Appendix I

Monterey County Mental Health Services Act

Community Program, Planning Process

FY 2022-2023

Provider

Focus Group

Summary of Findings

Monterey County Health Department, Behavioral Health Bureau

Mental and Behavioral Health Community Program Planning Process

Final Summative Report

FY 22/23

March, 2023

Table of Contents

I. Executive Summary

Monterey County Health Department, Behavioral Health Bureau (referred to as Monterey County Behavioral Health [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 community program planning process (CPPP) assessment was to collect primary data from community members and providers about the current mental and behavioral health issues in Monterey County. Additionally, suggestions were gathered from both community members and providers for expanding access to care, improving services, and reducing health disparities.

Between October 2022 and January 2023, surveys, focus groups, and listening sessions were used for data collection. The two surveys, a Provider Survey (n=140) and a Community Member Survey (n=646), were administered throughout the county. Each instrument was designed to gather perspectives on the current state of mental and behavioral health services and needs in Monterey County. To accommodate people who did not have access to technology or were uncomfortable using it, paper surveys were made available at locations across the county. Twelve focus groups (n=78) were conducted in November and December 2022. A list of community organizations to include in the focus groups was developed in a purposeful way to reflect a diverse set of voices within the community. Two listening sessions were conducted as in-person and open forums with participants being asked to register in advance. Four focus groups and the two listening sessions were conducted in Spanish; the rest were in English.

Results indicate that the major mental health issues as anxiety, chronic stress, depression, grief, and post-traumatic stress disorder. Behavioral issues that result from these leading mental health issues include abuse, bullying, substance misuse, violent behavior, and isolation. Other major contributing factors to mental and behavioral health issues were reported as homelessness; financial stress, unemployment, or lack of job opportunities; and stressful childhood experiences.

For availability of services, the population identified by the highest percentage of providers as lacking needed services to meet the need by age group was children while the highest unserved or underserved persons are those who are low-income. Focus group and listening session participants and survey respondents shared concerns about long wait lists and the affordability of services. Community members and providers noted the biggest barriers to services are the cost and lack of health insurance. Focus group and listening session participants made comments about both of these issues being barriers as well as stigma related to seeking out services and transportation to services.

Providers noted many strengths of the County's behavioral services such having a dedicated and helpful staff, collaboration with other agencies, addressing health disparities, and their support of underserved populations. The recommendations included a need for stigma reduction education and campaigns; more providers; additional translation services available in Trique, Zapoteco, and Mixteco; more services available for those with mild to moderate mental health issues; additional outreach; and transportation or clinic shuttle services.

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 need for services appears to have increased, particularly the anxiety that residents are experiencing. MCBH will need to continue to leverage resources and work with partners to meet this increased need.

II. Introduction

Monterey County Health Department, Behavioral Health Bureau (referred to as Monterey County Behavioral Health [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 assessment, which is a part of the community program planning process (CPPP), 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 expanding access to care, improving services, and reducing health disparities. Between October 2022 and January 2023, data collection took place. This document includes an explanation of the data collection methods used, demographics/profiles of the participants and respondents, and the results of the data collection.

III. Methodology

This section of the report explains the data collection and analysis process.

Data Collection

The data collection process utilized two surveys, 12 focus groups, and two listening sessions. The questions were developed by EVALCORP and approved by MCBH.

Surveys

The two surveys, a Community Member Survey and a Provider Survey, were administered throughout the county. 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 October 1, 2022 to December 1, 2022.

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. Email invitations to the online 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. Providers of prevention and early intervention services in the county also were asked to distribute the Community Member survey to residents on their email listservs. In addition, MCBH delivered paper surveys to sites to help reduce the digital divide. The completed surveys were scanned and submitted via email.

Focus Groups and Listening Sessions

To recruit focus group participants, a list of community organizations was developed in a purposeful way to reflect a diverse set of voices within the community. Community partners working in different areas of the county and with specific populations experiencing disparities in health and in access/utilization of behavioral health services (e.g., unhoused, veterans, LGBTQ+, under-represented racial and ethnic groups, immigrants) were asked to assist with enrolling focus group participants. These organizations, referred to as host sites, invited their clients to participate in a focus group at their organization; the facilitator joined virtually. To accommodate populations that did not have access to technology or were not comfortable using it, nine focus groups were held with the community members at the host site (n=52). Three focus groups were virtual [one in English (n=2) and two in Spanish (n=24)] to accommodate those who would not be able to attend in person. Two in-person listening sessions were conducted in Spanish, with English interpretation, in January 2023. These sessions were open to the community and not focused on a specific population. MCBH staff involved in the planning process were present during the focus groups and listening sessions in order to connect with community members and ask follow-up questions that would be helpful with their planning.

Participants of in-person focus groups and listening sessions were asked to complete a demographics form on paper. Demographic data was not captured during the virtual focus groups.

Data Analysis

Analyses of surveys, focus groups, and listening sessions 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 and identify patterns. The quantitative data was cleaned and analyzed using Excel. The qualitative data was reviewed and coded into themes.

IV. Profile of Survey Respondents and Focus Group and Listening Session Participants

This section presents an overview of the descriptive information of Provider and Community Member Survey respondents as well as focus group and listening session participants. Seven hundred eight-six surveys were completed between October 1, 2022 through December 1, 2022 (Table 1). Eighty-five people participated in the focus groups and listening sessions.

Table 1. Number of Surveys Collected by Survey Type

Survey Type	N
Provider Survey	140
Community Member Survey	646
Total	**786**

The combined demographics of community member survey respondents and focus group participants are in Table 9 in the Appendix. The data show that females were over-represented. Figure 2 in the Appendix shows the geographic regions of residence of community survey respondents. While the region with the highest number of responses is Salinas (33%), this is also the most populated city in

Monterey County (37% of the population). So while Salinas was slightly under-represented proportionally to their population, residents of Kings City and Gonzales were slightly over represented.

Table 10 in the Appendix includes additional non-demographic information about the survey respondents. There was significant representation from many underserved populations such as veterans and the LGBTQ+ population. The responses for questions with an "other" response option also are provided in the Appendix, grouped by common theme.

Community Member Survey Respondent Profile

Here are the highlights from the Community Member Survey respondents. Note that not all of the respondents answered each question so the percentages are for the present of the people who responded to that question.

- The highest number of participants fell in the age category of 41-59 years old (43%, n=191)
- For race and ethnicity, two-thirds of respondents were Hispanic or Latino (66%, n=292)
- The majority were female (84%, n=371)
- Slightly under half of participants (46%, n=206) speak English frequently at home while a third (n=147) speak English and Spanish

Provider Survey Respondent 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. Note that not all of the respondents answered each question so the percentages are for the present of the people who responded to that question. Provider respondents reported that most:

- Have a job role of program staff (46%, n=55)
- Work in the job sector of mental/behavioral counseling (49%, n=57)
- Work mostly with the age group of 25-59 year olds (57%, n=65)
- Serve persons who are in the low-income population (83%, n=94)
- Provide direct services all the time (46%, n=54)
- Are not an MCBH staff member (69%, n=81)

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

Focus Group and Listening Session Participants Profile

The percent of focus group and listening session participants who completed the demographic form was 65% (n=55). Here are data about the highest represented groups.

- Are 41-59 years old (36%, n=20)
- Have a Hispanic/Latino decent (60%, n=33)
- Are female (64%, n=35)
- Have a disability (36%, n=20)
- Have personal experience with mental and behavioral health challenges (42%, n=23)
- Most frequent language spoken at home is English (53%, n=29)

Details about focus group and listening session participant characteristics are in Tables 9 and 10 in the Appendix.

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=491-496)	Provider Survey (n=94-97)
Anxiety	**77%**	**86%**
Depression	72%	80%
Chronic Stress	69%	79%
Alcohol/Substance Use	73%	72%
Trauma	58%	84%
Suicide or Thoughts of Suicide	47%	52%

Both sets of respondents identified anxiety as their top major issue of concern. Suicide or thoughts of suicide was the least prioritized issue in both groups yet approximately half of respondents for both surveys noted it as a major issue, therefore, it should not be seen as non-problematic.

Focus group and listening session participants identified the needs in four themes.

1. *Emotional needs*. The emotional needs included anxiety, stress, grief, anger, aggression, gender dysphoria, and depression, including post-partum depression among new mothers.
2. *Behavioral needs*. It was noted that these emotional issues contribute to behavioral problems such as bullying, suicide, self-harm, isolation, domestic violence, child abuse, poor parenting, and substance misuse.
3. *Service needs*. The service needs included reduced wait times; outreach teams for the unhoused; services in Mixteco, Zapoteco, and Trique languages; shelters for domestic violence victims; Narcan kits; a website with a tutorial for youth and one for adults on how to access resources; a live chat and/or navigator about resource access; more services for mild to moderate need; services for middle-income families and individuals; additional needle-exchange programs; and more staff who have cultural knowledge of their backgrounds.. Parental support also is needed to assist with their past trauma and current situations such as financial stress. Participants also noted the need for services available in familiar community spaces, such as community centers and Parent Playgroups.
4. *Educational needs*. The educational needs included stigma reduction, how to identify mental illness, understanding the LGBTQ+ community (e.g., pronoun use, acceptance), LGBTQ+ youth and parental communication, how to help a friend or family member with mental illness who refuses to get services, what therapy is and the benefits, how to identify post-partum

depression, instructions on how to use Narcan in English and Spanish, the effects of substance misuse when taking medications and the importance of taking mental health medications, and information about current services in the community.

Focus Group Participants	
	"Integration post-pandemic has been hard because it wasn't easy to go back into school after having a less structured approach to learning for a year and a half".
	"We need to know how to support people with mental health issues. I have a friend living in a car, he will not see anyone for help, I need resources on how to help him. He is going to die [sobbing]".
	"I feel like farmworkers are some of the most vulnerable and neglected. We have gone to share information, but they have to work a lot".
	"We need to support community spaces and leverage existing relationships to help people."

Contributing Factors to Mental and Behavioral Health Issues

Community Member and Provider Survey respondents were asked to identify factors that they believe influence mental and behavioral health needs. Community members and providers identified the same factors as the top three major barriers: **financial stress, homelessness**, and **stressful childhood experiences** (Table 3).

Table 3. Top Contributing Major Factors to Mental and Behavioral Problems

Community Survey (n=460-466)	Provider Survey (n=95-98)
1. Financial stress, unemployment, or lack of job opportunities 80%	1. Financial stress, unemployment, or lack of job opportunities 92%
2. Homelessness 72%	2. Stressful childhood experiences 75%
3. Stressful childhood experiences 61%	3. Homelessness 65%

In addition to the major factors listed in Table 3, focus group participants also noted poor parenting skills, bullying in schools, 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.

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. The two questions related to availability asked about unserved and underserved populations (Table 4) and specific age groups (Figure 1).

Unserved and Underserved Populations

Of all responses, 87% reported services for persons with low income are available but are insufficient to meet the need. Other highest underserved populations identified by providers were persons who primarily speak Spanish (82%), are trauma exposed (79%), and immigrants (79%). Twenty-three percent of respondents shared that services are not available at all for individuals who do not speak either English or Spanish.

Table 4. Service Availability for Specific Populations per the Provider Survey (n=95-99)

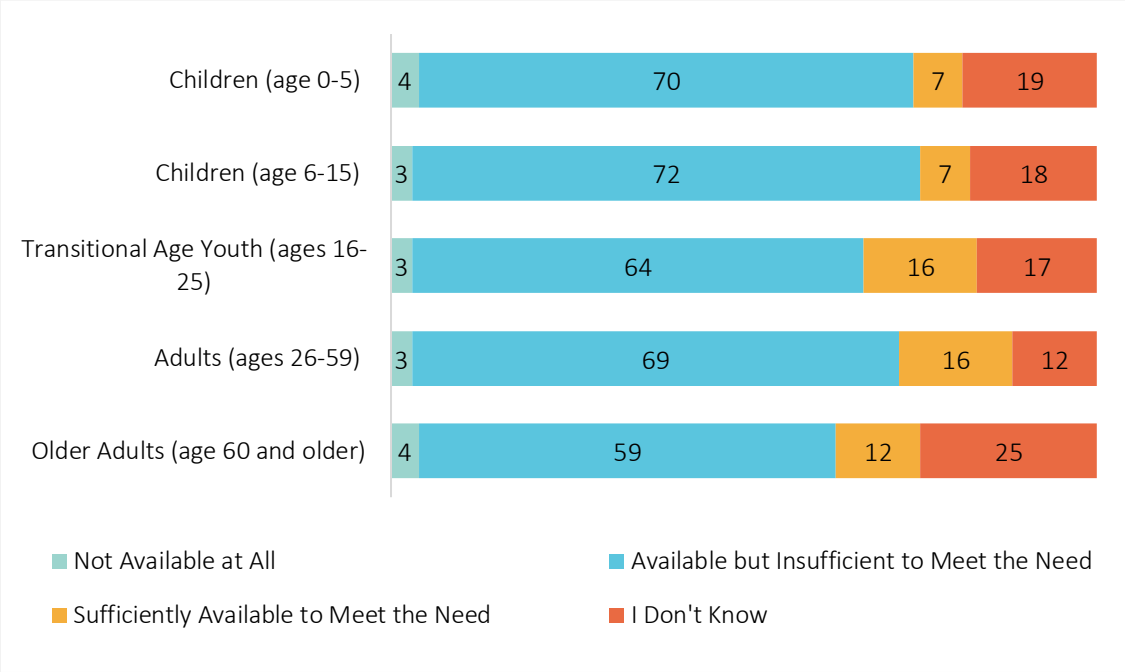
Population Type	Not Available at All	Available but Insufficient to Meet the Need
Persons who are low-income	2%	**87%**
Persons who primarily speak Spanish	2%	82%
Persons who are trauma-exposed	2%	79%
Immigrants	6%	79%
Persons experiencing homelessness	9%	75%
Family members, support persons, or caregivers of individuals with mental health conditions	6%	73%
Children/youth in stressed families	3%	72%
Persons who are victims/survivors of intimate partner/domestic violence	4%	70%
Children/youth at risk for school failure	2%	70%
Persons experiencing onset of serious psychiatric illness	6%	66%
Children 0-5 who have experienced early life stressors and/or trauma	6%	64%
Women with pre-/post-natal needs	2%	62%
Children/youth at risk of juvenile justice involvement	3%	63%
Persons with disabilities other than mental/behavioral health conditions	9%	60%
Persons who primarily speak a language other than English or Spanish	23%	55%
Persons who identify as LGBTQ+	6%	50%
Veterans	7%	48%
Persons who have been victims of human trafficking (including being commercially sexually exploited)	9%	47%
Other underserved populations	9%	36%

When asked to identify any additional populations not listed, respondents most frequently wrote in indigenous, Oaxacan communities, and families who speak Mixteco. A categorized list of write-in responses is provided in Table 21 in the Appendix.

Age Groups

Results from the provider survey reveal that services are available for all age groups. The "not available at all" responses were all less than 10% for all age groups, suggesting that the services are available and that a small percentage of providers are not aware of them or services are not available in their particular region. The age group with the highest responses that services are available but insufficient to meet the need was for children followed by adults ages 26 to 59 (Figure 1).

Figure 1. Availability of Services by Age Group (n=92-96)



Barriers to Accessing Mental and Behavioral Health Services

All data sources requested that 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.

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. Cost of services and lack of health insurance were noted as the top two barriers in both surveys.

Table 5. Barriers to Accessing Mental and Behavioral Health Services, Community Member Survey (n=454-461)

Barrier	Somewhat of a Barrier	A Major Barrier
Cost of services	15%	**76%**
Lack of health insurance	17%	74%
Stigma related to mental illness	24%	64%
Lack of knowledge of information about where to get help	25%	64%
Lack of childcare/caregiver relief	22%	64%
Appointment times are not convenient	23%	60%
Service locations are too far away/transportation	26%	59%
Lack of culturally appropriate services	32%	47%
Lack of language assistance	30%	47%

Table 6. Barriers to Accessing Mental and Behavioral Health Services, Provider Survey (n=94-96)

Barrier	Somewhat of a Barrier	A Major Barrier
Lack of health insurance	**28%**	**64%**
Cost of services	25%	63%
Stigma related to mental illness	30%	62%
Lack of childcare/caregiver relief	27%	61%
Lack of transportation	31%	58%
Lack of culturally appropriate services	29%	58%
Inadequate capacity to assist clients (lack of staff, space, or other resources)	26%	57%
Service locations are too far away	33%	54%
Lack of language assistance	37%	51%
Limited walk-in availability	31%	41%
Appointment times are not convenience	48%	36%
Inadequate staff skills/qualifications	43%	35%
Hours of operation are not convenience	48%	33%
Lengthy wait times in lobby to see provider	35%	33%

Focus groups participants stated that the lack of insurance, costs, long wait lists, and the locations of services being far were the most significant barriers. They also identified transportation, stigma, lack of knowledge about how to navigate the system, and lack of knowledge about therapy as barriers. Listening session participants noted technological limitations and inadequate or non-existent linguistically inclusive resources as significant barriers. Participants expanded on the need for linguistically as well as culturally responsive training for staff at all levels of care, but particularly at intake. It was noted that the first contact with service providers was an important touchpoint that could determine future outreach. Staff who are experienced with working with the Latino population was encouraged. Listening session participants commented that cultural norms could inhibit community members from opening up to therapists and other mental health professionals and having staff who understood norms without judgement would build trust. For the unhoused population, it was noted that they do not want to see providers for medication, because they feel they are looked down upon and providers assume they are only there for pain medication.

> *"If you need mental health supports, you're seen as "crazy" or "sick", so not many people are willing to identify their needs or receive services or supports".*
>
> —Focus Group Participant

> *"We need providers that will respectfully and patiently nudge to open up."*
>
> *"Suggest actual people, not just online resources, to help them navigate the mental health resource landscape and seek out resources for their specific needs….not just someone that speaks the language but also someone that understands the community."*
>
> —Focus Group and Listening Session Participants

Focus group and Listening session participants identified stigma as a prominent barrier. They noted that language highlighting the term "mental health" can push away individuals from accessing services, especially in Latino and Indigenous communities but pivoting to language that highlights emotions, feelings, and behaviors associated with mental health were more accepted. Participants recommended leveraging trusted community members or organizations, especially train-the-trainer models.

> "*Not everyone can use Google. They may not know how to read or write to do simple internet searches. And the indigenous languages are not even translated on Google.*"
>
> —Listening Session Participant

> *"Use Promotoras to help break the stigma among the Latino population. They can help people trust service providers and county agencies by vouching for them."*
>
> —Listening Session Participant

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 the perceived strengths of the county's mental and behavioral health services and recommendations or suggestions they had on how to better meet the mental and behavioral health needs in the communities that they serve.

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

- Text services offer an easier way for people to reach services and learn about resources
- Allows us to meet clients where they are
- Walk-in clinics
- Variety of services offered
- Access given to Medi-Cal enrolled children

Dedication and Expertise of Staff

- Exceptional leadership and collaboration
- Committed workers
- Diverse group of providers
- Culturally sensitive and compassionate staff
- Staff that responds empathetically to clients.

Coordination of Services across Providers

- Networks that work together to provide necessary services
- Effort in becoming more unified and less siloed
- Easy referral process.

Targeting Underserved Populations

- Expanded services to schools
- Funded programs that reach at-risk populations
- FSP programs
- Organizational focus on disparities.

"We have an innovative and forward-thinking county. Listens to their stakeholders and the needs of the community."

—Provider Survey Respondent

"Intention to serve underserved populations."

"Lean progress notes and problem lists allow us to spend more time with clients, instead of writing time consuming progress notes and tx plans."

—Provider Survey Respondents

"Staff I work with are very caring individuals who work hard, with limited resources, respond empathetically to clients."

"Early childhood mental health is proactive in providing early intervention around trauma-related concerns."

—Provider Survey Respondents

Provider Recommendations for Growth

Responses from providers (n=91) on recommendations for Monterey County were grouped into the three themes described in Table 8.

Table 8. Provider Recommendations to Meet Mental/Behavioral Health Needs

Enhance Program Resources and Infrastructure

- Additional preventative resources and services for 'less urgent' needs
- Parental mental health support
- Peer-to-peer education
- Residential services
- Family support
- Crisis services
- Funding

> *"The county only serves those with serious mental illness. We are finding that there are clients who have substance use disorders and mild to moderate mental illness that are falling through the cracks."*
>
> —Provider Survey Respondent

Improve Outreach and Education about Available Services

- Additional community and resource events
- Spaces embedded in the community that clinicians can utilize to see clients
- Outreach to reduce stigma
- Education about what mental health is and the process for getting treatment
- How to help someone with a mental illness

Improve Accessibility of Services

- Support expansion of available clinicians and the pipeline of future clinicians
- Access to translators for Triqui and Mixteco
- Provide transportation or clinic shuttle
- Expanded hours
- More staff

> *"Need more social work staff."*
>
> —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 need for services appears to have increased.

The CPPP 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 misuse.
- 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, transportation, and limited services in rural regions.

Important strengths in mental and behavioral health services were identified. Among these, top strengths included the experienced and dedicated staff, an easy referral process, and MCBH's focus on health disparities and the underserved.

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, the uninsured, and children are particularly insufficient to meet the need within the community. MCBH has dedicated and qualified staff, works well with community agencies as partners, and focuses on improving services for underserved populations. Recommendations include reducing wait lists; increased outreach; adding more services for those with mild to moderate mental health issues; and education for community members on how to support others with mental illness, how to access services, and how to navigate the system.

Appendix

Table 9. Community Participant Demographics by Percent, 2022-2023

Demographic	Community Member Survey	Focus Group and Listening Session Participants
Age	n=446	n=55
16-25	7%	20%
26-40	38%	29%
41-59	43%	36%
60 or older	13%	15%
Race/Ethnicity	n=446*	n=55*
American Indian or Alaska Native	3%	13%
Asian	3%	4%
Black or African American	2%	7%
Hispanic or Latino	66%	60%
Native Hawaiian or Pacific Islander	1%	--
White	28%	20%
Multiracial	5%	4%
Another race/ethnicity	4%	4%
Gender	n=442	n=55
Male	15%	29%
Female	84%	64%
Genderqueer	--	2%
Questioning/unsure of gender identity	--	2%
Other Gender Identity	1%	4%

*Respondents could select multiple options.

Table 10. Community Member Additional Information*

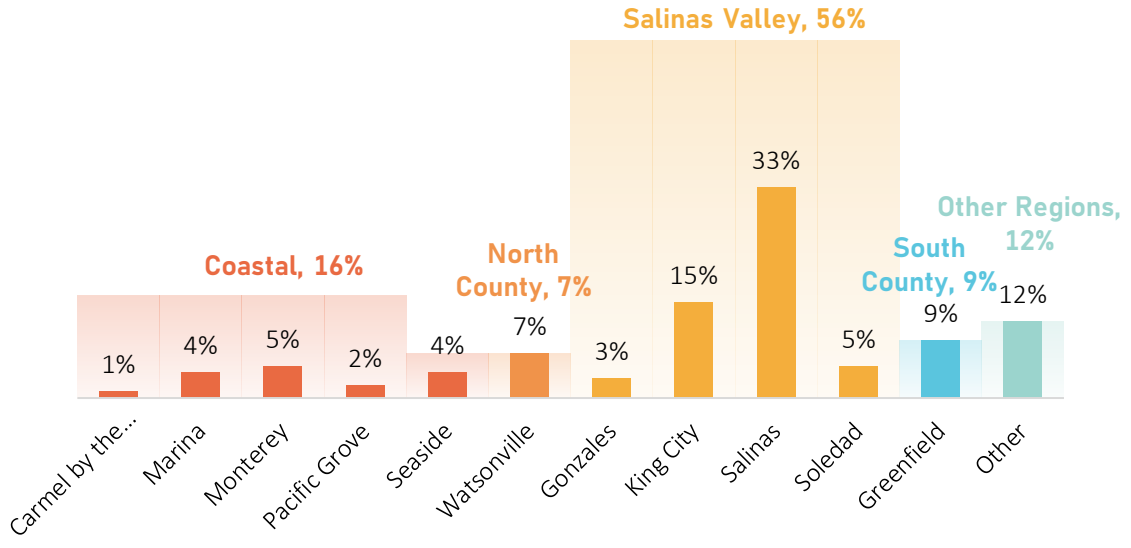
	Community Member Survey Respondents	Focus Group and Listening Session Participants
	n=444*	n=55*
Veteran	4%	18%
Have a disability	6%	36%
LGBTQ	4%	18%
I am a caregiver for an adult family member	7%	2%
I have personal experience with mental and behavioral health challenges	34%	42%
I do not have immigration status or live with someone who does not have immigration status	10%	4%
I am homeless or might become homeless in the near future	3%	16%
I am a single parent	13%	11%
Other	17%	--
Languages frequently spoken at home	n=437	n=55*
English	46%	53%
Spanish	30%	42%
English and Spanish	33%	13%
Another language	6%	13%

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

Community Member Respondents Demographic Information and Write-In Responses

Demographic and additional information from Community Member Survey respondents was elicited to help provide context to their responses. Figure 2 provides information about the city and county region where they live. For questions with an "other" response option, Tables 11 through 13 present the major themes for responses.

Figure 2. Community Member Place of Residence



EVALCORP Measuring What Matters

Table 11. Community Member Race/Ethnicity Specified under "Other"

Race/Ethnicity	#
Indigenous	4
American	1
Japanese	
Mistizo	1

Table 12. Community Member Language Frequently Spoken at Home Specified under "Other"

Language	#
Mixteco	4
Triqui	2
French	1
Japanese	1
German	1
Tagalog	1

Table 13. Community Member Other Supports Would Help Your Family Cope With Mental Health Challenges Specified under "Other": Major Themes

Other Supports	#
More affordable/free counseling	17
More information about mental health/PSAs	14
More professional availability (long wait lists and expanded business hours)	5
Community outreach/street medicine	5
Counseling at schools	4
Supports groups; parent and parent/child support groups	4
Transportation	3
More drug addiction therapy	2
Information about resources	2
Response team	1
More family events	1

Provider Demographic and Write-in 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 14 through 21 and Figures 3 through 6 present a profile of surveyed providers and their responses to 'other' write-in survey questions.

Table 14. Provider Job Roles (n=119)

Job Role	%
Program Staff	46%
Organization Leadership	35%
Admin/Office Support	3%
Other	16%
Total	**100%**

Table 15. Provider Work Sectors*

Work Sector	%
Mental/Behavioral Counseling	49%
Community-based Organization/Non-profit Service Provider	31%
Medical Treatment/Healthcare Services	14%
Social Services	16%
Law Enforcement/Probation/Justice System	3%
Public Health	14%
Pre-K through 12 Education	11%
College/Graduate Education	3%
Substance Use Prevention or Treatment Services Provider	10%
Other	11%

*Respondents could select more than one response item.

Table 16: Population Groups Served*

Population Groups	%
Persons who are low-income	83%
Persons who are trauma-exposed	68%
Immigrants	62%
Family members, support persons, or caregivers of individuals with mental health conditions	56

*Respondents could select more than one response item.

Figure 3. Do you provide direct services? (n=117)

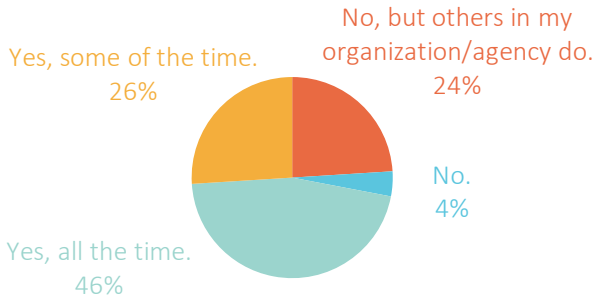


Figure 4. Are you a Monterey County staff member? (n=117)

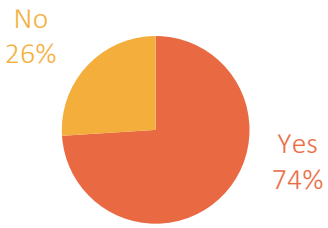
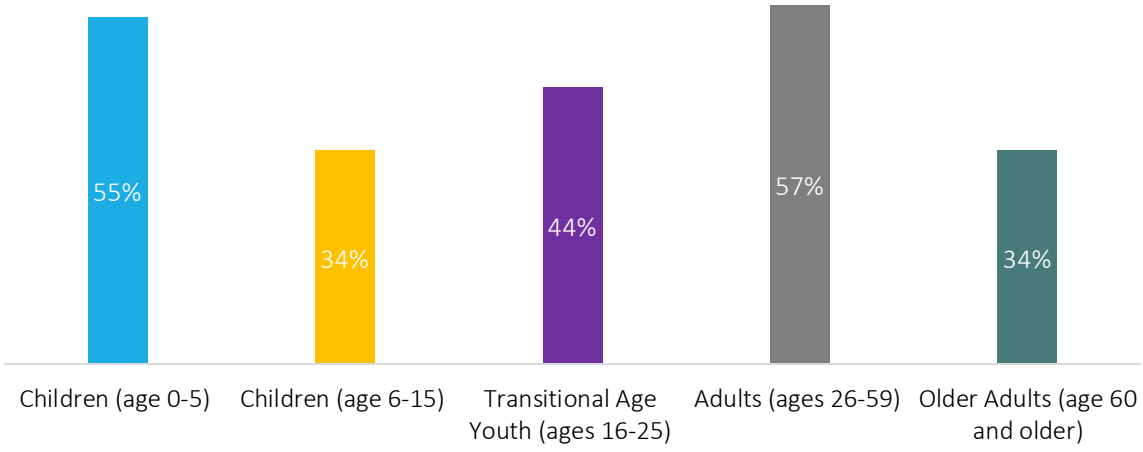


Figure 5. Age Groups Served Most Often by Percent*



*Respondents could select more than one response item.

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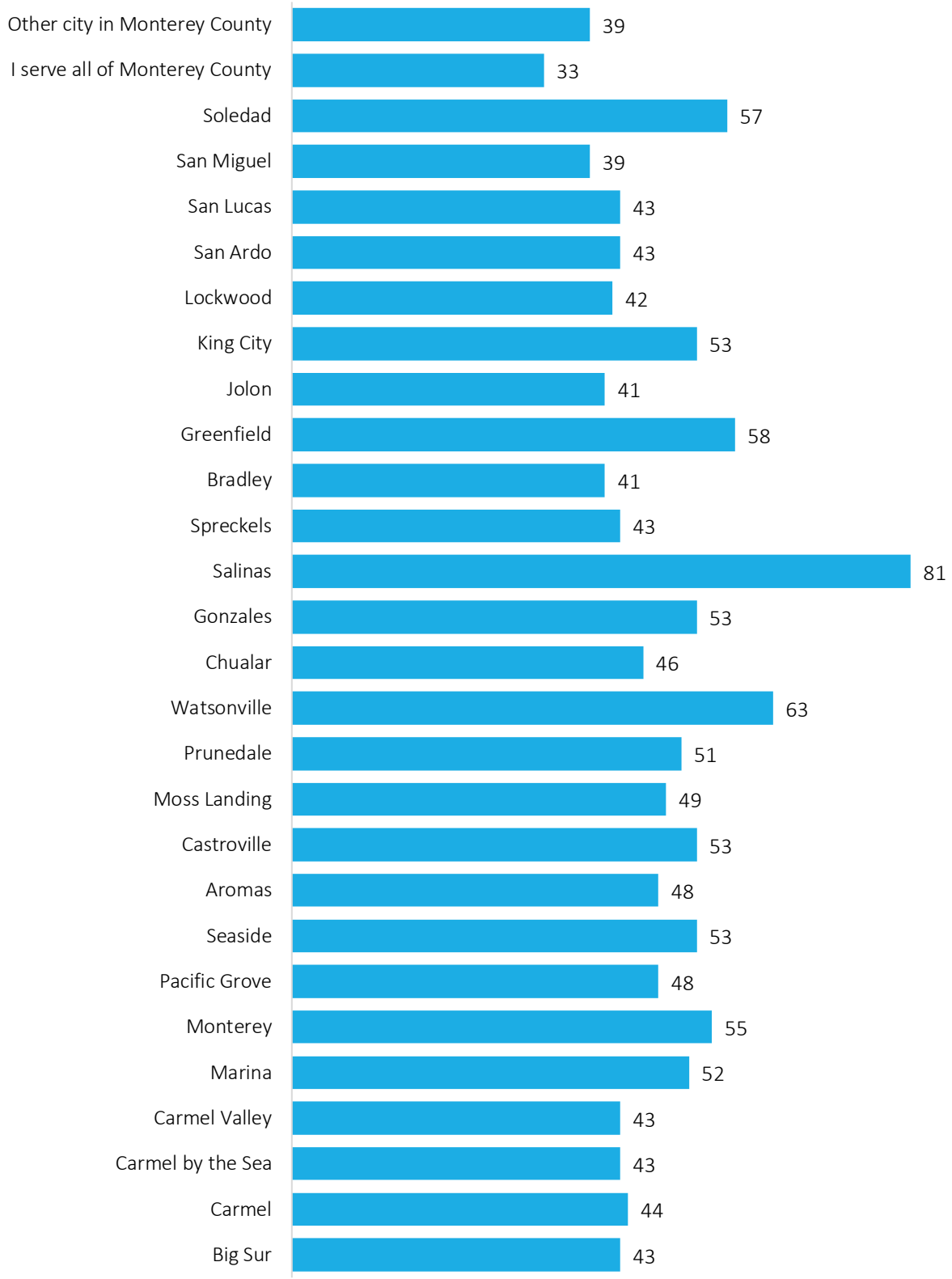
Figure 6. Geographic Regions Served by Percent*



*Respondents could select more than one response item.

Table 17. Providers' Job Roles Specified under "Other"

Job Role	#
Care Coordinator	4
Physician	3
Supervisor	2
Business Systems Analyst	1
Health care	1
Home visitor	1
Hospital CNA	1
Interpreter	1
MH Consultant	1
MSW student	1
Public Guardian	1
Teacher	1
Medical staff	1

Table 18. Providers' Sectors of Work Specified under "Other"

Sector	#
Early education and child care	2
Care coordination	2
Early intervention	1
Birth-5	1
Food service for food insecure	1
Parent education/home visitor	1
Parent as teacher educator	1
Residential care	1
Veterans and military	1
Working with moms with kids from 0-5 with ASQ	1

Table 19. Geographic Regions Specified under "Other city in Monterey County"

Region	#
Los Lomas	2
Pajaro	1
Student enrolled	1

Table 20. Other Populations You Work With Most Often by Providers

Population	#
Indigenous	3
Seniors	3
Justice involved	2
Non-English speakers	2
BIPOC	1
Pregnant and parenting teenagers	1
Child care providers	1
Women	1
Forensic involved	1
Families who live in rural areas	1

Table 21. Other Underserved Populations Identified by Providers

Underserved Population	#
Indigenous	10
Oaxacan community	4
Families who speak Mixteco	4
Seniors	1
Women	1
Blacks	1
Undocumented	1
Justice involved	1
Maternal mental health	1

Monterey County Mental Health Services Act

Community Program, Planning, Process

FY 2022–2023

PROVIDER FOCUS GROUP SUMMARY OF FINDINGS

Prepared by

EVALCORP

Measuring What Matters

Overview

First 5 Monterey County (F5MC) partnered with Monterey County Behavioral Health (MCBH) to encourage further inclusivity of the early childhood voice in the mental and behavioral health needs assessment. Evalcorp, a professional evaluation firm, conducted an additional assessment of the mental and behavioral health needs from the perspective of early childhood mental and behavioral health service providers. This report shares the findings from two focus groups conducted with those service providers of young children and their families.

Participants

Through an essential collaboration between F5MC and Bright Beginnings, two focus groups (Maternal Mental Health Task Force and a group of F5MC funded partners) were conducted with a total of 37 participants, representing 17 different Monterey County organizations. Organizations represented include government agencies, school district personnel, and community-based organizations, all of which serve children up to five (5) years of age and their families. Staff roles of focus group participants consisted of staff, management, and executive leadership with a range of 2-28 years of experience in their role.

Mental & Behavioral Health Concerns

Focus group participants were asked to identify common mental/behavioral health-related concerns among families served in Monterey County. Participants reported depressive symptomology as a mental health concern, followed by feelings of anxiety and substance use. Focus group participants discussed how depressive symptoms can be experienced throughout the perinatal period, with negative impacts on partners and children. **Table 1** lists the top three concerns identified by focus group participants, with example responses.

Table 1. Top 3 Mental Health/Behavioral Health Concerns

Concerns	Example Responses
Depressive Symptomology	• Depressive symptoms are being experienced during the perinatal period by both birthing and non-birthing partners. • Depressive symptoms are increasing the risk of harm to the parent and the child in the womb.
Feelings of Anxiety	• Feelings of anxiety are being experienced during the perinatal/post-partum period. • Community members may not always know how to identify and manage symptoms of anxiety.
Substance Use	• Higher levels of prenatal difficulties are being experienced by parents caught up in substance use. • Growing up around adults with substance use issues is negatively impacting the mental health of children as they mature into adults.

Contributors to Poor Mental & Behavioral Health

Focus group participants were invited to discuss the factors contributing to poor mental or behavioral health impacting families served in Monterey County. Focus group participants reported that traumatic experiences are a leading contributor to poor mental and behavioral health, along with lack of access to mental health care, and economic instability. Trauma was encountered in two ways: 1) distressing events that adults experienced as children, and 2) intergenerational trauma or trauma that had been internalized and passed down across generations. Both types of trauma were identified as having significant impacts on the community, influencing both parents and children. **Table 2** states the top three contributors to poor mental and behavioral health as identified by focus group participants, with example responses.

Table 2. Top 3 Contributors to Poor Mental and Behavioral Health

Contributing Factors	Example Responses
Traumatic Experiences	• Experiences with racism have been internalized by families over generations and are influencing parenting styles. • Survivors of traumatic experiences are not as able to recognize their children's developmental needs.
Lack of Access to Mental Health Care	• Limited health insurance coverage and long wait times for appointments are delaying access to mental health services. • The process of accessing care is overly complicated or cumbersome for many families with young children.
Economic Instability	• Poverty, housing, and job insecurity are all factors that are impeding health care. • The COVID-19 pandemic has exacerbated economic instability in families that are in greater need of mental and behavioral health care.

Strengths Across Organizations

Focus group participants were asked to identify their organization's strengths for addressing mental and behavioral health needs. The two assets described by participants were First 5 trainings and learning groups. Focus group participants identified "Facilitating Attuned Interactions" (FAN) as a helpful First 5 training. Learning how to deliver services using a relationship-based approach and be empathetic to individuals were key components highlighted. Focus group participants also described how First 5 learning groups allowed providers to collaborate and learn from one another to best serve the zero-to-five-aged population. **Table 3** states the top two strengths across organizations identified by focus group participants, with example responses.

> "I learn to say "when you're ready to start, we can start." That's beautiful. I allow each person time to be ready. I was a person who sees a problem and jumped to the solution. I learned that I need to listen and be present, not to immediately resolve a problem. You're there to walk with them."

Table 3. Top 2 Strengths in Addressing Mental and Behavioral Health Needs

Strengths	Examples
Relationship-based Practice	• First 5 trainings help contractors better engage with and support families with mental health needs. • Training on reflective practice results in thoughtful communication with clients
Provider Group Cohesion	• Learning groups enable perinatal providers to learn from one another. These groups unite stakeholders who serve the same target populations allowing for creative discussions about how to effectively address the community's mental health needs.

Recommendations to Improve Mental & Behavioral Health

Focus group participants were invited to share ideas on how to improve mental and behavioral health care in Monterey County. Recommendations shared by participants reflected two core desires, to 1) increase the mental and behavioral health impact of their organizations, and 2) expand the reach of services to all County regions and all vulnerable populations. Recommended strategies included the need to increase staff capacity (e.g., train and hire staff), support system cohesion (e.g., diversify funds, provide opportunities for collaboration) and foster community healing (e.g., offer support groups, parent education classes). **Table 4** details these top three recommendations for supporting mental and behavioral health care, along with detailed examples. The example responses below reflect the desire of focus group participants to provide elevated service quality and expand access to community members in need.

Table 4. Top 3 Recommendations and Ideas to Address Mental and Behavioral Health

Recommendations	Response Examples
Increase Staff Capacity	• Provide ongoing training to increase provider knowledge of mental/behavioral health intersections (e.g., substance use, abuse), trauma-informed care, and reflective practice. • Equip providers from various fields (e.g., quality early learning and medical) with consistent recommendations of best practices to serve families. • Hire additional mental health and behavioral health staff to improve the quality of care.
Cultivate System Cohesion	• Fund community resource centers that assess needs and connect families to the appropriate service networks. • Provide greater opportunities for collaboration among providers to increase the likelihood of a successful referral connection.
Foster Community Healing	• Organize community healing opportunities such as cultural support groups, healing groups, and parent education classes. • Offer services in languages spoken by the community to increase feelings of inclusivity that will promote healing.

> "We're working on how we do the work to have a place that serves parents and families. We have ongoing support for slowing down and thinking about how we say something. We make moms and parents feel safe and young children are learning by how they're treated."

> "Collaboration is so important. Knowing who is at the table, how to reach out to them, and making sure we can help a family. It's very frustrating to have a parent say, 'I have tried' and then you [as a provider] try and you still can't get the family services."

Summary of Key Findings

First 5 Monterey County (F5MC) partnered with Evalcorp, a professional evaluation firm, to conduct an assessment of the mental and behavioral health needs in the communities throughout Monterey County. The final section of this report presents key findings from two focus groups of providers of mental and behavioral health care to families of Monterey County residents with young children.

Mental and Behavioral Health Concerns

Focus group participants identified common mental/behavioral health-related concerns among families served in Monterey County. The top three concerns discussed were:

- Depressive Symptomology
- Feelings of Anxiety
- Substance Use

Contributors to Poor Mental & Behavioral Health

Focus group participants described factors that contribute to poor mental or behavioral health of families in Monterey County. The top three contributors to poor mental and behavioral health discussed were:

- Traumatic Experiences
- Lack of Access to Mental Health Care
- Economic Instability

Strengths Across Organizations

Focus group participants shared their organization's strengths in addressing mental and behavioral health needs. The top two strengths across organizations mentioned by focus group participants were:

- Relationship-based Practice - Trainings offered by First 5
- Provider Group Cohesion - as a result of First 5 learning groups

Recommendations to Improve Mental & Behavioral Health

To conclude the conversation, focus group participants provided recommendations to improve mental and behavioral health care in Monterey County. The top three recommendations and ideas shared were:

- Increase Staff Capacity
- Cultivate System Cohesion
- Foster Community Healing