. The agenda each participant had with regard to desire to participate varied, and at times it seemed that some participants had difficulty separating their personal experiences from their professional experiences. Excessive self-disclosure occurred in at least one service sector or children's service sector focus group. It seems likely that this occurrence altered the participation of other group members. In the second, or replicated, focus group there was no evidence that the self-disclosing member or the other group members were less inclined to engage in discussion because of the initial focus group experience.

Some focus groups clearly were affected by the presence of a member who in "real life" had greater power. It was difficult at times to ascertain whether the other group members tended to color their contributions in terms of how they might be received by the more esteemed member. In some groups there was a need to extend the discussion because the focus group took longer than anticipated to warm up, participants were emotionally engaged with the topic, or size required that more time be allowed so that all members could be heard. This was not always possible given the time constraints of participants or because the room in which the group was conducted was to be used for another purpose.

Quality was affected by location in that this did limit participation of some potential subjects. Most significantly, there was little response from those providing service to Native American populations. Also, one focus group requested that local nursing students be permitted to observe the discussion. This action served to limit the voice of some participants and led to their request for an opportunity following the group to discuss their thoughts about the topics considered during the main group.

Rigor and Trustworthiness Specific to the Secondary Analysis

Rigor and trustworthiness of the data, analysis and findings of the secondary analysis were reliant to a great extent on the efforts made to conduct enough focus groups to permit saturation of content. This saturation provided some reason for belief that the data was reflective of the range of information relevant to the topic and the population of interest. This was one means of attending to the generalizability of the data to topic and population.

The internal validity of the coding process and resultant conclusions were managed by the process of having multiple "authors" (to use the term consistent with the ATLAS.ti software) code data. Spot checks of the consistency with which codes were applied was considered a means of preventing arbitrary code assignment or the interference of a single investigator's bias from contaminating the findings. For the purpose of this project, the data consultant as well as the principal investigator coded the focus group data. Both parties coded the same data sources. ATLAS.ti was used to assess the consistency of coding between coders. Where discrepancy became evident, discussion and collaborative effort ensued.

The fact of multiple focus groups permits comparison of thematic content between groups that were similar and those that were different in constituency and geographic location. This represented a means for corroborating thematic content where it was repetitively presented or where a level of thematic saturation appeared to have occurred. In such instances, there was a degree of thematic generalizability that could be contemplated. Similarly, where thematic content from a single group failed to reappear in other similar groups, it was considered that the theme was representative of only that particular group. Where thematic consistency was evident only among similar constituency or geographic groups, it was considered that these themes were characteristic of that constituency or geography but not generalizable to groups beyond those with similar characteristics.

The ATLAS.ti program had the built-in ability to address issues such as the groundedness and the density of codes. This was important, as the groundedness has been described as representing the number of quotations that had been assigned a specific code and thus was an indication of evidence for a specific coded thematic content in the data. Density has been described as a measure of the extent to which other codes were linked to a given code of thematic content. "Codes with large (density) numbers can be interpreted as having a high degree of theoretical density" (Muhr, 1997, p. 40). Each of these characteristics was considered an extension of the concept of thematic content saturation and as such, a measure of internal consistency.

The capacity of ATLAS.ti to produce frequency matrixes was utilized to display the extent to which certain codes pertain to various source documents (focus groups transcripts), clusters of source documents or all documents in the full hermeneutic unit.

Threats to Validity Specific to Secondary Analysis

In the analysis phase of this study, the greatest threat to validity was the potential for over-analyzing the data. The data was collected as exploratory data. Given the power of the ATLAS.ti program, it was tempting to draw conclusions that extended beyond exploration and into the area of theory development. This temptation would not have been consistent with the original data and therefore must be deferred to future work. The time between when the original data was collected and when this secondary analysis was conducted created a venue for questioning the accuracy of the concerns expressed by participants in the focus groups. However, it did not reflect upon the potential for determining the value of the focus group method for accessing stakeholder voice.

The transcriptions from the original project were of an inconsistent quality with regard to completeness and in some instances accuracy. At least one focus group was not recorded due to mechanical and researcher assistant error. These limitations reflect missing data that could not be rectified. The plan for data management was to use the data as it stood with the exception that certain words clearly mis-recorded by transcriptionists were corrected. This was possible in part because the moderator for all of the focus groups was the principal investigator conducting this secondary analysis of the data.

The act of disengaging the transcripts from identifying information about participants provided for maintaining participant confidentiality, but also prevented comment on the analysis from being solicited of participants. In an ideal situation, feedback from focus group participants would be available to reflect the analytic validity or lack thereof. Inherent in this situation, the author of the research became the voice for the focus group participants without their explicit approval. In this way, the intent of the research, which was to explore means for accessing stakeholder voice rather than having those in positions of power speak for them, was derailed. While this may not fully negate the validity or credibility of the analysis, it certainly created a question as to the achievement of the normative objectives of the research.

Analysis Related to Specific Aims

The planned data analysis addressed specific aims of the research in the following manner. Focus group data consisting of multiple replicated and different constituencies and geographic locations were coded for thematic content. Comparisons were then made with regard to the consistency of thematic content. Where there was occurrence of repetitive thematic coding evident in similar focus groups, it could be considered that these themes were representative of the stakeholder opinion among similar groups of individuals. Where there was consistency of thematic content across the spectrum of focus groups including those that were representative of differing constituencies it could be considered that these themes were representative of a broader range of public opinion in a given geographic location. Thematic content that was restricted to a single focus group must be considered to be representative only of that specific group of individual participants.

To the extent that thematic units gleaned from focus groups extended across constituencies and geographic locale, there was support for the use of focus groups as a means for eliciting public opinion in a way that could be representative of the range of stakeholders rather than merely representative of interest group opinion. The thematic content of the focus groups provided a basis for understanding the contribution that could be made by eliciting the voice and opinion of stakeholders as public sector community mental health policies are developed and evaluated. This analytic process helped to clarify the potential for using focus groups to access this information and thereby enhanced the potential for public mental health policy to respond to need determination that is reflective of and in context with the characteristics and priorities of the community and service users. The issue of voice was embedded in the multiple themes analyzed for each focus group constituency; thus opportunity was provided for assessing the extent to which different constituencies perceived themselves as engaged in the planning, delivery, and evaluation aspects of public sector community mental health care.

Summary

This study was a secondary analysis of a series of multiple replicated focus groups conducted with four constituencies of the public sector community mental health system. The purpose of this analysis was to explore the use of focus groups as a means for accessing stakeholder voice and public opinion that may hold significance for the determination of service need and the development or evaluation of public mental health policy. ATLAS.ti, a computer based software program, was used for the analytic process and to create the final report. The research project was based in a normative framework and endeavored to attend to issues of power not only in the selection of the population of interest but also in the manner in which the data was managed and interpreted. Focus group research has been considered to be valid if the groups are "...Used carefully for a problem that is suitable for focus group inquiry..." (Krueger, 1994, p. 31). However, as the face validity of focus groups may be greater than is warranted in some circumstances, careful evaluation of the process and the results of the research is necessary. In the instance of this research, effort was taken to plan and manage the process and the analysis in such a way that threats to validity were both acknowledged and minimized.

Chapter IV

Analysis of Methods and Findings: Aims One and Two

Introduction

Specific Aims One and Two are considered in this chapter. The focus group method was analyzed with regard to its potential as a means for accessing stakeholder voice and as a valid indicator of public opinion as this relates to public sector community health services. The thirty focus groups analyzed in this study were originally convened as one aspect of a Washington State-funded triangulation study evaluating the impact of regulatory change on public sector community mental health services. The purpose of this secondary analysis was to explore the potential for focus groups to be used as a method to access stakeholder voice. The original research included more than thirty focus groups; however, inclusion in this analysis required that the transcripts were of comparable quality and completeness. Only thirty transcripts met this requirement.

The software program, ATLAS.ti 4.2, was used to manage the transcripts as primary documents in a single hermeneutic unit, to organize and consolidate codes, and to conduct queries using super-codes. Microsoft Excel was used for the descriptive statistical analysis of the frequencies and percentages of specific codes in individual primary documents and primary document families. Issues related to inter-rater reliability, the validity of coding, the comparison of theme content by means of code occurrence across and between the primary documents associated with clustered focus groups, as well as the consideration of differential stakeholder concerns are presented in this chapter. The purpose and specific aims of this research were as follows.

Purpose

The general purpose of this study was to explore the potential for using focus groups as a method for gathering information from the public stakeholders in the community mental health service delivery system. As such, the voices of stakeholder constituencies from whom information is not commonly solicited were given venue, and the use of focus groups was analyzed as a method for accomplishing this. The intention of the research was to facilitate the access to stakeholder voice by those responsible for determining and implementing public policy. An underlying consideration was to do so in a manner that attended to and valued issues of community need and social justice.

The Specific Aims central to this chapter are as follows:

1. To explore the potential for focus groups to be used as a means for accessing the voice of stakeholders in the public sector community mental health system.
2. To compare like and unlike constituency focus group data to determine whether the information obtained by means of focus group research can be used as a valid indicator of public opinion with regard to public sector community mental health services.

General Observations Regarding Focus Group Cohort

Focus groups were considered single respondent entities consisting of multiple participants. As with individual open-ended interviews, content and personal characteristics as well as group dynamics affected the quality and quantity of the data that was obtained. All of the focus groups in this study varied with regard to size, participant speech productivity and interaction. Focus group size ranged from one participant to greater than twenty; the average group size was 6 – 10 participants. In these groups, the level of participant knowledge about the public sector community mental health system influenced the productivity of the group discussion, and the relationship of participants outside the focus group context inherently affected the group process. Some of the focus group discussions required a great deal of moderator prompting, while others were succinct but productive in the process and others rambled, often until the moderator intervened.

The reality of the small communities included in this research was that individuals with similar stakes in the public sector community mental health system (or for that matter any other public system) were likely to have interaction prior to and following the focus group. These relationships at times were evident in the ways participants greeted each other or asked if other individuals had been invited. In other circumstances, participants were meeting in person for the first time and took the opportunity to network and share contact information. Although participants were not queried about the level of satisfaction they experienced related to being involved in the group, their general affect and animation was such that this seemed to be a positive event. In fact, at the close of some groups, individuals commented about feeling glad to have had the opportunity to have a venue for their opinions or concerns.

Code Occurrence

The frequency with which a theme presented in a given focus group transcript relied on a number of factors, including the strength of opinion held by the participants, the proclivity of participants to express or endorse opinions or to be talkative or assertive in stating concurrence with another participant. This reality of the focus group created some degree of difficulty in interpreting code occurrence rates. The occurrence of a certain opinion or theme in a focus group represented evidence that the related code had relevance for that group. Thus, in the process of analyzing the data, the "code occurred." However, the frequency with which a given code occurred was reflective of group personality and tendency as well as the significance of the particular theme. When a code assignment occurred repetitively, it was likely an indication of the strength of opinion about the associated theme content. A somewhat simplistic example of this was the repetitive reference to children by groups consisting of children's service providers. Other examples were inclined to be more complex and are addressed in later sections of this chapter. In fact, the high frequency of codes such as Kids/Teens in Children's

Services groups represented evidence of coding validity since it was in keeping with discussion content expected among those involved in providing Children's Services.

Moderator Issues

A single individual moderated the full cohort of focus groups for this research. This was a strength of design not always present or possible in a series of focus groups. The consistency of this circumstance enhanced the similarity of the process and management of the groups and facilitated the comparison of thematic content. The groups could not truly be replicated due to differences in room, participants, and the very mood of all participants; however, the role of moderator if differentially enacted would have had tremendous potential to alter the course of any of the focus groups. The moderator role assumed in this set of focus groups was relatively non-directive, with moderate intervention only when conversation veered from the topic of the public sector community mental health system or time management was required.

The management of groups was at times extremely comfortable and at other times somewhat difficult. The moderator for the groups was both familiar with the topical area and was an experienced psychotherapist with skill in group facilitation. This experience resulted in a relaxed style that nonetheless attended carefully to equity of participation. In spite of this, in certain groups participants tended to defer to an influential group member such as a judge who participated in Justice groups or an advocate who was of particular stature in the community. The moderator attempted to deflect attention from the influential members when possible, but at times needed to be cognizant of the group dynamic and abide by the group culture as a means for encouraging interaction.

Community Representation

As this research was a secondary analysis of focus groups convened in 1996 and 1997, and because of the confidentiality requirements of the original study, it was impossible to accurately describe the characteristics of those invited to participate and those who did participate in focus groups. In general, participants were Caucasian. The ethnic minority primarily represented in the Peninsula geographic cluster was Native American. Other ethnic or cultural minorities were not well represented and in many focus groups the needs of specific ethnic or cultural populations were not addressed. In Southwest there were references to language issues and cultural barriers specific to certain populations in that region.

In the recruitment process for the original study, efforts were made to identify and connect with organizations in each region that might facilitate inclusion of participants who were representative of the region's cultural and ethnic diversity. This process was less successful than had been hoped. At the time of recruitment some minority communities and remote communities communicated their experience of disenfranchisement and their view that participation in this project would have been yet another futile expenditure of time and effort. Certainly, the factors of distance and transportation were concretely problematic for many potential participants. It was also the case that the regions of Washington state in which these focus groups were convened were not selected on the basis of ethnic or cultural diversity. These regions volunteered to be a part of the state pilot project. Had the original research purposefully selected regions, these would have more likely included communities local to the Eastern Puget Sound specifically for the recruitment of a more diverse participant population. Concerns about the lack of data from minority individuals receiving public sector community mental health services led to pilot project solicitation of an additional survey sample from designated special population agency clientele in the Puget Sound region. As the focus groups were primarily constructed to facilitate understanding pre and post context for the larger study, additional focus groups were not convened as a part of the original project.

One Service focus group in Spokane was extremely representative of the community, including the deaf and hard of hearing community. This was also the only focus group in the original full series of groups in which concerns of specific relevance to African Americans were addressed. Unfortunately, the recording and transcription of this group were of such a poor quality that they were unusable for analysis. However, the group made a lasting impression on the moderator for several reasons; this group showed that it was possible to include individuals requiring sign interpretation in a focus group, and participants strongly advocated for separate and equal mental health services for special populations such as the deaf. In addition, this group was much larger that the recommended size, as more than 20 people chose to attend, yet all participants were given venue to speak and everyone did participate.

Aspects of Computer Assisted Analysis

A consultant was employed to assist in selection and implementation of a qualitative software program for use in this research. ATLAS.ti 4.2, a program marketed by Scientific Software Development for analysis, management, and model building with narrative, audio, and visual qualitative data, was used. It was chosen for this project primarily because of its user-friendly characteristics and because of its capability to combine and compare coded documents prepared by multiple coders working independently.

This research project was descriptive and not intended as a model building or grounded theory study. Although at times it was tempting to stretch beyond the scope of the project and employ the more sophisticated aspects of the program, the data was not gathered with such a purpose. Therefore, the full range of software capabilities was neither applied nor necessary for use in this analysis.

ATLAS.ti 4.2 required the original transcripts to be formatted similarly and then entered as individual documents in a single hermeneutic source document. This single unit was then differentiated into clusters for the purpose of understanding the similarities and differences between groups of focus group transcripts identified as primary document families. In this study, the primary clusters of documents or primary document families were determined on the basis of the geographic region or the constituency represented in the associated focus group. The software was especially helpful as a means for maintaining lists of codes with definitions and referencing quotations that had been identified and coded. It provided a system for cataloguing and counting codes, quotations and document associations. The memo function and the code family mapping function were not accessed for this project. The memo ability would have been useful and would have provided increased depth to the study had it been available during the data collection process to annotate information that was not evident in the transcript of specific focus groups.

Microsoft Excel was used in this project to produce and manipulate spreadsheets once the initial coding process was completed using ATLAS.ti 4.2. Code data from the full set of thirty focus groups was entered into Excel (see Appendix A). Spreadsheets were prepared for the full cohort as well as specified geographic or constituency clusters and individual groups. Frequency data was obtained for each code in each cluster, sub-cluster and individual group. Excel provided the capacity for the creation of graphic representation of selected data.

Coding Issues

Code Development and Consolidation

Consistent with the intention of learning from the data rather than imposing preconceived restrictions, the code dictionary was developed during the process of transcript document coding. The majority of codes were identified and defined during the coding of the first four transcripts. As additional codes were identified in the course of coding subsequent groups, these were added to the code dictionary. The first four transcripts were then re-coded to permit assignment of the new codes as appropriate. The primary investigator developed the initial code list and dictionary. Both coders then collaborated to reach a shared understanding of the codes and to add new codes as the need arose. The initial full code list included 93 codes. These were later evaluated for overlap and codes were collapsed into a smaller number through discussion and common consent. The resulting code dictionary contained 58 codes (see Appendix B, List of Collapsed Codes, Occurrence Frequencies, and Definitions).

Coding and Code Checking

Transcripts of the thirty focus groups were distributed to two coders for primary coding purposes. Twenty-one focus group transcripts were assigned to the primary investigator who also moderated the full cohort of focus groups. Nine focus group transcripts were assigned for coding by the consultant engaged for assistance with the technology aspect of the research, but who had only a layperson's understanding of the topic and no prior experience with focus groups. Random focus group transcripts were selected for blind code checking by the more experienced coder.

Five previously coded focus group transcripts were assigned for blind code checking. The identified quotations were retained in the selected transcripts but the codes associated with randomly selected quotations were stripped. Five quotations in odd-numbered focus groups were selected and checked starting at line 300, line 1000, and 200 lines from the end of the transcript. Five quotations in even-numbered focus groups were selected and checked at line 200, line 1000, and 300 lines from the end of the transcript.

Blind coding of quotations by different coders resulted in poor corroboration of codes. At times the code intent was similar, but the chosen code word differed. At other times the discordance was so great that it appeared that coders might have been reading completely different text. To determine whether the blind code checking result was due to the inconsistency of experience and context between the coders, the procedure was repeated. The more experienced coder proceeded to blind code quotations previously self-coded. The result of this effort also failed with regard to inter-rater reliability. This code discrepancy was likely exaggerated by the fact that the blind code checking was completed before the codes were collapsed into a more consolidated list to minimize overlap. However, code overlap did not account for the full extent of the discrepancy (see Appendix C, Code Checking Comparison).

This effort to use blind code checking to corroborate transcript coding failed to corroborate the coding process. Open over-coding was also performed on transcripts. This process led to a more rich coding and only rarely were previously assigned codes deleted. For this study, the same coder (who also moderated the focus groups) over-coded the full cohort of focus group transcripts. The result was considered to be a more full representation of the group voice and less of a representation of the coder's personal perception.

Findings Related to Aims One and Two

Cluster Analysis

Efforts to find differences between clusters of groups involved identifying clusters of groups in which the full cohort had the occurrence of a specific code that did not necessarily occur in the full sample of groups. Alternatively, the delineation of clusters of groups in which the occurrence of a specific code greatly exceeded the code occurrence anticipated on the basis of the percentage rate of all code occurrences in that cluster. Cluster characteristics began to emerge both in terms of similarities and differences. As such, data suggested that the focus groups in each stakeholder cluster of groups may have tapped into both over-arching community and state concerns as well as the concerns more specific to the identified stakeholder group cluster.

The analysis of the stakeholder constituency and geographic clusters of focus group transcripts was in terms of code occurrence and the extent to which code occurrence met or exceeded the anticipated frequency of code occurrence for a given cluster or sub-cluster. The anticipated code occurrence rate for the clusters was defined as the percentage of total focus group transcripts represented in the cluster or the overall percentage of code occurrence in the cluster. Where the percent of the full cohort and the percent of overall code occurrence differed greatly (Inclusive Service, 39% vs. 21.3%, and Justice, 38% vs. 21.3%), the latter was designated as the reference percent.

Constituency Cluster Analysis

Analysis of the four primary constituency group clusters of Consumer/Advocate, Justice, Children's Services, and Service Providers included only 28 of the full 30 groups. Of these, the Service cluster incorporated two groups in which some non-service individuals participated. These groups were primarily composed of individuals with a Service relationship to the Public Sector Community Mental Health System, but additional participants were included who were unable to attend the group to which they were originally invited. A comparison of code occurrence in the full cohort of Justice, Children's Services, Consumer/Advocate, and Service-Plus groups revealed that the 10 codes Access, Communication, Need Exceeds Service Availability, Responsiveness, Satisfaction, System Doesn't Work, Care Offset, Cost Issues, Needs of the Vulnerable, and Managed Care were present in each of these 28 groups (see Appendix D). The percentage of occurrence of these codes was generally similar across the groups profiled. It was only in the Consumer/Advocate groups that the occurrence of the Satisfaction code (40.6%) significantly exceeded the rate that might have been anticipated given that the groups represented 20% of the total groups and the code occurrence represented 21.6% of all codes.

Justice

The Justice Groups represented 38% of the total number of groups and 28.2% of the total code occurrences in all groups. In addition to the codes noted above, all groups in the Justice cluster referenced the following 9 codes:

- Who Gets Served (43.4%)
- Justice System (67.7%)
- Medical (25.1%)
- Effectiveness (19.2%)
- Services Work (28.6%)
- Co-occurring Disorders (39%)
- Dangerous/Potential for Violence (34.4%)
- Crisis (28.9%)
- Outcome Measures (20.7%)

The following codes occurred in 7 of 8 Justice groups:

- Involuntary Care (53.9%)
- Recidivism (43.9%)

The following code occurred in 6 of 8 Justice groups:

- Confidentiality as a Barrier to Care (42.9%)

The following codes occurred in 5 of 8 Justice groups:

- Transient Population (54.8%)
- Adults (44.8%)

Children's Services

The Children's Services groups represented 23% of all groups and 24.8% of all code occurrences. In addition to those codes noted above, the full cohort of groups included reference to the following 13 codes:

- Who Gets Served (26.1%)
- Kids/Teens (68.6%)
- Effectiveness (29.1%)
- Services Work (24.5%)
- Co-occurring Disorder (17.6%)
- Dangerous/Potential for Violence (26.6%)
- Care in the Community (28.3%)

- Outcome Measures (39.3%)
- In-patient Care (16.2%)
- Engagement in Services (30.6%)
- Insurance/Medicaid, Follow-up (27.7%)
- Lack of Services for the Most Severely Ill (29.5%)

The following codes occurred in 6 of 7 Children's Services groups:

- Crisis (24.6%)
- Staff Training (25.6%)
- School Services (75%)
- Recidivism (39.4%)
- Long Term Treatment Access (34.9%)

The following codes occurred in 5 of 7 Children's Services groups:

- Staff Time Limited (29.1%)
- Social Problems (32.5%)
- Paperwork (26.3%)
- Prevention (63%)
- Early Discharge (52.6%)

Consumer/Advocate

The Consumer/Advocate groups represented 20% of all groups and 21.6% of all code occurrences. In addition to the codes noted above, the full cohort of groups included reference to the following codes:

- Advocate Issues (58.2%)
- Medical Issues (36.4%)
- Effectiveness (28.6%)
- Services Work (27.2%)
- Case Management (29.1%)
- Crisis (21.8%)
- Outcome Measures (19.3%)
- Respectfulness (52.6%)
- In-patient Care (33.8)
- Engagement (24.4%)
- Insurance/Medicaid (23%)
- Power (36.4%)
- Family Frustration (74.4%)
- Staff training (23.3%)

The following codes occurred in 5 of 6 Consumer/Advocate groups:

- Work Opportunity (75%)
- Discrimination (67.6%)
- Paperwork (34.2)

The following codes occurred in 4 of 6 Consumer/Advocate groups:

- Confidentiality as a Barrier to Care (37.1%)
- Accountability (33.3%)
- Distance/Transportation Issues (27.8%)

Although these codes did not occur in all Consumer/Advocate groups, the rate of occurrence exceeded that expected.

Service

The Service groups represented 38% of all groups and 21.3% of all code occurrences. In addition to the codes noted above, the full cohort of groups included the 3 following codes:

- Crisis (23.2%)
- Respectfulness (20.3%)
- Staff Training (39%)

The following codes occurred in 7 of 8 Service groups:

- Co-occurring Disorders (41.5%)
- Case Management (41.2%)
- Staff Time Limited (38%)

The following codes occurred in 6 of 8 Service groups:

- Housing (42%)
- Elderly (82.9%)
- No Evidence of Service Outcome (52.4%)

The following codes occurred in 4 of 8 Service groups:

- Transient Population (45.2%)
- Cultural Barriers to Care (66.7%)
- Language Issues (45.5%)

The percentage of the total occurrences for each of these three codes was greater than that anticipated. Native American Issues as a code was represented in only 3 groups, but the percentage of overall occurrence was 69.2%. Similarly, the concern about People with Nothing to Do was only addressed in a single group, but this group accounted for 44.4% of all occurrences for this code.

Another means for comparing the occurrence of codes in group clusters was to consider those codes that were the ten most frequently occurring in each group, then determining the occurrence of these codes in the remaining groups within the same cluster. This process was considered to reveal the strength with which the group expressed the opinions or themes reflected in the various codes. The results of review were as follows.

Justice

Justice groups evidenced the occurrence of 20 codes in the full cohort. Of these, the following codes were among the ten most frequently occurring codes in each Justice group:

- Justice System (67.7%)
- Access (28.6%)
- Communication (28.6%)
- Who Gets Served (43.4%)
- Care Offset (37.2%)
- Responsiveness (26.1%)

The code Need Exceeds Service Availability (29.9%) was among the ten most frequently occurring codes in 6 of 7 Justice groups and was among the eleven most frequently occurring codes in the remaining group. The code System Doesn't Work (25.3%) met this criterion in 5 of 7 groups and was within the 16 most frequently occurring codes in the remaining two groups.

The codes Native American Issues, School Services, and Unrealistic Expectations of the Mental Health System did not occur in any of the Justice groups. The code No Evidence of Service Outcome (9.5% with incidence of 2) occurred in only 1 group. The codes People with Nothing to Do (22.2%) and Cultural Barrier to Care (13.2%) occurred in only two groups and the incidence was 1 in each group. The codes Prevention (11.1%

with incidence of 3), Early Discharge (15.8% with incidence of 3), Language Issues (36.4% with incidence of 4), and Discrimination (18.9% with incidence of 7) occurred in only 2 groups.

Children's Services

Children's Services groups evidenced the occurrence of 24 codes in the full cohort. Of these, the following codes were among the ten most frequently occurring codes in each Children's Services group:

- Access (22.2%)
- Responsiveness (25.4%)
- Kids/Teens (68.6%)
- Communication (29.9%)
- Need Exceeds Service Availability (25.4%)

In addition, Care Offset (26.8%) and Who Gets Served (26.1%) met this criterion in 6 of 7 groups and were among the eleven most frequently occurring codes in the remaining one group.

The codes Elderly and People with Nothing to Do did not occur in any of the Children's Services groups. The codes Work Opportunity (2.5% with incidence of 1) and Transient Population (6.5% with incidence of 2) occurred in only 1 of 7 groups. The codes Language Issues (18.2% with incidence of 2), Discrimination (5.4% with incidence of 2), Cultural Barrier to Care (20% with incidence of 3), and Confidentiality as a Barrier to Care (8.6% with incidence of 3) occurred in only 2 of 7 groups.

Consumer/Advocate

Consumer/Advocate groups evidenced the occurrence of 24 codes in the full cohort. Of these, the following codes were among the ten most frequently occurring codes in each Consumer/Advocate group:

- Satisfaction (40.6%)
- Access (23.6%)
- Responsiveness (24.1%)
- Need Exceeds Service Availability (16.7)

In addition, Advocate Issues (58.2%) and System Doesn't Work (27.2%) met this criterion in 6 of 7 groups and were among the thirteen most frequently occurring codes in the remaining group.

The code Native American Issues did not occur in any of the Consumer/Advocate groups while other codes evidenced rare occurrence.

The following codes occurred in 1 of 7 Consumer/Advocate groups:

- Language Issues (9.1% with incidence of 1)
- Cultural Barrier to Care (6.7% with incidence of 1)

- Unrealistic Expectations of the Mental Health System (14.3% with incidence of 2)
- Elderly (8.6% with incidence of 3)

The following codes occurred in 2 of 7 Consumer/Advocate groups:

- Transient Population (6.5% with incidence of 2)
- School Services (2.9% with incidence of 2)
- Prevention (7.4% with incidence of 2)
- Social Problems (7.5% with incidence of 3)
- Recidivism (4.5% with incidence of 3)
- People with Nothing to Do (33.3% with incidence of 3)
- No Evidence of Service Outcome (14.3% with incidence of 3)

Service Groups (Pure)

The Service group cluster including the two minimally combined groups evidenced the occurrence of 17 codes in the full cohort. The code School Services did not occur in any of the pure Service groups. Excluding the two combined groups, the cohort showed full occurrence of 20 codes. Of these, the following codes were among the ten most frequently occurring codes in each Service group:

- Access (13.5%)
- Care Offset (18.8%)
- Communication (17.9%)

In addition, the codes Need Exceeds Service Availability (16.4%) and Responsiveness (10.7%) met these criteria in 5 of 6 groups and were among the nineteen most frequently occurring codes in the remaining group.

The following codes occurred in 1 of 6 Service groups:

- Conflict of Interest (4.3% with incidence of 1)
- People with Nothing to Do (5.6% with incidence of 4)
- Adults (3.4% with incidence of 1)
- Discrimination (2.2% with an incidence of 2)

The following codes occurred in 2 of 6 Service groups:

- Prevention (11.1% with incidence of 3)
- Unrealistic Expectations of the Mental Health System (21.4% with incidence of 3)
- Early Discharge (10.5% with incidence of 2)
- Family Frustration (2.3% with incidence of 2)
- Language Issues (27.3% with incidence of 3)
- Work Opportunity (15% with incidence of 6)

Combined Community Groups

Three of these four groups were convened in a single geographic area at the request of community members because of desire to participate but refusal or inability to travel to the original group to which they were invited. This cluster of groups represented 13.3%

of all groups and 14.3% of all code occurrences. The Combined Community groups evidenced the occurrence of 26 codes in the full cohort. Of these, the following codes were among the ten most frequently occurring codes in each Combined Community group:

- Access (17.6%)
- Responsiveness (17.2%)
- Needs Exceed Service Availability (16.2%)
- Communication (12.1%)
- Care Offset (14.2%)
- Cost Issues (16.1%)

System Doesn't Work (16.9%) met this criterion in 3 of 4 groups and was among the twenty-four most frequently occurring codes in the 4th group. The group in which this code did not occur among the 10 most frequent was the group that differed in geographic location.

Codes that occurred at twice the anticipated frequency and percent of overall code occurrence of 14.3% included the following:

- Elderly (31.4% with incidence of 11 divided among 3 groups)
- Native American Issues (34.6% with incidence of 9; 8 of which occurred in group #1)
- Cultural Barrier to Care (46.7% with incidence of 7; 6 of which occurred in group

#1).

The codes Work Opportunity and People with Nothing to Do did not occur in any of the Combined Community groups. Other codes rarely occurred.

The following codes occurred in 1 of 4 Combined Community groups:

- Discrimination (2.7% with incidence of 1)
- Conflict of Interest (4.3% with incidence of 1)
- Paperwork (5.3% with incidence of 2)
- Accountability (5.1% with incidence of 2)
- Prevention (7.4% with incidence of 2)

The following codes occurred in 2 of 4 Combined Community groups:

- Unrealistic Expectations of the Mental Health System (14.3% with incidence of 2)
- Language Issues (18.2% with incidence of 2)
- Early Discharge (10,5% with incidence of 2)
- Confidentiality as a Barrier (5.7% with incidence of 2)

Interestingly, the same group was responsible for the single occurrences of Accountability, Prevention, and Conflict of Interest. The two groups held in the same community at different points in time had no occurrence of Discrimination, Paperwork, Language Issues, or Early Discharge.

Geographic Cluster Analysis

The three geographic sites for this study were in the same state and as such had similarities with regard to a number of issues related to the public sector community mental health system. However, they differed in some critical ways. For example, one site was primarily urban (Spokane), one was primarily rural, but with the population contained in a relatively confined area (Southwest), and one was primarily rural with a large land area and encompassing three counties with four small cities (Peninsula). These similarities and differences were expected to be evident in the analysis of the focus groups.

In Spokane, 7 groups were included in this analysis, accounting for a percentage of 23.3% of the groups, and the overall code occurrence was 22.3%. In Southwest, 9 groups were included in this analysis, accounting for 30% of the groups, and the overall code occurrence was 31.6%. In Peninsula, 14 groups were included in this analysis, accounting for 46.7% of the groups, and the overall code occurrence was 46.1%. For all geographic clusters, the percentage of the overall number of groups represented and the percentage of code occurrence were closely associated.

Ten codes were found to occur in all groups in all geographic clusters. These codes directly related to the questions that guided the discussion in all groups, therefore it was not unexpected that these codes were ubiquitous. The percentage with which these codes occurred in the different geographic clusters related closely to the overall percentages of code occurrence in each geographic region (Spokane, 23.3% code occurrence; Southwest, 31.6% code occurrence; Peninsula. 46.1% code occurrence). The codes that occurred in all 30 groups were as follows:

Code	Spokane	Southwest	Peninsula
Access	18.6%	34.7%	46.7%
Care Offset	22%	32.3%	45.7%
Communication	26.7%	23.7%	49.6%
Cost Issues	18.2%	35.1%	46.6%
Managed Care	26.6%	34.1%	39.4%
Need Exceeds Service Availability	19.6%	38.1%	42.3%
Needs of the Vulnerable	24.8%	40.7%	34.6%
Outcome Measures	20%	25%	55%
Responsiveness	24.8%	27.9%	47.4%
Satisfaction	23.5%	25.1%	51.4%
System Doesn't Work	24.7%	29.3%	46%

The finding of differences in full code occurrence among the 3 geographic regions suggested that the focus groups did elicit discussion of issues and concerns relevant to the community rather than only an individual focus group or constituency. The codes that occurred in all groups within designated geographic clusters, in addition to those noted above, were as follows:

<u>Spokane</u>

- Adults (62%)
- Advocate Issues (33.3%)
- Dangerous/Potential for Violence (28.6%)
- In-Patient Care (25.4%)
- Justice System (29.2%)
- Medical Issues (23%)
- Respectfulness (35.3%)
- Who Gets Served (20.4%)

<u>Southwest</u>

- Crisis (37.3%)
- Effectiveness (26.1%)
- In-Patient Care (27.7%)
- Insurance/Medicaid (45.2%)
- Involuntary Treatment (37.4%)
- Lack of Services for the Most Severely Ill (31.4%)
- Services Work (26.5%)
- Staff Training (36.6%)

- Follow-up Issues (35.7%)

Peninsula

- Crisis (39.4%
- Effectiveness (53.4%)
- Justice System (41.7%)

With regard to the frequency of code occurrence in a cluster of focus group transcripts, the perspective was taken that the important information was to be gained in looking closely at the most and the least frequently occurring codes in single groups or specified clusters of groups. The codes that occurred with greater than anticipated frequency or rate in a given cluster or sub-cluster, such as the Consumer/Advocate groups in a single geographic site, provided information of importance for that community or constituency. The following discussion highlights first the codes that were frequently occurring and then those that rarely occurred in the associated clusters.

Spokane

In Spokane groups, the following codes occurred in all but one group (6 of 7) and with the overall cluster percentage of total as listed. None of these codes occurred with twice the expected rate of 22.3% to 23.3%. It was reasonable to consider that the issues and concerns associated with these codes were representative of community and that the single group in which the theme was not identified may have had chance characteristics that were responsible for the outlier status.

Code	Occurrence	Group with Code Missing
Case Management	14.2%	1 Children's Services
Co-occurring Disorders	8.2%	1 Consumer/Advocate
Effectiveness	20.5%	1 Service
Follow-up	26.8%	1 Service
Housing	21.9%	1 Children's Services
Insurance/Medicaid	29.2%	1 Justice
Involuntary Treatment	25.2%	1 Service
Lack of Services for Most Severely Ill	12.4%	1 Service
Staff Training	17.1%	1 Children's Services
Social Problems	37.5%	1 Consumer/Advocate
Services Work	20.8%	1 Service
Power	30.7%	1 Children's Services
Paperwork	22.2%	1 Justice

Codes that occurred in only 1 of 7 Spokane groups presented an occurrence rate that was reasonably lower than the average expected percent of occurrence for overall codes. However, it was also interesting that these codes occurred with greater than the expected rate for only 1 of 7 groups. This was accounted for by the finding that these codes generally occurred in fewer groups in the full sample. Therefore, each group in which the following codes did occur accounted for a greater percentage than would otherwise have been the case.

Code	Occurrence	Group
Elderly	8.6%	Consumer/Advocate
Language Issues	9.1%	Children's Services
Native American Issues	7.7%	Children's Services
No Evidence of Outcome	19%	Children's Services
People with Nothing to Do	11.1%	Justice

These occurrences were considered to be important for the individual group and perhaps the constituency. However, the fact that the occurrence was not repeated even in another group with the same constituency in the same region prevented generalizability beyond the group.

Codes that occurred in 2 of 7 Spokane groups were as follows:

Code	Occurrence	Groups
Unrealistic Expectations of the Mental Health System	42.9%	2 Children's Services
Staff Morale	13.3%	Consumer/Advocate and Justice
School Services	16.2%	Consumer/Advocate and Children's Services
Cultural Barriers to Care	13.3%	Consumer/Advocate and Children's Services
Early Discharge	21.1%	Consumer/Advocate and Children's Services

The pattern of occurrence of these codes was interesting in that 3 codes occurred in only one Consumer/Advocate group transcript and one Children's Services group transcript. However, there was no clear rationale for this occurrence. The code Unrealistic Expectations of the Mental Health System occurred in the two Children's Services group transcripts from the same region. This was construed as an indication that the focus groups voiced sentiments that were generalizable to the Children's Services stakeholders in that community.

Southwest

In Southwest groups, the following codes occurred in all but the one group (8 of 9) and with the overall cluster percentage of total as listed. None of these codes occurred with twice the expected frequency rate of 31.6% to 30%.

Code	Occurrence	Groups with Code Missing
Advocate Issues	28.8%	Justice
Care in Community	15.6%	Service and Justice
Case Management	34.5%	Children's Services
Co-occurring Disorders	35.8%	Service
Kids/Teens	26%	Consumer/Advocate
Engagement in Services	35.5%	Consumer/Advocate
Recidivism	54.5%	Consumer/Advocate
Respectfulness	35.3%	Consumer/Advocate

Again, these codes appeared to be representative of the associated concerns in this community, and the lack of occurrence in the single group was likely attributable to the characteristics of the single group or a sub-cluster difference.

The following codes occurred in 2 of 9 Southwest groups:

Code	Occurrence	Groups
School Services	26.5%	2 Children's Services
Unrealistic Expectations of the Mental Health System	21.4%	Consumer/Advocate and Service

The Southwest region was less proximate to Native American populations than were the other geographic sites; therefore, it might have been anticipated that the code Native American Issues would not occur in Southwest group transcripts. The theme of School Services occurring in Southwest Children's Services group transcripts was an expected result as the code occurred in the full set of Children's Services groups' transcripts. However, the isolated occurrence of Unrealistic Expectations of the Mental Health System code in the Consumer/Advocate and Service group transcripts seemed randomly associated with those particular focus groups.

Five codes occurred in only 3 of 9 groups. Of these only one represented greater than twice the expected occurrence. This was the code People with Nothing to Do, which occurred in 1 Justice, 1 Service, and 1 Consumer/Advocate group and which accounted for 77.7% of total occurrence of this code.

The following codes occurred in 3 of 9 Southwest groups:

Code	Occurrence	Groups
Transient Population	38.7%	Justice, Service and Service/Justice
People with Nothing to Do	77.7%	Justice, Consumer/Advocate, and Service
No Evidence of Outcome	28.6%	2 Service and 1 Service/Justice
Adults	17.2%	Consumer/Advocate, Justice, and Service
Cultural Barriers to Care	20%	Service, Justice and Service/Justice

These code occurrences were difficult to understand. Occurrence in one-third of the geographic cluster, while not a preponderance, did press for consideration that the theme was potentially representative of the community or the sub-clusters. However, only the code People with Nothing to Do, with a 77.7% occurrence in 3 different sub-cluster group transcripts, seemed to highlight a particular community concern deserving of further exploration.

The following codes occurred in 4 of 9 Southwest groups:

Code	Total Occurrence	Southwest Occurrence	Groups
Work Opportunity	62%	76%	Consumer/Advocate sub-cluster
Confidentiality as a Barrier to Care	20%	71.4%	Justice sub-cluster
Elderly	45.7%	100%	Service/Justice combined group
Conflict of Interest	39.1%	66.7%	Consumer/Advocate groups (although the code occurred in Consumer/Advocate, Justice, and Children's Services groups)

Interpretation of occurrence for these codes required some attention because of the size of the frequencies of occurrence. The importance of Work Opportunity to the Consumer/Advocate constituency in this region could not be discounted. Similarly, the theme of Conflict of Interest occurred with an overall rate consistent with the geographic cluster's overall occurrence rate, although the sub-cluster most concerned with this theme was the Consumer/Advocate constituency.

Peninsula

In Peninsula groups, the following 5 codes occurred in all but 1 group (13 of 14) and with the overall cluster percentage of total as listed. None of these codes occurred with twice the expected rate of 46.1% or 46.7%.

The following codes occurred in 13 of 14 Peninsula groups:

Code	Occurrence	Groups with Code Missing
Dangerous/Potential for Violence	42.9%	Consumer/Advocate
Insurance/Medicaid Issues	43.4%	Service
Medical Issues	45.2%	Children's Services
Services Work	41.1%	Combined Community
Who Gets Served	44.5%	Combined Community

The preponderance of clusters that included the occurrence of these codes was reflective of the associated concerns and opinions as present in this community.

The following codes occurred in 12 of 14 Peninsula groups:

Code	Occurrence	Groups with Code Missing
Care in Community	70.6%	Combined Community and Consumer/Advocate
Lack of Services for the Most Severely Ill	56.2%	Consumer/Advocate and Service
Engagement in Services	52.4%	Justice and Service
Follow-up Issues	37.5%	Consumer/Advocate and Justice
Housing	53.8%	Justice and Combined Community

With the exception of the code Follow-up, these codes occurred with a frequency rate greater than that anticipated and reflected issues that were consistent with known regional characteristics, such as the existence of limited resources spread over an extensive geographic area, or the lack of access to local in-patient care for even voluntary admissions in much of this region. These codes likely represented generalizable community concerns.

In Peninsula, all codes occurred in at least one group. However, the code People with Nothing to Do occurred in only 1 Consumer/Advocate group (1 of 14 Peninsula groups) with a percentage of 11.1% of total occurrences. The code Language Issues occurred in only 2 of 14 Peninsula groups with a percentage of 18.2% of total in the Consumer/Advocate and Service groups. The code Cultural Barriers to Care occurred in 3 of 14 groups with the percentage of total being 66.7% and occurrence in Children's Services and Service groups. The limited occurrence of these codes could only be viewed as consequences of individual focus group concerns and could not be generalized to the community or region.

The following codes occurred in 4 of 14 Peninsula groups:

Code	Occurrence	Groups
Work Opportunity	25%	1 Consumer/Advocate, 2 Justice and 1 Service
Unrealistic Expectations of the Mental Health System	35.7%	1 Children's Services, 2 Service and 1 Combined Community
Prevention	37%	1 Consumer/Advocate, 2 Children's Services and 1 Combined Community

The occurrence of these codes was great enough to suggest the associated themes may have been of importance in the community, but the extent of concern or opinion in the community was not broadly or consistently evidenced.

Interesting Occurrences Within Geographic Clusters

Spokane

Within the Spokane cluster, the code Adults occurred in all groups and with a percentage of 62.1%, approximately triple that anticipated on the basis of the 22.3% to 23.3% expected percentage. Advocate Issues occurred with a slightly greater than anticipated rate of 33.3%, and of this, 72.9% of occurrence was in the 2 Consumer/Advocate groups. Justice System occurred at approximately the expected rate at 29.2%, but the Justice groups accounted for 67% of this occurrence. Kids/Teens occurred at an anticipated rate of 24.7%, but 89.6% of this occurrence was accounted for by occurrence in Children's Services groups.

The code Respectfulness occurred at a slightly higher than anticipated rate of 35.3%; however, 74.5% of this occurrence was accounted for by occurrence in 2 Consumer/Advocate groups. The code Staff Morale occurred at a lower than anticipated rate of 13.3%; however, 75% of this occurrence was due to occurrence in 2 Consumer/Advocate groups. The code Power occurred at a rate of 30.7% with 63% of this accounted for by occurrence in Consumer/Advocate groups. The code Family Frustration occurred at the anticipated rate of 26.7% but of this 95.7% was accounted for by occurrence in Consumer/Advocate groups. The occurrence of the Adult code was less well explained, although the others were indications of the credibility of the coding for the Spokane focus group transcripts. The themes associated with the codes Advocate Issues, Respectfulness, Staff Morale, Power, and Family Frustration presented in the Consumer/Advocate groups in this geographic region. This was an exemplar of the capacity of focus groups to gain access to stakeholder voice.

Southwest

Within the Southwest cluster, the code Language Issues accounted for 72.7% of the total code occurrence with no occurrence in Consumer/Advocate groups. Also within the Southwest cluster, the code People with Nothing to Do accounted for 77.7% of that code's total occurrence in 3 of 9 groups. The code Work Opportunity occurred 62.5% of the time in Southwest, and of this 76% of the occurrence was in 2 Consumer/Advocate groups. The code Discrimination occurred 45.9% of the time in the Southwest groups and of this 76% of the occurrences were in 2 Consumer/Advocate groups. The code Prevention occurred in Southwest 51.9% of the time and of this occurrence, 64.3% was in 2 Children's Services groups. The code Family Frustration occurred only 19.8% of the time in Southwest groups, but of this 58.8% of occurrences were in the Consumer/Advocate groups. The code Justice System occurred with the anticipated occurrence of 29.2%, but of this the Justice groups accounted for 79.5% of occurrences. The code School Services occurred at an expected rate of 26.5% in the Southwest groups; however, 100% of this occurrence was in the Children's Services groups. The sub-cluster occurrence of these codes fit the anticipated associations. As such, the credibility of the coding for the focus group transcripts from this geographic region was supported and there was evidence of the distribution of concerns held by members of the community.

Peninsula

In the Peninsula cluster, the code Responsiveness occurred at an anticipated 47.4% rate, with 83% of this occurrence in the Children's Services groups. Prevention occurred less often than would be expected, 37% of all occurrences. Of this, 70% of the occurrences were in Children's Services groups. Peninsula groups accounted for an anticipated 49.6% occurrence of the code Communication and of this 89% occurred in the Children's Services groups. In the Peninsula cluster the code School Services had an occurrence of 59% and of this 57.4% was in Children's Services groups.

Consumer/Advocate groups accounted for the preponderance of the Peninsula code occurrence of Work Opportunity, People with Nothing to Do, and Family Frustration. For example, while only 25% of Work Opportunity occurred in Peninsula groups, 70% of this occurrence was in the Consumer/Advocate groups. Likewise, Peninsula accounted for only 11.1% of the code occurrence for People with Nothing to Do, but 100% of this occurrence was in a single Consumer/Advocate group. While 53.5% of the code occurrence of Family Frustration occurred in Peninsula groups, 69.6% of this was in Consumer/Advocate groups.

In this region, the codes Elderly and Cultural Barriers to Care tended to occur primarily in the Service groups. The code Elderly occurred with an overall expected rate of 45.7% with a Service occurrence of 87.5%, while occurrence of the code Cultural Barriers to Care was 66.7% in Peninsula, with 80% of this occurring in Service groups. The differential stakeholder code occurrences in the Peninsula region were in keeping with the occurrence that was found overall among the same constituency clusters.

The code Distance as a Barrier to Care/Transportation Issues occurred with the most frequency (63.3%) in the Peninsula cluster of groups and was distributed among 11 of 14 focus groups; it also occurred in all of the constituency subgroups. This finding was consistent with the geographic challenges of the Peninsula region. In this location more than the others, the population was greatly dispersed and significant travel was necessary in order to access services.

Interpretation of Findings Related to Aims One and Two:

To interpret the findings of this secondary analysis the first and second specific aims were revisited. These aims were directed at exploring whether the focus group method represented a legitimate means for accessing stakeholder voice. In particular, the second aim of comparing like and unlike constituency focus group data to determine whether information obtained through focus group research can be used as a valid indicator of public opinion was key to this research. The potential of the focus group as a method for gathering valid data has been commonly discussed in the literature, but the means for evaluating this has been less than available. The current project exploited the unique opportunity afforded by having conducted multiple focus groups composed of defined stakeholder constituencies in different geographic regions of the same state and repetitively facilitated by the same moderator. The circumstances, while not controlled, did permit the possibility of answering this question qualitatively.

Comparisons of like and unlike focus group data by constituency group, combined community group and geographic region have been presented. The task of interpreting the meaning of this data was much less concrete. Code occurrence as an indicator that a theme or issue was addressed in a given group and frequency of code occurrence as an indicator of the intensity of the associated concern were used to understand the content of a specific focus group transcript. These indicators allowed for the comparison of multiple focus group transcripts. In the analysis, moderator quotations were not coded except when linked to an incomplete participant comment.

Code Checking and Consistency

The consistency with which codes were applied represented the area most critical to the credibility and validity of the analysis. For this reason, the initial analysis of the data was directed at ascertaining the best means for assuring coding consistency. The effort yielded unexpected results. Specifically, it was found that blind coding by different coders was not predictably consistent even when codes were clearly defined and the procedure was agreed upon prior to any coding work. The other surprise result was that even when the same coder participated in blind coding of duplicate transcripts, the consistency was unpredictable.

The result of the blind coding enterprise required consideration that the coder's perception actually changed over the course of the coding experience. This possibility allowed for recognition that the coding individual was learning through the process of coding and as such the context for each blind recoding of a transcript was affected by the altered context. The thematic content of the focus group transcripts represented an evolution for the coder and ultimately the views of the same coder changed during the coding process.

It then became more reasonable to think of the coding of the focus group transcripts in terms of developmental work and a learned skill. For this project, it was decided that transcripts were best coded in an additive fashion by the same coder. The practice of using multiple coders allowed for more than one transcript to be coded simultaneously and shortened the time for completion of data coding. However, the time gain was later balanced by the recognition that the full cohort of transcripts needed to be coded in an additive manner by all coders in order to produce comparable data. The result of multiple coders reviewing transcripts in this manner would have enhanced the depth with which a transcript was understood. However, the possibility needed to be entertained that the effect of additive coding by coders from different backgrounds might have resulted in the over-application of codes and the resultant dilution of meaning. In this study, the coding method was chosen after variations of code checking showed it to be the most clear and consistent (reliable) technique. The coding method was considered to be the most critical aspect of this analysis since code occurrence was designated as the indicator for determining the variance among the opinions held and expressed by participants of different focus groups representative of somewhat different stakeholders.

Interpretation of Code Occurrence Findings

The occurrence of a code as noted earlier was understood for the purposes of this study to indicate that the associated issue or concern was addressed in the group. It followed that the codes directly linked to the moderator's topical questions for all groups would occur in all groups. This was in fact the case. The codes Access, Care Offset, Cost Issues, Communication, Managed Care, Need Exceeds Service Availability, Needs of the Vulnerable, Responsiveness, Satisfaction, and System Doesn't Work occurred in all groups and were directly related to the questions posed. Similarly, codes directly related to the constituency interests of a given focus group were expected to occur in those groups. Examples of this included occurrence of the code Justice System in the Justice group cluster, occurrence of the code Kids/Teens in the Children's Services group cluster, and occurrence of the codes Family Frustration and Advocate Issues in the Consumer/Advocate cluster groups. Again, this was exactly what was found with regard to occurrence of codes. This observed occurrence of codes grossly supported the credibility of the focus group transcript coding. In addition, this finding provided support for the potential of focus groups to access issues of concern to stakeholder groups. The overlap of code occurrence among groups of differing stakeholders in the same community represented evidence that the focus groups accessed more than just the concerns of stakeholders in a population, but also the issues of importance in the community.

Interpretation of Code Frequency and Rate Findings

The frequency of code occurrence in a given focus group transcript, constituency or geographic cluster was more difficult to interpret than was the pattern of code occurrence. Certainly, the strength of conviction or opinion within a given group seemed a reasonable cause for a code frequency to exceed the overall expected frequency rate for the group or the cluster of groups. However, it might also have represented the personality of a group in which participants were inclined to repeat themselves or each other. For this reason, it was important to consider the overall occurrence of all codes for not only the cluster, but also the individual group. This helped to distinguish groups in which participants were over-talkative versus those in which single codes identified themes that were more prominent in discussion than were others. The fuzziness of these criteria was balanced by using a cut-off of double the anticipated rate of code occurrence. It was not likely that even an animated, verbose group dynamic would have led to the rate of only some codes being assigned with twice the expected frequency while resulting in other code occurrence rates falling within the anticipated range.

It was of interest that in the majority of groups and group clusters the frequency of code occurrence was in keeping with the expected rate. However, for codes representing themes that occurred with less frequency in general, each occurrence accounted for a higher than anticipated rate. In such circumstances, the rate of code occurrence served to highlight the occurrence, but could not necessarily be understood as an indication of strength of opinion or concern within the group or the cluster of groups. Therefore, interpretation of code occurrence frequency and rate needed to be considered in the context of the distribution and overall code occurrence in the full cohort of focus group transcripts.

Super-Codes

The codes Satisfaction and Responsiveness, while representative of important themes, were problematic for interpretation because they lacked specificity with regard to positive or negative attribution. As a means of grappling with this concern, the super-code capability of ATLAS.ti 4.2 was used. Satisfaction and Responsiveness were each combined in turn with the codes Services Work and System Doesn't Work to take advantage of the associated attributions and better understand the occurrence meaning of Satisfaction and Responsiveness. A process similar to that used for general code analysis was then applied to the four super-codes within the full cohort of focus group, constituency cluster, and geographic cluster transcripts.

The co-occurrence of the codes Responsiveness with Services Work was 80 of the total 610 Responsiveness occurrences or 13.1% of all Responsiveness occurrences, and the co-occurrence of Responsiveness with System Doesn't Work was 226 of the total 610 Responsiveness occurrences or 37% of all Responsiveness occurrences. The co-occurrence of the codes Satisfaction with Services Work was 132 of the total 498 Satisfaction occurrences or 26.5% of all Satisfaction occurrences, and the co-occurrence of Satisfaction with System Doesn't Work was 306 of the total 498 Satisfaction occurrences or 61.4% of all Satisfaction occurrences.

Using the codes Services Work and System Doesn't Work as the base codes, Responsiveness accounted for 80 of the total 192 occurrences of Services Work or 41.7% of all Services Work occurrences, and Satisfaction accounted for 132 of the total 192 occurrences of Services Work or 68.8% of all Services Work occurrences. Responsiveness also accounted for 226 of the total 478 occurrences of System Doesn't Work or 47.3% of all System Doesn't Work occurrences, and Satisfaction accounted for 306 of the total 478 System Doesn't Work occurrences or 64% of all System Doesn't Work occurrences.

The distribution of all four super-code occurrences was in all constituency and geographic clusters, but not all super-codes occurred in all individual groups. Responsiveness and Services Work co-occurred in 23 of the 30 focus group transcripts, Responsiveness and System doesn't Work co-occurred in 26 of 30 focus group transcripts, Satisfaction and Services Work co-occurred in 25 of 30 focus group transcripts, and Satisfaction and System Doesn't Work co-occurred in 27 of 30 focus group transcripts. Three group transcripts (Peninsula Consumer/Advocate Pre, Spokane Service Post, and Southwest Service Pre) evidenced no co-occurrence of Responsiveness with Services Work and/or System Doesn't Work. Three group transcripts (Port Townsend Post, Spokane Service Post, and Southwest Justice Post) evidenced no co-occurrence of Services Work with Responsiveness and/or Satisfaction. Only one group transcript (Peninsula Service Pre) evidenced no co-occurrence of System Doesn't Work with Responsiveness and/or Satisfaction. No consistent patterns of co-occurrence were found.

Summary

This chapter has presented and discussed findings related to the Specific Aims of exploring the potential for focus groups to be used as a means for accessing the voice of stakeholders in the public sector community mental health system, and comparing the like and unlike constituency focus group data to determine whether the information obtained by means of focus group research can be used as a valid indicator of public opinion with regard to public sector community mental health services. The data was obtained through the secondary analysis of thirty focus group transcripts. The thirty transcripts were subjected to qualitative analysis that required them to be coded. The coding process was then checked and a procedure for open over-coding was developed as a mechanism to enhance the consistency of code application and the validity of theme identification. Code occurrence and super-code occurrence were then analyzed with regard to frequency as well as rate in individual groups, the full cohort of groups, and clusters of groups based on constituency or geographic characteristics.

In this set of focus group transcripts, theme consistencies were found to occur in the transcripts of focus groups that addressed the same issues, were conducted using the same process, and consisted of stakeholder participants representing the same constituency with regard to population or geographic region. Where theme consistencies occurred throughout the full cohort of focus group transcripts, these were interpreted as a consequence of consistent guiding questions for all groups. Where theme consistencies occurred in clusters of groups with like constituency or geographic locale, these were interpreted as themes representative of overarching community issues or concerns. The findings suggest that focus groups are a potential means for accessing the voice of stakeholders in the public sector community mental health system, and the use of focus group data can be a valid indicator of public opinion with regard to public sector community mental health services.

Chapter V

Analysis of Findings: Aim Three

Quotations as Representation of Stakeholder Voice

Relevant to Aim Three, this chapter describes the data obtained through the use of focus groups and illustrates, through stakeholder quotations, the potential for enhancing the responsiveness of public policy to the needs of community members and service users. The findings of this research supported the use of focus groups as a method suited to endeavors intended to listen to and understand the meanings associated with the words used by stakeholder participants. Participants were recruited and groups were configured with the intention of accessing specific stakeholder constituencies or a range of stakeholders in a geographic region. Recruitment and group configuration were deemed as affecting the degree to which the groups could be considered representative of the related constituencies or communities. The question as to whether the coding process routinely used in qualitative research was a valid means for understanding the voices given venue in the focus groups remained problematic and was a key component of the analysis. Still, there were some concerns about the actual similarities of the quotations that were assigned a given code. For a full understanding of meaning, the identification of codes and themes were not enough; this required the quotations themselves to be considered.

Once the content validity of the focus group data was established, the actual words of participant stakeholders became a focus of attention. In the following section of this paper, quotations were randomly selected with the intention of honoring participants and in essence reflecting the heart of the project. Quotations related to the eleven codes found to occur in the full cohort of thirty focus group transcripts were selected from each stakeholder constituency group.

This was not a scientific sampling of quotations. In an effort to compensate for my own bias in selecting the following quotations, criteria for selection were established in the following way. Five constituencies were designated, namely, combined groups, Children's Services groups, Consumer/Advocate groups, Service Provider groups, and Justice groups. Geography was not considered in this process, as it would have led to a potential duplication since groups were randomly selected as representative of a constituency for each of the following theme codes. Quotations pertaining to the following codes were chosen as exemplars of the words used by participants in each constituency: Access, Care Offset, Communication, Cost Issues, Managed Care, Need Exceeds Service Availability, Needs of the Vulnerable, Outcome Measures, Responsiveness, Satisfaction, and System Doesn't Work. No effort was made to select quotations on the basis of whether they were reflective of positive, negative or neutral opinion related to the theme code. In some cases, the quotations were edited to minimize inclusion of content that appeared unrelated to the theme code or to abridge an extremely long quotation that was repetitive in content.

Comparison of the quotations from differing constituency groups, while interesting, could not in the context of this study be construed to be of more consequence. Research effort did not address the similarities or differences of the chosen quotations, as this was not the purpose of the current project. However, it was considered important to include the words of participants in this reporting of results to both provide context and to be respectful of participants. One consistency across groups was the value ascribed to being offered the opportunity for a public arena in which opinions and concerns about the public sector community mental health system could be expressed and extended to educate those who make policy. The quotations that follow are offered in recognition of the multiple community voices accessed in the course of the initial research project.

Access

> "We actually have a pretty fair success rate with people being referred there, but it does not seem that there are enough counselors to take them quickly enough to make it worth their while to continue to try to get through the door." (Combined #1)

> "... If they're not involved with them then us referring to mental health is a joke. If they have, if they have, um, a program that is already developed then very often it is excellent. It just so happens that with most of our kids they don't fit

> into the program…the barrier would be relevance of services and you talk about intake, uh, to ask a probation officer to refer somebody to mental health we usually get a great guffaw…." (Children's Services #28)

> "A lot of times you have to make the referral from the in-patient unit before they will really be accepted right away. I know the wait is at least 10 days to 2 weeks so if you're in semi-crisis, if you're on the edge of crisis and you ask to be seen or you turn in an application like anyone else it does take a lot…" (Service #29)

> "…to a degree it is difficult to access services as there is so much demand in the community. I think if we were not known as well, things would take longer. I have officers asking ME to make the call because people respond to my name and position at mental health. The average person it would be pretty difficult to get through." (Justice #18)

> "We have found that it has been very exhausting when we have a family member who you know is in dire need of treatment and yet there's that criteria, they have to be in danger to themselves or others before they can get treated." (Consumer/Advocate #4)

One thread among constituencies was the effort necessary to access services. The single sentence in the Justice quotation, "the average person it would be pretty difficult to get through," encompassed the spectrum of representative quotations related to the code Access.

Care Offset

> "It has already been our experience that the waits have been way too long. Services have not been responding fast enough even in crisis situation. We responded by completely bypassing them. First to the … providers then secondly we send the referrals to mental health. Most of the nurses are sending clients to mental health as lip service not expecting to find anything. They are pretty frustrated. They ask me why do they have to send people to mental health knowing that nothing will come of it." (Combined #14)

> "…Ah, when kids have mental health problem, it takes up a huge amount of the worker's time and his supervisor's time and of my time as well as trying to find appropriate services for that child. Ah, there just don't seem to exist for even when the child is placed in alternative…What happens to those children is they end up going through our system. We pay for counseling on the outside get their service outside in order to decrease our trying to get into the mental health system." (Children's Services #9)

> "The mental health system receives about 7 times the money that alcohol drug

> services receives in this state. And yet I feel the alcohol drug services are pressured to take a disproportionate number of mental health patients, to absorb them. My perception of the drug and alcohol service is that we are ready willing and somewhat able to learn to handle the MICA client, but the lion's share of that responsibility should be with the area that has the larger funding. My fear is that the drug and alcohol area is spreading too thin to do any good." (Service #22)

> "They are coming into the penal justice system because there is no place for them to go." (Justice #7)

> "I think that family members do not have the credibility. My daughter said she wanted to increase her medication. I would be responsible etc.; she did not get the increase. She ended up in a hospital for 6 months. Eventually, we got a private psychiatrist to help. I would not go back to public (care) unless I absolutely had to." (Consumer/Advocate #16)

Each of the five constituencies described finding ways to compensate for gaps and inadequacies of the public mental health services in their communities. In so doing, the practice of cost shifting for services to individuals suffering from mental illness was exposed, although each constituency addressed the circumstance from a different perspective.

Communication

"…And you know the communication aspect is so important because as a school counselor I have a lot of information about families, a lot of stuff. And it's not just, actually it's not just community counseling but a lot of times when I feel like I talk to Children's Protective Services….I feel like…like people don't think I know. And I know a lot about what's happening in families. And I, you know, I really resent that." (Combined #15)

"…So then the other thin I think that how much time is being spent in terms of the communication, I think there the big problem is keeping that connection and where we have problems is we have major, we have to account to court systems and have to have written reports and we have major, major problems almost universal of getting any kind of written reports from the therapists about the treatment plan. The progress that's being made or anything, and so workers are continually making phone calls…" (Children's Service #8)

"So there needs to be some system for at least for the client even to be in charge of their own case file or releases so that when they move from one place to another that information could travel with them. That would be ideal wouldn't it? I mean we have some real, we have had in the past some real touch and goes,

> I think at that point you go on your gut instinct you know but I have noticed that it's ok for me to give all the information in the world, but to get some back is hard to do." (Service #11)

> "...technically mental health providers are not to give out information. Without a release. Even to the agency who put them there..." (Justice #25)

> "You know about our interagency here? ...It's the best cooperation you've ever seen. Before the system started they didn't talk to each other, now they talk to each other. They have a patient, they come in and they bring the paperwork in and each agency that's going to be involved, no matter what it is, is setting there at that table, uh, uh, worked out, uh, what is it...it's, individual service plan, okay, and it's been worked out with the, the, uh, and the patient so then they bring it here to the interagency..." (Consumer/Advocate #24)

These quotations reflected the importance of communication amongst agencies and advocates for service and continuity. The benefits of a structure for supporting and facilitating communication were described in the quotation from the Consumer/Advocate constituency, as was the effect of enhanced satisfaction when such a process was in place.

Cost Issues

> “You’ve gotta pick your brain. You’ve gotta spend your money somewhere and they’re choosing to spend it on the chronic people and all the kids. But, it runs out fast and that’s where it’s being spent and it’s gone.” (Combined #2)

> “…When you are in an isolated situation sometimes it’s very difficult to be able to attract people unless you’ve got an inordinate amount of money to throw in that direction. And sometimes because of the demographics and the geography involved it’s difficult for those in small communities even within a general area to be able to collaboratively sit down and develop some sort of a program to provide joint services. So, yeah, I guess in some cases my attitude is that money and resources are the same thing. You are not going to get one without the other…” (Children’s Services #21)

> “I wanted to touch on the fact when you were talking about rental assistance I wish we had more for our mental health individual as well as, and I said it last time, prescription money. It just worries me so much because we don’t have that money nine times out of ten if the client is not able to take their meds they can’t get into a shelter…I actually called mental health - do you have any of these drugs on hand that you can give them for a while ‘til they get some money - and that worked I think a couple of times…” (Service #11)

> "My daughter is deaf, she goes to the doctor and they don't have an interpreter there. My wife has to go. It should be the doctor's responsibility... Interpreters, good ones, certified ones, it's very expensive, $300-400 a day..." (Justice #26)

> "Just make sure that part of the community system is also the State Hospital.... We do not want to see an end to the State Hospital. We want it to be there to serve those we cannot serve, that we do not have the ability to serve. And for a temporary place, we need the State Hospital; we need to continue to find it. When they send those patients home that money should follow them so we can serve them when they return to their home area..." (Consumer/Advocate #23)

The overarching concern expressed in all constituency groups was the fact that money equals resources and that because of expense, necessary resources tended to be lacking or too limited to meet recognized need.

Managed Care

> "Managed care is placing more hurdles in ones way spending more money and bureaucracy in the way to help. They are preventing you from having extensive service." (Combined #1)

"...the access center who is supposed to be the gatekeepers to determine what services a person gets. For us it has not worked as well at all...Now it may take two or three months because they cannot get into the dual diagnosis program unless both parts are completed...If they have managed care they only get so many sessions..." (Children's Services #27)

"Substance abuse is used to deny services. We have a lot of people who are extremely depressed and self-medicating is a way for them to survive, and yet they may have suicide issues and alcohol is a factor but they have a mental factor too." (Service #22)

"No. Most of the children that we see are on coupons. The coupons are paying for their treatment. There is a limit on that. Then if the doctor determines that they need more care, then they can continue on. With coupons, usually it's an HMO, which is different. Crime Victims makes the doctor validate the n4eed for more treatment. Probably as much as coupons do." (Justice #25)

"It depends on the doctor and what mood they are in that day... This woman is at Group Health. People who have other health needs the doctors do not confer with one another. This woman for her mental illness, it interfered with her heart, she has epilepsy, she almost died. Managed care is not addressing such issues." (Consumer/Advocate #16)

The representation of managed care expressed in quotations from all constituencies focused on the effect of limiting access to necessary services. Mechanisms for obtaining care by means of need validation by medical providers were described by the Justice and the Consumer/Advocate constituency groups, but none of the selected quotations reflected satisfaction with or support for managed care.

Need Exceeds Service Availability

> "...they are not strong enough to swing the gate and I feel a lot of kids that need assessments aren't assessed...I'm interested in...having kids seen and their meds evaluated, that's not being done in this community...I think our mental health needs are going up in size and for whatever reason our community mental health centers downsized by 20% in the last month and I find that just...atrocious. The sick, the poor and the ugly in this community are not served. If you have insurance or you have bucks you are served, if you are poor, you're not, you're turned away simply stated." (Combined #15)

> "We also have a contract for various services especially with sex offenders. It takes a long time, people are lost...Sexually aggressive youth, they sub-contract out with ....we can access for assessment. But long term counseling is confusing, it is sub-contracted through....I have been told directly that they do

> not provide sex offenders with therapy at community mental health."
> (Children's Services #20)

> "We, yeah, our legislators have been interested in the elderly. They have you know, we do have programs that have been trying to meet the elderly population, but, and, but it's certainly not enough. They do need more day treatment. People have to have a place to go during the day." (Service #30)

> "When I see there's things that got to be done and...I see people not doing it, I become very frustrated." (Justice #5)

> "...by the way these are the majority of the complaints we are getting from clients right now of the chronically mentally ill. They can't understand why they cannot have all the services that they have had before and they've heard a lot of rumors and they are scared to death of what's going to happen in January and they hear about all these money changes...and they're afraid that they're not going to be taken care of at all..." (Consumer/Advocate #3)

In the instance of the code Need Exceeds Service Availability, distinct constituency differences presented. Although all constituencies endorsed the fact of this situation, the multi-constituency quotation addressed poverty, the Children's Services quotation addressed the unmet needs of sexually aggressive youth, and the Service quotation highlighted the unmet needs of the elderly. The Justice group quotation expressed frustration with obvious needs being unmet and the Consumer/Advocate group quotation emphasized the fears experienced by those dependent on the public sector community mental health system. Interpreting these differences was impossible; however, one consideration was that the fact that unmet need affected multiple populations and the examples described by these participants are merely examples of the range of need in the community for which resources were inadequate.

Needs of the Vulnerable

> "So for kids who have long term treatments there's really not enough out there and so they're taking up a lot of time and it's almost like it's not particularly beneficial time either because there isn't anything actually coming of it." (Combined #2)

> "...Because of the continuity of we're trying to do some training of the parents these are really very important for your child. It is very important that you keep these appointments and that's why we go to their door, get them out of bed, get the little one's dressed, get 'em into the care and get 'em to the medical and dental. So and that's the biggest hunk of what our Readiness to Learn grant is is to connect the mental health as well as the medical and dental needs of children who aren't ready to learn because they are focused on things that are outside of

> their learning now such as shelter, clothing…" (Children's Services #10)

> "…it was until talking with people about their finances, how the Salvation Army can best address the physical needs of the person and the only reason why I've gotten into the mental health aspect of any of them is a lot of our people that come to us are ill, mentally ill, and unable to hold down a job because of the way they are. So we've had t address that situation and find them help…" (Service #29)

> "You know, for the, for the indigent people, mental health treatment is pretty scary. And like you said, by the time you finally get around to it, the problem is 2 or 3 months old, if it ever, if you ever get to it." (Justice #26)

> "…my concern is health and safety…As far as their dwelling is concerned. And to say that we can't dictate, uh, part of the job is to help them to understand that these things are necessary for your own well being. (Consumer/Advocate # 3)

The multi-constituency group and the Justice group quotations focused on the importance of availability and the potential for benefit from mental health services. However, the Children's Services, Service, and Consumer/Advocate group quotations highlighted the broad range of basic needs such as housing, clothing and health care as presenting daily challenges for individuals and families dependent on public sector community services including mental health services.

Outcome Measures

> "People with mental issues improving. Getting care, access to care. Would not have to be so creative to get care for clients who need it. The waiting period would be short. Follow through on assessment requests. Currently we do not get assessments. A willingness to collaborate with other agencies. Dual diagnosis clients would not be turned away." (Combined #14)

> "...you can't look at something in isolation you've got a cumulative effect here and its not only mental health it's all the other agencies. For lack of better terms, human services agencies whether it be schools, mental health or whatever it happens to be and I think that you've got to define on a community wide basis what are indicators of a healthy community. It's a lot of different things it's the employability of the population, it's the number of kids that are homeless, and on and on, but you can define those things, but how you break out individual responsibility I don't think that you necessarily can." (Children's Services #21)

> "People would know where to go for help and they'd get it." (Service #12)

> "...the ones that were falling through the cracks, because we can take them here

> and there but there's too many that fall through the cracks that we can't take them anywhere. And that aren't dealt with until some later date. But I think the easiest way for us to tell would be we wouldn't continue to run into these people day after day." (Justice #19)

> "I would want to know what their quality of life is after leaving the service and how often are they coming back to the mental health center for the same services." (Consumer/Advocate #16)

Overall, these quotations reflected access to care, diminished denial of services, and issues related to recidivism as well as service impact as desired outcomes of public sector community mental health services. The Children's Services group quotation, however, stressed the reality of community services integration and the difficulties of ascribing outcomes to a single public service entity.

Responsiveness

> "...as an agency I think they would be more responsive if they had more cohesiveness in communication." (Combined #15)

> "Basically and you know it was interesting because I met recently with the therapists the individual therapists that are involved with the mental health

> agency and you know they seemed responsive to suggestions that we as private non-profits would have…" (Children's Services #9)

> "…on the response time thing I know that's a problem for us. Cause we can call on a Friday afternoon or Friday evening or Saturday morning and nobody will come out until Monday afternoon to see somebody and sometimes by that time the person's left or other residents have left, they don't want to be there with that person." (Service #11)

> "….Well when he went to the hospital, the duty officer came down immediately and evaluated whether this guy was having mental problems or just physical problems because of intoxication. In this case, he decided both and they shipped him off to treatment…" (Justice #7)

> "…and that's life. And the system itself. I do think that they are beginning to listen. And say what can we do within the system to improve it…"
> (Consumer/Advocate #17

Service and Justice constituency quotations focused on issues of response time, which related to the roles and responsibilities most relevant to those groups. The multi-constituency, Children's Services, and Consumer/Advocate group quotations reflected concerns with the mental health system or the service providers' responsiveness in terms of communication and relationship.

Satisfaction

> "…But something's happening because those three individuals we don't have contact with them other than to drop a message off, so something's working." (Combined #2)

> "…People are saying 'what can you give me?' rather than what can we collectively do together. From our perspective they are great! Our working relationship must be quite a bit different than others here." (Children's Services #20)

> "…right, the clubhouse, I am talking some clubhouse individuals who have been diagnosed as schizophrenic for years and now, um, they are just blossoming. They seem to be doing really well. Um, people are understanding them better, not pushing on them, not controlling them, and taking over their life, but letting them be self-directed." (Service #29)

> "It was better when the officer could pick a person up take them to ER release them to ER, the person would be seen and the officer could get back on the street, the person stayed in the community they were familiar in the community

> they were familiar with and where often their family was. The family could then step in or at least be able to see the troubled family member." (Justice #6)

> "...and by and large I think they've done a fairly decent job. I know that it's big money and I know it's lots of money that came down and was spent, but I think we're better off today than we were when my son was ill."
> (Consumer/Advocate #24)

Interestingly, four of these five constituency group quotations described positive satisfaction with the progress made by the public sector community mental health system and services. The Justice group quotation was the only one in this selection that expressed finding the changes in the public sector community mental health system to have been problematic rather than beneficial. It was also evident that four of these five quotations reflected attention to the public sector community mental health system changes in the community.

<u>System Doesn't Work</u>

> "...Basically the mental health system in ... county has broken down to the point where the needs of the citizens are not being met at all. And it looks like the only way it has not broken down is that the people sitting around this very table work together to keep people from falling through the cracks. These

people are doing a lot of things that community mental health should be doing…." (Combined #14)

"…the regional support network is a bureaucratic entity now that is to operate that is hundreds of thousands of dollars and I see an awful lot of money being spent on positions and the like and less money for the direct service. In an increased time of need I find that really disturbing." (Children's Services #21)

"…And so in a sense, the system can only take you so far. There's no transition out…" (Service #13)

"I don't believe there are any strengths right now." "We are seeing a greater number of cases filing for guardianships of Alzheimer's cases. We see more family members going out of the area for help. People are ill and due to funding we cannot manage for them so they go elsewhere." (Justice #7)

"… I knew a gentleman who worked at a volunteer hotline for more than 2 years, he became depressed and asked for services, he was told 'we don't do that.' He moved to Arizona. They could not get services. He wanted therapy, he had volunteered there for 2 years." (Consumer/Advocate #16)

The focus of quotations taken from the five constituency groups reflected direct service needs that were deemed unmet by the public sector community mental health system. The Combined, Justice, and Consumer/Advocate group quotations directly described actions taken by those outside the mental health system to attend to areas of neglect. Two of these quotations reported need to move from the geographic area as the option used to grapple with the lack of service availability.

Summary

The actual words used by participants from differing constituencies and groups showed that concerns related to each of the coded themes were in more ways similar than different, although the specific content tended to be reflective of the relationship each constituency had with the public sector community mental health system and the associated providers and agencies. Quotations were not screened for consistency as criteria for selection; therefore, it was somewhat surprising that the theme direction was found to be as consistent as was evidenced. This exercise provided not only a means for participant voice to be experienced to some extent by the reader, but also perhaps a hint of the treasure trove of specific examples and issues policy makers might do well to consider.

Focus groups were found to be a valid indicator of public opinion and an efficacious means for accessing stakeholder voice regarding public sector community mental health services. It follows that focus groups can represent a means for including stakeholders in the determination of the need for and evaluation of community mental health services. Public mental health policy may then be enacted and managed in a way that fits the characteristics and priorities of community members as well as service users.

Chapter VI

Conclusion

This research explored the possibility that focus groups when used as a method for accessing the voice of stakeholders in the public sector community mental health system hold potential to enhance the ability of policy makers to attend to the issues of community need and social justice as they determine and implement programs. The specific aims of the study were as follows.

1. To explore the potential for focus groups to be used as a means for accessing the voice of stakeholders in the public sector community mental health system.
2. To compare like and unlike constituency focus group data to determine whether the information obtained by means of focus group research can be used as a valid indicator of public opinion with regard to public sector community mental health services.
3. To describe data obtained through the use of focus groups and in so doing to illustrate that facilitating the public voice of stakeholders enhances the potential for public mental health policy to respond to a determination of need that is reflective of and in context with the characteristics and priorities of the community and service users.

Interpretation of Findings Related to Specific Aims One and Two

Each of these aims was achieved. Aims One and Two were closely associated and, therefore, supported by the same findings. In particular, the evidence supporting these aims relates to patterns of theme occurrence across the range of like and unlike focus groups attending to the same topic and facilitated similarly. Theme consistency was found to occur in the transcripts of groups that addressed the same issues, were conducted using the same process and consisted of the same constituency with regard to stakeholder or geographic cluster. Transcripts of focus groups convened in the same region reflected similar concerns and priorities specific to the needs of the local population. These consistencies support the notion that stakeholder voice is attainable through the use of focus groups and that the thematic content in any given focus group discussion is likely to correlate with views held by those from a similar regional location. The finding that geographic location accounted for similar and understandable consistencies in the data obtained from varied constituencies of focus groups in the same region represents an indication of trustworthiness of the method as a means of accessing public opinion.

Themes that occurred in the full cohort of groups could be directly linked to the questions used to guide the discussion in all groups and were therefore evidence of the validity of the method as well as the analysis process since this was an expected outcome. In some group transcripts the actual code occurrence was found to be greater than might have been anticipated. Review of this finding reflected that the attendant theme(s) were likely to be of greater priority for a sub-set of focus groups with a common constituency or geographic locale. For example, it was to be expected that groups consisting of participants involved in Children's Services would be more likely to emphasize school services as a theme than would other focus group constituencies.

The coupling of findings that transcended specific constituencies or geographic sites with the predominance of certain theme occurrence in clusters of like groups in which the theme was closely associated with the constituency or location provided a balance of support for both Aims One and Two. The focus groups were successful in accessing both stakeholder voice related to specific concerns as well as a more broad reflection of public opinion that was not based in a particular constituency. The results of this study supported the trustworthiness, consistency and generalizability of the data gathered through focus groups.

Focus groups, once shown to be trustworthy, become an attractive alternative to the individual interview. Through the creation of a circumstance for public discussion to occur in a manner akin to the "ideal speech" situation described by Habermas, focus groups encourage participants to express opinions and to consider issues of concern. The richness of the data obtained through the focus group process tends to be greater than that which would be gathered through individual interviews with each focus group participant. The synergy of the focus group experience amplifies the range of participant opinion and response. As such, a smaller number of focus groups than individual interviews would be necessary to reach a point of thematic saturation. It follows that a series of thirty focus groups would then be of more benefit to policy makers than would thirty individual key informant interviews.

Interpretation of Findings Related to Specific Aim Three

This aim was met through the process of randomly selecting and considering participant quotations associated with the themes that occurred across the full cohort of constituencies and geographic communities. This endeavor revealed that randomly chosen quotations that were assigned the same code but which derived from different constituency groups did in fact convey similar meaning. Random quotations from each of the five types of constituency groups provided consistency of opinion that direct service needs were inadequately met by the public sector community mental health system. Quotations taken from Combined Community, Justice and Consumer/Advocate groups (representative of three of five constituencies) described actions taken by those outside the public sector community mental health system to attend to areas of unmet need for mental health services. Importantly, all groups, regardless of constituency or geographic location, expressed valuing the opportunity to engage in public discourse regarding the public sector community mental health system. Both hope and the desire to educate those who are in the position to make mental health policy were affirmed in all groups. The extent of engagement in the process of the focus group and the fruits of the discourse hint at the extent to which information from the public stakeholders, including the community at large, might be made available to public policy makers through the use of this method.

Implications: Research, Public Policy and Social Justice

Research

The importance of the research implications is perhaps the most evident of these three realms. Validation of the focus group as a trustworthy method for gathering information about the views of stakeholders in the public sector community mental health system or as a means for accessing public opinion hinged on the development of an evaluated model for focus group. The model proposed in this study requires the specification of a population or constituency, an iterative plan, moderator consistency, transcription of audio-taped data and the use of a computerized qualitative data software program for coding and analysis. As such, the validity or trustworthiness of focus group data gathered using this model, but for which an extensive set of groups may not be feasible, is accorded more credibility. Given the limitations of resources both with regard to time and funding, this is an important implication as it provides support for the focus group as a valid research method.

Public Policy

With regard to public policy, this research validates that focus groups conducted in a manner adherent to this model represent an affordable and reliable method for eliciting both stakeholder voice and public opinion for the purpose of informing policy makers as they work to determine need for public sector services, allocate public monies and evaluate programs or services. The consistency of themes found to be present in both like and unlike focus group constituencies within the same region works to diminish the concern that focus groups elicit only special interest opinions. The occurrence of expected thematic consistencies across multiple focus groups in this study supports the generalizability of data obtained from focus groups conducted using a like model. These two factors enhance the usefulness of the focus group as a trustworthy means of information gathering for officials responsible for making decisions in the public domain.

When stakeholders have voice with regard to public sector concerns, the ownership of responsibility for community policy decisions and expenditures becomes community based. The public is more inclined to fund services when they have participated in determining what these will be. Also, the likelihood is that public services would be more closely associated with community need and that public funding would be directed toward services tailored to meet community priorities if the public were more engaged in the associated discourse. There is also the potential for policy makers to understand what services are perceived as working, what services are not viewed as effective and why this is the case. Overlap of services provided by different layers of the public bureaucracy can better be identified and refined to be more efficacious. However, this is only the case when the voices of all constituencies of stakeholders in public services have the power to be heard by policy makers.

The issue of public ownership for services cannot be overstated in its importance. In this era of fiscal constraint and budget cuts in both the public and private sectors of the economy, distrust of spending choices by those in policy roles is great. As such, there is a reluctance to provide financial support for policies or programs that are not understood to be necessary or that have been developed outside the purview of the public stakeholders. The result of this for the public sector community mental health system has been an erosion of support and a diversion of potential funding to other sectors such as the justice system. Engaging the public in discourse and decision making about mental health service needs enhances the possibility that a greater equity and functional division of public priorities and finances will be achieved.

Social Justice

The social justice implications of this research are extensive. The public sector community mental health system is representative of one of the least empowered and most poorly funded domains in the public sphere. This study validates the potential for focus groups to serve as a means of facilitating inclusion of multiple stakeholder voices in the public discourse that drives public spending and directs public services. As such, it creates the possibility for diminishing the dominance of those with official authority, professional expertise or financial power in the determination of public need. The fact that the focus group is a method that requires the "ideal speech" situation and prioritizes the participation of all group members grounds it in the frame of social justice. The reality that social justice cannot be achieved without the inclusion of those historically disenfranchised and the difficulty of accomplishing this through routine research methods highlights the potential importance of the focus group for community research, that is, so long as it is determined that the focus group as a method provides an acceptable degree of validity and generalizability.

The validation of the focus group method in this research supports the possibility of enhancing the social justice of public sector service research and policy. When it becomes possible (as a matter of structure as well as cost) to access the opinions of stakeholders and those traditionally without voice in the public discourse, a shift occurs in power dynamics. This is not to purport that a revolutionary alteration occurs, but certainly when individuals or constituencies are given access to voice about issues that concern them, this increases the possibilities that the policies that result from the discourse will be more reflective of stakeholder need and desire. As a matter of course, this to some extent diminishes the official authority and the power of professional expertise in the determination of need because those who experience the need or who pay for the programs are allowed standing. While focus groups clearly remain a tool of the researcher or policy maker, the mere inclusion of those who would otherwise be excluded from the policy context moves the public process toward one that is more socially just.

Limitations

The areas of limitation of this research include the variation of transcript quality and completeness, the failure of attaining code confirmation through the procedure of blind code checking, the minimal ethnic and cultural diversity resulting from the original research project's regional composition, the lack of co-facilitator consistency and the lack of the capacity for obtaining participant review. These are each discussed in turn.

Transcript Quality Issues

This study highlighted the problems associated with the use of audio-taped records of varied sound quality and typed by different transcriptionists that are then used as a single data source. As was noted, two transcripts were not included in this secondary analysis due to quality and completeness problems that could not be overcome. In addition, there was great variation among the transcriptionists with regard to their ability to translate the taped discussion to a written report. The transcription of focus group discussions is far more complicated than general dictation transcription in which there is only one speaker as opposed to multiple participants speaking, at times simultaneously. Some transcriptionists seemed to become confused by the multiple speakers, some were familiar with the vocabulary used, others spelled in a consistently poor manner and still others left long blanks in quotations. While this created distortion in the actual data available for the project, it was compensated for as well as could be possible since the group moderator also coded the transcripts and had some recollection of the original speaker content. It would have improved the quality of the data if a conference microphone had been used for the full set of groups and if a single person skilled in the transcription of focus groups had prepared the transcripts.

Code Confirmation Issues

The inability to confirm code assignment by blind code checking created some concern about the quality of the coding process in this study. This circumstance may have been related to a number of factors, and certainly one conclusion might have been that the coding process had little validity. However, a more likely explanation is that the blind code checking process failed to account for learning that accrued in the coder during the process of coding multiple transcripts related to the same subject matter. If a true discrepancy of code application did occur, this would represent a clear threat to the validity of the theme findings gleaned from the focus group transcripts. However, the alternative explanation is compelling. As the researcher coded multiple transcripts related to the same topic, an understanding of the relatedness of certain codes and a tendency to consider the fit of codes for a specific quotation developed and changed. The coding became progressively more reflective of the content and intended meanings of the words expressed in the groups and recorded in the transcripts. For this reason, it became evident that blind code checking created a circumstance that in some ways penalized the coder for having developing deeper understanding of the content or themes embedded in the transcripts.

The usefulness of the blind code checking in this research was that it drew attention to the altered understanding the coder achieved merely by token of having coded multiple documents related to the same topic. In this project, it was eventually through same-coder over-coding of the transcripts that greater depth or clarification and the correction of misunderstandings were accomplished. In addition, it is worth noting that the blind code checking result would have been less extreme in the finding of discrepancy had the process of code consolidation been completed first. As such, the blind code checking effort helped to highlight the initial overlap in code meaning and code duplication that needed to be resolved before an analysis of code occurrence could be performed.

Ethnic Cultural Diversity Issues

The lack of substantial ethnic or cultural diversity in this set of focus groups reflected the challenges of the recruitment processes and created a difficulty with regard to the generalizability of the conclusions that could be drawn from this focus group data. The regions in which the original study was situated were predominantly Caucasian in population, especially in the more central or urbanized locations. This accounted to a great extent for the lack of diversity of participants. However, other factors clearly affected participation. During recruitment one representative of a Native American Tribe stated that not only would it be a waste of time to participate, it would be another way in which the tribe would be exploited by the State for the good of non-tribal members. Distance was also cited as being a barrier to participation, but the compelling message was that it would be a useless effort. In some communities, specific minority populations while small were known to represent a population in need of public sector services that were not necessarily available or accessed. Telephone calls and other efforts to connect with persons belonging to those constituencies were of limited success. Even in the Consumer/Advocate focus groups there was a noticeable lack of diversity present.

The impact of this reality is that the research results cannot be extended much beyond the Caucasian majority in the regions where the focus groups were convened. There were some groups in which local Native American and Tribal issues were discussed and in which members of the particular tribe did participate. However, it is necessary to question whether an alternative recruitment practice might have better engaged minority communities in the focus groups. Affiliation with the State as a funder of the original research may have acted as an incentive to participate for some individuals or groups and a disincentive for others. It is also possible that focus groups may not be readily accessed (by choice or through barrier) by those who feel separate from the majority community targeted, even when the community is defined by geographic and constituency parameters intended to be inclusive of diversity. Since this set of focus groups specifically addressed the public sector community mental health system, it must also be considered that the topic was of adequate stigma to cause some ethnic or minority groups in the community to be disinclined toward participation. In that event, the same individuals or groups might more readily participate in focus groups related to a different, less stigmatized topic. Language was addressed in this research as a potential barrier to accessing community mental health services, but in fact language may have acted as a barrier to participation in a focus group and accessing the public discourse. Language represents a concrete factor of marginalization and was quite possibly in part responsible for the composition of the focus groups used for this study.

Co-Facilitation Issues

The original research team consisted of individual research assistants who varied over time but who assumed the same role. It was this reason and the occasional lack of availability for a specific time that resulted in the use of multiple co-facilitators in the series of focus groups. The chief effect of this lack of consistency was that the moderator was at times required to assume greater responsibility for housekeeping aspects of the groups, when the moderator role really required full attention. The most significant problem related to this circumstance was the failure of one group to be recorded. The researcher became distracted and forgot to turn on the tape recorder. In subsequent focus groups, the moderator assumed responsibility for double-checking that the technology was working. Also, in some instances the co-facilitator was included by the group and in others stayed in the background. It is impossible to attribute this to co-facilitator style or to the group dynamic and constituency as this was not a variable planned for in the study design. The question as to whether there are some characteristics of co-facilitators that enhance the focus group process or that restrict it remains to be determined.

Issues of Power as Related to Participant Review and Transcript Quotations

Perhaps the most under-considered issue related to the use of focus groups as a means for accessing the voices of stakeholders is the reality that it is in the end the researcher who hears and reads and interprets the importance of quotations. It is the researcher who decides which quotations seem to be reflective of a given theme or even of the general mood or opinion of a group of individuals. Quotations are very powerful to those who read research, even those who may have some reservations about qualitative methods, because after all this is the voice of the participant, not merely an interpretation of the voice. However, like any data, quotations can be taken out of context either knowingly or from innocence or ignorance. Researchers who have an agenda in the area of study or have opinions of their own about the topic are unlikely to be completely successful in donning the veil of ignorance.

One mechanism for attending to this concern is to build in a mechanism for participants to approve or to comment on the analysis report. This process appears much more simplistic on the surface than it is in reality. In order to include participant comment or review in result validation, one must maintain a list of the participants who have volunteered to extend their involvement to this level. Then a process for submitting the report to the participants must be developed, a time frame designated for response, and some consensus of understanding about the manner in which comments might or might not be included in the subsequent final report. This process can be time consuming and costly. In some public policy circumstances the time or dollars required might not be available. However, the process is the most clear aspect of this endeavor.

This research was a secondary analysis of focus group data from a study that required the destruction of identifying information after completion. Therefore, it was not possible to elicit participant review or comment for the current project results. It is not entirely clear that such review would have contributed to the study results or implications. However, it would have perhaps added another element of validation. Participant review would have been a research element consistent with a social justice agenda and closely related to issues of power; however, such a process may or may not have reinforced the trustworthy nature of the focus group data.

Even when the procedure for participant review is comprehensive and unambiguous, questions remain as to issues of self-selection (of those who volunteer to review and comment on the researcher's report of results), the relative importance of comments that might be in direct conflict or even the relative importance of the researcher's experience and understanding that was consummated in the original report. This list of concerns emphasizes the complexity of attending to the equity of research participants, including the researcher. The more diversity of voice, the wider the lens, yet care must be taken to see that equity of opportunity for participation is maintained and not artificially masked. For instance, those who are less literate in English would be disinclined to offer to provide written comment on the written summary of the focus group, and they might in fact have views quite different from the participant who is comfortable making such an offer to provide feedback. It may be that the inclusion of comment from self-selected volunteers has the potential of weighting the results in favor of participants who are already more entitled.

Recommendations

The primary recommendation resulting from this research is that focus groups be viewed by those in research and policy roles as a cost effective and trustworthy means for obtaining public opinion and accessing stakeholder voice from constituencies and communities. However, the caveat is that this is only the case when the planning, implementation and analysis processes of the focus group are consistent and reliable. This requires that focus group recruitment procedures are explicated and faithfully applied once constituency populations have been specified. It also mandates that the topic questions and the moderator (as well as the co-facilitator if at all possible) are consistent. The procedure and equipment for recording the group must be of minimal distraction, but be reliable and uniformly used. The transcription of audio-tapes or videotapes must be completed by a single, experienced transcriptionist who also has the vocabulary and skill necessary to prepare the focus group transcripts accurately. Finally, the coding procedure recommended is a process of over-coding, whether by a single coder or by more than one coder. The importance is that the code dictionary is clear to all, and that all transcripts are coded in an iterative, additive fashion, by the same person or persons and by the same procedure, to provide consistency of the coding and to take advantage of the benefit of additive coding.

ATLAS.ti significantly facilitated the process of analysis without creating distance from the actual transcript data. This project was enhanced by the use of this program and as such provides support for the use of qualitative data analysis software as opposed to the manual coding and clustering of themes. The ability to obtain frequency data for code occurrence in individual groups, clusters of groups and the entire cohort of groups was essential for this evaluation of the focus group method. Such a task would have been doable without the software, but would have been extremely onerous for such a large set of focus groups. Therefore, it is strongly suggested that those engaging in the analysis of focus group data seriously explore this option for data management and analysis.

Recommendations for further validation of the focus group as a trustworthy method for accessing stakeholder voice and public opinion is that this project be repeated at a different site, with a more diverse population, related to a different segment of the public service sector and using the model developed and validated in this study. Applying these focus group procedures and then conducting a similar analysis looking for consistencies of thematic content between and among constituencies and regional groups would provide further understanding of the role of the focus group as a means for informing public policy.

Summary

The purpose of this secondary analysis of focus group data was to explore the usefulness of focus groups as a means for gathering information about public opinion and eliciting stakeholder voice regarding public sector community mental health services. A qualitative analysis of thirty focus group transcripts using the ATLAS.ti software program found the focus group data to be trustworthy. While the results were not conclusive given the qualitative nature of the research, the extent to which concurrence was found between actual thematic content and anticipated thematic content was compelling evidence of both content validity and generalizability. The need for further research regarding this method continues, but on the basis of this study, there is evidence that focus groups grounded in the model developed for this project are an effective method for accessing the voice of stakeholders and eliciting public opinion with regard to the public sector community mental health system.

It follows that focus groups would be a good methodological fit for other situations in which public policy makers require information about community interests and opinions regarding a specific topic. The problems of assuring that diversity is represented, adhering to a consistent model, achieving transcript quality and providing a mechanism for meaningful participant review of findings are inherent in any qualitative research conducted in the real world community setting. These issues must be attended to, but are not insurmountable. The focus group model as developed in this study is a research method that holds great potential for informing and enhancing public policy while incorporating elements of social justice in the process.

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Appendix A. Code Frequencies

CODES	P 1: forks_service_post	P 2: longview_service&justice_post	P 3: pen_consumer/Advocate_pre1	P 4: pen_consumer/Advocate_pre2	P 5: pen_justice_post1	P 6: pen_justice_post2	P 7: pen_justice_pre	P 8: pen_kids_post	P 9: pen_kids_pre1	P10: pen_kids_pre2	P11: pen_service_post	P12: pen_service_pre1	P13: pen_service_pre2	P14: PortTownsend_post	P15: PortTownsend_pre	P16: spokane_consumer/Advocate_post	P17: spokane_consumer/Advocate_pre	P18: spokane_justice_post	P19: spokane_justice_pre	P20: spokane_kids_post	P21: spokane_kids_pre	P22: spokane_service_post	P23: sw_consumers/Advocate_post	P24: sw_consumers/Advocate_pre	P25: sw_justice_post	P26: sw_justice_pre	P27: sw_kids_post	P28: sw_kids_pre	P29: sw_service_pre1	P30: sw_service_pre2	Totals
access to services/b	32	48	13	80	22	18	31	28	29	34	32	20	12	17	82	29	28	27	14	17	33	8	38	38	47	35	24	18	15	27	830
accountability	0	0	0	7	1	1	1	3	1	0	1	2	1	0	2	0	1	1	0	0	3	0	2	3	0	2	0	1	1	6	38
adults	1	1	0	0	1	0	0	2	1	0	0	0	0	0	1	1	6	2	6	1	1	1	1	0	3	0	0	0	0	0	29
advocate issues	4	0	15	28	0	0	1	4	2	0	2	3	0	2	8	13	30	3	1	2	6	4	8	13	13	4	1	2	4	8	177
care in community	0	0	0	12	12	10	15	10	11	10	10	10	1	8	20	5	8	0	5	2	7	0	4	3	2	1	10	1	1	8	180
care offset	8	18	4	13	15	10	18	18	24	17	29	10	10	9	31	5	7	31	27	7	18	8	1	3	23	33	23	20	16	18	473
case management	14	10	18	11	0	2	8	0	6	7	2	8	3	0	1	7	3	4	6	1	0	0	2	4	8	2	0	2	11	12	148
co-occurring disorde	4	18	1	6	10	3	12	6	4	2	9	7	18	3	4	1	0	2	3	1	1	5	4	1	10	6	5	8	0	8	159
communication	18	22	10	28	21	9	35	18	33	38	29	35	27	9	37	18	31	30	31	24	38	11	8	9	27	23	23	32	8	13	682
confidentiality as a	0	1	1	0	3	2	3	1	2	0	1	1	0	0	1	4	7	0	2	0	0	0	1	0	4	0	0	0	1	0	35
conflict of interest	0	0	0	4	2	0	0	1	0	0	0	1	0	0	1	1	0	1	0	0	3	0	5	1	2	0	1	0	0	0	23
cost issues	8	18	1	19	18	5	13	12	18	6	12	18	9	6	32	4	6	9	3	11	34	2	10	32	18	30	10	9	7	4	379
crisis	7	10	2	6	1	3	5	3	8	6	1	2	1	2	10	7	10	3	6	0	3	4	3	4	6	7	7	8	6	3	142
cultural barrier to	8	1	0	0	0	0	0	0	0	2	2	0	0	0	0	1	0	0	0	0	1	0	0	0	1	0	0	0	1	0	16
dangerous/potential	4	4	0	5	8	3	5	5	9	3	8	2	1	1	12	9	5	3	9	4	8	6	0	3	7	14	8	4	0	4	164
discrimination	1	0	0	4	0	0	0	0	0	1	2	0	0	0	0	1	7	3	0	0	1	0	10	3	0	4	0	0	0	0	37
distance/transportat	4	0	0	12	0	4	1	2	7	8	2	4	1	0	5	6	3	2	2	0	0	0	0	1	2	3	8	0	2	0	79
early discharges	1	1	0	1	0	0	0	4	1	1	1	0	0	0	0	0	1	0	0	0	3	0	1	0	0	2	1	0	0	1	19
effectiveness of ser	8	5	4	20	2	3	14	15	18	14	10	6	4	4	7	8	12	4	3	2	18	0	7	18	9	8	2	1	5	11	234
elderly	4	6	0	0	0	1	0	0	0	0	3	7	0	0	1	3	0	0	0	0	0	0	0	0	1	0	0	0	5	4	35
engagement in servic	4	10	2	3	1	0	13	11	3	9	3	0	2	3	11	2	2	1	6	3	1	0	0	8	8	3	9	2	2	4	124
family frustration	2	0	14	18	0	1	1	2	0	1	0	1	0	0	6	4	18	1	0	0	0	0	5	5	3	0	2	1	0	1	86
follow-up/continuity	3	8	0	2	2	0	1	5	3	8	4	2	5	2	7	4	1	3	11	4	7	0	4	6	4	4	4	2	4	4	112
housing	2	0	8	3	0	1	8	1	3	2	20	7	3	0	8	1	7	1	7	0	6	4	3	7	1	4	0	0	0	14	118
in-patient care	0	4	1	20	0	1	3	6	2	4	7	8	1	0	8	8	7	5	4	1	5	3	2	6	6	6	1	2	2	7	130

Appendix A. Code Frequencies

CODES	P 1: forks_service_post	P 2: longview_service&justice_post	P 3: pen_consumerAdvocate_pre1	P 4: pen_consumerAdvocate_pre2	P 5: pen_justice_post1	P 6: pen_justice_post2	P 7: pen_justice_pre	P 8: pen_kids_post	P 9: pen_kids_pre1	P10: pen_kids_pre2	P11: pen_service_post	P12: pen_service_pre1	P13: pen_service_pre2	P14: PortTownsend_post	P15: PortTownsend_pre	P16: spokane_consumerAdvocate_post	P17: spokane_consumerAdvocate_pre	P18: spokane_justice_post	P19: spokane_justice_pre	P20: spokane_kids_post	P21: spokane_kids_pre	P22: spokane_service_post	P23: sw_consumerAdvocate_post	P24: sw_consumerAdvocate_pre	P25: sw_justice_post	P26: sw_justice_pre	P27: sw_kids_post	P28: sw_kids_pre	P29: sw_service_pre1	P30: sw_service_pre2	Totals
Insurance/Medicaid	3	9	1	8	3	2	2	6	4	4	0	1	2	4	9	2	1	1	0	3	4	2	4	10	7	2	4	1	10	4	113
involuntary care	2	9	0	1	0	8	4	1	4	0	5	5	4	1	8	5	4	4	11	2	3	0	3	1	11	15	2	2	0	0	115
justice system	2	27	2	14	26	27	43	6	15	2	3	2	3	2	13	4	14	28	46	2	14	3	0	2	28	37	6	10	0	3	384
kids/teens	7	9	8	10	1	0	0	25	40	31	0	2	2	3	25	1	6	0	0	22	47	1	0	2	11	2	30	19	3	5	312
lack of services for	4	4	0	5	2	2	9	4	13	1	8	3	0	1	6	1	6	3	1	1	1	0	2	2	2	5	8	2	1	8	105
Language issues	1	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3	0	1	0	2	1	11
long term treatment	0	6	0	1	1	0	1	1	2	1	0	2	1	0	3	0	2	0	2	3	5	0	1	0	4	1	3	0	0	3	43
Managed Care/Gate Ke	9	3	1	3	1	3	5	8	6	4	4	3	4	6	17	4	6	11	5	10	12	2	12	7	18	6	6	3	7	2	188
Medical	9	7	4	24	10	5	6	4	0	22	5	4	4	2	9	17	16	8	8	2	3	1	9	17	10	6	2	0	4	21	239
Native American issu	8	0	0	0	0	0	0	3	1	1	1	9	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	26
Need Exceeds Service	19	26	8	25	16	6	22	17	27	14	28	17	13	14	39	12	18	16	23	16	36	2	21	19	33	42	27	22	12	32	622
needs of vulnerable	2	7	4	9	4	1	19	7	7	3	8	3	5	2	11	4	7	7	16	5	22	1	6	12	17	13	19	7	7	13	248
no evidence of servi	2	2	2	1	0	0	0	1	1	0	0	2	1	1	0	0	0	0	0	0	4	0	0	0	0	0	0	0	3	1	21
outcome measures	1	4	1	5	2	4	7	13	12	12	4	4	4	1	7	6	4	4	3	2	8	0	5	6	2	3	2	6	3	5	140
paperwork	2	0	1	6	2	1	2	4	1	0	0	0	0	0	0	1	3	1	0	1	1	1	0	2	1	2	0	3	2	1	38
People with Nothing	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	2	0	1	0	0	0	4	9
power	2	0	1	7	1	0	3	0	0	0	3	1	1	2	13	5	11	3	3	0	3	1	4	3	7	4	1	7	0	1	88
prevention	0	0	0	1	0	0	0	0	1	6	0	0	0	0	2	0	1	0	1	0	1	0	0	0	0	2	6	3	2	1	27
recidivism	0	11	0	0	0	1	5	2	3	0	0	0	1	0	1	1	0	4	3	1	8	0	0	2	3	2	3	9	4	2	66
respectfulness	2	3	4	8	2	0	1	0	1	0	3	3	1	3	11	12	23	2	3	1	3	3	17	6	1	0	3	5	1	11	133
Responsiveness	22	21	9	29	13	8	19	26	34	23	16	23	5	15	47	30	31	25	23	7	30	5	29	19	23	26	17	18	5	12	610
satisfaction	8	10	16	47	11	13	21	13	18	8	27	28	5	9	32	23	43	18	8	6	16	3	43	28	6	8	10	11	2	7	498
school services	2	0	0	1	0	0	0	8	2	13	0	0	0	0	13	0	1	0	0	0	10	0	0	0	0	0	17	1	0	0	68
services work	3	12	2	4	3	4	18	5	11	6	4	7	4	0	8	7	9	4	8	3	9	0	17	13	1	5	8	5	1	11	192
social problems	2	0	0	0	2	0	4	0	1	2	2	1	1	0	1	0	2	1	2	1	8	1	0	1	2	3	1	0	0	2	40

Appendix A. Code Frequencies

CODES	P 1: forks_service_post	P 2: longview_service&justice_post	P 3: pen_consumerAdvocate_pre1	P 4: pen_consumerAdvocate_pre2	P 5: pen_justice_post1	P 6: pen_justice_post2	P 7: pen_justice_pre	P 8: pen_kids_post	P 9: pen_kids_pre1	P10: pen_kids_pre2	P11: pen_service_post	P12: pen_service_pre1	P13: pen_service_pre2	P14: PortTownsend_post	P15: PortTownsend_pre	P16: spokane_consumerAdvocate_post	P17: spokane_consumerAdvocate_pre	P18: spokane_justice_post	P19: spokane_justice_pre	P20: spokane_kids_post	P21: spokane_kids_pre	P22: spokane_service_post	P23: sw_consumerAdvocate_post	P24: sw_consumerAdvocate_pre	P25: sw_justice_post	P26: sw_justice_pre	P27: sw_kids_post	P28: sw_kids_pre	P29: sw_service_pre1	P30: sw_service_pre2	Totals
staff morale	1	1	0	0	0	0	0	3	0	5	0	3	1	1	1	3	0	1	0	0	0	0	2	2	2	0	1	0	0	3	30
Staff Time Limited	8	3	0	0	0	0	3	5	7	5	2	0	1	1	3	1	4	3	1	0	2	0	4	3	0	3	0	4	4	12	79
staff training	1	2	7	2	0	0	0	3	1	4	8	6	1	2	3	2	5	1	1	0	4	1	1	2	1	2	8	1	2	11	82
system doesn't work	12	6	6	38	9	10	12	10	13	6	24	16	1	17	46	16	30	17	14	10	29	3	24	17	23	30	13	6	4	16	478
transient population	0	5	0	1	0	0	1	0	0	0	5	2	0	0	1	1	0	2	4	0	2	0	0	0	0	5	0	0	0	2	31
unrealistic expectat	1	0	0	0	0	0	0	1	0	0	0	0	2	0	1	0	0	0	0	3	3	0	2	0	0	0	0	0	1	0	14
who gets served	0	7	6	12	17	14	33	12	20	13	16	12	12	9	26	11	2	16	20	12	26	3	0	1	43	44	20	16	18	11	452
work opportunity	0	0	0	7	1	0	1	0	0	0	0	0	1	0	0	1	3	0	0	0	1	0	17	2	0	1	0	0	0	5	40
Totals	288	376	178	537	246	185	428	345	427	357	364	311	180	161	619	313	451	318	352	182	518	88	337	347	456	458	382	278	189	357	9990

Appendix A. Code Frequencies

SUPER CODES	P 1: fortis_service_post	P 2: longview_service&justice_post	P 3: pen_consumerAdvocate_pre1	P 4: pen_consumerAdvocate_pre2	P 5: pen_justice_post1	P 6: pen_justice_post2	P 7: pen_justice_pre	P 8 pen_kids_post	P 9: pen_kids_pre1	P10: pen_kids_pre2	P11: pen_service_post	P12: pen_service_pre1	P13: pen_service_pre2	P14: PortTownsend_post	P15: PortTownsend_pre	P16: spokane_consumerAdvocate_post	P17: spokane_consumerAdvocate_pre	P18 spokane_justice_post	P19: spokane_justice_pre	P20: spokane_kids_post	P21: spokane_kids_pre	P22: spokane_service_post	P23: sw_consumerAdvocate_post	P24: sw_consumerAdvocate_pre	P25: sw_justice_post	P26: sw_justice_pre	P27: sw_kids_post	P28: sw_kids_pre	P29: sw_service_pre1	P30: sw_service_pre2	Totals
Responsiveness & Services Work	0	2	0	3	1	2	6	3	7	5	2	5	2	0	6	3	4	3	1	1	6	0	6	6	0	3	4	1	0	0	80
Responsiveness & System Doesn't Work	3	2	0	15	4	4	6	7	8	3	11	4	0	8	25	13	14	12	8	4	16	0	10	6	17	14	5	4	0	3	226
Satisfaction & System Doesn't Work	2	1	4	27	4	5	2	3	3	0	16	6	0	7	20	8	18	10	1	2	6	1	12	6	4	7	0	2	1	3	306
Satisfaction & Services Work	1	7	2	4	2	4	14	3	7	3	3	6	3	0	7	7	9	3	3	0	6	0	13	12	0	0	6	2	1	4	132

Appendix B

List of Collapsed Codes, Occurrence Frequencies, and Definitions

Access to services/barriers to care (830)
Relates to whether a specific mental health service or general mental health services are readily accessed or not. Also relates to personal, economic, distance, availability issues among others that represent a barrier to an individual seeking or receiving mental health care.

Accountability (39)
Relates to whether the individual service provider or the mental health center or the mental health system assumes accountability or not for actions and decisions about mental health care or the system of services.

Adults (29)
Relates to any concern or service or system that is directed toward adults as opposed to children. This code is helpful in identifying, for example, that the access to adult mental health care may be fine, but the elderly or children have more difficulty accessing care.

Advocate issues (177)
Relates to any issue that either is described by the speaker as related to advocacy, or any problem that infers need for advocacy, or a situation in which only those who have advocates receive what they need from the mental health provider or system.

Care in community (180)
Refers to whether a form of care is available in the community and whether the care in a given community meets community needs – essentially used to reflect any statement that specifically indicates reference to the community resources or pattern, etc.

Care offset (473)
Analogous to medical cost offset for the mental health system – when the mental health system fails to provide care and as a result other systems such as the justice system or the health care system or the school system need to intervene and provide services or pay for care or incarcerate, etc. This code was combined with the code "time devoted to mental health," which referred specifically to the amount of time an individual not employed by the mental health system spends accessing mental health service for themselves, a family member or accessing or advocating for mental health services for someone unrelated, or providing mental health services not funded by the public sector community mental health system. Examples of the latter include schools that provide in-school services through private contracts, the police or probation services providing services they view as the responsibility of the mental health system or spending hours negotiating for services for a shared client or population.

Case management (148)
Refers to any statement that expresses opinion about case management – be it satisfaction or accessibility, or inadequacy, etc. Case management is coordinated mental health care that collaborates with other providers and systems such as probation or health care or housing for a person enrolled in the mental health system. This was combined with the code "access to case management" that relates to whether case management is available and how easy or difficult it is to obtain, and the code "lack of case management," which refers to circumstances in which case management services are either not available or are not provided adequately or at all.

Co-occurring disorder (159)
Refers to the co-existence of mental health disorder with chemical dependency disorder specifically. However, may also refer to co-existing mental health disorder and a health problem such as AIDS or mental retardation.

Communication (692)
Refers to sharing of information in a productive manner between individual clients, providers, advocates or others. May be used to indicate either a positive or a negative circumstance. This code was combined with the code "collaboration needs" that refers to situations in which care or service delivery requires more than one provider or system to work together to effectively serve an individual or a community, the needs may or may not be effectively met; the code "coordination and linkage issue" that refers to issues related to the interaction or need for interaction between more than one system or mental health organization to meet the needs of one or more clients, or to prevent the duplication of services; and the code "information" that refers to any resource material or the communication about mental health services or resources either provided to or needed by clients, advocates, families, mental health care providers or other members of the community.

Confidentiality as a barrier to service (35)
Refers to situation in which the lack of a release of information document impedes an individual receiving the necessary care or intervention because communication does not occur.

Conflict of interest (23)
Refers to situation in which an individual mental health practitioner, service agency or the mental health system is in a position where personal or system interests may not be consistent with the needs of one or more clients. It may be that the need of the client is subverted to the interests of the system, or it may be simply that the conflict exists.

Cost issues (379)
Refers to any direct statement related to cost associated with mental health services, or circumstances that are directly associated with cost such as lack of certain services because of cost or lack of individual access to mental health services because of cost

being too high. This code was combined with the code "funding cutbacks" which refers to statements made by participants about decreases in funding for mental health services, or which reflect such decreases; and with the code "funding limits services" which refers to situations in which ideal mental health care or services are not available or provided due to inadequate funding to support such services or care.

Crisis (142)
Refers to any situation in which the speaker refers to the circumstance as being a crisis, an emergency, or in which the crisis intervention delivery system is engaged; these situations may be adequately managed by the mental health system or not adequately managed.

Cultural barrier to care (15)
Refers to circumstance in which mental health services available in a community are not used by a group of individuals in need of mental health care because the services are either not provided in a culturally acceptable manner, there is a cultural stigma that prevents identification of mental illness or there is a distrust of services due to cultural bias of client, community or provider.

Dangerous/potential for violence (154)
Refers to any situation that is unsafe or might be unsafe either related to an individual client's behavior or to the process of a system or lack/delay of a mental health service. This code was combined with the code "potential for violence," which refers to the extent to which environment or process of the mental health system or the behavior of an individual client are unsafe; may reflect a situation in a home or other place.

Discrimination (37)
Relates to any circumstance in which individual or group care or the response of a provider reflects stigma due to mental illness or other characteristic such as race or gender.

Distance/transportation as a barrier to care (79)
Refers to circumstances in which care is not obtained because distance between residence or school and needed mental health services are too great to be overcome at all or on a regular basis. This code was combined with the code "transportation issues," which refers to issues related to transportation to necessary mental heath services. This may be weekly or daily transportation to a mental health center for care, or it may reflect a three-hour ambulance ride to the nearest in-patient psychiatric facility. This may even reflect difficulty that exists in communities where population is widely dispersed and centralized services are difficult to access due to distance. It may also reflect cost of transportation that may make it onerous to those most in need of mental health care.

Early discharge (19)
Refers to situation in which discharge from an in-patient or out-patient mental health

service is judged by the speaker or inferred to have been premature, the outcome of early discharge may be that client need is inadequately met.

Effectiveness of services (234)
Relates to the judgment of the speaker as to whether services delivered to an individual client or the process of service delivery to the community or the cluster of services provided are effective; the services in question may be deemed effective or ineffective.

Elderly (35)
Refers to older adult clients who require services that are different than those provided to young or middle aged adults. Age range might begin at 55 y/o; however, many individuals who are 55 y/o do not require older adult services.

Engagement in service (124)
Refers to both the effort directed to connect with prospective mental health service clients, and the outreach effort to find clients who may be difficult to serve due to perhaps being homeless or fearful of the mental health care system. Also refers to the actual extent to which the client is involved in mental health services and the involvement of the client in therapy or case management.

Family frustration (86)
Refers to statements that reflect frustration experienced by family members of individuals with mental illness, whether or not mental health services are obtained in a given situation.

Follow-up/continuity of care (112)
Refers to actions or communication that is needed after an interaction with a client. The interaction may have been related to case management about housing or finances, etc., or it may have been an episode of in-patient mental health care. The codes "follow-up" and "continuity of care" were combined.

Housing (119)
Refers to any statement or described situation related to housing for one or more persons suffering from mental illness.

In-patient care (130)
Refers to psychiatric care provided in the hospital setting.

Insurance/Medicaid (113)
Refers to any third-party payer for mental health care or health care. This may be private insurance or public insurance such as Medicaid (state-funded, need-based insurance for health and mental health care).

Involuntary care (115)
Refers to mental health treatment that is provided against the individual's wishes. This may be involuntary psychiatric hospitalization or may be out-patient care provided under civil court order for a period of perhaps 90 days or 180 days. This care is considered more restrictive when in-patient, and less restrictive when out-patient. For involuntary commitment to occur there is first a requirement for assessment by a county designated mental health professional, who can detain an individual for 72 hours. Should further treatment be deemed necessary, a court hearing is required. The grounds for involuntary treatment in Washington state include imminent danger to self, others or property, or grave disability.

Justice system (384)
Refers to the range of organizations and services inclusive of law enforcement, the courts, legal advocates, juvenile justice, probation, and detention facilities. This code is combined with the code "jail" that refers to any statement made by a participant that is related to jail. The context relates to individuals who suffer from mental illness and the interaction they have with jail or refers to the mental heath services provided by a jail. This code is also combined with the code "law enforcement," which refers to the police, sheriff, the organization, or others who enforce the law in a community or on a reservation and who may be in a position of first response to a mental health client in crisis or breaking the law/disrupting the peace.

Kids/teens (312)
Refers to individuals under the age of 18 years old. The codes for kids and teens are combined.

Lack of services for most severely ill (105)
Refers to situation in which mental health services fail to meet the needs of individuals who are the most vulnerable or mentally ill.

Language issues (11)
Refers to circumstances in which language presents a problem, concern or barrier to mental health care.

Long-term treatment access (43)
Refers to whether long-term residential care is available and if so ease with which it is obtained.

Managed care/gate keeping (188)
Refers to the system of administering the mental health system (public or private) that requires oversight by organizations that determine eligibility for services and the extent of services to be provided by practitioners. This code is combined with the code "gate keeping" which refers to the process of one service or provider having the ability to control access to other services. Generally this refers to specific mental health services or

enrollment in mental health care, but can be used to refer to other systems or services. This code is combined with the code "denial of services," which refers to a circumstance in which an individual who has requested or applied for mental health services has been declined enrollment in mental health care or access to a specific service.

Medical (239)
Refers to non-psychiatric health care provided by non-psychiatric practitioners. This code is combined with the code "access to psychiatric prescriber" which refers to whether a psychiatric prescriber is available and how easy or difficult it is to obtain the services of a psychiatric prescriber. This code is also combined with the code "medication issues," which refers to any situation in which psychiatric medications are at issue or discussed by participant speaker.

Native American issue (26)
Refers to any issues that relate to tribal government, services or funding as well as Native American cultural issues that may have an impact on access to mental health care. This code is combined with the code "tribal jurisdiction," which refers to the boundaries of tribal government and services, for example, individuals who reside on a reservation or who are members of a tribe and may or may not be eligible for tribal services, but may not have access to non-reservation services so long as they are on the reservation. This may also refer to the boundaries of responsibility and limits of authority of tribal services. This code is also combined with the code "reservation issues," which refers to issues specific to Native American reservation and the provision of mental health services to individuals who reside on the reservation. This includes those who are Native and are eligible for Native health services as well as those who are not Native. Issues include distance and distrust as barriers to seeking or obtaining mental health services off the reservation. In addition this code is combined with the code "Native mental health program," which refers to mental health services provided to Native Americans and funded by tribal monies.

Need exceeds service availability (622)
Refers to any situation in which mental health services are required but are not accessible either because dollars have been directed elsewhere toward other mental health services or because available services are full. This code is combined with the code "services full," which refers to circumstances in which a need has been identified and mental health services are generally available in the community. This code is also combined with the code "client gets lost," which refers to the situation in which a client who is supposed to be receiving mental heath services stops being served, perhaps an appointment is missed and can't easily be rescheduled, perhaps the client moves to another residence or town and can't be located. Also refers to situation in which the barriers to mental health services are not navigable for an individual or family. In addition, this code is combined with the code "crack in the system," which refers to circumstance in which a necessary service is unavailable in a community or to an individual, situation in which a person in need of mental health care is not eligible for services, needs care not available, or is not a

good fit for the available services so either does not pursue them, or is denied what is available. An example is the person who is homeless, chemically dependent, and mentally ill.

Needs of the vulnerable (246)
Refers to the needs of those who are most severely mentally ill or who are most fragile due to circumstance such as homelessness, etc.

No evidence of service outcome (21)
Refers to situations in which mental health practitioners or the mental health system have provided a service, but there seems to be no change or benefit associated with the service.

Outcome measure (140)
Refers to means for determining the impact of mental health services. Individually these may be based on target symptoms that are assessed for change or improvement; at a systems level these may address measurable ways to determine such issues as access or satisfaction.

Paperwork (38)
Refers to the paperwork required by the public sector mental health system and is often associated with expression that it impedes the actual delivery of mental health services.

People with nothing to do (9)
Refers to the lack of structured activity or other meaningful activity available to persons with mental illness.

Power (88)
Refers to the capacity of an individual, organization or system to effect an outcome or influence, in this instance the provision or determination of mental health services.

Prevention (27)
Refers to efforts in place or those needed to prevent mental illness or the morbidity and mortality associated with mental illness.

Recidivism (66)
Refers to the revolving door of the mental health system, a circumstance in which a client repeatedly presents for mental health services previously received. Often refers to episodes of repeated psychiatric hospitalization rather than stabilization with tenure in the community. This code is combined with the code "high-utilizer," which refers to individual mental health service clients or groups of clients who have similar characteristics and who require an exceptional amount of mental health services and the dollars associated with provision of those services.

Respectfulness (133)
Refers to the degree to which those who interact with the mental health system or with individual mental health practitioners feel they are treated with respect. Also refers to the overall impression as to whether the system and those employed by it are respectful toward clients, family members, other service providers and the members of the community.

Responsiveness (610)
Refers to whether the participant views the mental health system as being responsive to meeting the needs of the individual and the community in an interaction or with regard to the overall process of providing mental health services. This code is combined with the code "lack of helpful response" which refers to circumstances in which the participant speaker clearly states that the response of a provider or the mental health system was less than helpful, or described event in which this is evident. This code is also combined with the code "slow response time," which refers to statements or inferences by participants that the mental health services respond to individuals in need slowly – whether the individual is a client, potential client or other member of the community. May refer to time delay in returning calls or delays in obtaining services. In addition, this code is combined with the code "wait list," which refers to statements made by participants reflecting a waiting list for mental health services.

Satisfaction (499)
Refers to specific statements made by participants with regard to their sense of satisfaction (good or bad) with the mental health system or a specific service.

School services (68)
Refers to mental health services provided at the school. These may be provided by the mental health system or funded by the school system as a means of filling a perceived gap.

Services work (192)
Refers to situations or overall impressions of participants that the mental health services in the community (or specific services as opposed to all services) are effective and accessible.

Social problems (40)
Refers to problems related to interaction with the environment that may or may not be directly related to mental illness.

Staff morale (30)
Refers to participant perception of the extent to which staff providing mental health services are or are not happy with their job, feel satisfied, etc.

Staff time limited (79)
Refers to impression by participants that there is inadequate staffing for adequate service provision and that individual practitioners have excessive caseloads. This code is combined with the code "provider time limited," which refers to the constraints that are placed on the time of mental health providers that are likely due to funding and caseload, but which result in limited access by an individual in need of services.

Staff training (82)
Code used to indicate any reference to staff training. May refer to the extent to which advocates and clients find or report they must train staff or may refer to the extent of training and education staff have received either independently or as an aspect of their work. This code may reflect need for training or accomplishment of training.

System doesn't work (478)
Refers to statements of participants regarding their perceptions or beliefs that the mental health system does not work, is not functional. May also refer to situations that are described that reflect ways in which the system fails to function effectively. This code is combined with the code "bad feelings toward mental health services," which refers to that sentiment expressed by the participant speaker. This code is also used when the sentiment is evident from the content of the quotation. Often this code is used with satisfaction to indicate dissatisfaction. This code is also combined with the code "system gets fired." which refers to situations in which mental health services are either avoided or refused due to past negative experience with the mental health system. May reflect the reaction of either a client or another member of the community.

Transient population (31)
Refers to individuals who may be homeless, but who are also likely to be mobile between communities and extremely difficult to engage in meaningful mental health services.

Unrealistic expectations of the mental health system (14)
Refers to expectations stated by participants that are beyond the scope and authority of the public sector community mental health system or beyond the possibilities of funding available to the system.

Who gets served (452)
Refers to characteristics of individuals or groups of individuals that tend to affect their ability to access needed mental health care. Examples of such characteristics include poverty, culture or special needs such as those of sexually aggressive youth.

Work opportunity (40)
Refers to opportunity available to those who suffer from mental illness to engage in work or vocational activity.

Appendix C

Code Checking Comparison

(*** indicates code not identified by both coders)

Coder # 1 Transcript 29 and 30	Coder # 2 Transcript 29 and 30
Medicaid	***
Time devoted to mental health	Time devoted to mental health
Managed care	***
Medicaid	***
Time devoted to mental health	Time devoted to mental health
Care offset	***
Time devoted to mental health	Time devoted to mental health
Follow-up	***
Insurance	Insurance
Managed care	Managed care
Medicaid	Medicaid
Needs of the vulnerable	Needs of the vulnerable
Who gets served	Who gets served
Cultural barrier to care	***
Language issues	Language issues
Outcome measures	Outcome measures
Effectiveness of services	***
Effectiveness of services	***
Outcome measures	Outcome measures
No evidence of service outcome	***
Reservation issues	***
Crisis	Crisis
Follow-up	Follow-up
Lack of helpful response	***
Medication issue	Medication issue

Need exceeds service availability	***
Barriers to mental health care	***
Paperwork	Paperwork
Time devoted to mental health	Time devoted to mental health
Continuity of care	***
Need exceeds service availability	Need exceeds service availability
Paperwork	Paperwork
Recidivism	Recidivism
Barriers to mental health care	Barriers to mental health care
Case management	Case management
Communication	***
Effectiveness of services	Effectiveness of services
Family frustration	Family frustration
Funding limits service	***
***	Lack of helpful response
Language issues	Language issues
Medical care	Medical care
Medication issues	Medication issue
Need exceeds service availability	Need exceeds service availability
No appropriate services	***
Recidivism	Recidivism
Responsiveness	Responsiveness
Slow response time	Slow response time
System doesn't work	System doesn't work
Teens	Teens
Housing	
Needs of the vulnerable	***
Access to services	Access to services
***	Bad feeling toward mental health
Barriers to mental health care	***
Medication Issue	Medication issue
***	Services? full
System doesn't work	System Doesn't work
Barriers to mental health care	Barriers to mental health care
***	Co-occurring disorder
***	Provider time limited
Need exceeds service availability	Need exceeds service availability
Short staffed	Short staffed
Staff morale	Staff morale
Staff training	***

Staff training	Staff training
System doesn't work	***
Housing	Housing
Need exceeds service availability	***
Advocacy Issues	***
Care in community	Care in community
Care offset	***
Housing	Housing
Needs of the vulnerable	***
Access to services	Access to services
Accountability	Accountability
Advocacy issues	***
Care in community	Care in community
Effectiveness of services	Effectiveness of services
Information	***
Access to services	Access to services
Coordination and linkage issues	***
Lack of helpful response	Lack of helpful response
Access to case management	Access to case management
Accountability	Accountability
Advocate issues	Advocate issues
Case management	Case management
Dangerous	Dangerous
Effectiveness of services	Effectiveness of services
Housing	Housing
In-patient care	In-patient care
Time devoted to mental health	***

Coder #1 Coding Transcript 6 and 7	**Coder #1 Blind Check** Transcript 6 and 7
Access to services	Access to services
***	Bad feeling toward mental health
***	Barriers to mental health
Care in community	***
***	Care offset
***	Cost issues
Crack in the system	***
***	Distance as a barrier to care
Elderly	Elderly
***	Family frustration
Funding limits services	Funding limits services
***	Need exceeds service availability
***	Needs of the vulnerable
***	No appropriate services
***	Satisfaction
System doesn't work	***
Time devoted to mental health	***
***	Transportation issues
***	Who gets served
Access to services	Access to services
Care in community	***
***	Care offset
***	Crack in the system
***	Need exceeds service availability
***	Responsiveness
***	System doesn't work
Time devoted to mental health	Time devoted to mental health
Who gets served	***
Crisis	Crisis
Involuntary care	Involuntary care
Access to case management	***
Bad feeling toward mental health services	***
Barriers to mental health care	***
***	Case management
Collaboration needs	***
Coordination and linkage issues	***
Crack in the system	***
Denial of Services	***
Jail	Jail
Lack of helpful response	Lack of helpful response
***	Lack of case management

Need exceeds service availability	Need exceeds service availability
Responsiveness	Responsiveness
Satisfaction	Satisfaction
System doesn't work	System doesn't work
Who gets served	Who gets served
***	Access to services
***	Bad feeling toward mental health services
***	Care offset
***	Client gets lost
***	Continuity of care
***	Coordination and linkage issues
Crack in the system	***
Crisis	Crisis
Denial of services	***
Effectiveness of services	***
Involuntary care	Involuntary care
Justice system	***
Lack of helpful response	Lack of helpful response
***	Need exceeds service availability
Responsiveness	Responsiveness
Satisfaction	Satisfaction
System doesn't work	System doesn't work
***	Time devoted to mental health
Who gets served	Who gets served
Access to psychiatric prescriber	Access to psychiatric prescriber
***	Barriers to mental health care
Jail	Jail
Medication issue	Medication issue
Who gets served	Who gets served
Access to case management	***
Access to psychiatric prescriber	***
Access to services	Access to services
Barriers to mental health care	Barriers to mental health care
***	Care offset
Case management	Case management
Collaboration needs	***
***	Continuity of care
Coordination and linkage issues	Coordination and linkage issues
Cost issues	***
Crack in the system	Crack in the system
Funding limits services	Funding limits services
Insurance	***
Jail	Jail
***	Lack of case management
Lack of helpful response	***
Medicaid	***
***	Need exceeds service availability

***	No appropriate services
***	Responsiveness
Satisfaction	***
Slow response time	Slow response time
System doesn't work	System doesn't work
Wait list	***
Who gets served	Who gets served
Access to services	Access to services
***	Continuity of care
***	Coordination and linkage issues
***	Crack in the system
Jail	Jail
***	Justice system
Medication issue	Medication issue
***	Need exceeds service availability
System doesn't work	***
Who gets served	Who gets served
Collaboration needs	Collaboration needs
Coordination and linkage issues	Coordination and linkage issues
Crack in the system	***
***	Jail
Medication issue	Medication issue
***	Care offset
Paperwork	Paperwork
Time devoted to mental health	Time devoted to mental health
Access to services	***
Accountability	***
Barriers to mental health care	***
Care in community	***
***	Care offset
***	Collaboration needs
***	Coordination and linkage issues
***	Gate keeping
***	Lack of helpful response
***	Responsiveness
***	System doesn't work
***	Access to services
***	Care in community
***	Collaboration needs
Coordination and linkage issues	Coordination and linkage issues
Justice system	Justice system

***	Power
***	Responsiveness
***	Satisfaction
***	Time devoted to mental health
Care in community	***
Collaboration needs	Collaboration needs
Communication	***
Coordination and linkage issues	***
Justice system	Justice system
Satisfaction	Satisfaction
Services work	Services Work
***	Time devoted to mental health
Collaboration needs	Collaboration needs
Communication	Communication
***	Continuity of care
Information	Information
***	Collaboration needs
Communication	Communication
Coordination and linkage issues	Coordination and linkage issues
***	Effectiveness of services
***	Engagement in service
***	Follow-up
Justice system	Justice system
Satisfaction	Satisfaction
Services work	Services work
Time devoted to mental health	Time devoted to mental health
Collaboration needs	Collaboration needs
Communication	Communication
***	Coordination and linkage issues
Effectiveness of services	***
Justice system	Justice system
Responsiveness	Responsiveness
Satisfaction	Satisfaction
Services work	Services work
Access to services	Access to services
***	Bad feeling toward mental health services
Barriers to mental health care	Barriers to mental health care
Care in community	Care in community
***	Care offset
Co-occurring disorder	Co-occurring disorder
Crack in the system	***
Justice system	Justice system
Lack of helpful response	Lack of helpful response

Need exceeds service availability	Need exceeds service availability
No appropriate services	No appropriate services
***	Potential for violence
***	Responsiveness
Satisfaction	Satisfaction
System doesn't work	System doesn't work
***	Time devoted to mental health
Who gets served	Who gets served
Access to services	Access to services
***	Bad feelings toward mental health services
Barriers to mental health care	Barriers to mental health care
Client gets lost	***
Co-occurring disorder	Co-occurring disorder
Collaboration needs	Collaboration needs
Coordination and linkage issues	***
Cost issues	Cost issues
Crack in the system	Crack in the system
Effectiveness	Effectiveness of services
***	Funding limits services
Justice system	Justice system
Lack of helpful response	Lack of helpful response
Need exceeds service availability	***
No appropriate services	No appropriate services
Responsiveness	***
***	Satisfaction
***	System gets fired
System doesn't work	***
Time devoted to mental health	Time devoted to mental health
Who gets served	Who gets served
***	Collaboration needs
***	Communication
Access to services	Access to services
***	Bad feeling toward mental health services
Barriers to mental health care	Barriers to mental health care
***	Care offset
Crack in the system	***
Jail	***
Justice system	Justice system
Lack of services for the most severely ill	***
Need exceeds service availability	Need exceeds services availability
Needs of the vulnerable	***
No appropriate services	No appropriate services
System doesn't work	***
Who gets served	***
Access to services	Access to services

Care offset	Care offset
Client gets lost	Client gets lost
Co-occurring disorder	Co-occurring disorder
***	Collaboration needs
***	Coordination and linkage issues
Crack in the system	Crack in the system
***	Dangerous
Jail	Jail
Justice system	Justice system,
Lack of helpful response	***
Potential for violence	***
System doesn't work	***
Who gets served	Who gets served
Collaboration needs	***
Communication	Communication
Coordination and linkage issues	Coordination and linkage issues
***	Information
Jail	Jail
Justice system	Justice system
Medication issue	Medication issue
***	System doesn't work
Collaboration needs	Collaboration needs
***	Communication
***	Coordination and linkage issues
Justice system	Justice system
Care in community	***
***	Case management
Client gets lost	***
Collaboration needs	Collaboration needs
Communication	***
Confidentiality as a barrier to service	Confidentiality as a barrier to service
Coordination and linkage issues	Coordination and linkage issues
***	Crack in the system
Information	Information
Justice system	Justice system
***	Accountability
Collaboration needs	Collaboration needs
Communication	Communication
***	Coordination and linkage issues
***	Crack in the system
Communication	***
Paperwork	***
Satisfaction	Satisfaction

***	Barriers to mental health care
***	Collaboration needs
Communication	Communication
Confidentiality as a barrier to service	Confidentiality as a barrier to service
***	Information
Justice system	***
Law enforcement	***
Paperwork	***
Access to services	Access to services
***	Barriers to mental health care
***	Care in community
Co-occurring disorder	Co-occurring disorder
***	Gate keeping
Involuntary care	Involuntary care
***	Need exceeds service availability
***	Power
***	System doesn't work
***	Dangerous
***	In-patient care
High utilizers	***
Involuntary care	Involuntary care
***	Justice system
***	Recidivism
Recidivism	Responsiveness
Responsiveness	Satisfaction
Satisfaction	Services work
Services Work	***
Who gets served	***
Access to services	***
Care offset	Care offse6t
Dangerous	Dangerous
Housing	Housing
***	Jail
***	Justice system
Needs of vulnerable	Needs of vulnerable
Potential for violence	Potential for violence
Who gets served	***
Care offset	Care offset
Collaboration needs	**
Cost issues	Cost issues
***	Crack in the system
Engagement in service	***
***	Funding limits services

***	High utilizers
***	Housing
***	Jail
Justice system	Justice system
***	Need exceeds service availability
Needs of vulnerable	Needs of vulnerable
***	No appropriate services
***	System doesn't work
***	Time devoted to mental health
***	Transient population
***	Who gets served
Care offset	***
Collaboration needs	Collaboration needs
***	Communication
***	Continuity of care
Cost issues	Cost issues
Effectiveness	Effectiveness
***	Follow-up
***	High utilizers
***	Housing
Jail	Jail
Justice system	Justice system
***	Law enforcement
Outcome measures	Outcome measures
Recidivism	***
***	Satisfaction
Services work	Services work
Time devoted to mental health	Time devoted to mental health
Effectiveness of services	Effectiveness of services
Outcome measures	Outcome measures
***	Satisfaction
***	Services work
Effectiveness of services	Effectiveness of services
Medication issues	Medication issue
Outcome measures	Outcome measure
***	Services work

Appendix D

Use of Code Occurrence as Indication of Focus Group Data Themes

(~ indicates codes occurring in all groups in a cluster; * indicates codes occurring in all but 1 group in a cluster; # indicates codes occurring in all but 2 groups in a cluster)

Kids #8	Kids #9	Kids #10	Kids #20
Access ~	Kids/Teens ~	Communication ~	Communication ~
Responsiveness ~	Responsiveness ~	Access ~	Kids/Teens ~
Kids/Teens ~	Communication ~	Kids/Teens ~	Access ~
Care Offset *	Access ~	Responsiveness ~	Need Exceeds ~
Communication ~	Need Exceeds ~	Medical	Who Gets Served *
Need Exceeds ~	Care Offset *	Care Offset *	Cost Issues
Effectiveness	Who Gets Served *	Effectiveness	Managed Care
Outcome	Cost Issues	Need Exceeds ~	System Doesn't Work
Satisfaction	Satisfaction	School Services	Care Offset *
Cost Issues	Effectiveness	Who Gets Served *	Responsiveness ~
Who Gets Served	Justice System	Outcome	Satisfaction
Engagement	Lack of Services	Care in Comm	Needs of Vulnerable
Care in Comm	System Doesn't Work	Engagement	Dangerous
System Doesn't	Outcome	Distance/Transport	Follow-up
Managed Care	Care in Comm	Satisfaction	Engagement
School Services	Services Work	Case Management	Engagement
Needs of Vulnerable	Dangerous	Cost Issues	Insurance
Co-occurring D/O	Crisis	Crisis	Long-Term Treatment
In-patient Care	Distance/Transport	Follow-up	Services Work
Insurance	Needs of Vulnerable	Prevention	Unrealistic Expectations
Justice System	Staff Time Limited	Services Work	Advocate Issues
Dangerous	Case Management	System Doesn't Work	Care in Comm
Follow-up	Managed Care	Staff Morale	Effectiveness
Services Work	Co-occurring D/O	Staff Time Limited	Involuntary Care
Staff Time Limited	Insurance	In-patient	Justice System
Advocate Issues	Involuntary Care	Insurance	Medical
Early Discharges	Engagement	Managed Care	Outcome
Lack of Services	Follow-up	Staff Training	Adults
Medical	Housing	Dangerous	Case management
Paperwork	Recidivism	Needs of Vulnerable	Co-occurring D/O

Kids Groups

Kids #21	Kids #27	Kids #28
Kids/Teens ~	Kids/Teens ~	Communication ~
Communication ~	Need Exceeds ~	Need Exceeds ~
Need Exceeds ~	Access ~	Care Offset *
Cost Issues	Care Offset *	Access ~
Access ~	Communication ~	Kids/Teens ~
Responsiveness ~	Who Gets Served *	Responsiveness ~
System Doesn't Work	Needs of Vulnerable	Who Gets Served *
Who Gets Served *	Responsiveness ~	Satisfaction
Needs of Vulnerable	School Services	Justice System
Effectiveness	System Doesn't Work	Co-occurring D/O
Care Offset	Care in Comm	Cost Issues
Satisfaction	Cost Issues	Recidivism
Justice System	Satisfaction	Crisis
Managed Care	Engagement	System Doesn't Work
School Services	Lack of Services	Needs of Vulnerable
Outcome	Dangerous	Power
Services Work	Distance/Transport	Outcome
Dangerous	Justice System	Respectfulness
Recidivism	Managed Care	Services Work
Social Problems	Services Work	Dangerous
Care in Comm	Staff Training	Staff Time Limited
Follow-up	Crisis	Managed Care
Advocate Issues	Prevention	Paperwork
Housing	Co-occurring D/O	Prevention
In-patient	Follow-up	Advocate Issues
Long-Term Tx	Insurance	Case Management
Insurance	Long-Term Tx	Engagement
No Outcome	Recidivism	Follow-up
Staff Training	Respectfulness	In-patient
Accountability	Effectiveness	Involuntary Care

Consumer/Advocate Groups

C/A #3	C/A #4	C/A #16	C/A #17
Satisfaction ~	Access ~	Responsiveness ~	Satisfaction ~
Case Management	Satisfaction ~	Access ~	Communication
Advocate Issues *	System Doesn't Work *	Satisfaction ~	Responsiveness ~
Family Frustration	Responsiveness ~	Communication	Advocate Issues *
Access ~	Advocate Issues *	Medical	System Doesn't Work *
Communication	Confidentiality	System Doesn't Work *	Access ~
Responsiveness ~	Need Exceeds ~	Advocate Issues *	Respectfulness
Housing	Medical	Need Exceeds ~	Need Exceeds ~
Kids/Teens	Effectiveness	Respectfulness	Family Frustration
Need Exceeds ~	In-patient	Who Gets Served	Medical
Staff Training	Cost Issues	Dangerous	Justice System
System Doesn't Work	Family Frustration	Effectiveness	Effectiveness
Care Offset	Justice System	In-patient	Power
Effectiveness	Care Offset	Case Management	Crisis
Medical	Care in Comm	Crisis	Services Work
Needs of Vulnerable	Distance/Transport	Services Work	Care Offset
Respectfulness	Who Gets Served	Distance/Transport	Confidentiality
Crisis	Case Management	Outcome	Discrimination
Engagement	Kids/Teens	Power	Housing
Justice System	Needs of Vulnerable	Care in Comm	In-patient
No Outcome	Insurance	Care Offset	Needs of Vulnerable
Services Work	Respectfulness	Involuntary Care	Adults
Co-occurring D/O	Accountability	Confidentiality	Care in Comm
Confidentiality	Power	Cost Issues	Cost Issues
Cost Issues	Work Opportunity	Family Frustration	Kids/Teens
In-patient	Paperwork	Follow-up	Lack of Services
Insurance	Communication	Justice System	Managed Care
Managed Care	Crisis	Managed Care	Dangerous
Outcome	Dangerous	Needs of Vulnerable	Staff Training
Paperwork	Lack of Services	Elderly	Involuntary Care
Power	Outcome	Staff Morale	Outcome
	Co-occurring D/O	Engagement	Staff Time Limited
	Discrimination	Insurance	Case Management
	Services Work	Staff Training	Distance/Transport
	Engagement	Adults	Paperwork
	Housing	Co-occurring D/O	Work Opportunity
	Managed Care	Conflict of Interest	Engagement
	Follow-up	Cultural Barrier	Long-Term Tx
	Staff Training	Discrimination	Social Problems
	Early Discharges	Housing	Who Gets Served
	Involuntary Care	Kids/Teens	Accountability
	Language Issues	Lack of Services	Early Discharges
	Long-term Tx	Paperwork	Follow-up
	No Outcome	Recidivism	Insurance
	Nothing to Do	Staff Time Limited	Prevention
	Prevention	Transient Population	School Services

School Services
Transient Population
Work Opportunity

Consumer/Advocate Groups

C/A #23	C/A #24
Satisfaction ~	Access ~
Access ~	Cost Issues
Responsiveness ~	Satisfaction ~
System Doesn't Work *	Need Exceeds ~
Need Exceeds ~	Responsiveness ~
Respectfulness	Medical
Services Work	System Doesn't Work *
Work Opportunity	Effectiveness
Managed Care	Advocate Issues *
Cost Issues	Services Work
Medical	Needs of Vulnerable
Effectiveness	Insurance
Advocate Issues	Communication
Communication	Engagement
Conflict of Interest	Housing
Family Frustration	Managed Care
Needs of Vulnerable	Follow-up
Outcome	In-patient
Care in Comm	Outcome
Co-occurring	Respectfulness
Follow-up	Family Frustration
Insurance	Case Management
Power	Crisis
Staff Time Limited	Accountability
Crisis	Care in Comm
Housing	Care Offset
Involuntary Care	Dangerous
Accountability	Discrimination
Case Management	Power
In-patient	Staff Time Limited
Lack of Services	Justice System
Staff Morale	Kids/Teens
Unrealistic Expect	Lack of Services
Adults	Paperwork
Care Offset	People with Nothing to Do
Confidentiality	Recidivism
Early Discharges	Staff Morale
Long-term Tx	Staff Training
Staff Training	Work Opportunity
	Co-occurring D/O
	Conflict of Interest
	Distance/Transport
	Involuntary Care
	Social Problems
	Who Gets Served

Service Groups

Service #11	Service #12	Service #13	Service #22
Access ~	Communication ~	Communication ~	Communication ~
Care Offset ~	Satisfaction	Co-occurring D/O	Care Offset ~
Communication ~	Responsiveness *	Need Exceeds *	Access ~
Satisfaction	Access ~	Access ~	Dangerous
Need Exceeds *	Cost Issues	Who Gets Served	Co-occurring D/O
System Doesn't Work	Need Exceeds *	Care Offset ~	Responsiveness *
Housing	System Doesn't Work	Cost Issues	Advocate Issues
Who Gets Served	Who Gets Served	Follow-up	Crisis
Responsiveness *	Care in Comm	Needs of Vulnerable	Housing
Cost Issues	Care Offset ~	Responsiveness *	In-patient
Care in Comm	Case Management	Satisfaction	Justice System
Effectiveness	Native American Issues	Effectiveness	Respectfulness
Co-occurring D/O	In-patient	Involuntary Care	Satisfaction
Lack of Services	Co-occurring D/O	Managed Care	System Doesn't Work
Dangerous	Elderly	Medical	Who Gets Served
Need of Vulnerable	Housing	Outcome	Cost Issues
Staff Training	Services Work	Services Work	Insurance
In-patient	Staff Training	Case Management	Managed Care
Involuntary Care	Effectiveness	Housing	Need Exceeds
Medical	Involuntary Care	Justice System	Adults
Transient Population	Distance/Transport	Engagement	Kids/Teens
Follow-up	Medical	Insurance	Medical
Managed Care	Outcome	Kids/Teens	Needs of Vulnerable
Outcome	Advocate Issues	Unrealistic Expect	paperwork
Services Work	Lack of Services	Accountability	Power
Elderly	Managed Care	Care in Comm	Social Problems
Engagement	Needs of Vulnerable	Crisis	Staff Training
Justice System	Respectfulness	Dangerous	
Power	Staff Morale	Distance/Transport	
Respectfulness	Accountability	In-patient	
Advocate Issue	Crisis	Long-Term Tx	
Case Management	Dangerous	No Outcome	
Cultural Barrier	Follow-up	Power	
Discrimination	Justice System	Recidivism	
Distance/Transport	Kids/Teens	Respectfulness	
Social Problems	Long-Term Tx	Social Problems	
Staff Time Limited	No Outcome	Staff Morale	
Accountability	Transient Population	Staff Time Limited	
Confidentiality	Confidentiality	Staff Training	
Crisis	Conflict of Interest	System Doesn't Work	
Early Discharges	Family Frustration	work Opportunity	
Native American Issues	Insurance		
	Power		
	Social Problems		

Service #29	Service #30
Who Gets Served	Needs Exceed *
Access ~	Access ~
Care Offset ~	Medical
Need Exceeds *	Care Offset ~
Case management	System Doesn't Work
Insurance	Housing
Communication ~	Communication ~
Cost Issues	Needs of Vulnerable
Managed Care	Case Management
Needs of Vulnerable	Responsiveness *
Crisis	Staff Time Limited
Effectiveness	Effectiveness
Elderly	Respectfulness
Responsiveness	Services Work
Advocate Issues	Staff Training
Follow-up	Who Gets Served
Medical	Advocate Issues
Recidivism	In-patient
Staff Time Limited	Satisfaction
System Doesn't Work	Care in Comm
Kids/Teens	Co-occurring D/O
No Outcome	Lack of Services
Outcome	Accountability
Distance/Transport	Kids/Teens
Engagement	Outcome
In-patient	Work Opportunity
Language Issues	Cost Issues
Paperwork	Dangerous
Prevention	Elderly
Satisfaction	Engagement
Staff Training	Follow-up
Accountability	Insurance
Care in Comm	Nothing to Do
Confidentiality	Crisis
Cultural Barrier	Justice System
Lack of Services	Long-Term Tx
Respectfulness	Staff Morale
Services Work	Managed Care
Unrealistic Expect	Recidivism
	Social Problems
	Transient Population
	Early Discharges
	Family Frustration
	Language Issues
	No Outcome
	Paperwork
	Power
	Prevention

Justice Groups

Justice #5	Justice #6	Justice #7	Justice #18
Justice System ~	Justice System ~	Justice System ~	Care Offset ~
Access ~	Access ~	Communication ~	Communication ~
Communication ~	Who Gets Served ~	Who Gets Served ~	Justice System ~
Cost Issues	Satisfaction	Access ~	Access ~
Who Gets Served ~	Care in Comm	Need Exceeds *	Responsiveness ~
Need Exceeds *	Care Offset ~	Satisfaction	Satisfaction
Care Offset ~	System Doesn't Work #	Needs of Vulnerable	Who Gets Served ~
Responsiveness ~	Communication ~	Responsiveness ~	System Doesn't Work #
Care in Comm	Responsiveness ~	Care Offset ~	Need Exceeds *
Satisfaction	Involuntary Care	Services Work	Managed Care
Co-occurring D/O	Need Exceeds	Care In Comm	Cost Issues
Medical	Cost Issues	Effectiveness	Medical
System Doesn't Work	Medical	Cost Issues	Needs of Vulnerable
Dangerous	Distance/Transport	Engagement	In-patient
Needs of Vulnerable	Outcome	Co-occurring D/O	Case Management
Confidentiality	Services Work	System Doesn't Work	Effectiveness
Insurance	Co-occurring D/O	Lack of Services	Involuntary Care
Services Work	Crisis	Housing	Outcome
Conflict of Interest	Dangerous	Outcome	Recidivism
Effectiveness	Effectiveness	Medical	Services Work
Follow-up	Managed Care	Case Management	Advocate Issues
Lack of Services	Case Management	Crisis	Crisis
Outcome	Confidentiality	Dangerous	Dangerous
Paperwork	Insurance	Managed Care	Discrimination
Respectfulness	Lack of Services	Recidivism	Follow-up
Social Problems	Accountability	Involuntary Care	Lack of Services
Accountability	Elderly	Social Problems	Power
Adults	Family Frustration	Confidentiality	Staff Time Limited
Crisis	Housing	In-patient	Adults
Engagement	In-patient	Power	Co-occurring D/O
Kids/Teens	Needs of Vulnerable	Staff Time Limited	Distance/Transport
Long-Term Tx	Paperwork	Insurance	Respectfulness
Managed Care	Recidivism	Paperwork	Transient Population
Power		Accountability	Accountability
Work Opportunity		Advocate Issues	Conflict of Interest
		Distance/Transport	Engagement
		Family Frustration	Family Frustration
		Follow-up	Housing
		Long-Term Tx	Insurance
		Respectfulness	Paperwork
		Transient Population	Social Problems
		Work Opportunity	Staff Morale
			Staff Training

Justice #19	Justice #25	Justice #26
Justice System ~	Access ~	Who Gets Served ~
Communication ~	Who Gets Served ~	Need Exceeds *
Care Offset ~	Need Exceeds *	Justice System ~
Need Exceeds *	Communication ~	Access ~
Responsiveness ~	Justice System ~	Care Offset ~
Who Gets Served ~	Care Offset ~	Cost Issues
Needs of Vulnerable	Responsiveness ~	System Doesn't Work #
Access ~	System Doesn't Work #	Responsiveness ~
System Doesn't Work #	Needs of Vulnerable	Communication ~
Follow-up	Cost Issues	Involuntary
Involuntary Care	Managed Care	Dangerous
Dangerous	Advocate Issues	Needs of Vulnerable
Medical	Involuntary Care	Satisfaction
Satisfaction	Kids/Teens	Crisis
Services Work	Co-occurring D/O	Co-occurring D/O
Housing	Medical	In-patient
Adults	Effectiveness	Managed Care
Case Management	Case Management	Medical
Crisis	Dangerous	Effectiveness
Engagement	Insurance	Lack of Services
Care in Comm	Power	Services Work
Managed Care	Crisis	Transient Population
In-patient	Engagement	Advocate Issues
Transient Population	In-patient	Discrimination
Co-occurring D/O	Satisfaction	Follow-up
Cost Issues	Confidentiality	Housing
Effectiveness	Follow-up	Power
Outcome	Long-Term Tx	Distance/Transport
Power	Adults	Engagement
Recidivism	Family Frustration	Outcome
Respectfulness	Language Issue	Social Problems
Confidentiality	Recidivism	Staff Time Limited
Distance/Transport	Care in Comm	Accountability
Social Problems	Conflict of Interest	Case Management
Advocate Issues	Distance/Transport	Early Discharges
Lack of Services	Lack of Services	Insurance
Nothing to Do	Outcome	Kids/Teens
Prevention	Social Problems	Paperwork
Staff Time Limited	Staff Morale	Prevention
Staff Training	Cultural Barrier	Recidivism
	Elderly	Staff Training
	Housing	Care in Comm
	Paperwork	Long-Term Tx
	Respectfulness	Nothing to Do
	Services Work	Work Opportunity
	Staff Training	

Combined Groups

Group #1 Penn	Group #2 SW	Group #14 Penn	Group #15 Penn
Access ~	Access ~	Access ~	Access ~
Responsiveness ~	Need Exceeds ~	System Doesn't Work *	Responsiveness ~
Need Exceeds ~	Justice System	Responsiveness ~	System Doesn't Work *
Communication ~	Communication ~	Need Exceeds ~	Need Exceeds ~
Case Management	Responsiveness ~	Care Offset ~	Communication ~
System Doesn't Work *	Care Offset ~	Communication ~	Cost Issues ~
Managed Care	Co-occurring D/O	Satisfaction	Satisfaction
Medical	Cost Issues ~	Who Gets Served	Care Offset ~
Care Offset ~	Services Work	Care in Comm	Who Gets Served
Cost Issues ~	Recidivism	Cost Issues ~	Kids/Teens
Effectiveness	Case Management	Managed Care	Care in Comm
Native American Issues	Crisis	Effectiveness	Managed Care
Satisfaction	Engagement	Insurance	Justice system
Staff Time Limited	Satisfaction	Co-occurring D/O	Power
Crisis	Insurance	Engagement	School Services
Kids/Teens	Involuntary Care	Kids/Teens	Dangerous
Cultural Barrier	Kids/Teens	Respectfulness	Engagement
Advocate Issues	Follow-up	Advocate Issues	Needs of Vulnerable
Co-occurring D/O	Medical	Crisis	Respectfulness
Dangerous	Needs of Vulnerable	Follow-up	Crisis
Distance/Transport	Who Gets Served	Justice System	Insurance
Elderly	Elderly	Medical	Medical
Engagement	Long-Term Tx	Needs of Vulnerable	Advocate Issues
Lack of Services	System Doesn't Work	Power	In-patient
Follow-up	Effectiveness	Staff Training	Involuntary Care
Insurance	Transient Population	Dangerous	Services Work
Services Work	Dangerous	Involuntary Care	Effectiveness
Family Frustration	In-patient	Lack of Services	Follow-up
Housing	Lack of Services	Native American Issues	Outcome
Involuntary Care	Outcome	No Outcome	Family Frustration
Justice System	Managed Care	Outcome	Housing
Needs of Vulnerable	Respectfulness	Staff Morale	Lack of Services
No Outcome	Staff Time Limited	Staff Time Limited	Distance/Transport
Paperwork	No Outcome		Co-occurring D/O
Power	Staff Training		Long-Term Tx
Respectfulness	Adults		Staff Time Limited
School Services	Confidentiality		Staff Training
Social Problems	Cultural Barrier		Accountability
Adults	Early Discharges		Prevention
Discrimination	Language Issues		Adults
Early Discharges	Staff Morale		Case management
Language Issues			Confidentiality
Outcome			Conflict of Interest
Staff Morale			Elderly
Staff Training			Recidivism
Unrealistic Expect			Social Problems
			Staff Morale
			Transient Population
			Unrealistic Expect

Group #1 Penn	Group #14 Penn	Group #15 Penn
Access ~	Access ~	Access ~
Responsiveness ~	System Doesn't Work *	Responsiveness ~
Need Exceeds ~	Responsiveness ~	System Doesn't Work *
Communication ~	Need Exceeds ~	Need Exceeds ~
Case Management	Care Offset ~	Communication ~
System Doesn't Work *	Communication ~	Cost Issues ~
Managed Care	Satisfaction	Satisfaction
Medical	Who Gets Served	Care Offset ~
Care Offset ~	Care in Comm	Who Gets Served
Cost Issues ~	Cost Issues ~	Kids/Teens
Effectiveness	Managed Care	Care in Comm
Native American Issues	Effectiveness	Managed Care
Satisfaction	Insurance	Justice system
Staff Time Limited	Co-occurring D/O	Power
Crisis	Engagement	School Services
Kids/Teens	Kids/Teens	Dangerous
Cultural Barrier	Respectfulness	Engagement
Advocate Issues	Advocate Issues	Needs of Vulnerable
Co-occurring D/O	Crisis	Respectfulness
Dangerous	Follow-up	Crisis
Distance/Transport	Justice System	Insurance
Elderly	Medical	Medical
Engagement	Needs of Vulnerable	Advocate Issues
Lack of Services	Power	In-patient
Follow-up	Staff Training	Involuntary Care
Insurance	Dangerous	Services Work
Services Work	Involuntary Care	Effectiveness
Family Frustration	Lack of Services	Follow-up
Housing	Native American Issues	Outcome
Involuntary Care	No Outcome	Family Frustration
Justice System	Outcome	Housing
Needs of Vulnerable	Staff Morale	Lack of Services
No Outcome	Staff Time Limited	Distance/Transport
Paperwork		Co-occurring D/O
Power		Long-Term Tx
Respectfulness		Staff Time Limited
School Services		Staff Training
Social Problems		Accountability
Adults		Prevention
Discrimination		Adults
Early Discharges		Case management
Language Issues		Confidentiality
Outcome		Conflict of Interest
Staff Morale		Elderly
Staff Training		Recidivism
Unrealistic Expect		Social Problems
		Staff Morale
		Transient Population
		Unrealistic Expect

Vita

Susan Elizabeth Caverly was born in Buffalo, New York. She lived in upstate New York and Vermont prior to moving to Seattle in 1978. She earned a Bachelor of Science degree in Nursing at the State University of New York at Buffalo in 1976 and a Master of Arts degree in Nursing with a minor in Educational Psychology from the University of Washington in 1980. In 2002 she earned a Doctor of Philosophy at the University of Washington in the Individual Ph.D. Program. The focus of her Ph.D. study was in Health Policy. Her publications include articles and book chapters related to advanced practice nursing, psychiatric nursing, psychopharmacology and the evaluation of mental health services. She holds dual national certifications as a Clinical Specialist in Child Adolescent and Adult Psychiatric Mental Health Nursing. She is licensed in the State of Washington as an Advanced Registered Nurse Practitioner. She is the current president elect of ARNP's United, the Washington State Nurse Practitioner organization, and past president of the Association of Advanced Practice Psychiatric Nurses.