2017

Evaluating satisfaction of participants within the outreach and engagement program of MECCA

Farrah K. Khaleghi

Pepperdine University

Graduate School of Education & Psychology

EVALUATING SATISFACTION OF PARTICIPANTS WITHIN THE OUTREACH AND ENGAGEMENT PROGRAM OF MECCA

A clinical dissertation presented in partial satisfaction

Of the requirements for the degree of

Doctor of Psychology

by

Farrah K. Khaleghi

June, 2017

Miguel E. Gallardo, Psy.D. – Dissertation Chairperson

This clinical dissertation, written by

Farrah K. Khaleghi

under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

Doctoral Committee:

Miguel E. Gallardo, Psy.D., Dissertation Chairman

Shelly P. Harrell, Ph.D., Committee Member

Maryam Sayyedi, Ph.D., Committee Member

TABLE OF CONTENTS

Page

LIST OF TABLES

Page

LIST OF FIGURES

Page

ACKNOWEDLGEMENTS

I would like to thank Dr. Morteza Khaleghi, Dr. Karen Khaleghi, Seymone Khaleghi, Dustin Khaleghi, Skylar Khaleghi, Dr. Margaret Rubin, Kingston, and Lulu for their love and support of my personal, professional, and academic growth. I would like to thank my mentor and dissertation chair, Dr. Miguel Gallardo, for his unwavering nurturance of my development as a culturally responsive and collaborative person and professional. I would also like to thank my colleague and research partner Sheva Assar for her comradery and support throughout our graduate school careers. Finally, I would like to thank my dissertation committee for their guidance and encouragement.

Sheva Assar, M.A. ASC Lab partner and Co-author

Melanie Afshar, M.A. ASC Lab partner and Co-author

Miguel E. Gallardo, Psy.D., Dissertation Chairman

Shelly P. Harrell, Ph.D. & Maryam Sayyedi, Ph.D., Committee Members

VITA

EDUCATION

9/2013 – Present **Pepperdine University**
Graduate School of Education & Psychology
Los Angeles, CA
Doctor of Psychology in Clinical Psychology
Expected May 2017

May 2013 **Pepperdine University**
Graduate School of Education & Psychology
Malibu, CA
Master of Arts (M.A) in Clinical Psychology, with an emphasis in Marriage and Family Therapy

May 2011 **University of San Francisco**
San Francisco, CA
Bachelor of Arts (B.A.) in Psychology

CLINICAL EXPERIENCE

9/2016 – Present Twin Towers Correctional Facility and Century Regional Detention Facility
Los Angeles, CA
Chief, Psychological Services/Director of Training: Cheryl D. van der Zaag, Ph.D.
Supervisors: Rachel Tapscott, Psy.D., Farida Anwar, Ph.D., Maureen Gonzalez-Burris, Ph.D., & Krystle Madrid, Psy.D.

9/2015 – 7/2016 Harbor-UCLA Medical Center- Department of Psychiatry
Dual Diagnosis Treatment Program
Los Angeles, CA
Director: John Tsuang, M.D.
Supervisor: Lee M. Gomberg, Ph.D.

9/2013 – 7/2016 Pepperdine Psychological and Educational Clinic
West Los Angeles Community Counseling Center
Los Angeles, CA
Supervisors: Aaron Aviera, Ph.D. & Dity Brunn, Psy.D.

9/2015 – 7/2016 Union Rescue Mission
Los Angeles, CA

Supervisor: Aaron Aviera, Ph.D.

9/2013 – 7/2015 Union Rescue Mission
Los Angeles, CA
Supervisor: Aaron Aviera, Ph.D., Neva Chauppette, Psy.D., & Cary Mitchell, Ph.D.

9/2014 – 8/2015 Los Angeles County + USC Medical Center
Neuropsychological Services
Los Angeles, CA
Supervisor: Nora Jimenez, Ph.D.

1/2012 – 6/2013 Interface Children Family Services
Ventura, CA
Supervisor: Kim Patterson, MFT

ABSTRACT

The present study aimed to provide literature on community-based programs and correlated participant satisfaction, to examine the factors that contribute to participant satisfaction within community-based programs, and to evaluate outcomes of participant satisfaction for MECCA's O&E program, as well as reflection on components of the O&E program that produce satisfaction ratings. The primary research question of the present study was: Were participants satisfied with their participant in MECCA's O&E program for both fiscal years and if so, what factors may have contributed to their satisfaction? Through use of description analyses on outcomes of the Participant Satisfaction Survey from MECCA's six community-based agencies, findings indicate that MECCA provided culturally-responsive and linguistically congruent services. Additionally, participants were satisfied overall with the O&E services and would elect to obtain services from the O&E program again. O&E's success can be attributed to MECCA's foundation in cultural responsiveness, diversity empowerment, destigmatizing mental health services, and collaboration with the communities to create and provide community-based programs.

Introduction

The Multi-ethnic Collaborative of Community Agencies (MECCA) in Orange County, California, consists of six ethnocultural community mental health agencies, specifically a Vietnamese-speaking (Vietnamese Center of Orange County [VNCOC]), Korean-speaking (Korean Community Services [KCS]), two Spanish-speaking (Orange County Children's Therapeutic Art Center [OCCTAC] and ABRAZAR, Farsi-speaking [OMID Multicultural Institute of Development], and Arabic-speaking agencies [ACCESS CAL]. The collaborative of agencies was unified to pursue resources for the underserved ethnic communities and empower community members in Orange County, California. The agencies each serve particular ethnic communities, often providing services to monolingual individuals and families. MECCA serves the needs of ethnic communities by providing services that include support groups, psychoeducation workshops, skill-building classes, case management, and culturally appropriate referrals. Within these six community-based agencies, two county-funded programs are conducted: Early Intervention Program for Older Adults (formerly called the Socialization Program), and Outreach and Engagement Program (O&E). Both programs focus on uplifting ethnic communities through support and resources that have frequently been inaccessible for marginalized communities. The Early Intervention Program for Older Adults has recently been modified and granted county support to become a more clinically oriented program that focuses on mental health needs, reintegrating isolated individuals back in the community in a culturally congruent manner, as well as case management. The Outreach and Engagement (O&E) program strives to assist and connect community members with resources and referrals to culturally responsive agencies and services, as well as engage members through agency-specific and MECCA collaborative classes and events. Due to the unique opportunity provided within the

O&E program of empowering participants as cultural beings within the context of their lives, and equipping participants with strength-focused coping skills, the O&E program will be the primary focus of this study. This program is of particular interest because of the impact it has had, and continues to have, in the lives of various individuals from numerous cultures, especially in the prevention of mental health conditions through individual and culture-specific interventions. In addition to individual services such as case management, life coaching, and skill building, participants are invited to participate in group classes that aim to facilitate mutual sharing of experiences and skill building, with a focus on culture as the foundation of class experiences. The classes vary and involve topics such as learning how to speak English, complete government forms, play guitar, cooking, art, sewing and making clothing, and other skill-based classes with the purpose of gaining knowledge while sharing experiences. Participants achieve short-term goals through short-term life coaching and case management. The program provides mental health services as well as medical, legal, and social services. The O&E program seeks to reduce risk factors by increasing support through referrals and linkages to other community agencies and culturally responsive treatments, with early intervention and prevention of worsening problems as the goals of this program. The O&E program strives to decrease stigma associated with mental health issues, as well as increase protective factors to aid community members in overcoming external and internal stressors.

Importance & Levels of Stigma Associated with Mental Health

When looking at diverse ethnic groups living within low socioeconomic conditions, it is important to understand the barriers that make accessing mental health services difficult (Kaczorowski et al., 2011). Accordingly, research has targeted barriers and indicate that access to mental health treatment can be improved by making transportation and child care available,

providing low-cost assistance that is optional for home-based forms, offering independent, phone-based, or video-based treatments, and creating a community treatment approach that integrates other families (Snell-Johns, Mendez, & Smith, 2004). For diverse ethnic groups, researchers highlight the importance of cultural beliefs of the individual while living within United States culture as crucial in understanding the individual's outlook on accessing mental health treatment (Sood, Mendez, & Kendall, 2010). Additionally, research has emphasized reducing stigma and doing so through promoting awareness, as well as, providing accurate information about mental health (U.S. Department of Health and Human Services, 1999). Furthermore, diverse and low socioeconomic families have been found to have early treatment dropout rates (Kazdin & Mazurisk, 1994). Researchers found that, amongst Latinos, barriers to treatment included mental health treatment stigma, concern surrounding legal status in the United States, and fear of discrimination due to ethnicity (Rastogi, Massey-Hastings, & Wieling, 2012). As a result of these issues that inhibit diverse communities from accessing mental health services, it is important to consider the development and implementation of community-based services that are capable of engaging and providing culturally responsive services.

Various levels of stigma are a product of a vast history within psychology where a lack of attention was placed on the diversity of the human experience. Research shows that racism is embedded in the history of psychology and education as a whole with the extinction of "Indigenous Knowledge" and the eclipse of Eurocentrism (Dumbrill & Green, 2008). The important message to extract is that racism is a powerful, omnipresent foundation of society that clinical psychology is not immune to. Furthermore, it is imperative that mental health professionals work intensely to have awareness, focus, and compassion for overt and covert acts of racism (Thompson-Miller & Feagin, 2007). Additionally, it is critical that mental health

professionals evaluate their racist frame of thinking, feeling, behaving, and conceptualizing that has been inherited through the environment within which the mental health professional has been shaped (Thompson-Miller & Feagin, 2007). A valuable, central component in the discussion of the construct of "race" is the lived experience of individuals and groups. Daily experiences of undeniable racism facilitate long-term "racism-related stress" and thus influence humanity constantly. Harrell (2000) suggests that mental health professionals should explore the major ways individuals experience racism, including "racism-related life events, vicarious racism experiences, daily racism microstressors, chronic contextual stress, collective experiences of racism, and the transgenerational transmission of group traumas" (p. 45). Through an assessment of an individual's lived experiences of "racism-related stress," the program provider can work towards establishing rapport and cultural competence, cautiously hoping to lead towards trust and safety in the therapeutic context. However, the reality of embedded racism in many facets of psychology calls for true cultural competency, including further research and greater awareness on the role of the construct of "race" in clinical psychology practices.

Purpose of Program Evaluation

Given the multi-ethnic, community-based focus of the services provided by MECCA, it is essential to implement a program evaluation for various reasons. Evaluation is an essential principle that allows for the measurement of the efficacy of a program and provides guidance for future program improvement (Baron-Epel, 2003). In addition, program evaluation can provide insight regarding identifying and solving existing problems in the implementation of the program (Chyung, Wisniewski, Inderbitzen, & Campbell, 2013), as well as highlight the strengths of the program and areas that should continue to be focused on. By evaluating the Outreach and Engagement Program within MECCA, the objective is to provide stakeholders with knowledge

of the effectiveness of the program with the goal of improving consumer satisfaction, enhancing staff performance levels, and increasing cultural awareness and humility in engaging with consumers of mental health.

Community-Based Programs and Participant Satisfaction

Reflecting on the development and implementation of other community-based programs can illuminate important components to be considered in the development and evaluation of community-based programs, including MECCA's Outreach and Engagement program. Sink, Covinsky, Newcomer, and Yaffe (2004) present an evaluation of the prevalence and pattern of behavior for individuals with dementia related symptoms within a community. With regards to prevalence, they found that there was a significantly greater number of Black and Latino individuals living with dementia symptoms within the community (Sink et al., 2004). The researchers explored the ways these multi-ethnic individuals managed their symptoms, specifically regarding their rationale for not seeking a higher level of care and their experience of living within the community as a multi-ethnic individual with dementia symptoms. Researchers have identified a number of components that may affect the higher prevalence of Black and Latino individuals within the community that have dementia symptoms in comparison to White individuals with dementia symptoms. For example, Black and Latino caregivers of Black and Latino individuals do not wish to put the individual struggling with dementia symptoms in an institution and Black and Latino caregivers may conceptualize and report the symptoms of the individual struggling in a different way (as cited in Sink et al., 2004). There are many components to this research that affect the development of community-based programs that are effective and congruent with the community members. For the multi-ethnic community members struggling with dementia symptoms, the prevalence and pattern of behavior within the

community is based on an individual's cultural context that in turn determines the need for intervention. In the process of developing a community-based program that aims to assist community members from a wide variety of cultural backgrounds, one must consider that the program should include various modes of delivering services as well as a collaborative conceptualization in defining, supporting, and creating interventions that are best suited for the community member.

In a study by Nicolaidis et al. (2012), a community-based program was developed and implemented to help African American women who have survived Intimate Partner Violence. The researchers utilized a community-based participatory research approach in creating a program that was consistent with the needs of the African American women and then implemented the program that was congruent with the development process (Nicolaidis et al., 2012). In their collaborative process, the researchers conducted a needs assessment to understand the women's needs, as well as their experience of current services. The researchers noted that the women reported "perception of racism, with a deep mistrust of the healthcare system as a 'white' system" (Nicolaidis et al., 2012, p. 531). The women also reported for a community-based program to most appropriately meet their needs the program should be implemented by African Americans who had also struggled with similar experiences (Nicolaidis et al., 2012). Due to the collaborative process, the researchers shifted their conceptualization of the program development to accommodate the needs of the women, which meant that the program would be implemented in a community-based center that was specifically utilized to support those struggling with domestic violence (Nicolaidis et al., 2012). The program intervention consisted of providing services for six months by an African American Intimate Partner Violence survivor, referred to as a Health Advocate. The Health Advocate managed the participant's care, provided

psychoeducation, promoted self-care, and created links for the participant to receive services from the healthcare system (Nicolaidis et al., 2012). The researchers used a variety of self-report questionnaires to evaluate depression, self-esteem, and various self-care behaviors. Upon completion of the intervention, participants were asked to answer open-ended questions during termination interviews regarding their experience within the program. Findings from the intervention indicated increases in self-care behavior, improvement in depression symptoms, and improved self-esteem (Nicolaidis et al., 2012). The researchers gathered themes from the interviews with participants regarding their experience in the program, specifically soliciting the participants to identify why and how the program was effective. The themes identified include: "African-American focus and community setting," "Ability to trust," and "Information and strategies with practical, lasting value" (Nicolaidis et al., 2012, pp. 534-535). These themes were qualitatively gathered and provided rationale as to why the participants felt satisfied and reported improvement as a result of the program's intervention. When reflecting on the outcomes of this community-based program and the reported satisfaction with the program, it is important to consider the development of the program. The program developers took considerable efforts to collaboratively construct a program that was directed by the needs of the individuals within the community, as well as their desire for ethnic matching between provider and participant.

In a study by Kiger (2003), the prevalence and severity of breast and cervical cancer for women within low-income African American and Hispanic communities was identified as significantly greater than Caucasian women. Specifically, in the geographic region of Los Angeles African American and Hispanic women with such a significantly greater prevalence correlated to the underutilization of services available within the community (Kiger, 2003). Kiger identified a number of reasons that African American and Hispanic women do not seek

resources and screenings like Caucasian women in Los Angeles, such as lack of exposure or beliefs that they are unqualified for services, fear and confusion about the process of screening for cancer, decreased time for self-care behaviors, and the unawareness of the value of early screening and treatment. Additionally, Kiger identified specific challenges such as barriers of language differences, the lack of "ethnically appropriate educational materials" regarding the value or early screening and cancer treatment (p. 309), historical and systemic context of seeking services, concerns regarding trust and modes of communication, and the exclusionary nature of the eligible population identified for many early screening and cancer treatment programs (Kiger, 2003). In order to promote awareness and increase the participation of women from varying ethnic backgrounds, the project included three specific tools to disseminate information: "Tell A Friend, The Witness Project, and Promatoras" (Kiger, 2003, p. 311). The project utilized professionals and trained volunteers from the community who worked with the community in a collaborative process to share information about resources that provide support to multi-ethnic women that need early screening and cancer treatment. As a result of this project, the study identified important lessons that should be shared with other program developers. Kiger found that cultural beliefs, the need for transportation and childcare, and the lack of time for women in low-income communities affected their ability to engage in services identified by the project. Additionally, this project highlighted that a compilation of methods should be implemented in creating an approach to community-based interventions with multi-ethnic, underserved populations (Kiger, 2003). In conjunction, Kiger found that it is important to align a new project with pre-existing programs and find avenues for new programs within the community in order to foster a collaborative, coherent community of programs that are designed to assist women of the community. Kiger also found that it is important to consider ways to increase convenience for

women in order to improve the likelihood of seeking community-services, thus creating mobile services that can adjust to the geographic location as well as the schedules of women that need services (Kiger, 2003). Finally, Kiger found that it is imperative to work with community leaders in creating and implementing programs that seek to bring services to community members because community leaders are aware of the beliefs that will guide program implementation and utilization.

In a study by Andrade, Filha, Vianna, Silva, & Costa (2012), researchers examined the development and effectiveness of Community Therapy in Brazil. The Family Health Strategy was developed in Brazil in 1994 to "ensure that primary health care services were made available to families and communities, primarily those economically underprivileged and at greater risk for disease" (p. 326). As part of the Family Health Strategy development, it was suggested that mental health support be integrated into the community-based health care model (Andrade et al., 2012). Due to this integration of mental health needs, Community Therapy was highlighted as a useful tool in supporting community members. Andrade et al. identified the development of Community Therapy, 21 years ago in Brazil in order to support communities enduring emotional distress. This modality of mental health support is facilitated by community therapists in community gatherings during which community members are encouraged to share their concerns and struggles, which results in community members that "exhibit fortitude and increasingly solidified community identity" (p. 326). In a study of one 198 participants who engaged with community therapists within the Family Health Strategy, Andrade et al. gathered participants' satisfaction with Community Therapy through implementation of the Brazilian Mental Health Services Use Satisfaction Scale (Satis-BR). This self-report measure evaluating participants' satisfaction with mental health services rendered through Community Therapy consists of 44

questions that participants respond to using a 5-point Likert scale. Additionally, Andrade et al. utilized the Client Satisfaction Questionnaire because it is specifically designed to ascertain participants' satisfaction with Community Therapy. Findings indicate that 165 participants felt respected, 109 felt adequately listened to, 87 felt carefully listened to, 110 felt well understood, and 85 felt well understood. Additionally, researchers found through use of the 5-point Likert scale of satisfaction, 146 participants reported feeling satisfied with the therapists' listening skills and 52 felt very satisfied with the therapists' listening skills, 142 felt they were receiving accurate assistance for their needs through Community Therapy, and 118 felt that Community Therapy was excellent at being receptive to their individuals needs (Andrade et al., 2012). Specifically in regards to satisfaction with the Community Therapy program intervention overall, 95 participants were very satisfied, 103 noted the intervention to be good, 170 stated that they would return for services should more issues arise, 178 reported they would refer loved ones to Community Therapy, 100 reported to be very satisfied with community meetings for Community Therapy, and 98 stated that they were satisfied with community meetings for Community Therapy. The researchers discuss the rationale for the satisfaction outcomes, identifying Community Therapy as flexible to the needs of the group within a support group setting because such a group setting fosters a space of mutual understanding for shared experiences. An important aspect of understanding the satisfaction outcomes of this study is the framework that Community Therapy operates from, such that there is a collaborative process in the intervention. Community Therapy fosters a community to form within the larger community that collaborates to progress through five phases: "welcoming, selecting a theme, contextualization, problematization, and closing" (Andrade et al., 2012, p. 330). It is noted that there is no maximum number of people who can join the intervention and the community therapists are

empowered to incorporate as many participants into the group. The quantitative methodology implemented to gather participants' satisfaction and feedback regarding this community-based intervention is a valuable model to understanding the context within which community-based programs operate, as well as their method of gathering feedback from their participants.

In a study by Goodkind et al. (2014), researchers reflect on the prevalence of adult African refugees struggling with psychological distress within the United States and existing interventions targeted to aid adult African refugees. Goodkind et. al., noted the profound need for mental health services for refugees within the United States and the prevailing challenges within the current mental health system, such that the current mental health system is not consistently responsive of specific needs of refugees and the pervasive stigma associated with seeking help (as cited in Goodkind et al., 2014). Goodkind is cited in this study for developing and testing a community-based program for adult Hmong adult refugees that is focused on: "increasing environmental mastery through individual and group learning opportunities, improving refugees' access to resources through advocacy, creating meaningful social roles by valuing refugees' culture, experiences, and knowledge, and reducing refugees' social isolation" (p. 335). The researchers utilized the program developed by Goodkind for adult Hmong adult refugees and adapted the 6-month program with adult African refugees participating in the Refugee Well-Being Project (Goodkind et al., 2014). Goodkind et al. described the intervention to consist of Learning Circles, which is a forum for cultural exchange between participants and program facilitators, and Advocacy, during which program facilitators worked with participants to engage with community resources. The researchers described the Learning Circles to consist of the families of the refugee adult, which integrated the sharing of the lived experiences of the refugees' children. This study occurred over a three-year period (2006-2008) and was facilitated

by trained undergraduate students. Experiences of participants were gathered through open-ended interviews that took place in the participants' home and were facilitated by a facilitator that was both trained and bilingual (with interpreters available when needed). Additionally, Goodkind et al. utilized many quantitative measures to evaluate participants' experiences and outcomes, such as Rumbaut's (1985) Psychological Well-Being Scale (as cited in in Goodkind et al., 2014), Satisfaction with Life Areas scale (as cited in in Goodkind et al., 2014), Life Satisfaction Index A (as cited in in Goodkind et al., 2014), Satisfaction with Resources scale (as cited in in Goodkind et al., 2014), the Difficulty Obtaining Resources scale (as cited in in Goodkind et al., 2014), Basic English Skills Test (BEST), Rumbaut's 1989 4-item scale for Perceived English proficiency (as cited in in Goodkind et al., 2014), and the Whitbeck Encultural Scale (as cited in in Goodkind et al., 2014). Additionally, the 36 participants (each completed four interviews) were asked to describe their satisfaction with the program using a seven-point Likert-scale that ranged from 'very dissatisfied' to 'very satisfied' during an interview at the end of the intervention. Findings indicate a high level of satisfaction with the intervention, such that overall project satisfaction resulted in a mean score of 4.8, the Learning Circles component resulted in a scored a mean score of 4.9, and the Advocacy component resulted in a mean score of 5.4 (Goodkind et al., 2014). During the interviews, participants were asked to provide feedback on outcomes of the intervention and aspects that were helpful. This qualitative data gathering yielded crucial information, specifically that participants found improved English fluency to be central to feeling like they are part of the community and that a significant increase in access to resources was imperative to participants' improved life experience (Goodkind et al., 2014). The resources identified as important to the participants were: "housing, education, transportation, identity cards, learning how to drive, computer skills, health care, employment,

and assessing food and food stamps" (Goodkind et al., 2014, p. 340). Synthesizing outcomes from quantitative and qualitative measures, Goodkind et al. (2014) found that participants benefit with increased English proficiency and improvements in quality of life as well as decreases in psychological distress. However, the researchers stated that there was not the same level of increase in access to resources when applying the intervention to adult African refugees in comparison to the Hmong refugees (Goodkind et al., 2014). This study suggests that fostering collaborative relationships that empower the refugees' strengths and individual experiences, while also facilitating access to resources could significantly impact refugees' well-being and quality of life (Goodkind et al., 2014).

The process of gathering a participant's feedback requires consideration of the measures utilized and the administrative protocol by which feedback is gathered. In a study of an intervention program intended to service HIV-positive youth, participant satisfaction was gathered and analyzed through a participant feedback questionnaire (LaGrange et al., 2012). LaGrange et al. (2012) identified and used one measure, the participant feedback measure, to gather participant feedback and satisfaction. Through convenience sampling, the researchers recruited and enrolled participants that were HIV-positive youth. The participants engaged in the group and individual sessions, and then were asked for their feedback regarding their experience in the program. The researchers differentiated satisfaction outcomes into subsequent sections: participant satisfaction, session-specific preferences, activity helpfulness, participant attendance, and limitations (LaGrange et al., 2012). The researchers stated that the participant feedback questionnaire consisted of a "three-point Likert scale in response to the question, 'what did you like?' " (LaGrange et al., 2012, p. 122). The researchers described a significant amount of data that indicated varying levels of satisfaction with the program's individual and group

interventions. The researchers identified a number of ways to increase participant satisfaction, such as consideration of scheduling of interventions, incentives, and implementation of a program that provides services in both group and individual modalities (LaGrange et al., 2012).

In other intervention programs, researchers have utilized quantitative methodologies to gather participant satisfaction. Woods, Catroppa, Giallo, and Anderson (2012) implemented an intervention program for families with a child that struggles with brain injury. Woods et al. (2012) utilized The Consumer Satisfaction Scale [25] that consists of 9 items for which participants used a five-point scale, ranging from 'strongly disagree' to 'strongly agree.' Additionally, Woods et al. (2012) asked the parents of the children with brain injury to complete The Consumer Satisfaction Scale [25] with a focus on rating "their feasibility" (p. 193) of the intervention materials. As a result of the methodology implemented, the researchers gathered a wealth of data regarding the parents' experience of the intervention. In another intervention program, Bakas et al. (2009) implemented a program for stroke caregivers. Bakas et al. developed rating forms that would be administered during telephone interviews by assistants to the study. The satisfaction rating forms were comprised of questions that asked participants to rate their experience on a five-point Likert scale, ranging from 'strongly disagree' to 'strongly agree' (Bakas et al., 2009). In addition to this quantitative measure of participant satisfaction, the researchers implemented an open-ended question aspect of the telephone interview that was recorded in order to provide exact feedback that could later be evaluated (Bakas et al., 2009). Bakas et al. described the usefulness in gathering quantitative, as well as qualitative measures of participants' satisfaction with the intervention program.

Important Factors that Impact Participant Satisfaction

The process of developing and implementing culturally-responsive mental health services is challenging, as it highlights programs that lack optimal outcomes and demands new programs be effective in meeting the needs of ethnocultural communities. Prior to enrolling participants in community-based programs, there is a vital process of engaging community members in community-based agencies. The process of engaging community members is wrought with a variety of factors that create the underlying foundation upon which a community member decides whether or not to access mental health services or support outside of their current support system. A large component that affects access to mental health services is the experience of disenfranchisement, wherein community members have continuously felt minimized and "less than" by the dominant culture. Consequently, these experiences of disenfranchisement have inhibited their sense of self-efficacy in seeking and utilizing resources, which can then lead to further negative consequences and deterioration of the relationship between community members and community-based agencies (Miliora, 2000). Once participants are enrolled in community-based programs, there are a variety of methods to evaluate their overall satisfaction. More literature is needed that focuses on the impact of culture and how culture is the foundation upon which an individual experiences services as well as report of those services. Participants' responses to services and feedback may be impacted by many different variables and thus a myriad of evaluation methods are necessary to appropriately capture their satisfaction levels.

Within community-based programs are providers and program developers, which call for cultural competence that empowers the providers and consumers to have services within the programs that are culturally responsive. To be culturally competence, one "acknowledge and incorporates- at all levels- the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that results from cultural differences of services to meet culturally

unique needs" (Betancourt, Green, Carrillo, & Ananeg-Firempong II, 2003, p. 294). Furthermore, embodying cultural competence within a community-based program entails:

> understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system… and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (Betancourt et al., 2003, p. 297)

A provider's cultural competence will undoubtedly impact their ability to recognize variations in participants' culture, needs, and experience within a community-based program wherein mental health services and support are rendered. Meyer and Zane (2013) identified the importance of conceptualizing and treating the participant within their cultural context, then fully integrating it into their mental health experience. The more the participant feels understood and validated through the use of culturally responsive interventions, the greater likelihood that the participant will feel satisfied with the program and continues accessing services (Meyer & Zane, 2013). Researchers suggest a key method of improving the experience for multi-ethnic participants is to bring in members of the "communities targeted by the programs" (p. 489) to facilitate the program, such that doing this "capitalizes on the community-based staff member's inherent sensitivity to, or awareness of, the targeted community's customs and contexts, thereby ensuring culturally sensitive service delivery" (Mistry, Jacobs, & Jacobs, 2009, p. 489). In developing and conceptualizing programs and interventions, researchers have constructed a framework that can aid in development and implementation, which consists of: "language, persons, metaphors, content, concepts, goals, methods, and context" (Bernal & Saez-Santiago, 2006, p. 127). Through consideration, reflection, and conceptualizing a program's development and

implementation from a culturally responsive, community-based approach, a program will hopefully achieve better outcomes with participants.

In the process of considering the outcomes and satisfaction ratings reported by participants, it is important to consider the nature of the interventions being offered within the community-based program. A participant's satisfaction with a program is a result of the type, exposure, experience, and results of exposure to interventions within the program. Every intervention within a program is "culturally embedded" (Ingraham & Oka, 2006, p. 133), which serves as the foundation of the intervention and thus creates challenge in evaluating the level of success and satisfaction with the program. If the intervention is described to be unsatisfactory, there is a dilemma in understanding whether the intervention is problematic, whether the provider is problematic, or whether it was a poor fit between the intervention and the cultural group represented by the participant (Ingraham & Oka, 2006). Within community-based work, interventions vary across settings, populations, and ethnicities. Embedded within communities are multi-ethnic consumers who illuminate the need to reconsider interventions that are integrated within community-based programs. There are various ways to make this adjustment, one of which is to adapt interventions provided in all mental health settings for the specific cultural needs of the participant (Hall, 2001, 2005). With a desire to utilize culturally congruent interventions, it would be beneficial for community-based programs to train providers from a culturally responsive framework, as well as have bilingual and multi-ethnic members as part of the program employment. For example, researchers utilized data from the U.S. Census Bureau (2010) that identified 34.5 million people that speak Spanish in the United States, with half of those people with low English proficiency, thus experiencing great difficulty in obtaining mental

health services due to only 5% of the mental health field providing services in Spanish (Verdinelli & Biever, 2013).

For program developers that strive to cultivate a meaningful relationship with the community and collaboratively construct a program to be implemented within the community, there are guiding principles that can be followed. Goodman et al. (2004) suggest awareness of one's personal values, equal power amongst collaborators, empowering those who have been oppressed, heightened awareness of historical context as well as the current systemic framework, significant attention paid to strengths of the community and individuals, and a meaningful collaboration that provides tools to the community and individuals in order to facilitate change. Collaboration as the nucleus of conceptualizing community-based program development and implementation is critically important in establishing a foundation upon which community members engage in programs. Implementation of a program that is consistent with the community's needs, experiences, and beliefs, as well as consistent with those of diverse communities, is important in ultimately serving the community's needs, and attaining optimal outcomes and satisfaction ratings. In addition to increased cultural responsiveness and inclusion of multi-ethnic staff, participant satisfaction can be improved through the empowerment and conceptualization of the O&E program as a multicultural collaborative. A significant amount of the literature has focused on increasing cultural responsiveness of the providers within a single community-based agency. However, when considering the unique collaborative of MECCA, it would be beneficial to conceptualize the process of engagement between members of the different agencies in an effort to improve satisfaction throughout the collaborative. With conceptualization of O&E as collaboration, the program developers and the program providers can mutually share ideas, needs, and beliefs during the formulation of the program and

implementation of interventions. In this rare experience, there are at least two levels of collaboration. One level of collaboration is between the agency leaders and community. Another level of collaboration is between the community organization and members. Through collaboration, program developers work with "the people who live within a geographic boundary, the people served by a certain agency or program, or a group of people who have shared identity and experiences, similar beliefs, values, and norms" (Flaskerud, 2007, p. 122). In this process of collaboration, program development is created alongside those who live within the community and thus the program gains insight to needs, beliefs, and experiences that can be formative in how participants access, receive, and experience program services.

Method

The present study aimed to add to the current body of literature on participant satisfaction with community-based programs through descriptive analysis of the subjective reports of satisfaction for participants of the Outreach & Engagement (O&E) program, which is a community-based program that provides culturally responsive services to multi-ethnic individuals within the community-based participatory action research framework. This study intended to add to the current literature in three ways. The first objective was to provide literature on community-based programs and correlated participant satisfaction. The second objective was to examine the factors that contribute to participant satisfaction within community-based programs. The third objective was to evaluate outcomes of participant satisfaction for MECCA's Outreach and Engagement program, as well as reflect on components of the O&E program that produce satisfaction ratings. The primary research question in this study was: To what degree were participants in MECCA's Outreach and Engagement (O&E) program satisfied with their participation in the program? This study identified factors that could contribute to participant satisfaction within community-based programs. This study identified the outcomes of participant satisfaction for MECCA's Outreach and Engagement (O&E) program. Descriptive analysis of the data assisted in understanding participant satisfaction with the Outreach and Engagement program and gained awareness of satisfaction across MECCA as a whole. This study hoped to gather satisfaction outcomes of the O&E program and, through looking at aspects of the Satisfaction Survey (see Appendix B), hypothesized on factors and services of the O&E program that may have been helpful to program participants (see Figure 1.), which will hopefully add to the current body of literature and provide future implications for culturally responsive community-based programs.

Subjects

The proposed study utilized quantitative data from the Outreach and Engagement program during the 2012-2013 and 2013-2014 fiscal years. The quantitative data was gathered from one measure completed by male and female participants, between ages of 6-60-years-old or older, enrolled in the O&E program as well as participants who engaged in outreach and educational classes/workshops facilitated at the six community-based agencies of MECCA. Each of the six community-based agencies of MECCA served specific ethnic communities, thus participants will include Latina/o, Iranian, Korean, Vietnamese, White, Arabic, Black/African American, and Japanese individuals.

Of the individuals who received services from the O&E program in fiscal year 2012-2013, 17.2% were of Hispanic, Latino, or Spanish Origin, 23.9% Asian, .1% Pacific Islander, and 18% Iranian. Regarding language preference during fiscal year 2012-2013, 25.4% were non-English speaking, 10% were American Sign Language, and 28.8% were Limited English Proficiency. Of the individuals who received services from the O&E program in fiscal 2013-2014, .5% were Black or African-American, 9.62% were Iranian, 57.72% were Korean, 6.15% were Vietnamese, 1.98% were White or Caucasian, 21.97% were Hispanic, Latino, or Spanish Origin, and 1.1% were Arab. Regarding primary language, 0.96% spoke Arabic, 7.86% spoke English, 9.51% spoke Farsi, 55.26% spoke Korean, 20.36% spoke Spanish, and 5.83% spoke Vietnamese.

This study utilized participants who were enrolled in the O&E program during the 2012-2013 and 2013-2014 fiscal years. In fiscal year 2012-2013, a total number of 254 participants participated in services and of those 254 participants enrolled in the program 153 (60.23%) completed the satisfaction survey. In fiscal year 2013-2014, a total number of 292 individuals

participated in services and of those 292 participants enrolled in the program 258 (88.36%) completed the satisfaction survey. The sample included males and females whose ages ranged between 6-60-years-old or older. This sample consisted of people from multi-ethnic communities and is comprised of the following ethnic groups: Latina/o, Iranian, Korean, Vietnamese, White, Arabic, Black/African American, and Japanese.

In the data set for fiscal year 2012-2013, the initial sample size was 153 participants but nine participants were missing data for responses to the three components of item number nine and were therefore excluded from all subsequent analyses. This resulted in a final sample size of 144 for fiscal year 2012-2013. In the data set for fiscal year 2013-2014, the initial sample size was 258 participants but 16 participants were missing data for responses to the three components of item number nine and were therefore excluded from all subsequent analyses. This resulted in a final sample size of 242 fiscal year 2013-2014.

For this study, data analysis included data cleaning and screening in order to eliminate and organize data outcomes. Question number nine on the Participant Satisfaction Survey asks participants to reflect on their overall experience in the Outreach and Engagement program, specifically asking participants to rate their experience of language and cultural responsiveness employed by program staff. Thus, participants missing responses to the three components of question number nine on the Participant Satisfaction Survey were excluded because their Participant Satisfaction Survey would be incomplete on a critical survey item. Additionally, participants were organized into one large sample size with each participant identified based on the agency they obtained O&E services. During subsequent descriptive analyses, means on satisfaction criteria and satisfaction domains were gathered.

Procedures

Through convenience-based sampling, data was gathered from participants enrolled in the O&E program during 2012-2013 and 2013-2014 who completed the Participant Satisfaction Survey. This data was collected, organized, and entered into a SPSS statistical format by research assistants.

Throughout participants' involvement in the O&E program, agency staff collaborated with participants to complete agency paperwork as well as baseline and follow-up measures regarding their well-being and subjective experience of depression. The agency staff that worked at the O&E program was most often from the same cultural background as the participants seeking services at the agency and thus could often speak in the preferred language of the participant. At the point of the participants' completion in the O&E program, participants were asked to complete a survey on their subjective experience of the services provided in the O&E program. The staff would provide the participants with the hard-copy measure and ask the participant to "do their best" in completing the measure without support from the agency staff member. In order to assist participants' autonomy in completing the satisfaction survey, the Participant Satisfaction Survey was provided in the culture's predominant language, for example the Korean-speaking agency (KCS) was provided Participant Satisfaction Survey in Korean. Upon completion of the measure, the participant submitted the survey to the staff member.

Instrument

For the purposes of this study, satisfaction was evaluated based on criteria (see Figure 2.) that were formulated based on the MECCA O&E Participant Satisfaction Survey (see Figure 3.).

This study utilized the Participant Satisfaction Survey (see Appendix B), which is a measure that was developed by the Orange County Healthcare Agency in collaboration with the MECCA agencies and MECCA program developers. The Participant Satisfaction Survey aims to

gather information regarding participants' experiences in the O&E program. The Participant Satisfaction Survey is a quantitative, self-report, 11-item measure. Of the 11 items on the Participant Satisfaction Survey, 10 items are scored using a 5-point Likert scale (1 to 5, where 1 equals 'strongly disagree,' 2 equals 'disagree,' 3 equals 'agree,' 4 equals 'strongly agree,' and 5 equals 'don't know/unsure' which is removed from statistical computation so answers scored 5 do not inaccurately skew results) and one item is scored on a 10-point Likert scale (0 to 10, where 0 is the 'worst' and 10 is the 'best').

Results

Participant satisfaction domains (overall satisfaction, cultural competency among staff, program impact, and access to care) are discussed for participants' satisfaction with the MECCA O&E program. Satisfaction domains were determined by participants' responses on the Satisfaction Survey.

Data Analysis of Satisfaction Scores for Full Sample from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 144 participants with a mean score of 13.049, with a standard deviation of 3.5406, with higher scores indicating greater satisfaction. Overall satisfaction scores were found through a summing of questions one, two (reverse coded), and question eight. Participants' scores were found to be high when answering question two, "I could have received the MECCA O&E services through another agency" which was reverse scored to mean "I couldn't have received the MECCA O&E services through another agency." Participants' satisfaction scores were rated high when answering question eight as well, "To rate my overall satisfaction with the MECCA O&E as a program in the past 30 days, where 0 is the worst program possible and 10 is the best program possible, the number I would use is."

Cultural competency among staff. Cultural Competency Among Staff was found across 144 participants with a mean score of 16.229, with a standard deviation of 3.0536, with higher scores indicating greater cultural competency. Cultural competency among staff scores were found through a summing of questions four, seven, nine (part a), nine (part b, reverse coded), and nine (part c). Participants' satisfaction scores were found to be high when answering question nine (part a), "Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: Sessions were provided in my preferred language."

Program impact. Positive program impact was found across 137 participants with a mean score of 3.380, with a standard deviation of .6545, with higher scores indicating greater satisfaction with the program's impact. Program impact scores were found through question six. Participant scores were found to be relatively high when answering question six, "The MECCA O&E staff helped me achieve my goals."

Access to care. An increase in access to care was found across 133 participants with a mean score 3.489, with a standard deviation of .6230, with higher scores indicating greater satisfaction with accessibility of care. Access to care scores were found through question five. Participant scores were found to be relatively high when answering question five, "I would say that my meeting places and times with the MECCA O&E Program in the past 30 days have been convenient."

Descriptive statistics of the full sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 1.). Further analysis on agency-specific satisfaction outcomes will help understand variations amongst agencies. KCS, the Korean-speaking community agency, had insufficient data to conduct these agency-specific analyses.

Data Analysis of Satisfaction Scores for ABRAZAR from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 26 participants with a mean score of 14.15, with a standard deviation of 3.00, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 26 participants with a mean score of 16.50, with a standard deviation of 2.75, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 23 participants with a mean score of 3.35, with a standard deviation of .4870, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 21 participants with a mean score 3.62, with a standard deviation of .498, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the ABRAZAR sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 2.).

Data Analysis of Satisfaction Scores for VNCOC from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 39 participants with a mean score of 13.41, with a standard deviation of 1.85, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 39 participants with a mean score of 15.54, with a standard deviation of 3.58, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 35 participants with a mean score of 3.40, with a standard deviation of .775, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 37 participants with a mean score 3.5, with a standard deviation of .77, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the VNCOC sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 3.).

Data Analysis of Satisfaction Scores for OCCTAC from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 54 participants with a mean score of 12.54, with a standard deviation of 4.04, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 54 participants with a mean score of 16.3, with a standard deviation of 3.16, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 54 participants with a mean score of 3.33, with a standard deviation of .70, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 52 participants with a mean score 3.4, with a standard deviation of .603, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the OCCTAC sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 4.).

Data Analysis of Satisfaction Scores for OMID from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 12 participants with a mean score of 14.67, with a standard deviation of 1.61, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 12 participants with a mean score of 17.67, with a standard deviation of 2.06, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 12 participants with a mean score of 3.75, with a standard deviation of .45, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 11 participants with a mean score 3.82, with a standard deviation of .40, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the OMID sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 5.).

Data Analysis of Satisfaction Scores for ACCESS CAL from Fiscal Year 2012-2013

Overall satisfaction. Overall satisfaction was found across 13 participants with a mean score of 10.4, with a standard deviation of 5.5, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 13 participants with a mean score of 16.3, with a standard deviation of 1.75, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 13 participants with a mean score of 3.23, with a standard deviation of .44, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 12 participants with a mean score 3.3, with a standard deviation of .49, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the ACCESS CAL sample for fiscal year 2012-2013 Satisfaction Scores are indicated (see Table 6.).

Data Analysis of Satisfaction Scores for Full Sample from Fiscal Year 2013-2014

Overall satisfaction. Overall program satisfaction was found across 236 participants with a mean score of 13.441, with a standard deviation of 3.6845, with higher scores indicating greater satisfaction. Overall satisfaction scores were found through a summing of questions one, two (reverse coded), and question eight. Participants' scores were found to be high when answering question eight, "To rate my overall satisfaction with the MECCA O&E as a program in the past 30 days, where 0 is the worst program possible and 10 is the best program possible, the number I would use is."

Cultural competency among staff. Cultural Competency Among Staff was found across 242 participants with a mean score of 16.686, with a standard deviation of 3.3964, with higher scores indicating greater cultural competency. Cultural competency among staff scores were found through a summing of questions four, seven, nine (part a), nine (part b, reverse coded), and nine (part c). Participants' scores were found to be high when answering question nine (part a), "Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: Sessions were provided in my preferred language." Participants' scores were found to be high when answering question nine (part c), "Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: I felt the MECCA staff was sensitive to my language and ethnicity."

Program impact. Positive program impact was found across 216 participants with a mean score of 3.458, with a standard deviation of .6456, with higher scores indicating greater satisfaction with the program's impact. Program impact scores were found through question six. Participant scores were found to be relatively high when answering question six, "The MECCA O&E staff helped me achieve my goals."

Access to care. An increase in access to care was found across 219 participants with a mean score of 3.479, with a standard deviation of .6305, with higher scores indicating greater satisfaction with accessibility of care. Access to care scores were found through question five. Participant scores were found to be relatively high when answering question five, "I would say that my meeting places and times with the MECCA O&E Program in the past 30 days have been convenient."

Descriptive statistics of the full sample for fiscal year 2013-2014 Satisfaction Scores (see Table 7.). Further analysis on agency-specific satisfaction outcomes will help understand variations amongst agencies.

Data Analysis of Satisfaction Scores for ABRAZAR from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction was found across 15 participants with a mean score of 13.60, with a standard deviation of 3.04, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 15 participants with a mean score of 17.6, with a standard deviation of 1.99, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 15 participants with a mean score of 3.73, with a standard deviation of .46, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 15 participants with a mean score 3.5, with a standard deviation of .52, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the ABRAZAR sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 8.).

Data Analysis of Satisfaction Scores for VNCOC from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction was found across 114 participants with a mean score of 13.43, with a standard deviation of 3.82, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 116 participants with a mean score of 16.32, with a standard deviation of 3.64, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 101 participants with a mean score of 3.44, with a standard deviation of .65, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 103 participants with a mean score 3.5, with a standard deviation of .61, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the VNCOC sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 9.).

Data Analysis of Satisfaction Scores for OCCTAC from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction was found across 97 participants with a mean score of 13.53, with a standard deviation of 3.7, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across 101 participants with a mean score of 16.9, with a standard deviation of 3.34, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across 90 participants with a mean score of 3.43, with a standard deviation of .67, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across 92 participants with a mean score 3.43, with a standard deviation of .7, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the OCCTAC sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 10.).

Data Analysis of Satisfaction Scores for OMID from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction was found across three participants with a mean score of 11.33, with a standard deviation of 6.03, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across three participants with a mean score of 16.67, with a standard deviation of 2.52, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across three participants with a mean score of 3.67, with a standard deviation of .6, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across two participants with a mean score 3.5, with a standard deviation of .71, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the OMID sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 11.).

Data Analysis of Satisfaction Scores for KCS from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction from one participant with a score of 13.00.

Cultural competency among staff. Cultural Competency Among Staff from one participant with a score of 20.00.

Program impact. Positive program impact from one participant with a score of 4.0.

Access to care. An increase in access to care from one participant with a score 4.0.

Descriptive statistics of the KCS sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 12.).

Data Analysis of Satisfaction Scores for ACCESS CAL from Fiscal Year 2013-2014

Overall satisfaction. Overall satisfaction was found across six participants with a mean score of 12.8, with a standard deviation of 1.72, with higher scores indicating greater satisfaction.

Cultural competency among staff. Cultural Competency Among Staff was found across six participants with a mean score of 18.00, with a standard deviation of 1.9, with higher scores indicating greater cultural competency.

Program impact. Positive program impact was found across six participants with a mean score of 3.33, with a standard deviation of .52, with higher scores indicating greater satisfaction with the program's impact.

Access to care. An increase in access to care was found across six participants with a mean score 3.3, with a standard deviation of .52, with higher scores indicating greater satisfaction with accessibility of care.

Descriptive statistics of the ACCESS CAL sample for fiscal year 2013-2014 Satisfaction Scores are indicated (see Table 13).

Discussion

The results of participant satisfaction outcomes of fiscal year 2012-2013 and 2013-2014 of the O&E program indicate the culturally-responsive nature of the community-based O&E program. Results show that one of the primary reasons this program may have been satisfactory for participants was that the program delivered culturally responsive and linguistically congruent services to participants. Participants' satisfaction scores indicate that the O&E program, including staff, were culturally-responsive to the ethnicity and language of participants. Further, participants' satisfaction scores indicate that participants were satisfied overall with the services received and would elect to obtain services from the O&E program again. O&E's success can be attributed to MECCA's foundation in cultural responsiveness, diversity empowerment, destigmatizing mental health services, and collaboration with the communities to create and provide community-based programs.

In working with MECCA's staff, researchers and program developers took time to understand the needs of each ethnic community being targeted and how those needs could be best conceptualized and served. The MECCA staff were members of each of the ethnic communities they served, while also being staff of MECCA and the community-based agency, which provided invaluable insight into the mental health needs as defined within the community. As Goodman et al. (2004) suggested, it is shared power, self-awareness, and empowerment of people that are marginalized from the process that will lead to change. MECCA's O&E program shows that collaboration with diverse ethnic communities is possible if done effectively, with sensitivity, and with the intention of creating satisfactory community-based programs that are steeped in the roots of the ethnic communities themselves.

Participants' satisfaction scores from fiscal year 2012-2013 and 2013-2014 can be compared across the four satisfaction domains, which consist of overall satisfaction, cultural competency, program impact, and access to care. Between fiscal year 2012-2013 and 2013-2014 the mean scores on overall satisfaction, cultural competency among staff, and program impact slightly increased, from 13.049 to 13.441 on overall satisfaction, from 16.229 to 16.686 on cultural competency among staff slightly increased, and from 3.380 to 3.458 on program impact. Between fiscal year 2012-2013 and 2013-2014 the mean score on access to care remained consistent, with 3.489 and 3.479. In hypothesizing about components of the O&E program that may have led to improvements in satisfaction scores across three of the four satisfaction domains, it is possible that the clarity in purpose of the program as well as the gained experiences of the MECCA O&E program staff led to more positive experiences for program participants. MECCA staff, program developers, researchers, and county funders underwent a process of adjustment at the outset of the O&E program that entailed a reconciliation of prioritizing the needs of the underserved ethnic communities targeted, providing culturally responsive services across six different ethnic community-based agencies, and adherence to mainstream-informed county funder's expectations on program development and implementation. Throughout the beginning phases of reconciling these factors, all of the factors involved had to find ways to co-exist while maintaining cultural responsiveness at the center of decision making. As MECCA staff became more informed on expectations placed upon them, MECCA staff became more equipped to gather data to fulfill the needs of the funders' outcome reporting requirements, while also prioritizing the services and timing for the diverse ethnic participants. As time went on with implementation of the O&E program, increased participant satisfaction and increases in the amount of data gathered could be due to the fact that MECCA

staff were able to provide better and more culturally responsive services while also becoming more skilled in gathering data within county funders' parameters. The county funders were also called upon to understand the diverse ethnic communities, learning that qualitative measures gathered more descriptive data and that diverse populations may not be immediately comfortable with revealing their thoughts, feelings, and experiences in requested, mainstream-informed, paper and pencil methods.

During fiscal year 2012-2013, there were 144 participants' scores for the overall satisfaction domain, 144 participants' scores for the cultural competency among staff domain, 137 participants' scores for the program impact domain, and 133 participants' scores for the access to care domain. During fiscal year 2013-2014, there were 236 participants' scores for the overall satisfaction domain, 242 participants' scores for the cultural competency among staff domain, 216 participants' scores for the program impact domain, and 219 participants' scores for the access to care domain. With an increase in participant satisfaction data gathered during the 2013-2014 fiscal year, it is important to consider what may have led to this outcome. It is likely that an increase in participants between the two fiscal years led to a greater number of participant scores on each domain. Between fiscal year 2012-2013 and 2013-2014, more participants were enrolled in the O&E program, from 254 participants (with 153 who completed satisfaction surveys) to 292 participants (with 258 who completed satisfaction surveys). It is also possible that program protocol and administration of the Participant Satisfaction Survey improved, which yielded a greater number of completed satisfaction surveys. Furthermore, MECCA staff and the O&E program developed more methods of meeting the needs of their communities while also following the documentation requests of the county funders.

While specific protocols were put in place for administering measures and facilitating the O&E program across MECCA, culture has an indelible influence on how any one person and agency operates. Thus, the nature of data collection could have varied from agency to agency and impacted the type and amount of data gathered. In looking at fiscal years 2012-2013 and 2013-2014, there appears to be significant differences when looking at the amount of satisfaction outcome data gathered from each agency, which can be seen by looking at the number of scores for each domain. For fiscal year 2012-2013, there was insufficient data to complete agency-specific analyses for KCS.

The significant differences in number of participant outcomes provided by each agency raise specific questions, specifically questions about why certain agencies were able to provide many satisfaction surveys and some were unable to provide more than one. It is possible that the amount of data gathered was impacted by cultural variations in approach to providing services and interacting with others while also completing paperwork. When talking with MECCA staff and agency staff at KCS and VNCOC, staff remarked on their beliefs towards completing tasks and paperwork as requested. However, it is notable that KCS did not provide a significant amount of Satisfaction Surveys. An area to investigate further is the impact of culture through all of the agencies in the completion of surveys by its participants, specifically the Satisfaction Survey, because the survey asked participants to rate their experiences of the MECCA staff. Additionally, the Satisfaction Survey asked participants to rate their experiences of services, which could create a conflict with participants attempting to respond in socially desirable ways to maintain social norms or politeness and keeping personal information or experiences private. When talking with MECCA staff and agency staff at all of the agencies, staff remarked on the difficulty in completing measures overall due to cultural preferences of talking to provide

information instead of writing personal information and stated that quantitative measures are not congruent with the more descriptive, open-ended conversational style of their cultures. In looking at the amount of Satisfaction Surveys provided by OCCTAC and ABRAZAR, it is possible that the staff at those agencies had previously developed strong relationships within their communities and thus with participants, which may have led to more comfort in administration and completion of Satisfaction Surveys. In looking at both fiscal years, OCCTAC and VNCOC provided the highest number of Satisfaction Surveys. It is possible that the staff at each of these agencies had an impact on these outcomes and further research would be useful to understand the impact of the cultural beliefs of the Spanish-speaking and Vietnamese-speaking communities.

In considering limitations of this study, there are a number to consider. The Participant Satisfaction Survey was developed by the Orange County Healthcare Agency in collaboration with the MECCA agencies and MECCA program developers. The Participant Satisfaction Survey did not undergo a formalized process of validation across different populations, rather it was developed and adjusted during discussions and with feedback from community members. This lack of validation for the Participant Satisfaction Survey is further complicated by the possibility that implementation of the survey could have varied across the six community-based agencies providing the O&E program. Thus, the gathered data could be compromised and possibly not accurately representative of participants' satisfaction with the O&E program. Further in regard to limitations, MECCA staff initially did not have knowledge of research or clinical relevance of material that may have impacted the gathering of measures. An additional limitation of the data presented in this study is the possible impact that social desirability placed in the responses participants endorsed on the self-report measure. It is possible that participants

were worried that staff would think less of them should the participant provide a low satisfaction rating of the services provided. Additionally, while it is a strength that the Participant Satisfaction Survey was translated into the preferred language of each of the six community-based agencies (e.g. Korean, Farsi, Spanish, Arabic, and Vietnamese) it is also a limitation, as it is possible that the translated versions of the measure did not accurately inquire about the intended domain or may have been translated in a manner that may have been linguistically inconsistent with the community members language usage. Lastly, the participant satisfaction data that was gathered was not directly linked to the services obtained by each participant which limits the causality that can be drawn between services received and participant satisfaction.

In future research that aims to gather participant satisfaction with community-based services, it would be beneficial to utilize both quantitative and qualitative methods of data collection. Goodkind et al. (2014) and Bakas et al. (2009) utilized open-ended questions during interviews alongside quantitative measures to ascertain detailed information on participant satisfaction, an approach to data collection that could be utilized in future research within community-based programs for ethnically diverse, underserved communities. Additionally, it would be beneficial for improvement in tracking of services received by participants in order to draw more detailed and accurate correlations between services received, location of services received, demographic data of participants, and reported satisfaction with programmatic services.

In the quest to understand participant satisfaction with MECCA's Outreach and Engagement (O&E) program, this study found that participants were satisfied with the O&E program on domains of overall satisfaction, cultural competency among staff, program impact, and access to care. The culturally-focused, collaborative mindset woven into the ethos of MECCA has manifested through an unwavering commitment to providing culturally responsive

community-based services while challenging the expectations expressed by county funders. Through collaboration, MECCA and the funders have undergone reciprocal education on the needs and preferences of ethnic communities as well as the ways in which funders prefer to gather information on program impact.

REFERENCES

Andrade, F. B., Filha, M.O.F., Vianna, R.P.T., Silva, A.O., & Costa, I.C.C. (2012). Evaluation of participant satisfaction with community therapy: A mental health strategy in primary care. *Psychiatric Quarterly*, *83*, 325-334. doi:10.1007/s11126-011-9202-2

Bakas, T., Farran, C. J., Austin, J. K., Given, B. A., Johnson, E. A., & Williams, L. S. (2009). Content validity and satisfaction with a stroke caregiver intervention program. *Journal of Nursing Scholarship, 41*(4), 368-375. doi:10.1111/j.1547-5069.2009.01282.x

Baron-Epel, O. (2003). Consumer-oriented evaluation of health education services. *Patient Education and Counseling, 49,* 139-147. http://dx.doi.org/10.1016/S0738-3991(02)00073-3.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong II, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*, 293-302

Bernal, G., & Saez-Santiago, E. (2006). Culturally centered psychosocial interventions. *Journal of Community Psychology*, *34*(2), 121-132.

Chyung, S., Wisniewski, A., Inderbitzen, B., & Campbell, D. (2013). An improvement- and accountability-oriented program evaluation: An evaluation of the Adventure Scouts program. *Performance Improvement Quarterly*, *26*(3), 87-115. doi:10.1002/piq.21155

Dumbrill, G. C., & Green, J. (2008). Indigenous knowledge in the social work academy. *Social Work Education, 27*(5), 489-503. doi:10.1080/02615470701379891

Flaskerud, J. H. (2007). Cultural competence: What is it? *Issues in mental health nursing*, 28, 121-123. doi:10.1080/01612840600998154

Goodkind, J. R., Hess, J. M., Isakson, B., LaNoue, M., Githinji, A., Roche, N…. & Parker, D. P. (2014). Reducing refugee mental health disparities: A community-based intervention to address postmigration stressors with African adults. *Psychological Services, 11*(3), 333-346. doi:10.1037/a0035081

Goodman, L. A., Liang, B., Helms, J. E. Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologists as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist*, *32*, 793-837.

Hall, G. C. (2005). Introduction to the special section on multicultural and community psychology: clinical psychology in context. *Journal of Consulting and Clinical Psychology*, *73*(5), 787-789. doi:10.1037/0022-006X.73.5.787

Hall, G. C. N. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69,* 502–510.

Harrell, S. P. (2000). A multi-dimensional conceptualization of racism-related stress: implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70,* 42-57.

Ingraham, C. L. & Oka, E. R. (2006). Multicultural issues in evidence-based interventions. *Multicultural Issues in School Psychology*, 127-149. doi:10.1300/J370v22n02_07

Kaczorowski, J. A., Williams, A. S., Smith, T. F., Fallah, N., Mendez, J. L., & Nelson–Gray, R. (2011). Adapting clinical services to accommodate needs of refugee populations. *Professional Psychology: Research And Practice*, *42*(5), 361-367. doi:10.1037/a0025022

Kazdin, A. & Mazurick, J. (1994). Dropping out of child psychotherapy: Distinguishing early and late dropouts over the course of treatment. *Journal of Consulting and Clinical Psychology, 62,* 1069–1074. doi:10.1037/0022-006X.62.5.1069

Kiger, H. (2003). Outreach to multiethnic, multicultural, and multilingual women for breast cancer and cervical cancer education and screening; A model using professional and volunteer staffing. *Family & Community Health*, *26*(4), 307-318

LaGrange, R. D., Abramowitz, S., Koenig, L. J., Barnes, W., Conner, L., & Moschel, D. (2012). Participant satisfaction with group and individual components of Adolescent Impact: a secondary prevention intervention for HIV-positive youth. *AIDS Care*, *24*(1), 119-128.

Meyer, O. L., & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology*, *41*(7), 884-901.

Miliora, M. T. (2000). Beyond empathic failures: Cultural racism as narcissistic trauma and disenfranchisement of grandiosity. *Clinical Social Work Journal*, *28*(1), 43-54. doi:10.1023/A:1005159624872

Mistry, J., Jacobs, F., & Jacobs, F. (2009). Cultural relevance as program-to-community alignment. *Journal of Community Psychology*, *37*(4), 487-504.

Nicolaidis, C., Wahab, S., Trimble, J., Meja, A., Mitchell, R., Raymaker, D…. & Waters, A. S. (2012). The interconnections project: Development and evaluation of a community-based depression program for African American violence survivors. *Journal of General Internal Medicine, 28*(4), 530-538. doi:10.1007/s11606-012-2270-7

Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012). Barriers to seeking mental health services in the Latino/a community: A qualitative analysis. *Journal of Systemic Therapies*, *31*(4), 1-17. doi:10.1521/jsyt.2012.31.4.1

Sink, K. M., Covinsky, K. E., Newcomer, R., & Yaffe, K. (2004). Ethnic differences in the prevalence and pattern of dementia-related behaviors. *Journal of the American Geriatrics Society*, *52*, 1277-1283.

Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004). Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology, 18,* 19–35. doi:10.1037/0893-3200.18.1.19

Sood, E., Mendez, J., & Kendall, P. (2010). Acculturation, religiosity, and ethnicity predict mothers' causal beliefs about separation anxiety disorder and preferences for help-seeking. *Journal of Cross Cultural Psychology.* Advance online publication. doi:10.1177/0022022110389492

Thompson-Miller, R., & Feagin, J. R. (2007). Continuing Injuries of Racism: Counseling in a Racist Context. *The Counseling Psychologist, 35*(1), 106-115. doi:10.1177/0011000006294664

U.S. Department of Health and Human Services, (1999). *Mental health: A report of the surgeon general.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health. *Retrieval from* https://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBHS

Verdinelli, S., & Biever, J. L. (2013). Therapists' experiences of cross-ethnic therapy with Spanish-speaking Latina/o clients. *Journal Of Latina/O Psychology*, *1*(4), 227-242. doi:10.1037/lat0000004

Woods, D. T., Catroppa, C., Giallo, R., Anderson, & V.A. (2012). Feasibility and consumer satisfaction following an intervention for families who have a child with acquired brain injury. *NeuroRehabilitation, 30*, 189-198. doi:10.3233/NRE-2012-0744

TABLES

Table 1.

Descriptive Statistics for Full MECCA Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	138	1.0	4.0	3.406	.7213
Satisfaction Question 2	86	1.0	4.0	2.442	.9406
Satisfaction Question 3	133	1.0	4.0	3.383	.6597
Satisfaction Question 4	142	1.0	4.0	3.556	.6471
Satisfaction Question 5	133	1.0	4.0	3.489	.6230
Satisfaction Question 6	137	1.0	4.0	3.380	.6545
Satisfaction Question 7	123	1.0	4.0	3.455	.6684
Satisfaction Question 8	130	4.0	10.0	9.223	1.1086
Satisfaction Question 9A	138	1.0	4.0	3.768	.6076
Satisfaction Question 9B	140	1.0	4.0	2.771	1.3213
Satisfaction Question 9C	136	1.0	4.0	3.669	.7703
Overall Satisfaction	144	3.0	18.0	13.049	3.5406
Program Impact	137	1.0	4.0	3.380	.6545
Cultural Competency Among Staff	144	6.0	20.0	16.229	3.0536
Access to Care	133	1.0	4.0	3.489	.6230
Satisfaction Total	144	17.0	46.0	35.715	6.0576
Valid N (listwise)	52				

Table 2.

Descriptive Statistics for ABRAZAR Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	25	2.0	4.0	3.480	.5859
Satisfaction Question 2	18	1.0	4.0	2.444	.9835
Satisfaction Question 3	23	3.0	4.0	3.565	.5069
Satisfaction Question 4	25	3.0	4.0	3.600	.5000
Satisfaction Question 5	21	3.0	4.0	3.619	.4976
Satisfaction Question 6	23	3.0	4.0	3.348	.4870
Satisfaction Question 7	24	3.0	4.0	3.542	.5090
Satisfaction Question 8	25	5.0	10.0	9.480	1.0847
Satisfaction Question 9A	25	4.0	4.0	4.000	.0000
Satisfaction Question 9B	26	1.0	4.0	1.923	1.4120
Satisfaction Question 9C	26	4.0	4.0	4.000	.0000
Overall Satisfaction	26	5.0	18.0	14.154	3.0026
Program Impact	23	3.0	4.0	3.348	.4870
Cultural Competency	26	9.0	20.0	16.500	2.7459
Among Staff Access to Care	21	3.0	4.0	3.619	.4976
Satisfaction Total	26	19.0	45.0	36.538	6.0678
Valid N (listwise)	10				

Table 3.

Descriptive Statistics for VNCOC Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	38	1.0	4.0	3.342	.8471
Satisfaction Question 2	21	1.0	4.0	2.000	1.0488
Satisfaction Question 3	33	1.0	4.0	3.303	.7699
Satisfaction Question 4	38	1.0	4.0	3.553	.7604
Satisfaction Question 5	37	1.0	4.0	3.486	.7682
Satisfaction Question 6	35	1.0	4.0	3.400	.7746
Satisfaction Question 7	33	1.0	4.0	3.455	.6657
Satisfaction Question 8	39	7.0	10.0	9.077	.9837
Satisfaction Question 9A	35	1.0	4.0	3.543	.7413
Satisfaction Question 9B	38	1.0	4.0	2.895	.9806
Satisfaction Question 9C	37	1.0	4.0	3.324	.8836
Overall Satisfaction	39	8.0	16.0	13.410	1.8456
Program Impact	35	1.0	4.0	3.400	.7746
Cultural Competency	39	6.0	20.0	15.538	3.5825
Among Staff	37	1.0	4.0	3.486	.7682
Access to Care	39	17.0	43.0	35.308	6.1651
Satisfaction Total	16				
Valid N (listwise)					

Table 4.

Descriptive Statistics for OCCTAC Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	50	1.0	4.0	3.460	.6131
Satisfaction Question 2	26	1.0	4.0	2.538	.9047
Satisfaction Question 3	52	1.0	4.0	3.346	.6827
Satisfaction Question 4	54	1.0	4.0	3.500	.6936
Satisfaction Question 5	52	1.0	4.0	3.404	.6026
Satisfaction Question 6	54	1.0	4.0	3.333	.7004
Satisfaction Question 7	41	1.0	4.0	3.293	.8138
Satisfaction Question 8	47	4.0	10.0	9.319	1.2702
Satisfaction Question 9A	53	1.0	4.0	3.849	.6012
Satisfaction Question 9B	51	1.0	4.0	3.196	1.2809
Satisfaction Question 9C	51	1.0	4.0	3.667	.9092
Overall Satisfaction	54	3.0	18.0	12.537	4.0409
Program Impact	54	1.0	4.0	3.333	.7004
Cultural Competency	54	6.0	20.0	16.259	3.1574
Among Staff Access to Care	52	1.0	4.0	3.404	.6026
Satisfaction Total	54	22.0	46.0	35.407	6.1691
Valid N (listwise)	14				

Table 5.

Descriptive Statistics for OMID Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	12	1.0	4.0	3.333	1.1547
Satisfaction Question 2	9	2.0	4.0	3.222	.6667
Satisfaction Question 3	12	2.0	4.0	3.667	.6513
Satisfaction Question 4	12	3.0	4.0	3.917	.2887
Satisfaction Question 5	11	3.0	4.0	3.818	.4045
Satisfaction Question 6	12	3.0	4.0	3.750	.4523
Satisfaction Question 7	12	3.0	4.0	3.750	.4523
Satisfaction Question 8	12	8.0	10.0	8.917	.9003
Satisfaction Question 9A	12	3.0	4.0	3.917	.2887
Satisfaction Question 9B	12	1.0	4.0	3.167	1.3371
Satisfaction Question 9C	9	3.0	4.0	3.889	.3333
Overall Satisfaction	12	13.0	18.0	14.667	1.6143
Program Impact	12	3.0	4.0	3.750	.4523
Cultural Competency	12	14.0	20.0	17.667	2.0597
Among Staff Access to Care	11	3.0	4.0	3.818	.4045
Satisfaction Total	12	32.0	44.0	39.583	3.1467
Valid N (listwise)	6				

Table 6.

Descriptive Statistics for ACCESS CAL Sample from Fiscal Year 2012-2013

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	13	3.0	4.0	3.308	.4804
Satisfaction Question 2	12	2.0	3.0	2.417	.5149
Satisfaction Question 3	13	3.0	4.0	3.154	.3755
Satisfaction Question 4	13	3.0	4.0	3.385	.5064
Satisfaction Question 5	12	3.0	4.0	3.333	.4924
Satisfaction Question 6	13	3.0	4.0	3.231	.4385
Satisfaction Question 7	13	3.0	4.0	3.538	.5189
Satisfaction Question 8	7	8.0	10.0	9.000	1.0000
Satisfaction Question 9A	13	2.0	4.0	3.462	.7763
Satisfaction Question 9B	13	1.0	4.0	2.077	1.2558
Satisfaction Question 9C	13	3.0	4.0	3.846	.3755
Overall Satisfaction	13	3.0	17.0	10.385	5.5458
Program Impact	13	3.0	4.0	3.231	.4385
Cultural Competency Among Staff	13	13.0	19.0	16.308	1.7505
Access to Care	12	3.0	4.0	3.333	.4924
Satisfaction Total	13	25.0	42.0	33.000	6.1373
Valid N (listwise)	6				

Table 7.

Descriptive Statistics for Full MECCA Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	227	1.0	4.0	3.542	.6253
Satisfaction Question 2	142	1.0	4.0	2.768	.9503
Satisfaction Question 3	215	1.0	4.0	3.516	.6474
Satisfaction Question 4	230	1.0	4.0	3.591	.5969
Satisfaction Question 5	219	1.0	4.0	3.479	.6305
Satisfaction Question 6	216	1.0	4.0	3.458	.6456
Satisfaction Question 7	212	1.0	4.0	3.505	.6272
Satisfaction Question 8	212	1.0	10.0	9.316	1.2234
Satisfaction Question 9A	226	1.0	4.0	3.863	.4256
Satisfaction Question 9B	225	1.0	4.0	3.253	1.1775
Satisfaction Question 9C	226	1.0	4.0	3.823	.5288
Overall Satisfaction	236	3.0	18.0	13.441	3.6845
Program Impact	216	1.0	4.0	3.458	.6456
Cultural Competency Among Staff	242	4.0	20.0	16.686	3.3964
Access to Care	219	1.0	4.0	3.479	.6305
Satisfaction Total	242	8.0	46.0	36.029	7.9924
Valid N (listwise)	89				

Table 8.

Descriptive Statistics for ABRAZAR Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	15	3.0	4.0	3.800	.4140
Satisfaction Question 2	11	1.0	4.0	1.818	.8739
Satisfaction Question 3	15	3.0	4.0	3.800	.4140
Satisfaction Question 4	15	3.0	4.0	3.800	.4140
Satisfaction Question 5	15	3.0	4.0	3.467	.5164
Satisfaction Question 6	15	3.0	4.0	3.733	.4577
Satisfaction Question 7	14	3.0	4.0	3.714	.4688
Satisfaction Question 8	13	9.0	10.0	9.769	.4385
Satisfaction Question 9A	15	4.0	4.0	4.000	.0000
Satisfaction Question 9B	14	1.0	4.0	2.500	1.5566
Satisfaction Question 9C	15	4.0	4.0	4.000	.0000
Overall Satisfaction	15	5.0	16.0	13.600	3.0426
Program Impact	15	3.0	4.0	3.733	.4577
Cultural Competency	15	15.0	20.0	17.600	1.9928
Among Staff Access to Care	15	3.0	4.0	3.467	.5164
Satisfaction Total	15	32.0	44.0	38.400	3.0190
Valid N (listwise)	7				

Table 9.

Descriptive Statistics for VNCOC Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	107	1.0	4.0	3.551	.6179
Satisfaction Question 2	75	1.0	4.0	2.787	.9904
Satisfaction Question 3	98	1.0	4.0	3.500	.6619
Satisfaction Question 4	107	1.0	4.0	3.654	.5338
Satisfaction Question 5	103	1.0	4.0	3.524	.6079
Satisfaction Question 6	101	1.0	4.0	3.436	.6545
Satisfaction Question 7	102	1.0	4.0	3.461	.6081
Satisfaction Question 8	102	1.0	10.0	9.245	1.4312
Satisfaction Question 9A	104	1.0	4.0	3.769	.5614
Satisfaction Question 9B	106	1.0	4.0	3.349	1.0424
Satisfaction Question 9C	105	1.0	4.0	3.829	.4694
Overall Satisfaction	114	3.0	18.0	13.439	3.8213
Program Impact	101	1.0	4.0	3.436	.6545
Cultural Competency Among Staff	116	4.0	20.0	16.319	3.6442
Access to Care	103	1.0	4.0	3.524	.6079
Satisfaction Total	116	9.0	46.0	35.647	8.5448
Valid N (listwise)	45				

Table 10.

Descriptive Statistics for OCCTAC Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	95	1.0	4.0	3.495	.6664
Satisfaction Question 2	49	1.0	4.0	3.000	.8165
Satisfaction Question 3	92	1.0	4.0	3.467	.6704
Satisfaction Question 4	98	1.0	4.0	3.480	.6770
Satisfaction Question 5	92	1.0	4.0	3.435	.6843
Satisfaction Question 6	90	1.0	4.0	3.433	.6712
Satisfaction Question 7	86	1.0	4.0	3.523	.6813
Satisfaction Question 8	88	5.0	10.0	9.466	.9340
Satisfaction Question 9A	97	3.0	4.0	3.959	.1999
Satisfaction Question 9B	95	1.0	4.0	3.253	1.2460
Satisfaction Question 9C	96	1.0	4.0	3.812	.6209
Overall Satisfaction	97	3.0	18.0	13.526	3.6886
Program Impact	90	1.0	4.0	3.433	.6712
Cultural Competency Among Staff	101	4.0	20.0	16.861	3.3378
Access to Care	92	1.0	4.0	3.435	.6843
Satisfaction Total	101	8.0	46.0	36.040	8.0845
Valid N (listwise)	32				

Table 11.

Descriptive Statistics for OMID Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	3	3.0	4.0	3.667	.5774
Satisfaction Question 2	2	2.0	3.0	2.500	.7071
Satisfaction Question 3	3	3.0	4.0	3.333	.5774
Satisfaction Question 4	3	3.0	4.0	3.667	.5774
Satisfaction Question 5	2	3.0	4.0	3.500	.7071
Satisfaction Question 6	3	3.0	4.0	3.667	.5774
Satisfaction Question 7	3	3.0	4.0	3.333	.5774
Satisfaction Question 8	2	8.0	10.0	9.000	1.4142
Satisfaction Question 9A	3	3.0	4.0	3.667	.5774
Satisfaction Question 9B	3	1.0	4.0	2.333	1.5275
Satisfaction Question 9C	3	3.0	4.0	3.667	.5774
Overall Satisfaction	3	5.0	17.0	11.333	6.0277
Program Impact	3	3.0	4.0	3.667	.5774
Cultural Competency	3	14.0	19.0	16.667	2.5166
Among Staff Access to Care	2	3.0	4.0	3.500	.7071
Satisfaction Total	3	25.0	40.0	34.000	7.9373
Valid N (listwise)	0				

Table 12.

Descriptive Statistics for KCS Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	1	4.0	4.0	4.000	.
Satisfaction Question 2	0				
Satisfaction Question 3	1	4.0	4.0	4.000	.
Satisfaction Question 4	1	4.0	4.0	4.000	.
Satisfaction Question 5	1	4.0	4.0	4.000	.
Satisfaction Question 6	1	4.0	4.0	4.000	.
Satisfaction Question 7	1	4.0	4.0	4.000	.
Satisfaction Question 8	1	9.0	9.0	9.000	.
Satisfaction Question 9A	1	4.0	4.0	4.000	.
Satisfaction Question 9B	1	4.0	4.0	4.000	.
Satisfaction Question 9C	1	4.0	4.0	4.000	.
Overall Satisfaction	1	13.0	13.0	13.000	.
Program Impact	1	4.0	4.0	4.000	.
Cultural Competency Among Staff	1	20.0	20.0	20.000	.
Access to Care	1	4.0	4.0	4.000	.
Satisfaction Total	1	41.0	41.0	41.000	.
Valid N (listwise)	0				

Table 13.

Descriptive Statistics for ACCESS CAL Sample from Fiscal Year 2013-2014

	N	Minimum	Maximum	Mean	Standard Deviation
Satisfaction Question 1	6	3.0	4.0	3.333	.5164
Satisfaction Question 2	5	2.0	3.0	2.400	.5477
Satisfaction Question 3	6	3.0	4.0	3.833	.4082
Satisfaction Question 4	6	3.0	4.0	3.667	.5164
Satisfaction Question 5	6	3.0	4.0	3.333	.5164
Satisfaction Question 6	6	3.0	4.0	3.333	.5164
Satisfaction Question 7	6	3.0	4.0	3.500	.5477
Satisfaction Question 8	6	7.0	9.0	7.500	.8367
Satisfaction Question 9A	6	3.0	4.0	3.667	.5164
Satisfaction Question 9B	6	3.0	4.0	3.667	.5164
Satisfaction Question 9C	6	3.0	4.0	3.500	.5477
Overall Satisfaction	6	11.0	16.0	12.833	1.7224
Program Impact	6	3.0	4.0	3.333	.5164
Cultural Competency	6	15.0	20.0	18.000	1.8974
Among Staff Access to Care	6	3.0	4.0	3.333	.5164
Satisfaction Total	6	35.0	44.0	37.500	3.3912
Valid N (listwise)	5				

FIGURES

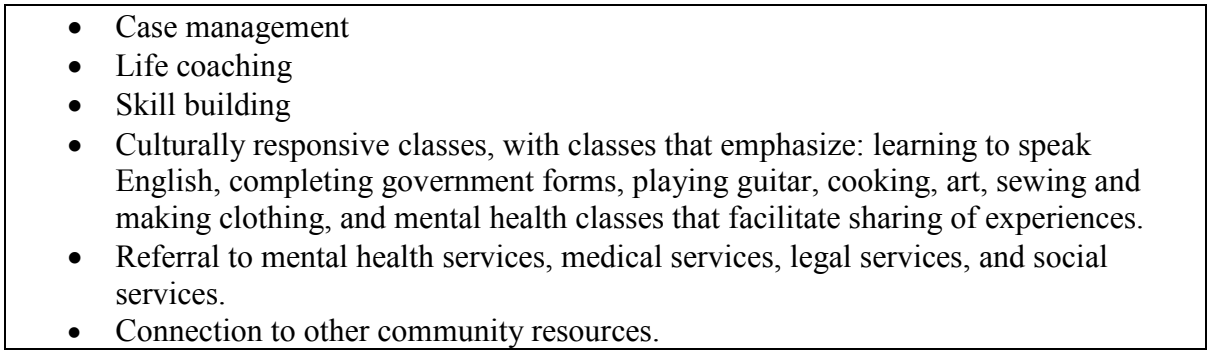

Figure 1. MECCA's outreach and engagement services

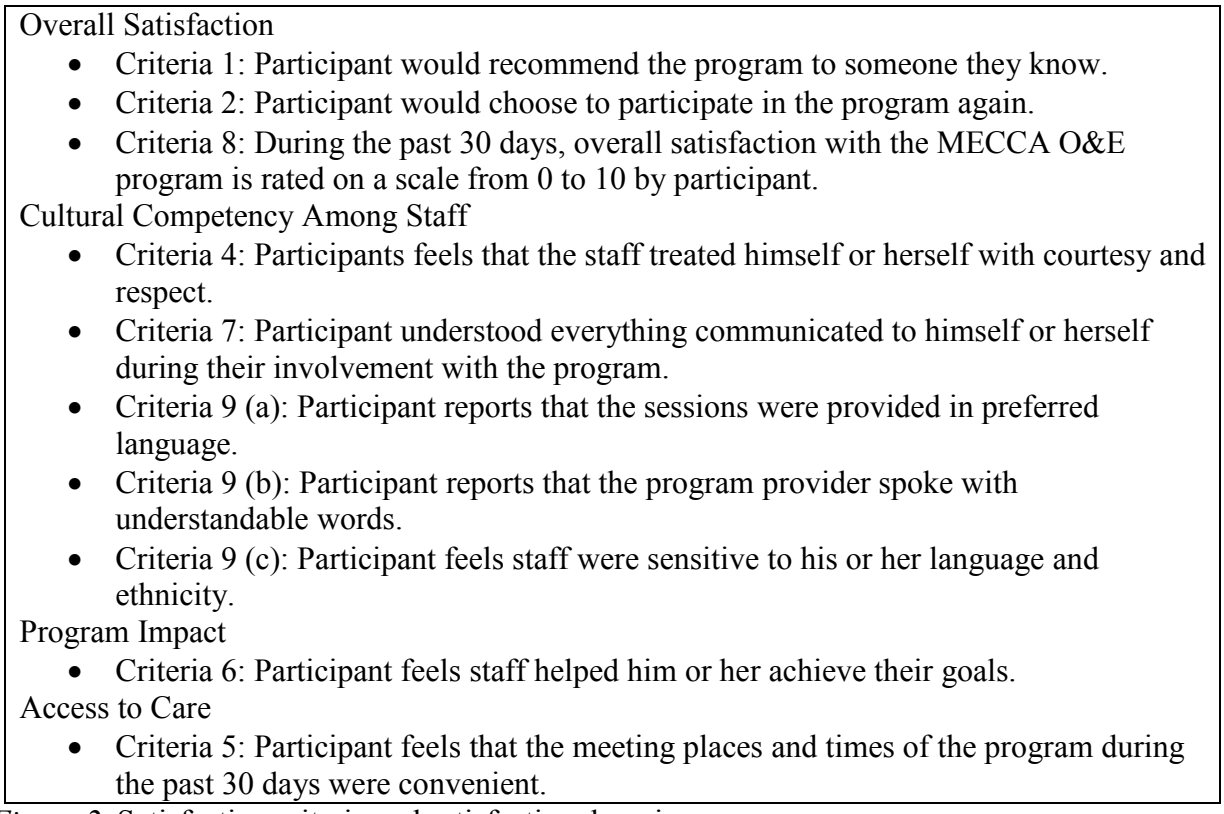

Figure 2. Satisfaction criteria and satisfaction domains

1. I would recommend the MECCA O&E Program to a friend, relative or someone I know.
2. I could have received the MECCA O&E services through another agency.
3. The MECCA O&E staff responded to my needs in a timely manner.
4. During my most recent activity with the MECCA O&E Program, the staff treated me with courtesy and respect.
5. I would say that my meeting places and times with the MECCA O&E Program in the past 30 days have been convenient.
6. The MECCA O&E staff helped me achieve my goals.
7. I understood everything that was communicated to me during my involvement with the MECCA O&E Program.
8. To rate my *overall satisfaction* with the MECCA O&E as a program in the past 30 days, where 0 is the worst program possible and 10 is the best program possible, the number I would use is:
9.
    a. Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: Sessions were provided in my preferred language
    b. Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: When the staff was speaking to me, s/he used words that I did not understand.
    c. Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that: I felt the MECCA staff was sensitive to my language and ethnicity.

Figure 3. Satisfaction survey questions

APPENDIX A

Extended Review of the Literature

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Bernal, G., & Saez-Santiago, E. (2006)	Culturally centered psychosocial interventions	To highlight the importance of cultural-focused treatment within the field of psychology			Literature review; discussion on culture centered treatment; framework for culture centered treatment discussed	Growing number of ethnic individuals within the U.S. indicate the necessity for culture centered treatment due to the powerful role of culture; call for research on the efficacy of culture centered treatments; offer a method of adapting interventions for work with ethnic individuals: "eight elements or dimensions that must be incorporated into treatment to augment both the ecological validity and the overall external validity of a treatment study. These centering elements are: (a) language, (b) persons, (c) metaphor, (d) content, (e) concepts, (f) goals, (g) methods, and (h) context. In addition, this model emphasizes the consideration of developmental, technical, and theoretical issues" (p. 127); key to understand environment within which community intervention is provided/offered
Dumbrill, G. C., & Green, J. (2008)	Indigenous knowledge in the social work academy	To understand the impact of Eurocentrism on mental health provider education and to identify new ways of integrating Indigenous knowedge into mental health services			Literature review; examining societal organization of power and identity; offering of a new model to reorganize society	"The term 'Indigenous knowledge' refers to the traditional ways of knowing and being of Aboriginal peoples" (p. 489); domination of native peoples during European colonization was through education and thus removal of unique identities; "successful inclusion does not hinge on being sensitive to Aboriginal ways of knowing and open to including this knowledge in the academy, but on being sensitive to the ways European knowledge dominates the academy and open to disrupting this domination" (p. 490); "storytelling is often used within Indigenous communities as a method of teaching that invites listeners to find meaning through reflection and analysis of the narrative" (p. 492); "The Medicine Wheel provides a means of re-conceptualizing both academic and societal space... there are four components of the Wheel representing the following: (a) four face of mother earth: red yellow, black, and white; (b) four seasons: spring, summer, fall, and winter; (c) four components of our being: spiritual, emotional, physical, and mental; and (d) four aspect of life: infant, youth, adult, and elder" (p. 495); the model also provides new configuration, with "east: engage in critical historical analysis...south: explore difference and other knowledge...west: make space for other knowledge and establish academi standards...north: evaluation and

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Flaskerud, J.H. (2007)	Cultural competence: What is it?	To understand cultural competence			Literature review	Highlights three areas for adherence to cultural comptence: "cultural knowledge cultural sensitivity, and collaboration with the community to be served. Cultural knowledge means actively learning about the community- its ethnicities, languages, origins, immigration or migration history, acculturation level, economy, sources of income, family and social structures and roles, value systems and beliefs, education levels and literacy, geography, and ecologic environment. Cultural sensitivity includes an ethic or a moral imperative to value and respect the beliefs, norms, and practices of the people to be served. This begins with an awareness of our own cultural beliefs and practices and moves toward beingnon-judgmental and respectful in dealing with people whose culture is different than our own" (p. 121-122). "Collaboration with the community to be served can mean the people who live within a geographic boundary, the people served by a certain agency or program, or a group of people who have shared identity and experiences, similar beliefs, values, and norms. Collaboration with the community in research means that community members participate in all aspects of research from question identification and design to implementation, analysis and evaluation, to
Goodkind, J.R., Hess, J.M., Isakson, B., LaNoue, M., Githinji, A., Roche, N., Vadnais, K., & Parker, D.P. (2014)	Reducing Refugee Mental Health Disparities: A community-based intervention to address postmigration stressors with African adults	To understand the mental health needs of refugees within the U.S., specifically through discussing research findings of causes of refugee stress and implementing a community-based program to service the needs of the Arican refugee community; examining the effectiveness and competency of the Refugee Well-Being Project with individuals from African	Sample = 36, 19 of which were women and 17 of which were men ranging from 18 to 71 years-old, consisting of 17 Burundian, one Rwandan, 13 from Democratic Republic of Congo, three Liberian, and two Eritrean.	Rumbaut's Psychological Well-Being Scale (1985); Satisfaction with life Areas scale (Ossorio, 1979); Satisfaction with Resources scale; Difficulty Obtaining Resources scale; Basic English Skills Test (BEST); Whitbeck Enculturation Scale; interviews	Extensive literature review; administration of measures and interviews during four markers of study (every three months) in order to gather longitudinal information	Qualitative is important in getting information about a participants' experience; "participants in both studies experienced significant increases in English proficiency and quality of life and significant decerases in psychological distress" (p. 342); the Refugee Well-being Project was adaptable to other cultures and can be "adapted for ethnically and linguistically diverse refugee who settle in different parts of the United States" (p. 342)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Goodman, L.A., Liang, B., Helms, J. E. Latta, R.E., Sparks, E., & Weintraub, S.R. (2004)	Training Counseling Psychologists as Social Justice Agents: Feminist and Multicultural Principles in Action	To discuss the way that work for social justice can be informed by feminism and multicultural counseling; to explore how to adapt a graduate program to be oriented toward social justic; how to manage difficulties in implementing social justice as psychologists			Extensive literature review	Found important "principles for social justice work in counseling psychology" (p.798), which includes "ongoing self-examination…sharing power…giving voice…consciousness raising…focus on strengths…leaving clients with tools" (p. 799-807); had first-year graduate students immersed in community-based treatment as foundational clinical experience for their first year that facilitated "skills in prevention, interprofessional collaboration, and advocacy" (p. 808) and through this process the students were challenged and trained to embody social justice in their clinical conceptualizations and collaborative work; it is an ethical imperative to tailor services to each unique consumer and empowerment alongside collaboration is a requirement; highlight difficulties in this kind of work as emotional toll, the experience of systemic barriers, and the lack of focus on social justice during clinical training
Hall, G.C. (2005)	Introduction to the special section on multicultural and community psychology: clinical psychology in context	To understand how to meld multiculturalism and community psychology			Literature review	Highlights the importance of maintaing emic and etic perspectives in doing clinical work and conceptualizing individuals; key to learn and use multicultural and community dynamics as foundation to understanding
Hall, G. C. N. (2001)	Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues	Examining the difference between culturally sensitive therapy and empirically supported therapies; examining the integration of culture within psychotherapy and how research is utilized			Extensive literature review	Highlight interdependence as a key difference in diverse ethnic communities when compared to European American culture; spirituality can vary and impacts treatment so it is important to understand the role of spirituality in that ehtnic community; important to not blame individual for reactions and experiences of racism due to their identity; 10 steps are outlined for making empirically supported therapies more culturally responsive: "1. Identify expert EST and CST researchers to collaborate on all components of the project... 2. Identify a disorder from which there is a well-established EST... 3. Identify an ethnic minority population to study and a site where there is access to this population... 4. Identiy the unique cultural aspect of the ethnic minority group relate to other groups... 5. Identify cultural dimensions that have a specific bearing on the disorder to be studied... 6. Identify relevant outcome measures... 7. Adapt the treatment to be culturally sensitive... 8. Include therapists of the same ethnicity as the clients as well as therapists of a different ethnicity to examine the possible effect of ethnic matching... 9. Solicit and respond to client feedback on therapy... 10. Evaluate the relative efficacy of EST versus CST" (p. 508)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Harrell, S. P. (2000)	A multi-dimensional conceptualization of racism-related stress: implications for the well-being of people of color	Deeping one's understanding of stress caused by racism; understanding historical context of racism; conceptualizing the wellbeing of ethnic people and improvement of wellbeing for ethnic people within the context of racism, and its stress			Extensive literature review, historical context through previous research and key perspectives on the timeline of racism and its mark on time	Found that for ethnic people, "life stress must also include consideration of experiences that are related to theunique person-environment transactions involving race" (p. 44) and "experiences of racism are embedded within interpersonal, collective, cultural-symbolic, and sociopolitical context, and can be sources of stress" (p. 44); identified six forms of racism-related stress: "racism-related life events... vicarious racism experiences... daily racism microstressors... chronic-contextual stress... collective experiences... transgenerational transmission" (p. 45-46); wellbeing on all levels of the individuals is impacted by the various forms of racism-related stress and the ethnic individual's characteristics at birth, as well as socioculturally, have tremendous impact on overall wellbeing and experiences of distress; research also highlights mediators of such distress (internal versus external)
Harrell, S.P. & Bond, M.A. (2006)	Listening to diversity stories: Principles for practice in community research and action	Examination of the *Diversity Principles for Community Research and Action* ("Community Culture, Community Context, and Self-in-Community" (p. 365)) with the intention of deeping understanding of diversity and guiding one's actions within community work			Beginning with each of the three *Diversity Pricinples for Community Research and Action* , then integrating extensive literature reviews and experiences to provide well-rounded description of the elements of each principle	Found: "every community has multilayered cultural characteristics and diversity dynamics" (p. 366), important to ask one's self "how do dimensions of diversity and their interactions currently affect this community?" (p. 366), understand the community's structure as functional and a result of factors that have molded the community, one's personhood is always present in one's work, "informed compassion" (p. p. 368) is critical; "each of the stances embedded in the three Diversity Principles-informed compassion, contextualized understanding, and empowered humility-incorporate a combination of respect and challenge, and they synergistically fold into a stance of *connected disruption* " (p. 374).
Ingraham, C.L. & Oka, E.R. (2006)	Multicultural issues in evidence-based interventions	Navigating the implementation of evidence-based intervention within multiethnic communities and diverse settings			Literature review	In considering use of treatments, researchers highlight that it is important to evaluate "the quality of evidence available to support a given intervention and… the generalizability and transferability of the given intervention to their intended setting and context" (p. 141); every intervention within a program is “culturally embedded” (p. 133)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Kaczorowski, J. A., Williams, A. S., Smith, T. F., Fallah, N., Mendez, J. L., & Nelson–Gray, R. (2011)	Adapting clinical services to accommodate needs of refugee populations	Focusing on refugees within the U.S. and their experiences, identifying barriers to treatment for refugeees and developing and implementing methods to providing culturally competent services	Clinicians (graduate students under the supervision of licensed clinical psychologists) providing services at a graduate school's training clinic who elected to be part of a team that responded to the a small grant to adapt clinic services to be provided efficaciously to underserved communities (specifically refugees); team consisted of two superivosrs and four clinicians	Treatment team adapted the clinic's assessment protocol to allow for qualitattive methods of gathering individual's experiences due to research findings that indicated that qualitative (e.g. open-ended questions) data collection yields more culturally competent and rich information	6-week discussion period to prepare clinicians to provide culturally competent services, spoke with multiculturally-focused faculty, and became more knowledgeable of struggles within the refugee community (e.g. attended conference), preparing and using interpreters in clinical practice, integration of CBT tools, and treatment team reflection on successes and processes of working with refugee population	Clinically important distress found amongst refugees receiving the adapted treatment team's services in two areas: "culture-of-origin issues and issues related to refugee status and acculturation" (p. 364); when using interpreters in practice it is important to be in a therapeutic team as all parties are part of the emotional exchange in therapy and interpreters can provide valuable sentiments; "consistent attendance, low attrition, a strengthen bond between the client and therapist, more frequent in-session laughter, increasded understanding of mental health treatment, and utilization of coping skills are better indicators of progress than traditional assessment methods" (p. 365); imperative to continue adaption of clinical services to meet the needs of growing refugee population within the U.S.
Kazdin, A., & Mazurick, J. (1994)	Dropping out of child psychotherapy: Distinguishing early and late dropouts over the course of treatment.	To examine factors (e.g. child, parent, family) that predict children's drop out from therapy when seeking treatment for volatile behavioral problems, and corresponding diagnoses	Sample = 257, consisting of 56 girls and 201 boys between the ages of 4 and 13, with 154 White children, 91 Black children, 9 Hispanic children, 2 Asian children, and 1 child of mixed ethnicity	General information sheet; Research Diagnostic Interview; Risk Factor Interview; Parenting Stress Index; Beck Depression Inventory; Hopkins Symptoms Checklist; Interview for Antisocial Behavior; Self-Report Delinquency Checklist; Wechsler Intelligence Scale for Children-Revised; Child Behavior Checklist; Child Behavior Checklist-Teacher Report Form	Participants completed assessment measures; children and their parents participated in treatment that varied based on the age of the child (all receiving "Cognitive problem-solving skills training (PSST) for the child and parent management training (PMT)" (p. 1070)); completion (seven to eight months for full course) was tracked for each child; ANOVA, Chi-square tests, and regression analyses used to analyze data gathered	Found that "younger mothers, single parents, and children from homes headed by a nonbiological parent were more likely to terminate treatment" (p. 1071).
Kiger, H. (2003)	Outreach to multiethnic, multicultural, and multilingual women for breast cancer and cervical cancer education and screening; A model using professional and volunteer staffing.	Screening, education, and causes are targeted in this study in order to understand and provide more accesible services for multiethnic women in need of breast and cervical cancer screening	Studied beahviors of women at Center for Healthy Aging		Examined prevalence rates and demographics within Los Angeles County; hypothesized on elements of the Center for Healthy Aging that makes it accessible for diverse women and what could be improved	Reasons that African American and Hispanic women do not seek resources and screenings like Caucasian women in Los Angeles: lack of exposure or beliefs that they are unqualified for services, fear and confusion about the process of screening for cancer, decreased time for self-care behaviors, and the unawareness of the value of early screening and treatment; identified specific challenges such as barriers of language differences, the lack of “ethnically appropriate educational materials” regarding the value or early screening and cancer treatment (pg. 309), historical and systemic context of seeking services, concerns regarding trust and modes of communication, and the exclusionary nature of the eligible population identified for many early screening and cancer treatment programs

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
LaGrange, R.D., Abramowitz, S., Koenig, L.J., Barnes, W., Conner, L., & Moschel, D. (2012)	Participant satisfaction with group and individual components of Adolescent Impact: a secondary prevention intervention for HIV-positive youth.	To examine participant satisfaction of HIV-positive youth in an intervention program	Sample = 166 between 12 and 21 years-old, 94% African-American or Hispanic, 53% female	Demographics; participant feedback questionnaires	Convenience sample; participated in Adolescent Impact program over 13 weeks then we asked to report; satisfaction divided into participant satisfaction, session-specific preferences, activity helpfulness, participant attendance, and limitations; satisfaction with the program evaluated	A significant amount of data that indicated varying levels of satisfaction with the program's individual and group interventions; researchers identified a number of ways to increase participant satisfaction, such as consideration of scheduling of interventions, incentives, and implementation of a program that provides services in both group and individual modalities
Meyer, O. L., & Zane, N. (2013)	The influence of race and ethnicity in clients' experiences of mental health treatment	To determine the impact that cultural responsiveness has on individuals seeking mental health services	Sample = 102, consisting of 57 White Americans, nine Asian/Pacific Islanders, nine Latinos, 16 African Americans, eight Native Americans, and three biracial; age range from 18 to 65 years-old	Cultural Acceptability of Treatments Survey; Mental Health Statistics Improvement Program	Participants seeking outpatient mental health treatment; asked for completion of measures; used multivariate analysis of variance and regression analyses	"These results indicate a generally higher level of importance of cultural elements for ethnic minority clients compared with White clients" (p. 891); "minorities also felt that it was significantly more important that their provider by knowledgable about their ethnic/ racial group's history of prejudice and discriminations... than Whites" (p. 891); "when mental health clients felt like a cultural element was important in their care, but did not perceive it to be present, they were less satisfied with aspects of their treatment" (p. 894)
Miliora, M. T. (2000)	Beyond empathic failures: Cultural racism as narcissistic trauma and disenfranchisement of grandiosity	To understand the impact of cultural racism on the individual			Synthesized existing ego psychology research and early psychodynamic literaure, as well as examples from literature and a clinical example to compile in-depth understanding of the impact of cultural racism on one's sense of self	Found that "how one imagines he or she is perceived by others, including the therapist, is related to one's personal and social history. This illusion or apperception affects one's sense of self. A racially-mixed therapeutic relationship presents special challenges in this regard. it is important to explore a patient's imagined perception by the therapist and in the case where a patient has been the victim of cultural racism to examine a possible link between the person's perception and his or her history of victimization" (p. 53)
Mistry, J., Jacobs, F., & Jacobs, F. (2009)	Cultural relevance as program-to-community alignment	Cultural competence in community-based programs; to see cultural competence and sensitivity of programs	Sample = "data from a large-scale evaluation of a family support program for young families" (p. 491); used three different programs	Personnel Demographic Survey; observation; ethnographic interviews; participant data system	Looked at three programs, "focused on documenting and understanding the program's operations and implementations, while the outcome study examined whether it had achieved its intended results" (p. 491)	Researchers suggest a key method of improving the experience for multi-ethnic participants is to bring in members of the "communities targeted by the programs" to facilitate the program, such that doing this "capitalizes on the community-based staff member's inherent sensitivity to, or awareness of, the targeted community's customs and contexts, thereby ensuring culturally sensitive service delivery (p. 489)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Nicolaidis, C., Wahab, S., Trimble, J., Meja, A., Mitchell, R., Raymaker, D., Thomas, M.J., Timmons, V., & Waters, A.S. (2012)	The interconnections project: Development and evaluation of a community-based depression program for African American violence survivors	To examine a community-based program for African American women who survived Intimate Partner Violence	Sample = 59 African American women, with history of Intimate Partner Violence and current depression	Demographics; Conflict Tactics Scale-Revised; Women's Experiences of Battering Scale; Patient Health Questionnaire	Used CBPR approach to understand needs of community then implemented program; took time to understand needs and what culturally responsive services would look like; facilitated intervention for six months, implemented questionnaires, asked for participation in termination interviews	Findings from the intervention indicated increases in self-care behavior, improvement in depression symptoms, and improved self-esteem (Nicolaidis et al., 2012). The researchers gathered themes from the interviews with participants regarding their experience in the program, specifically soliciting the participants to identify why and how the program was effective. The themes identified include: “African-American focus and community setting,” “Ability to trust,” and “Information and strategies with practical, lasting value” (Nicolaidis et al., 2012, pgs. 534-535). These themes were qualitatively gathered and provided rationale as to why the participants felt satisfied and reported improvement as a result of the program’s intervention.
Rastogi, M., Massey-Hastings, N., & Wieling, E. (2012)	Barriers to seeking mental health services in the Latino/a community: A qualitative analysis.	Targeted Latinos living in the Midwest to understand barriers to mental health treatment and if services are appropriate for their needs	Sample = 18 individuals, consisting of 15 women and 3 men (age range = 27 to 50), ethnic breakdown: 10 Mexican, 4 Puetro-Rican, 1 Mexican-American, 1 Latino, 1 Guatemalan, 1 Ecuadorian;	Demographic questionnaire (Spanish and English version); focus groups (90 minutes each); individual interviews with Mexican American, Spanish speaking graduate student	Asked study participants to particate in five focus groups, one individual interview, and to provide demographic information; data analysis of information gathered was done through constant comparison	Found that 12 of the 18 particiapnts would "seek a Spanish-speaking provider" (p. 8), "five people felt that the Latino community needs more information about potential resources in order to access MHS" (p. 8); family problems were highlighted by 15 of the 18 participants as reasons for seeking help; "seven of the 18 respondents noted that they and other individuals were "ignorant" about mental health programs and providers" (p. 9); "six participants pointed out that when Latinos seek MHS, their family might be stigmatized" (p. 9); "four participants believed that their community did not have much information or knowledge about mental illness" (p. 9); many cited they would go to primary care physician first for help instead of mental health providers; many expressed concern that legal status in the U.S. would be jeopardized if they received mental health services; "the cost of MHS and lack of medical insurance was cited by 13 out of 18 participants as the major reason that Latinos did not seek MHS" (p. 10); study particiapnts emphasize the importance of "increasing awareness and information... improving access to mental health... supporting other Latinos in seeking help" (p. 10-12) and integration of Spanish-speakers amongst mental health providers
Sink, K.M., Covinsky, K.E., Newcomer, R., & Yaffe, K. (2004)	Ethnic differences in the prevalence and pattern of dementia-related behaviors	Examining individuals with varying degrees of dementia to determine impact of ethnicity on behaviors related to dementia	Sample = 5,776, consisted of 5,090 White, 469 Black, and 217 Latino Medicare consumers who were part of the Medicare Alzheimer's Disease Demonstration and Evaluation study from 1989 to 1991 in the U.S.	Clinical interview; Mini-Mental State Examination; impairment organized based on patient's ability to independently complete actiities of daily living; Zarit Burden Interview	Used analyses of variance to examine relationships amongst patient and their dementia-related symptoms, caregiver traits, and ethnicity	Amongst Black and Latino dementia patients living within the community, there appears to be higher rate of behaviors related to dementia status in comparison to White patients thus it is critical to develop more resources of education for caregivers of patients within these ethnic communities as well as more dementia assistancce within these communities.

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Snell-Johns, J., Mendez, J. L., & Smith, B. H. (2004)	Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families	To understand factors that create underserved families, to develop methods of improving assess to treatment for underserved families, to identify ways to increase treatment engagement, and to identify methods of encouraging change			Empirical litearture review	Methods of increasing access: "offer transportation, child case, and low-cost services… use the telephone… provide home-based services… facilitate self-directed and video-based interventions… use the format of multiple-facmily groups" (p. 21-25); methods to increase treatment engagement: "decrease time families spend on the waiting list... monitor therapists' behaviors and expectations... offer incentives for attendance... conduct brief interventions... make therapists readily available... address parents' individual needs" (p. 26-28); methods of encouraging change: "prepare families for theapy and address expectations... provide culturally competent services... give family task assignments... focus on families' strengths... conduct motivational interviewing" (p. 30-31)
Sood, E., Mendez, J., & Kendall, P. (2010)	Acculturation, religiosity, and ethnicity predict mothers' causal beliefs about separation anxiety disorder and preferences for help-seeking	Focused on Indian American, Latin American, and European American mothers in investigating their beliefs about separation anxiety as well as their help-seeking behaviors.	Sample = 117, consisted of 39 Indian American mothers, 39 Puerto Rican mothers, and 39 European American mothers	Gathered demographic information, used the Hollingshed Four-Factor Index to gather SES information, used the Vancouver Index of Acculturation to gather aculturation information, and used the Santa Clara Strength of Religious Faith Questionnaire to gather information on the importance of religion in their life.	Gathered participants from medical services' waiting rooms and community centers; asked participants to complete questionnaires, vignette, and measures; used "hierarchical multiple regression analyses" and "exploratory regression analyses" (p. 400) in analyzing data	Acculturation to U.S. and role of religion in mothers' lives had a significant impact on the mothers' beliefs about separation anxiety and preferred ways of getting help.
Sue, S., Fujino, D.C., Hu, L., Takeuchi, D.T., & Zane, N.W.S. (1991)	Community mental health services for ethnic minority groups: a test of the cultural responsiveness hypothesis	Examined mental health treatment seeking behaviors and outcomes for Asian-Americans, African-Americans, Mexican-Americans, and Whites in Los Angeles County, specifically mental healthcare	Gathered sample from 1983 to 1988; sample = 3.1% Asian American, 20.5% African Americans, 25.5% Latinos, 43% Whites, and 7.9% other	Automated Information System (AIS); Diagnostic and Statistical Manual of Mental Disorers, 3rd edition (DSM-III)	Researchers gathered data from AIS (tracking system used by LA County DMH) of demographic information as well as onset, frequency, and duration of services used; AIS also tracked therapist demographics; LA County DMH was utilizing DSM-III to diganose mental health needs of individuals receiving services; through overall regression analyses and within-group analyses, researchers examined: client and therapist demoographics, ethnic/gender/language match, and duration of services rendered	Found "Asian Americans and Latino Americans were underrepresented, whereas African Americans were overrepresented in the mental health system in comparison with their respective County populations" (p. 535-536), however less African American women were found to have received services; "In general, the SES of clients was low, with African Americans having a higher percentage of clients qualifying for Medi-Cal than Mexican Americans, who were higher than Asians and Whites" (p. 536); 1/3 of individuals experienced ethnic matching in comparison to 3/4 of White clients receiving services from White therapists; dropout rates (dropout = missing 1 session): "19.4% for African Americans, 15.3% for Whites, 14.6% for Mexican Americans, and 10.7% for Asian Americans" (p. 536); "results indicated that for all groups except African Americans, ethnic matched resulted in substaintially lower odds of dropping out than for unmatched clients" (p. 536)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Sue, S., Zane, N., Nagayama Hall, G.C., & Berger, L.K. (2009)	The case for cultural competency in psychotherapeutic interventions	Focused on understanding cultural competency, examining its propoenents and opponents, and how to be a culturally competent mental health provider			Examined existing literature on defining cultural competence and the importance of it; extensie literature review on various culturally competent resources available; literature review on the impact and importance of cultural competency of mental health providers	To be culturally competent, one must have "knowledge, skills, and problem solving germane to the cultural background of the help seeker" (p. 529); disagreements regarding cultural competence is largely due to misunderstanding and requires attention in oder to refocus the necessity of cultural competence as a response to the many centuries of injustice and biases towards culture; deficits in cultural comptence and its impact have been addressed in provider guidelines; key components of cultural competent interventions are adressing "method of delivery... content... storytelling... family... CBT" (p. 534-537) as areas for adjustment based on the culture of origin of the individual seeking services; interventions that are adapted for cultural competency have been found to produce better outcomes
Sullivan, C. M., & Bybee, D. I. (1999)	Reducing violence using community-based advocacy for women with abusive partners	Examine effectiveness of community-based program for women enduring violence within their relationship, specifically ways to reduce violence	Sample = 278 women, 45% African American, 42% European American, 7% Latina, 2% Asian American; ranged from 17 to 61 years-old	Modified Conflict Tactics Scale; Index of Psychological Abuse; quality of life satisfaction questionnaire; Center for Epidemiological Studies-Depression Scale; quesionnaire on "social support, effectiveness in obtaining resources, and difficulty obtaining resources" (p. 46)	Trained advocates who were providing intervention, provided intervention and asked participants to complete measures, analyzed data using multivariate analysis of variance	"Women who received the free services of paraprofessional advocates for 10 weeks experienced less physical violence over time and reported icnreased quality of life, higher social support, less depressive symptoms, and increased effectiveness in obtaining resources compared with women in the control condition" (p. 49-50); "women who has worked with advocates experienced less abuse at each time point except the 6-month follow-up. This temporary increase was likely due to the removal of the advocate as a "protective factor" after the cessation of the 10-week intervention" (p. 50)
Surgeon General (1999)	Mental Health: A report of the Surgeon General	Highlighting knowledge gained on the prevalence and impact of mental health issues on the overall human experience within the United States	Surgeon General sites Global Burden of Diseease study, the World Health Organization, the World Bank, and Harvard University as resources in gathering data on the international prevalance of mental illness and it's impact on economy and the total percentage of people facing of mental illness international compared to other significant life conditions such as accidents and medical conditions.		Synthesizes information from international resources and empirical studies to provide findings on mental health's significance, treatment, and systemic impact	Requires a public sector response; mental illness has a profound impact on individuals and the societies they inhabit; mental illness occurs on a spectrum; mental illness treatment requires hollistic conceptualization; stigma has had a profound impact on how people seek help, pay for help, and how stigma needs to be intentionally address and reduced in order to help individuals with mental illness heal

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Thompson-Miller, R., & Feagin, J. R. (2007)	Continuing Injuries of Racism: Counseling in a Racist Context	Cite Robert T. Carter's (2007) article as launching point for their research; examining the effect of racism (e.g. discrimination and oppression) and it's cumulative/long-term impact; emphasizing the importance of understanding White privilege's impact as shaping of society's perspective/beliefs/valuess and the mind's of most all (especially important for those preparing to be clinicians)			Extensive literature review; experiential commentary; expound on foundational article by Robert T. Carter (2007)	Historical trauma for the Black community has produced long-term impact that shapes mental health, "a past and continuing reality that must be kept constantly in mind when a mental health clinician is attempting to help a person of color deal with racism's chronic health consequences" (p. 108); impact of trauma and ways of coping are passed throughout generations; racism drains people experiencing racism of energy and take emotional toll ; important for mental health providers to put their client's experiences in historical and environmental context, highlighting that their experiences are not abnormal and require respect; imperative to hold White community accountable for current and future environments of direct or indirect racism
Verdinelli, S., & Biever, J. L. (2013)	Therapists' experiences of cross-ethnic therapy with Spanish-speaking Latina/o clients	To understand bilingual therapists and their development into comfort and preferences in providing mental health treatment to diverse individuals	Sample = 14, consisting of eight women, 6 men; 13 White, one african American	Demographics; evidence-based interviews to gather participants' experiences	Conducted interviews; interviews transcribed; constant comparative method used to analyze findings	Following themes were found: "interesting in the Spanish language: immersion experiences and class (general)…living abroad (typical)…genuine interest in another culture (typcial)… traveling (typical)…spanish was easy to learn (typical)…need for Spanish-speaking therapists and job benefits (general)... support from others (general)... practice in the field: learning by doing therapy and from clients (typical)...pride in serving the underserved (typical)...attending to client's culture (general)...showing appreciation and interest (typical)...acknowledging ethnic and linguistic differences (typical)....addressing the impact of values (typical)...boundaries (varient)...linguistic challenges (general)... clients' context and immigration issues (typical)" (p. 232-237)

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Whaley, A.L. & Davis, K.E.	Cultural competence and evidenced-based practice in mental health services	To understand the intersection of cultural competence and evidence-based mental health treatment			Extensive literature review	"Culture can be defined as a dynamic process involving worldviews and ways of living in a physical and social environment shared by groups, which are passed from generation to generation and may be modfiied by contacts between cultures in a particular social, historical, and political context" (p. 564); "view cultural competence as a set of problem-solving skills that includes (a) the ability to recognize and understand the dynamic interplay between the heritage and adaptation dimensions of culture in shaping human behavior; (b) the ability to use the knowledge acquired about an individual's heritage and adaptational challenges to maximize the effectiveness of assessment, diagnosis, and treatment; and (c) internalization (i.e., incorporation into one's clinical problem-solving repertoie) of this process of recognition, acquisition, and use of cultural dynamics tso that it can be routinely applied to diverse groups" (p. 565); increases in ethnically diverse populations within the U.S. indicate the need for valid, researched, ethical, culturally competent mental health treatment; important to identify how therapeutic change is established for diverse ethnic communities; critical to adapt and evaluate effectiveness of evidence-based treatments within ethnic communities
Whitbeck, L. B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004)	Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians	Amongst American-Indian people, understanding the impact of "interrelated factors of discrimination, historical loss and enculturation" (p. 411) on alcohol use (and "emotional and behavioral problems" (p. 411))	Sample = 452 American-Indian parents or caretakers who had children between 10 and 12-years-old, consisting of 351 women (average age of 39 for women and 42 for men); sample collected from "Healing Pathways Project" on two American-Indian reservations that lasted three years	American-Indian cultural identification items by Oetting and Beauvais (1990-1991) adapted; Historical Loss scale; Historical Loss Associated Symptom Scale; an 11-item measure on perceptions of discimination; University of Michigan Composite Internaional Diagnostic Interview	Collaborated with reservations to obtain "tribal resolutions" (p. 411) in order to conduct project and an advisory board on the reservation was established; participants provided interview prior to joining project; participants completed measures and diagnostic interview; statistical analysis using bivariate correlations and structural equation modeling	Found "nearly three fourths (73.5% of the adults in the sample (81.4% men; 71.1% women) met DSM-III-R criteria for lifetime alcohol abuse. Of these, 15.1% of the adults met DSM-III-R 12-month criteria for alcohol abuse (15.7% women; 13.3% men)" (p. 413); "perceived discrimination was strongly positively associated with historical loss... historical loss, in turn, was positively associated with alcohol abuse among women" (p. 413); "enculturation did not mediate the effects of discrimination among American-Indian adults... perceived discrimination was possitively associated with enculturation... and with alcohol abuse... enculturation was negatively associated with alcohol abuse" (p. 415); enculturation was not found to be a protective factor
Woods, D.T., Catroppa, C., Giallo, R., Anderson, V.A. (2012)	Feasibility and consumer satisfaction following an intervention for families who have a child with acquired brain injury	To understand the needs of families with children struggling with brain injury and to determine the satisfaction with an intervention program (Signposts for Building Better Behavior)	Sample = 48 families with children 3 to 12 years old varying severities of brain injury	Consumer Satisfaction Scale [25]; Acquired Brain Injury (ABI) Booklet;	Provided intervention; gathered information on family regarding social risk; implemented satisfaction measure	"…parents reported a high level of confidence in managing their children's beahvior. All parents approved of the skils taught and a majority felt the materials were helpful in dealing with challenging behavior as well as teaching new skills. In its two services delivery modes the program was strongly received by parents of children with mild. moderate, and severe brain injury" (p. 195); positive satisfaction ratings for telephone interventions

Author/ Year	Title	Research Questions/ Objectives	Sample	Instrumentation	Research Approach/ Design	Major Findings
Yaffe K., Fox P., Newcomer, R., Sands, L., Lindquist, K., Dane, K., & Covinsky, K.E. (2002)	Patient and caregiver characteristics and nursing home placement in patients with dementia	Focus on the field of treatment for diverse ethnic patients with dementia; create set of predictors of level and setting of treatment for these individuals	Sample = 5,788 people divided into the development cohort (mean age of 78.9; ethnicity breakdown: 3,378 White, 320 Black, 145 Hispanic) and the validation cohort (mean age of 78.8; ethnicity breakdown: 1,712 White, 149 Black, 63 Hispanic), within the US that were part of the Medicare Alzheimer's Disease Demonstration and Evaluation study from 1989 to 1994	Demographic information gathered through in-home interview; Mini-Mental State Examination; Katz activties of daily living; Zarit Scale; Geriatric Depression Scale; Medicare records to track time frame of patient's placement in a nursing home	Participants completed assessment measures and interview; participants' outcomes were tracked through Medicare records; participants randomly separated into a development cohort and a validation cohort; analyses through Kaplan-Meier and Coz proportional hazards to generate data points on who and when patients began residing in nursing homes, including information on caregivers of patients prior to moving into a nursing home	Found that both Hispanic and Black patients were "less likely to be placed in a nursing home throughout the three years" (p. 2094); the following were factors for patients being placed in a nursing home: lower Mini-Mental State Examination scores, more activities of daily living that required the assistance of anoyher person, living alone, and a minimum of one problemmatic behavior; "caregivers who were 65 years or older (compared with those <65 years of age) and who had higher Zarit Burden scores were more likely to have their family member go to a nursing home" (p. 2094)

APPENDIX B

Satisfaction Survey

MECCA O&E Participant Satisfaction Survey

Thank you for choosing to provide your feedback about the MECCA Outreach & Engagement (O&E) Program, a service provided with support from the Orange County Health Care Agency. Your feedback will be used to help improve the program's services, and will not affect your services in any way. Please do not write your name on this form.

- **Please check the box of the response that most closely shows how you feel.** Please tell the truth when responding to these statements. You may skip items if they do not make sense to you or make you feel uncomfortable.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know/Unsure
1. I would recommend the MECCA O&E Program to a friend, relative or someone I know.					
2. I could have received the MECCA O&E services through another agency.					
3. The MECCA O&E staff responded to my needs in a timely manner.					
4. During my most recent activity with the MECCA O&E Program, the staff treated me with courtesy and respect.					
5. I would say that my meeting places and times with the MECCA O&E Program in the past 30 days have been convenient.					
6. The MECCA O&E staff helped me achieve my goals.					
7. I understood everything that was communicated to me during my involvement with the MECCA O&E Program.					

FOR OFFICE USE ONLY

PartID#: __ __ __ __ -1__ - __ __ __	Location: ☐HV ☐ OV ☐ Phone ☐ Other _____	Today's Date: __ __ / __ __ / __ __
Staff/Volunteer Name:	Staff/Volunteer Signature:	

MECCA O&E Participant Satisfaction Survey

8. Overall Satisfaction
To rate *my overall satisfaction* with **MECCA O&E** as a program in the past 30 days, where 0 is the worst program possible and 10 is the best program possible, the number I would use is: *(circle one number below)* *Worst* 0 1 2 3 4 5 6 7 8 9 10 *Best*

9. Thinking about my overall experience with the MECCA O&E Program within the past 30 days, I would say that:	Never	Sometimes	Usually	Always	Don't Know / Unsure
a. Sessions were provided in my preferred language.					
b. When the staff was speaking to me, s/he used words that I did not understand.					
c. I felt the MECCA staff was sensitive to my language and ethnicity.					

Additional Feedback

Of the services I was provided through the MECCA O &E Program, the following services were most beneficial to me: (Please check all that apply)

Outreach and Engagement Program

- ☐ **Individual Engagement**
- ☐ **Educational/Skills Classes**
- ☐ **Referrals/Linkages**
- ☐ **Transportation**

Some suggestions I have to improve the services I have received from the MECCA O & E program are:

Additional Comments:

Please check one of the boxes below:

- ☐ I completed this survey myself.
- ☐ A friend or family member helped me complete this survey.
- ☐ A staff person helped me complete this survey.

Thank you for your help! Your feedback is important to us!

FOR OFFICE USE ONLY

PartID#: __ __ __ __ -1__ - __ __ __	Location: ☐HV ☐ OV ☐ Phone ☐ Other _____	Today's Date: __ __ / __ __ / __ __
Staff/Volunteer Name:	Staff/Volunteer Signature:	

APPENDIX C

Notice of Approval for Human Research

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: July 06, 2016

Protocol Investigator Name: Sheva Assar

Protocol #: 16-05-267

Project Title: Evaluating a Community-Based Program within Multi-ethnic Communities: Examining the Outreach and Engagement Program of MECCA

School: Graduate School of Education and Psychology

Dear Sheva Assar:

Thank you for submitting your application for exempt review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. Upon review, the IRB has determined that the above entitled project meets the requirements for exemption under the federal regulations 45 CFR 46.101 that govern the protections of human subjects.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Since your study falls under exemption, there is no requirement for continuing IRB review of your project. Please be aware that changes to your protocol may prevent the research from qualifying for exemption from 45 CFR 46.101 and require submission of a new IRB application or other materials to the IRB.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

Judy Ho, Ph.D., IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist