MONTEREY COUNTY HEALTH DEPARTMENT, BEHAVIORAL HEALTH BUREAU

Mental and Behavioral Health Needs Assessment
Summative Report

Submitted February 9, 2022

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I. Executive Summary

Monterey County Health Department, Behavioral Health Bureau (referred to as Monterey County Behavioral Health Department [MCBH]) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. The purpose of this needs assessment was to collect primary data from community members and providers about the current mental and behavioral health issues in Monterey County and to gather suggestions for improving access to care and services and reducing health disparities.

Between November 2021 and January 2022, online surveys and focus groups were used for data collection. The two surveys, a Provider Survey (n=276) and a Community Member Survey (n=200), were administered throughout the community. Each instrument was designed to gather perspectives on the current state of mental and behavioral health services and needs in Monterey County. Seven focus groups (n=56) were conducted in December 2021 and January 2022. Ten focus groups were scheduled; two had no participants and one had to be cancelled due to COVID-19 staff outages. A list of community organizations was developed in a purposeful way to reflect a diverse set of voices within the community. To accommodate a population that did not have access to technology or were uncomfortable using it, one focus group was held with the community members at the host site and the facilitator joined virtually. Two focus groups were conducted in Spanish, and one in English and Spanish using a translator.

The results indicate that community members and providers identify the major mental and behavioral health issues as anxiety, chronic stress, depression, alcohol/substance use, and trauma. The major contributing factors to mental and behavioral health issues were reported as homelessness; financial stress, unemployment, or lack of job opportunities; stressful childhood experiences; COVID-19; and stigma and discrimination. For availability of services, the population identified by the highest percentage of providers as being available but insufficient to meet the need was among persons who are low-income. Focus group participants shared concerns about long wait lists and the affordability of services. Community members noted the biggest barriers to services is the cost of services; providers identified it as a lack of knowledge about available services and services for Indigenous language speakers. Focus group participants made comments about both of these issues being barriers as well as stigma. Providers noted many strengths of the County's behavioral services such having services available in different languages, telehealth, dedicated and helpful staff, collaboration with other agencies, and targeting underserved populations. The recommendations included a need for stigma reduction education and campaigns, more providers, more services available in different languages, additional promotion about how to connect to services, and a central source for service information.

MCBH provides services to many people in need, including underserved populations. There is a need to improve access to services and reduce barriers. COVID-19 has impacted the community in many ways and hence the needs for services appears to have increased, especially in areas such an anxiety. MCBH will need to leverage resources and continue to work with partners to meet this increased need.

II. Introduction

Monterey County Health Department, Behavioral Health Bureau (referred to as Monterey County Behavioral Health Department [MCBH]) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. The purpose of this needs assessment was to collect primary data from community members and providers about the current mental and behavioral health issues in Monterey County and to gather suggestions for improving access to care and services and reducing health disparities. Between November 2021 and January 2022, online surveys and focus groups were used for data collection. This document includes an explanation of the data collection methods used, demographics/profiles of the participants and respondents, and the results of the surveys and focus groups.

III. Methodology

This section of the needs assessment explains data collection and data analysis.

Data Collection

The data collection process utilized two surveys and seven focus groups. Ten focus groups were scheduled; two had no participants and one had to be cancelled due to COVID-19 related staff outages. The questions were developed by EVALCORP and approved by MCBH.

Online Surveys

The two surveys, a Community Member Survey and a Provider Survey, were administered throughout the community. Each instrument was designed to gather a respondent's perspective on the current state of mental and behavioral health services in Monterey County. In order to gather detailed and robust feedback, the surveys included closed and open-ended questions. The surveys were open from November 9, 2021 through December 17, 2021.

The Community Member Survey was designed to gather feedback from residents of Monterey County with mental health needs, as well as family members and other community members affected by mental health issues. This survey was offered in both Spanish and English to mitigate any language barriers of Monterey County residents.

The Provider Survey was designed to gather feedback from a broad range of people, agencies, and systems who work directly with persons who are receiving or are in need of mental health services. Respondents invited to take the survey represented multiple service sectors, such as education, law enforcement, social services, and other community service agencies and organizations.

The Community Member and Provider Surveys were distributed via email with a link that directed participants to the survey in the language of their choice. The link to both surveys were also posted to the MCBH website. Email invitations to the surveys were sent to all Monterey County staff, ; the Behavioral Health Commission; community-based agencies that contract with MCBH; service providers from medical, public health, community, and public agencies; mental and behavioral health service providers; and other stakeholders from the Mental Health Services Act Community Program Planning (CPP) process. Providers of prevention and early intervention services in the county also distributed the Community Member survey to residents on their email listservs.

Focus Groups

A list of community organizations was developed in a purposeful way to reflect a diverse set of voices within the community. The community partners working in different areas of the county and with specific populations where the county is seeing disparities in health and in access/utilization of behavioral health services (e.g., unhoused, elderly, LGBTQ+, under-represented racial and ethnic groups, immigrants). These organizations, referred to as host sites, invited their clients to participate in the focus group. Members of the host site and MCBH were not present during the focus group in order to create a safe space for participants to speak freely. To accommodate populations that did not have access to technology or weren't comfortable using it, one focus group was held with the community members at the host site and the facilitator joined virtually.

Seven 60-minute focus groups (n=56) were conducted in December 2021 and January 2022. Ten focus groups were scheduled; two had no participants and one had to be cancelled due to COVID-19 related staff outages. The two focus groups that had no attendees were scheduled in mid-January 2022. The COVID-19 variant was wide-spread at that time, which may have had an impact on participation. The other focus groups were well attended. During recruitment, the focus groups were referred to as community conversations. Two focus groups were conducted in Spanish, and one in English and Spanish using a translator. Using the Zoom polling feature, demographics were captured from the participants. When participants met at the host site, the site asked them to complete a demographics form on paper.

Data Analysis

Analyses of survey and focus group responses flowed through two phases. The first phase began with an evaluation of each data source independent from one another. In the second phase, results were synthesized across data sources to achieve greater depth of information.

IV. Profile of Survey Respondents and Focus Group Participants

This section presents an overview of the descriptive information of Provider and Community Member Survey respondents as well as focus group participants. Four-hundred seventy-six surveys were collected online from November 9, 2021 through December 17, 2021 (see Table 1). Fifty-six people participated in the focus groups. Therefore, information was received from 532 people.

Table 1. Number of Surveys Collected by Survey Type

Survey Type	N
Provider Survey	276
Community Member Survey	200
Total	**476**

Community Member Profile

Demographic and additional information from Community Member Survey respondents and focus group participants were elicited to help provide context to their responses. The percent of focus group participants who completed the poll or demographic form was 55% (n=31).

Community member survey respondents:

- Had an age category with the highest number of participants between 41-59 years old (39%, n=70)
- For race and ethnicity, Hispanics/Latinos (37%, n=74) and Whites alone (37%, n=73) were equally represented
- Almost three-quarters were female (74%, n=147)
- Almost all participants (96%, n=191) speak English at home

The combined demographics of community member survey respondents and focus group participants are compared to the county demographics in Table 10 in the Appendix to illustrate the representativeness of the respondents and participants. The data show that females were over-represented, which was the area where the difference between community participants and county demographics were the largest. There was a slight (12%) under-representation of Hispanics/Latinos. Figure 2 in the Appendix shows the geographic regions of residence of community survey respondents. There were limited respondents from North and South County regions.

Table 11 in the Appendix includes additional non-demographic information about the survey respondents. The responses for questions with an "other" response option also are provided in the Appendix as a full list of responses, grouped by common theme.

Provider Profile

Providers were asked to give information about their professional roles/job titles; the sector they work in; whether they provide direct services; and the age groups, populations, and regions they serve. Provider respondents reported that they:

- Have a job role of program staff (41%, n=113)
- Work in the job sector of mental/behavioral counseling (33%, n=92)
- Most often serve persons who are in the low-income population (76%, n=210)
- Work most with the age group of adults 25-59 (74%, n=203)
- Provide direct services (71%, n=196)

Further details about providers' characteristics are in the Appendix. The responses for questions with an "other" response option are also provided in the Appendix as a full list of responses, grouped by common theme.

V. Prioritized Mental and Behavioral Health Issues and Contributing Factors

Mental and Behavioral Health Issues

Respondents to the Community and Provider Member Surveys were asked to rate the severity of mental and behavioral health issues in the community. Response options were (1) not an issue, (2) somewhat of an issue, (3) a major issue, and (4) I don't know. The responses to the major issue option are shown in Table 2.

Table 2. Major Issue Responses for Community and Provider Member Surveys

Health Issue	Community Survey (n=86-156)	Provider Survey (n=122-208)
Anxiety	**78%**	**75%**
Chronic Stress	70%	70%
Depression	65%	73%
Alcohol/Substance Use	68%	65%
Trauma	57%	69%
Suicide or Thoughts of Suicide	43%	44%

Both sets of respondents identified anxiety as their top major issue of concern. Seventy-percent of community and provider respondents identified chronic stress as a major concern. Suicide or thoughts of suicide was the least prioritized issue in both groups.

Focus group participants identified the needs in four themes.

1. *Emotional needs*. The emotional needs included coping with fear, anxiety, stress, isolation, grief, anger, aggression, and depression.
2. *Behavioral needs*. It was noted that these emotional issues contribute to behavioral problems such as overeating, trouble sleeping, suicide, having a 'short fuse', domestic violence, child abuse, and substance misuse (fentanyl, opioids, prescription drugs).
3. *Service needs*. The service needs included reduced wait times, outreach teams for the unhoused, culturally competent services for African Americans and Blacks, services in Mixtec language, and family counseling (including for multi-generation families). Parental support also is needed to assist with their past trauma and current situations such as divorce.
4. *Educational needs*. The educational needs included how to interact with children with mental and behavioral problems for parents and how to work with people with mental illness for law enforcement. Additional educational needs included stigma reduction, conflict resolution skills, what therapy is and the benefits, prevention on being financially scammed for seniors, coping with discrimination, and knowledge about current services in the community for providers and community members.

Focus Group Participants	
	"We really don't know how to interact with our kids that have mental problems or behavioral problems".
	"A lot of the families that I work with are also going through like divorces, separation, custody issues, and so a lot of times they're looking for some type of family counseling or even just counseling for the kids that are dealing with that separation".
	"My doctor just told me to come here to call this place, but people don't have an understanding of what therapy really is or what we're trying to achieve through it".

Contributing Factors to Mental and Behavioral Health Issues

Community Member and Provider Survey respondents were asked to identify factors that they believed influence mental and behavioral health needs. Community members and providers identified **financial stress, homelessness**, **stigma and discrimination,** and **adverse childhood experiences** as top contributors (see Table 3).

Table 3. Top Contributing Factors to Mental and Behavioral Problems

Community Survey (n=117-135)	Provider Survey (n=170-206)
1. Homelessness 68%	1. Financial stress, unemployment, or lack of job opportunities 75%
2. Financial stress, unemployment, or lack of job opportunities 65%	2. Stressful childhood experiences 67%
3. Stigma and discrimination 59% 3. Stressful childhood experiences 59%	3. Homelessness 62%

Focus group participants also identified COVID-19, stigma, and lack of knowledge about therapy as contributing factors to poor mental and behavioral health. As interviewees noted, the effects of stigma may prohibit individuals from seeking therapy or inhibit open participation in therapy. One young adult stated that when she told her mother she wanted to go to therapy her mom stated that therapy was for 'crazy people'. Not knowing about the benefits of therapy also prevents people from seeking care.

> *Many people are taking sleeping pills now due to anxiety caused by COVID".*
>
> *"A lot of our families struggle with trauma, and that could be trauma that they suffered in their immigration process or in their families. A lot of physical emotional abuse that has happened in their families and that they are then carrying forward to their own families. And so we see a lot of our parents struggling with that right and figuring out how to process all of that trauma to then not let it affect the way that their parenting".*
>
> —Focus Group Participants

Additionally, participants noted stressors of poverty, discrimination, life stressors (e.g., child custody battles), and trauma as contributing factors.

VI. Availability of Mental and Behavioral Health Services

Respondents to the Provider Survey were asked to indicate the extent to which they thought mental and behavioral health services were available to the communities and regions they served, including specific populations and age groups. (Note: The Community Member Survey did not include these questions as they were designed to elicit feedback on the availability of services across multiple populations and groups, and community members were asked to speak only to their personal experiences and perspectives with mental and behavioral health needs and services.) Focus group participants were also asked about accessibility of mental and behavioral health services in the community.

General Availability of Services

Respondents to the Provider Survey were asked to rate the overall availability of services as either not available at all, available but insufficient to meet the need, or sufficiently available to meet the need. Respondents to the Provider Survey indicated that services were available to communities and regions they served, but were insufficient to meet the need.

Focus group participants feedback about the general availability of services was concerning as long wait lists were mentioned often. In addition, language barriers, transportation, a lack of service integration and medical homes, and expense were noted. Statements were made about not having culturally-competent care for the African American community and the need for more group therapy programs.

Specific Unserved and Underserved Populations

Respondents to the Provider Survey were also asked to rate the availability of services for specific populations as either not available at all, available but insufficient to meet the need, sufficiently available to meet the need, or I don't know. For persons of low income, 66% (n=182) of respondents reported services are available but are an insufficient to meet the need. This was followed by persons who are trauma exposed (65%, n=179) and those experiencing homelessness (64%, n=177). Table 4 lists each identified sub-population and the corresponding percent of respondents who rated services as either not available at all or insufficient to meet the need.

Focus group participants also discussed availability of services for specific underserved populations. Notably, participants were focused on the monolingual Spanish-speaking residents and the indigenous residents who find it difficult to locate services in the languages that they speak. There was mention of the difficulties within the County of addressing the diverse and urgent needs of African American/Black residents in the county. Other populations mentioned were those who are uninsured and low-income.

> *"The indigenous communities have different languages, even different dialects within a language. I don't know of one therapist that speaks an indigenous language".*
>
> —Focus Group Participant

Table 4. Service Availability for Specific Populations per the Provider Survey (n=276)

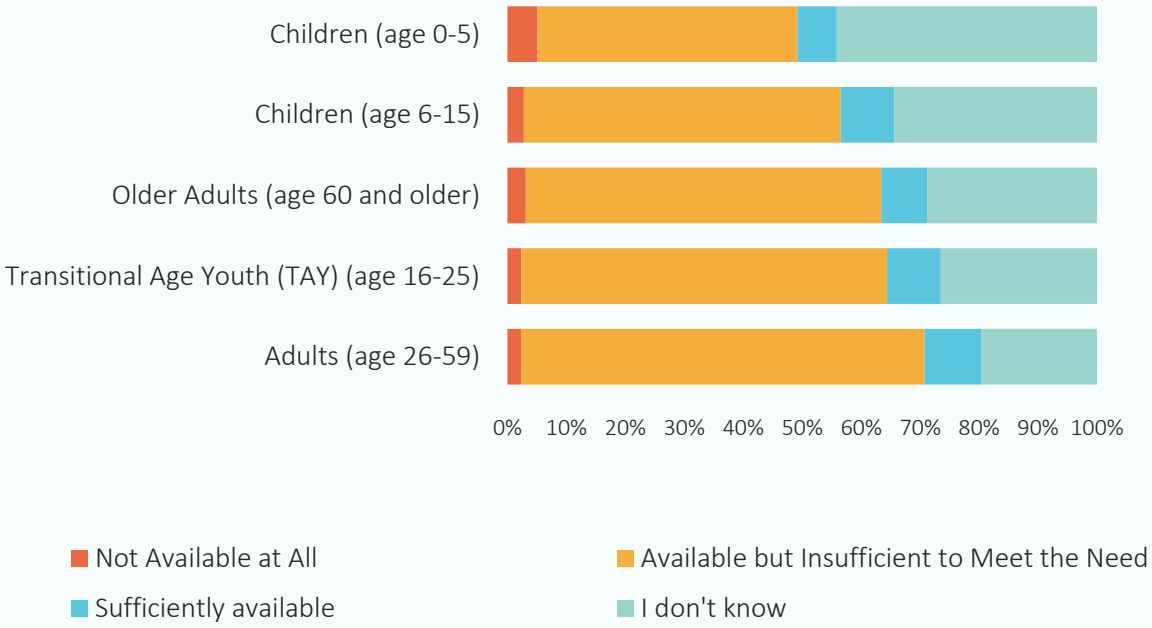
Population Type	Not Available at All	Available but Insufficient to Meet the Need
Persons who are low-income	4%	**66%**
Persons who are trauma-exposed	2%	65%
Persons experiencing homelessness	6%	64%
Persons who primarily speak Spanish	2%	62%
Immigrants	7%	56%
Persons who are victims/survivors of intimate partner/domestic violence	2%	55%
Family members, support persons, or caregivers of individuals with mental health conditions	4%	55%
Persons experiencing onset of serious psychiatric illness	4%	55%
Persons with disabilities other than mental/behavioral health conditions	5%	53%
Children/youth in stressed families	3%	49%
Children/youth at risk for school failure	3%	44%
Persons who primarily speak a language other than English or Spanish	13%	44%
Children/youth at risk of juvenile justice involvement	3%	43%
Persons who identify as LGBTQ+	7%	42%
Veterans	5%	41%
Women with pre-/post-natal needs	3%	38%
Children 0-5 who have experienced early life stressors and/or trauma	5%	37%

When asked to identify any additional populations not listed, respondents most frequently wrote in seniors, individuals dealing with substance use disorders, and incarcerated persons. A categorized list of write-in responses is provided in Table 22 in the Appendix.

Age Groups

Provider Survey respondents were similarly asked to rate the availability of services by age group as either not available at all, available but insufficient to meet the need, sufficiently available to meet the need, or "I don't know." Results reveal that services are available for all age groups. The "not available at all" responses were all less than 10% for all age groups indicating that the services are available and that a small percentage of providers are not aware of them. The age group with the highest responses that services are available but insufficient to meet the need to adults ages 26 to 59 (65%, n=178). This is likely related to the long wait lists mentioned by focus group participants. Figure 1 lists each age group and the corresponding percent of respondents who rated service availability.

Figure 1. Availability of Services by Age Group per Provider Survey



Barriers to Accessing Mental and Behavioral Health Services

All data sources requested participants identify barriers to accessing mental and behavioral health services. Community members and providers were asked to rate a list of barriers as either a major barrier, somewhat of a barrier, not a barrier at all, or "I don't know." Focus group participants were asked to identify the biggest challenges community members face when trying to access mental or behavioral health services.

> *"There's like no central place online or just anywhere that I can just call and be like, hey, can I get some resources?"*
>
> —Focus Group Participant

Table 5 shows the responses to barriers for accessing mental and behavioral health services from the community member survey and the provider survey results are in Table 6. Community members identified cost as the largest major barrier, which was rated fourth by providers. Providers identified the lack of knowledge of available services in the community as the largest major barrier, which was rated as fourth by community members.

Table 5. Barriers to Accessing Mental and Behavioral Health Services, Community Member Survey

Barrier	Somewhat of a Barrier (n=28-68)	A Major Barrier (n=59-129)
Cost of services	14%	**65%**
Stigma related to mental illness	20%	58%
Lack of insurance coverage	22%	56%
Lack of knowledge of available services in the community	29%	51%
Lack of childcare/caregiver relief	24%	47%
Appointment times are not convenient	23%	44%
Service locations are too far away	28%	42%
Lack of culturally appropriate services	33%	32%
Lack of language assistance	34%	30%

Table 6. Barriers to Accessing Mental and Behavioral Health Services, Provider Survey

Barrier	Somewhat of a Barrier (n=60-95)	A Major Barrier (n=86-163)
Lack of knowledge of available services in the community	29%	**59%**
Stigma related to mental illness	25%	56%
Inadequate capacity to assist clients (lack of staff, space, or other resources)	24%	55%
Lack of insurance coverage	29%	51%
Cost of services	25%	51%
Lack of transportation	34%	48%
Lack of culturally appropriate services	32%	45%
Lack of childcare/caregiver relief	25%	45%
Service locations are too far away	32%	43%
Limited walk-in availability	24%	43%
Lack of language assistance	34%	38%
Appointment times are not convenience	34%	33%
Inadequate staff skills/qualifications	32%	33%
Hours of operation are not convenience	33%	32%
Lengthy wait times in lobby to see provider	22%	31%

Results from focus groups were similar. Participants stated that the lack of knowledge about where to get help was a key barrier along with cost, long wait lists, and the locations of services being far. They expressed that program staff were working to meet the needs of those they served, but they lacked the

knowledge of where to send individuals who needed different services than their specific program provided. Participants suggested that providers be more educated about services in the area and that awareness be raised by using flyers, teachers informing students, and a community liaison or hot line. They also suggested having an online site to go to that shows the services provided and insurance types accepted.

VII. Additional Provider Responses

Respondents to the Provider Survey were given an opportunity to write in answers to open-ended questions. The questions inquired about their perceived strengths of the county's mental and behavioral health services, the changes they have seen in client needs as a result of COVID-19, and recommendations or suggestions they had on how to better meet the mental and behavioral health needs in the communities that they serve.

> *"Monterey County is actively working on ensuring that consumers have access to services, providing a wider variety of services, and trying to think outside the box about how to address barriers."*
>
> —Provider Survey Respondent

Strengths of County Mental and Behavioral Services

Provider responses (n=114) converged into four major themes described in Table 7.

Table 7. Strengths of Monterey County Mental and Behavioral Health Services

Availability of Services
(e.g., no to low-cost services; the availability of staff who speak other languages; implementation of additional methods of providing services e.g., telehealth, telephone; ease of access to services once the correct point of contact is made; availability at school site and other locations across the county)

Dedication and Expertise of Staff
(e.g., the realization that more training opportunities are needed for line staff and providing that 'in-house'; caring and dedicated workers; direct service staff are committed to serving the community; experienced staff; staff are capable and motivated; client-centered, strengths-based, and trauma informed services)

Coordination of Services across Providers
(e.g., collaboration among agencies and other community partners; staff willing to collaborate with other programs; the strong connection with non-profit agencies to connect clients with housing, case management, use public transport, willingness to recognize gaps in service and seek out community partners)

Targeting Underserved Populations
(e.g., more services for the homeless and those who suffer from substance abuse are being offered, language and culturally-appropriate services, outreach to LGBTQ community, an effort is made to reach hard-to-reach groups and youth)

"I see more services now being available for the homeless population and those suffering from alcohol and drug abuse and addiction issues."

—Provider Survey Respondent

"Monterey County is actively working on ensuring that consumers have access to services, providing a wider variety of services, and trying to think outside the box about how to address barriers."

—Provider Survey Respondent

"I can see hard working, committed, and dedicated staff to all services being provided. Keep up the amazing job."

"Willingness to hear from community and implement change."

—Provider Survey Respondents

Changes in Client Needs in Response to COVID-19

Providers offered insight on changes they have seen in their clients as a result of COVID-19. Responses (n=98) fell into three main categories and are detailed in Table 8.

Table 8. Provider Insight on COVID-19's Impact on Community Needs

Increased Need to Combat Isolation
(e.g., relapses in isolation; clients are lonely, isolated, and resistant to getting help; people craving a human connection; there is a reduction of natural supports)

Increase in Negative Affective Symptoms
(e.g., increased suicides, social anxiety, paranoia, domestic violence, anxiety, stress, depression, violent behavior, hopelessness; more burden and stress on parents; clients are reactive and have difficulty returning to baseline)

Issues Accessing and Connecting to Support
(e.g., a need for electronic device training to support people with accessing services remotely, need for telehealth, some clients had difficulty with accessing services remotely or the modality was ineffective, have seen successes with getting better connected to indigenous community with What's App)

Although not represented in the table 10, one provider noted improvements due to being separated from stressors such as bullying and racism. Provider responses also noted an additional need for assistance

"Clients and families who previously had transportation issues have found it helpful to have telehealth services. This has improved access services for a lot of families."

—Provider Survey Respondent

"The isolation has been horrendous on our behavioral health clients and a definite uptick in substance use disorders."

—Provider Survey Respondent

with housing, financial stress, and higher unemployment within the county during the COVID-19 pandemic. Additional stress among providers was noted.

Focus group participants identified similar themes for behavioral and mental health needs in the community. Anxiety and fear related to COVID-19 were noted as major mental and behavioral health problems. Anxiety for children returning to school was identified. Children have been out of school due to closures and going back to school and social situations is anxiety producing for them. As a result of the pandemic, there is an increased need for grief counseling, family counseling, and child-care. The pandemic has changed family structures and due to deaths, illness, and school and child-care center closures, parents are stressed to find care for their child and/or driving long distances for child-care services.

Provider Recommendations for Growth

Responses from providers (n=91) on recommendations for Monterey County were grouped into the five themes described in Table 9.

Table 9. Provider Recommendations to Meet Mental/Behavioral Health Needs

Enhance Program Resources and Infrastructure
(e.g., increase opportunities for mental and physical wellness such as martial arts, homeless solutions, a residential care facility for adults, 24-hour mobile crisis intervention to work with law enforcement)

Improve Outreach and Education about Available Services
(e.g., health literacy information for the community, create a campaign that addresses mental health stigmas and stereotypes, mobile shower services and portable toilets for the homeless, advertise services on social media, more training for law enforcement)

Improve Accessibility of Services
(e.g., grow the availability of services in different languages/dialects, offer transportation to mental health services, increase staff to reduce long wait lists, investigate additional service hub in North County, continue telehealth services, residential substance use treatment for teens, increased trained volunteers)

Improve Quality of Services
(e.g., equity and cultural sensitivity, better trauma-informed care, better supervisors)

> *"I would like to see a county wide ACES initiative to prevent health problems and to help people get resources to build resiliency."*
>
> —Provider Survey Respondent

> *"I think providers need to be better compensated for their skill sets."*
>
> —Provider Survey Respondent

VIII. Summary of Findings and Implications for Prevention and Early Intervention Programs

The MCBH and contracted agencies provide services to many people in need, including underserved populations. COVID-19 has impacted the community in many ways and hence the needs for services appears to have increased.

The needs assessment highlights that there is general alignment from both community members and providers with respect to unmet mental and behavioral health concerns in the county.

Specifically, assessment findings showed:

- There is a high need for mental health services for anxiety, chronic stress, depression, and alcohol and substance abuse.
- There is a substantial impact from financial insecurity, childhood trauma, and homelessness on residents' mental and behavioral health.
- There are continued challenges to accessing services including stigma, lack of knowledge about available services, cultural barriers specifically noted for African Americans, and appropriate/relevant services for monolingual Spanish-speaking and Indigenous-speaking communities.

Important strengths in mental and behavioral health services were identified. Among these, top strengths included the experienced and dedicated staff who provided mental and behavioral health services, the range of available services, telehealth, service locations, and the broad system of care.

In sum, there continues to be a need for services as wait lists are long and mental health issues related to anxiety, for example, are high. Services for low-income persons are particularly insufficient to meet the need. MCBH has dedicated and qualified staff, work well with community agencies as partners, and have improved access to services for underserved populations. Recommendations include reducing long wait lists and increase the availability of services in different languages. Promotion of how or where to access available services and stigma reduction should be improved among providers of mental and behavioral health services to enhance connectivity of community members to available resources.

Appendix

Table 10. Aggregated Community Participant Demographics by Percent, 2021

Demographic	Community Member Survey (n=200)	Focus Group Participants (n=56)	Combined Community Members (n=256)	Monterey County (n=434,061)[1]	Difference
Age	n=177	n=31	n=208		
16-25	4%	10%	5%	n/a	n/a
26-40	33%	35%	33%	n/a	n/a
41-59	39%	42%	39%	n/a	n/a
60 or older	24%	13%	23%	19%[2]	-4%
Race/Ethnicity	n=200*	n=31*	n=231*		
American Indian or Alaska Native	2%	--	2%	3%	-1%
Asian	5%	--	5%	7%	-2%
Black or African American	3%	6%	3%	3%	No difference
Hispanic or Latino	37%	65%	47%	59%	-12%
Native Hawaiian or Pacific Islander	1%	6%	2%	1%	+1%
White (not alone)	9%	--	9%	12%	-3%
White alone	37%	26%	35%	29%	+6%
Multiracial	8%	3%	7%	4%	+3%
Another race/ethnicity	1%	--	1%	n/a	n/a
Gender	n=169	n=31	n=200		
Male	16%	29%	20%	51%	-31%
Female	74%	65%	84%	49%	+35%
Other Gender Identity	6%	6%	6%	n/a	n/a

*Total percentages exceed 100% because respondents could select multiple options.

[1] U.S. Census Bureau (2019). American Community Survey 1-year estimates. Census Reporter Profile page for Monterey County, CA. http://censusreporter.org/profiles/05000US06053-monterey-county-ca/

[2] U.S.Census Bureau. (n.d.). QuickFacts. https://www.census.gov/quickfacts/montereycountycalifornia

Table 11. Community Member Additional Information*

	Community Member Survey Respondents (n=200)	Focus Group Participants (n=31)
Veteran	2%	6%
Have a disability	9%	19%
LGBTQ	6%	6%
I am a caregiver for an adult family member	14%	13%
I have personal experience with mental and behavioral health challenges	52%	61%
I do not have immigration status or live with someone who does not have immigration status	6%	6%
I am homeless or might become homeless in the near future	1%	6%
Other	18%	--
Languages spoken at home		
English	96%	45%
Spanish	5%	58%
Another language	2%	6%

*Total percentages exceed 100% because respondents could select multiple options.

Community Member Respondents

Demographic and additional information from Community Member Survey respondents was elicited to help provide context to their responses. Figure 2 through provides information about the city and county region where they live. For questions with an "other" response option, Tables 12 through 14 in the Appendix present a full list of responses, grouped by common theme.

Figure 2. Community Member Place of Residence

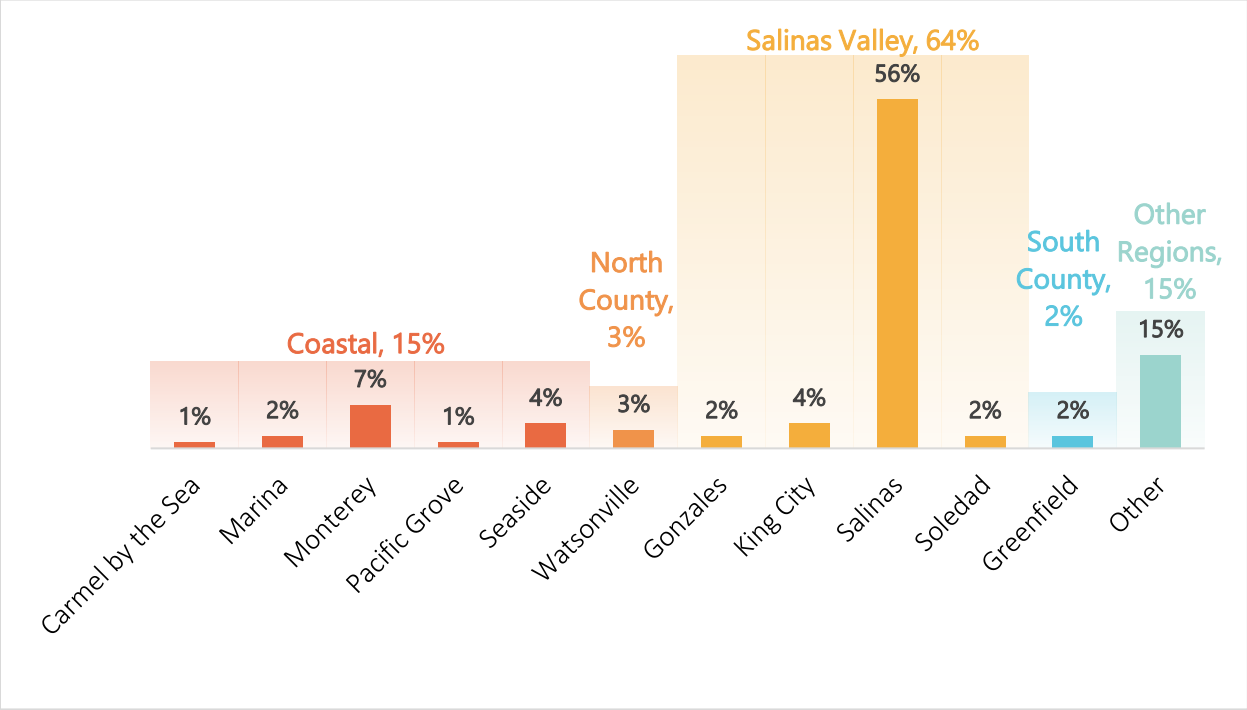


Table 12. Community Member Race/Ethnicity Specified under "Other"

Race/Ethnicity	#
Irish	1
Latin American	1

Table 13. Community Member Language Frequently Spoken at Home Specified under "Other"

Language	#
Cantonese	1
Swedish	1
French	1
Japanese	1

Table 14. Community Member Other Supports Would Help Your Family Cope With Mental Health Challenges Specified under "Other": Major Themes

Other Supports	#
More professional availability (long wait lists and expanded business hours)	1
More affordable/improved insurance coverage	1
Access to mental health services via telemedicine	1
Better integration of primary care and behavioral health	1
Group support sessions	1
Hotline after hours or a sponsor to talk to after work hours	1
ACES training for childcare and healthcare workers	1
Child and adolescent services - ideally linked to the schools - need to be enhanced	1
More community and online resources	1
Information about what resources exist	1
More communication to parents and teach children from a young age how to identify and deal with emotions	1
More LGBTQ+ resources	1
More peer navigators and persons with lived experience sharing their success in the field	1
More Spanish-speaking mental health providers	1

Provider Respondents

Providers were asked to give information about their professional roles/job titles; the sector they work in; whether they provide direct services; and the age groups, populations, and regions they serve. Tables 15 through 17 and Figures 3 through 6 present a profile of surveyed providers.

Table 15. Provider Job Roles (n=276)

Job Role	%
Program Staff	41%
Organization Leadership	32%
Admin/Office Support	17%
Other	11%
Total	**100%**

Table 16. Provider Work Sectors (n=276)

Work Sector	%
Mental/Behavioral Counseling	33%
Community-based Organization/Non-profit Service Provider	8%
Medical Treatment/Healthcare Services	6%
Social Services	17%
Law Enforcement/Probation/Justice System	8%
Public Health	7%
Pre-K through 12 Education	2%
College/Graduate Education	1%
Substance Use Prevention or Treatment Services Provider	7%
Other	12%

Table 17: Population Groups Served (n=276)

Population Groups	%
Persons who are low-income	76%
Persons who are trauma-exposed	58%
Persons experiencing homelessness	58%
Immigrants	53%

Figure 3. Do you provide direct services? (n=276)

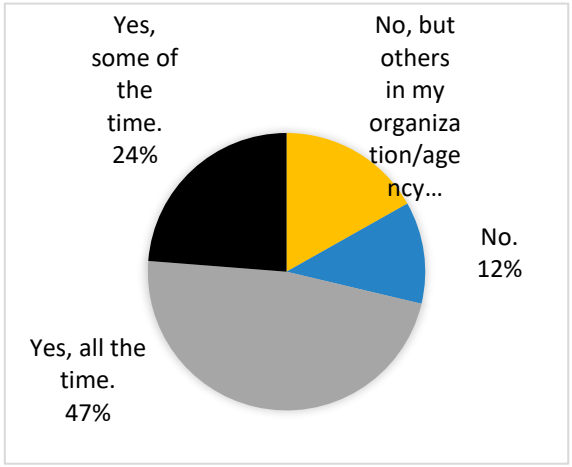


Figure 4. Are you a Monterey County staff member? (n=276)

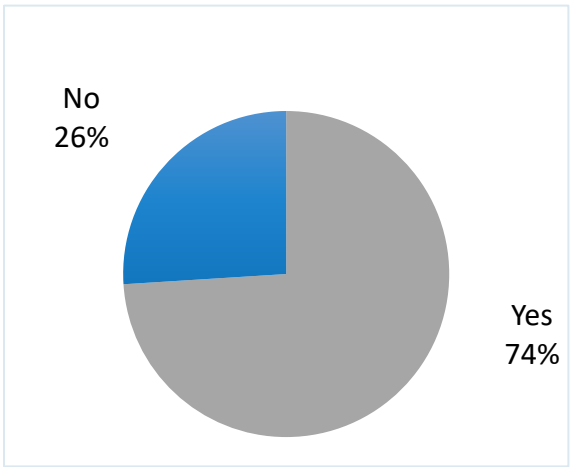


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Figure 5. Age Groups Served Most Often* (n=276)

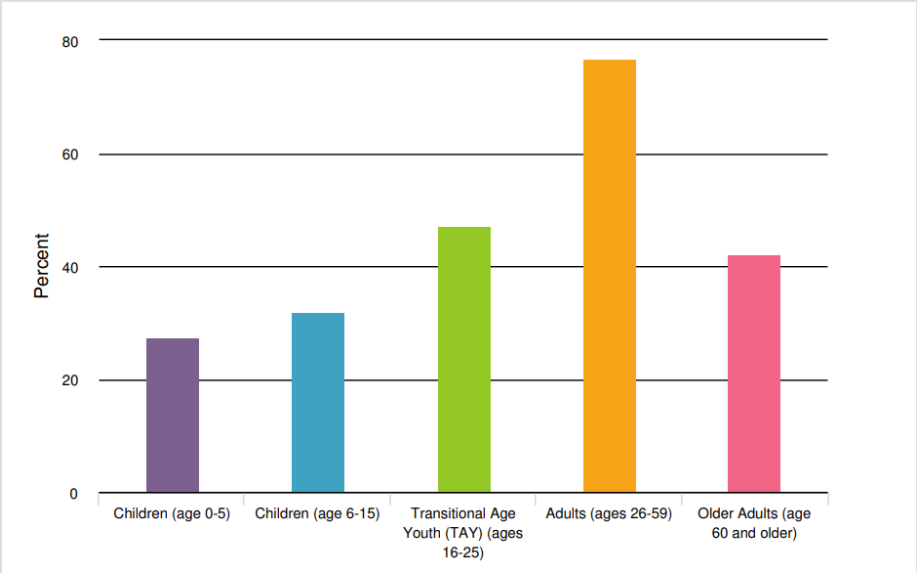
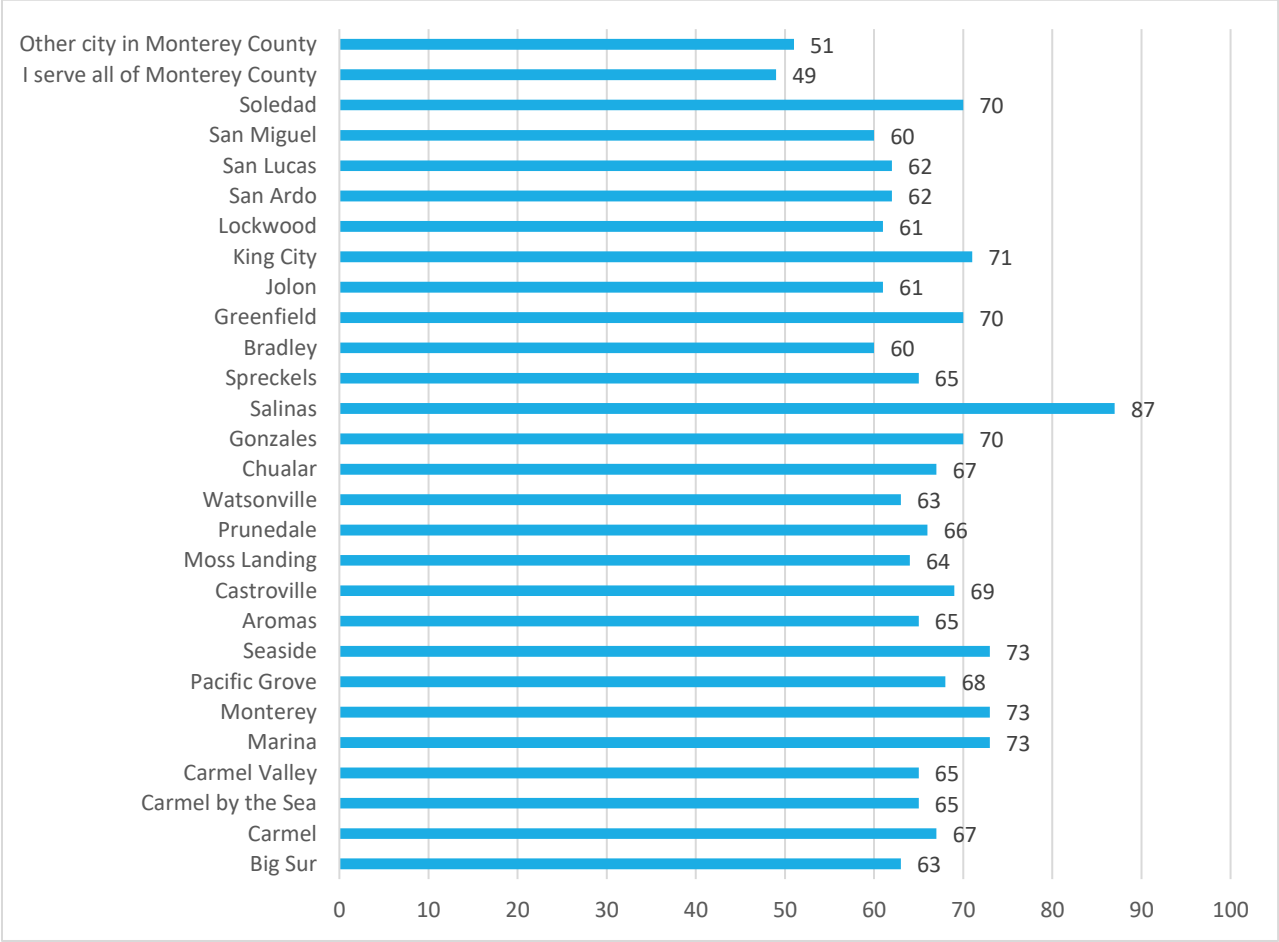


Figure 6. Geographic Regions Served* (n=276)



* Total percentages exceed 100% because respondents could select multiple options.

Community Member Survey Write-in Responses

For questions with an "other" response option, Tables 18 and 19 include a full list of responses, grouped by common theme.

Table 18. Race/Ethnicity Specified under "Another race/ethnicity"

Races/ethnicities	#
Irish	1
Latin American	1

Table 19. Additional Personal Characteristics Specified under "Other"

Characteristic	#
A 12 yo daughter unsure of sexual orientation	1
Living in a community where many young people are using drugs and experiencing mental illness	1
Family members mental health and addiction	3
Have had difficulty accessing mental health services for myself and my child	1
Have limited BH services for my patients	1
I have experienced homelessness	2
Work related stress	1
I am a caregiver of elderly clients who have varying disabilities, mental health issues, etc.	1

Provider Survey Write-in Responses

For questions with an "other" response option, Tables 20 through 24 provide a full list of responses, grouped by common theme.

Table 20. Providers' Job Roles Specified under "Other"

Job Role	#
Analyst	1
Animal Care Technician	1
Associate Marriage & Family Therapist	1
Building Maintenance	1
Case Manager	1
Central Assistance	1
Clinical Staff	1
Counsel	1
Counselor	2
Enterprise Architect	1
Faculty, Nursing	1
Law Enforcement	1
Lined Staff	1
Medical Assistant	1
Mental Health Staff	1
Nurse/ Nurse Practitioner	4
Persona de la Comunidad	1
Physician	3
Probation Officer	1
PSW	3
Team Member	2

Table 21. Providers' Sectors of Work Specified under "Other"

Sector	#
BH Admin	1
Building Maintenance	1
CAO	1
City	1
County Ag	1
Early Childhood	1
Early Education	1
Engineering	1
Family Education	1
Finance	1
Forensic Mental Health	1
Grief Counselor Volunteer	1
Information Technology	1
IT-Government	1
Legal Advice	1
Legal to include DSS/FCS	1
Library Public Service	2
Location Intelligence Support	1
Mental Health and Substance Abuse Treatment	3
Mental Health RN	1
Physician	1
Regional Center	1
Residential Care for the Elderly	1
Run Reports/Paper Pusher	1
Transportation/Public Works	1
Workforce Development	1

Table 22. Geographic Regions Specified under ""Other city in Monterey County"

Region	#
All Monterey County	1
Hartnell College	1
If a person comes into office from another county	1
Royal Oaks	1
Santa Cruz and Monterey County	1
We have a focus on South county, bet serve clients from all of Monterey County	1

Table 23. Other Populations You Work With Most Often by Providers Specified under "Other"

Population	#
60+ living alone/homebound/seniors	4
AA/Latino women and men	1
Substance abuse clients	6
Elderly	1
Farmworkers	2
Foster and adopted youth	2
Adults with developmental disorders	2
Eating disorders	1
Incarcerated individuals/those re-entering society	3
Veterans	2
LGBTQ	1

Table 24. Other Underserved Populations Identified by Providers

Underserved Population	#
290 status	1
AA/Latinos	2
Clients who have co-occurring substance use/abuse issues	3
Couples therapy	1
COVID impacted multigenerational families	1
Deaf population	3
Russian and Asian dialects	1
Foster and adoptive youth	1
Geriatric population	3
Homebound/living alone	2
Women suffering from postpartum depression/anxiety	1
Indigenous populations	5
Individuals who are not able to access technology for telehealth services	1
Jail/prison re-entry counseling and incarcerated	4
Parenting single men	1
People with chronic illness	1
Traumatic brain injury victims	1
Triqui and Mixteco	2
Victims of violent crimes	1
Undocumented	1
Individuals who are gravely mentally disabled	1