

WRMA

Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

**SERVICE AREA 1 – ANTELOPE VALLEY
COMMUNITY FORUMS**

CONDUCTED FOR THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN
IN LOS ANGELES COUNTY

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Prepared for:

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Table of Contents

I. Overview	1
Purpose	1
Outcomes	1
II. Community Forum Methodology	2
Participants	2
Format	3
Breakout Groups	3
III. Service Area 1 Summary	4
IV. Top Priority Populations Selected	6
V. Age Group Recommendations	7
Children, 0-5 Years	7
Priority Populations	7
Sub-Populations	8
Strategies	10
Children, 6-15 Years	11
Priority Populations	11
Sub-Populations	12
Strategies	13
Transition-Age Youth, 16-25 Years	14
Priority Populations	14
Sub-Populations	15
Strategies	17
Adults, 26-59 Years	18
Priority Populations	18
Sub-Populations	19
Strategies	20
Older Adults, 60 Plus Years	21
Priority Populations	21
Sub-Populations	22
Strategies	23
VI. Recommendations for Additional Needs or Populations	24

I. OVERVIEW

The Los Angeles County Department of Mental Health (LACDMH) is engaged in an intensive, inclusive, and multi-faceted approach to developing the County's Prevention and Early Intervention (PEI) Plan to be funded through the Mental Health Services Act (MHSA) enacted by California voters in 2004.

The focus for developing the PEI Plan is at the Service Area level, utilizing informational meetings, key individual interviews, focus groups, and community forums in each of the eight geographic areas of Los Angeles County. Because each Service Area has distinct and varying populations, geography, and resources, it is critical for PEI services to be specific and responsive to regional and community-based needs.

PURPOSE. The community forums presented an exciting opportunity for community participants to make recommendations regarding priority populations and strategies for their communities that will help keep community members healthy.

This report presents the findings from the Community Forum conducted in Service Area 1 – Antelope Valley. The purpose of the Community Forum was:

1. To introduce participants to the Department of Mental Health's Prevention and Early Prevention planning efforts.
2. To summarize what was learned from existing research, other community residents and service providers in this service area about needs, barriers and strategies for providing quality prevention and early intervention mental health services, and
3. To hear suggestions for where and to whom Prevention and Early Intervention services should be provided.

OUTCOMES. The Community Forum had two specific outcomes:

1. To identify the specific priority populations to be served in this service area.
2. To develop recommendations for strategies to serve these priority populations.

II. COMMUNITY FORUM METHODOLOGY

The community forums were designed to provide community members an additional opportunity to provide their input regarding priorities and strategies for addressing the six MHSA priority populations. With one exception (i.e., Service Area 1), a total of two community forums were held in each service area, for a total of 15 service area community forums. In addition, one countywide forum was held that focused on specific populations. Each community forum was organized around age- and language-specific breakout sessions/groups for which community members registered in advance. Each service area community forum followed the same format and procedures.

PARTICIPANTS. Participants were community members interested in taking part in a discussion about the mental health service strategies that would most effectively address the mental health needs in their communities.

- Each Service Area Advisory Committee conducted a concerted outreach effort to educate the public about the MHSA and the PEI planning process. Outreach efforts also placed a large emphasis on encouraging community members to attend the community forums and provide their ideas and suggestions on effective ways to improve the social and emotional well-being of people in their communities.
- When interested community members registered to attend the community forum in their Service Area, they also elected to participate in one of the following five age-specific breakouts: 1) Children 0 to 5 years; 2) Children 6 to 15 years; 3) Transition-Age Youth, 16 to 25 years; 4) Adults 26 to 59 years; and, 5) Older Adults 60 years or older. Additional language-specific breakout sessions were conducted as needed. Each breakout session was comprised of no more than 35 participants.
- A total of 90 community members attended the one community forum held in Service Area 1 and represented a diverse array of community sectors. Of the 90 participants, 32 percent represented mental health providers, 28 percent represented social services, 19 percent each represented education and health, 16 percent represented consumers, and 11 percent represented the underserved. Between less than 1 and 8 percent represented community family resource centers (8%), parents and families of consumers (6%), law enforcement (6%), and employment (1%). Thirteen percent of participants did not indicate which sector they represented.
- A total of five age-specific breakout sessions were held across the community forum conducted in Service Area 1. A breakdown of the number of community participants in each breakout session/group is presented in **Table 1**.

Table 1.
Community Forum Attendance by Location and Breakout Group

Location	Children 0 to 5	Children 6 to 15	Transition- Age Youth 16-25	Adults 26-59	Older Adults 60+	Total
Antelope Valley Inn	11	19	34	14	12	90

FORMAT. The community forum in Service Area 1 took place on a weekday. Translators were available for mono-lingual speakers of various languages at other forums, but were not needed at this forum. The agenda at the forums included: 1) A welcome from the Service Area District Chief; 2) An introduction to the MHSA and prevention and early intervention Plan; 3) The results of the LACDMH needs assessment conducted in each area in terms of key indicators, key individual interview findings, and focus group findings; 4) Age- and language-specific breakout group discussions; 5) Key findings from breakout sessions/groups to all participants; and, 6) Final thoughts and acknowledgements from the District Chief and LACDMH staff.

BREAKOUT GROUPS. The age-specific breakout sessions/groups were conducted by facilitators representing LACDMH as a neutral third-party. Each breakout session/group was conducted by a team of two staff members from Walter R. McDonald & Associates, Inc. (WRMA) and their subcontractors, EvalCorp Research & Consulting, Inc. and Laura Valles and Associates, LLC. One team member facilitated the breakout session/group, while another served as scribe and recorded participants' responses on flip charts, which participants could refer to throughout the discussion. The emphasis of the breakout groups was on identifying the top priority populations to be served in the service area and the appropriate strategies for the community.

III. SERVICE AREA 1 SUMMARY

The community forum for Service Area 1 was held on November 12, 2008 from 9:00 am to 12:00 pm at the Antelope Valley Inn in Lancaster.

A total of five breakout sessions/groups were conducted in Service Area 1; of them, all five were age-specific and directly corresponded to the five CDMH age categories.

Table 2.
Summary of Breakout Groups' Priority Selections

Numbers in parentheses indicate the number of participants in the breakout group and the number of votes

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
Children 0-5 Years		
November 12, 2008 Lancaster, CA (11)	1. Children/Youth in Stressed Families (6)	Early assessments and referrals for parents during pregnancy and for children 0-5 at childcare centers, hospitals, Women Infant and Children (WIC) offices and other community based organizations
	2. Trauma Exposed (3)	Funding to increase the number of staff to provide services
Children 6-15 Years		
November 5, 2008 Lancaster, CA (19)	1. Children/Youth in Stressed Families (6)	Increased services for children and families, including affordable after school programs, respite care, homeless support, transportation and re-distribution of resources to the Antelope Valley to better fund these programs – this redistribution should be based on the concentration of poverty, rather than the number of people in the area
	2. Children/Youth at Risk for School Failure (6)	Strategies to improve the way schools work with children and their families, including implementing school-wide positive behavior support programs, incentives to engage parents as part of that education, and train teachers in cultural competence to reduce misdiagnoses of children
Transition Age Youth 16-25 Years		
November 12, 2008 Lancaster, CA (34)	1. Children/Youth in Stressed Families (14)	School and community based education/programs regarding substance abuse, mental health and life skills

	2. Children/Youth at risk for School Failure (5)	Increase the capacity of community based organizations to provide a variety of services (i.e. tutoring, mentoring, counseling and one-on-one support)
Adults 26-59 Years		
November 12, 2008 Lancaster, CA Group #1 (14)	1. Trauma Exposed (6)	Provide education to the public about existing mental health resources and mental health issues, such as domestic violence, substance abuse, co-occurring disorders, physical abuse, sexual abuse, and emotional abuse. Participants emphasized that all education needs to be linguistically and culturally sensitive
	2. Children/Youth in Stressed Families (5)	Provide low-cost or no-cost early intervention counseling services in non-traditional settings (i.e. in-home) for DCFS birth parents, couples, families, and individuals who may not have a diagnosis. Participants emphasized that counseling services should be linguistically and culturally sensitive
November 12, 2008 Lancaster, CA Group #2 (23)	1. Underserved Cultural Populations (13)	Funding for prevention for particular populations, i.e., deaf, substance abuse, developmentally disabled communities.
	2. Children/Youth in Stressed Families (5)	Education and outreach for families, community members, and providers on detecting early warning signs, reducing stigma, etc.
Older Adults 60+ Years		
November 5, 2008 Lancaster, CA (12)	1. Trauma Exposed (6)	Increased access to mental health services
	2. Individuals Experiencing Onset of Serious Psychiatric Illness (3)	Increased access to mental health services

IV. TOP PRIORITY POPULATIONS SELECTED

After the facilitator introduced all the participants to the goals and focus of the breakout session/group, each participant was asked to vote on one of the six MHSA identified priority populations. Given the limited PEI resources, LACDMH requested the participants' assistance to identify which populations within a specific age group needs to be a priority for the provision of PEI services and supports. Table 3 shows the top two priority populations selected in each age category in Service Area 4.

In Table 3, each priority population selected by an age-specific breakout group is indicated by a check mark (✓).

Table 3. Top Two Priority Populations by Age Group

Priority Populations	Children, 0 to 5	Children, 6 to 15	Transition-Age Youth, 16 to 25	Adults, 26 to 59	Older Adults, 60+
Underserved cultural populations					
Individuals experiencing onset of serious psychiatric illness					✓
Children and youth in stressed families	✓	✓	✓	✓	
Trauma-exposed	✓			✓	✓
Children/youth at-risk for school failure		✓	✓		
Children/youth at-risk of or experiencing juvenile justice involvement					

The session group representing Children 0 to 5 selected Children and youth in stressed families and Trauma-exposed individuals. The session/group representing Children 6 to 15 selected Children and youth in stressed families and Children and youth at risk for school failure as their priority populations. The session/group representing Transition-Age Youth (16-25) selected the same priority populations as the Children 6 to 15 session/group (i.e., Children and youth in stressed families and Children at risk for school failure). The session/group representing Adults (26-59) voted for the same priority populations as those representing Children 0 to 5 (i.e., Children and youth in stressed families and Trauma-exposed). Lastly, the session/group representing Older Adults (60+) chose Individuals experiencing onset of serious psychiatric illness and Trauma-exposed.

V. AGE GROUP RECOMMENDATIONS

The recommendations that emerged from the top priority populations selected in the breakout sessions/groups are presented below. Once each group had selected the top priority populations, they were asked to drill deeper and list the sub-populations that fell under each priority population.

Participants also were asked to identify strategies for addressing the mental health needs of the priority populations selected. At the end of the discussion, the strategies were consolidated and each participant was given an opportunity to vote for one strategy under each priority population. This section presents the top two to three strategies that emerged from those discussions as well as the sub-populations cited for each population by age group.

CHILDREN, 0-5 YEARS



PRIORITY POPULATIONS. One age-specific breakout session/group was conducted representing Children 0 to 5. This group identified the following two priority populations: Children and youth in stressed families and Trauma-exposed.

Table 4 shows the number of participants in the group who voted for the top priority populations representing Children 0 to 5. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants across the group.

Table 4. Percentage of Participants Who Selected the Top Priority Populations for Children, 0 to 5

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children and youth in stressed families	1	6	11	55%
Trauma-exposed	1	3	11	27%

SUB-POPULATIONS. Table 5 displays how participants defined the sub-populations for Children and youth in stressed families and Trauma-exposed.

Table 5. Priority Population Sub populations: Children, 0 to 5

Priority Populations	Sub-populations
	Group 1 (N=11)
Children and Youth in Stressed Families	<ul style="list-style-type: none"> • Young children in out-of-home care. • Children being cared for by a grandparent or other relative caregiver; children of parents who have mental health issues and developmental disabilities; or, children of adolescent mothers and fathers. • Children in families with multiple needs and where daily needs are not met, including families with low socioeconomic status, families with special needs children, and families experiencing food scarcity, children in families without transportation, or children in families on cash aid. • Children in families linked with the Department of Children and Family Services. • "High utilizers," meaning that despite services rendered, families continue to have problems and be unstable, including situations where there is homelessness or a mental health need; or, children of seriously depressed mothers and fathers during their prenatal period, which can contribute to poverty, homelessness, and lower levels of education. • Children in families where they are exposed to substance use and abuse. • Children with parents who have language barriers, especially Spanish-speaking parents. • Children experiencing pain, depression, and poor-self esteem because of serious dental problems, when family cannot afford restorative treatment.
	Group 1 (N=11)
Trauma-exposed	<ul style="list-style-type: none"> • Mothers who do not receive prenatal care; children of teen mothers who are in foster homes or have a long history of being in foster care, who often experience insecure attachment; or, children who did not obtain secure child-parent/caregiver attachment. • Mothers exposed to domestic violence, violent environments (in home and community), and/or drug use during pregnancy, which impedes child brain development • Children whose parents have been sexually or physically abused. • Children living in high crime and violent areas. • Children exposed to alcohol, crack and/or other substances (although the effects of the exposure are not technically classified as mental health issues and are often overlooked).

Table 5. Priority Population Sub populations: Children, 0 to 5

	Sub-populations
	<ul style="list-style-type: none">• Children who are bullied or at risk of bullying at school.• Children who are predators because they have been abused.• Children who have been removed from their home or primary care giver and placed under the Department of Children and Family Services.• Siblings of children who have been traumatized; or, siblings of children with developmental disabilities such as autism, Down's syndrome, and/or mental retardation.• Children who have experienced natural disasters or fires.• Children who have experienced serious medical illnesses, such as cancer.

STRATEGIES. The two to three top strategies selected by the breakout session/group representing Children 0 to 5 are presented in Table 6.

Table 6. Top Strategies by Priority Population: Children, 0 to 5

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children and Youth in Stressed Families	1 (N=11)	Early assessments and referrals for parents during pregnancy and for children 0-5 at childcare centers, hospitals, Women Infant and Children (WIC) offices, and other community based organizations (n=5).	Expanded and improved services, to include respite care, medical, dental, and mental health care, and financial and nutritional supports (n=4).	Education for parents, caregivers, and childcare providers and other agencies (n=1).
Trauma-exposed	1 (N=11)	Funding to increase the number of staff to provide services (n=7).	Emergency response teams for traumatic events and natural disasters (n=2).	Parent and caregiver classes, trainings, and therapy, such as anger management, psychotherapy, and interactive trainings focused on behavior (n=1).

CHILDREN, 6 TO 15 YEARS



PRIORITY POPULATIONS. One breakout session/group was conducted representing Children 6 to 15. The participants in this group identified two priority populations: Children and youth in stressed families and Children and youth at-risk of school failure. Table 7 shows the number of participants in the groups who voted for the priority populations representing Children 6 to 15. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 7. Percentage of Participants Who Selected the Top Priority Populations for Children, 6 to 15

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children and youth in stressed families	1	6	19	32%
Children/youth at-risk for school failure	1	6	19	32%

SUB-POPULATIONS. Table 8 displays the sub-populations for Children and youth in stressed families and Children at-risk for school failure that were identified by the participants representing Children, 6 to 15.

Table 8. Priority Population Sub-populations: Children, 6 to 15

Priority Populations	Sub-populations
	Group 1 (N=19)
<p style="text-align: center;">Children and Youth in Stressed Families</p>	<ul style="list-style-type: none"> • Children of single parents without support outside immediate family; or, children of families in isolation of immediate family and any outside support such as friends and/or awareness of support services. • Foster children and youth; or, homeless children. • Children who experience child abuse, domestic violence, divorce or any kind of neglect where the child's needs are not met. • Children experiencing their first mental health episode. • Children who have parents with substance abuse addiction issues. • Children of parents who work outside of Antelope Valley and in Los Angeles, and as a result are "latch-key kids." • Children whose family has lost income and/or their home as a result of difficult financial times.
	Group 1 (N=19)
<p style="text-align: center;">Children/Youth at risk for School Failure</p>	<ul style="list-style-type: none"> • Children who are English language learners; or, children who "mainstream" or transition from ESL, from a different class, or different schools into regular and/or other classrooms. • Children who lack parental involvement; or, children lacking role models and positive support systems. • Children with disruptive behavior, including truancy, attention deficit disorder, and who are defiant; or, children who have chronic absentee records. • Children whose learning style is not addressed and/or learning style and teaching style are not matched or supported by the school; children who do not have behavior support services in class; or, children who need learning disability assessment. • Children who have experience with the juvenile justice system; or, foster children and youth who change schools often. • Children who do not receive referrals in a timely manner from their school; or, children whose mental health and physical health concerns are not addressed. • Children who have difficulty learning math and are below grade level in math; children who lack academic readiness skills; children reading one to two years below current grade level; or, children who lack problem solving skills.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above are presented in Table 9.

Table 9. Top Strategies by Priority Population: Children, 6 to 15

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children and Youth in Stressed Families	1 (N=19)	Increased services for children and families, including affordable after-school programs, respite care, homeless support, transportation to these services and re-distribution of resources to the Antelope Valley to better fund these programs. This redistribution should be based on the concentration of poverty, rather than on the number of people in the area (n=6).	Mentoring for children and families, including sports programs, support systems for children and families, and after-school programs at family resource centers (n=5).	Personalized service linkages, including a space where service providers, schools, and caseworkers are involved in treatment decision meetings to address individual needs, to assist foster families and foster children with case management to help families become self sufficient, and to provide in-home coordinated services. (n=4).
Children/ Youth at risk for School Failure	1 (N=19)	Strategies to improve the way schools work with children and their families: implement school-wide positive behavior support programs; provide incentives to engage parents as part of the educational team and do not place them in intimidating roles or circumstances; and, train teachers in cultural competence to reduce misdiagnoses of children (n=8).	Increased funding for elementary schools so that DMH can provide support for educators, including assigning psychologists to schools for assessments; administering psychological and educational assessments to provide learning-style specific instruction; training teachers about mental health issues, including how to recognize mental health symptoms and behaviors, and how to refer students to services; and collaborations between schools and mental health agencies that seamlessly link children to services. (n=6).	Community outreach aimed to increase volunteers and expand mentorship for children and families in schools, which would improve educational outcomes for children (n=2).

TRANSITION-AGE YOUTH, 16 TO 25 YEARS



PRIORITY POPULATIONS. One age-specific breakout group was conducted representing Transition-Age Youth. Table 10 presents the number of participants in the group who voted for the selected priority populations. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 10. Percentage of Participants Who Selected the Top Priority Populations for Transition-Age Youth, 16 to 25

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Children and youth in stressed families	1	14	34	41%
Children/youth at risk for school failure	1	5	34	15%

SUB-POPULATIONS. Table 11 displays the sub-populations for the two populations identified above by participants representing Transition-Age Youth.

Table 11. Priority Population Sub-populations: Transition-Age Youth, 16 to 25

Priority Populations	Sub-populations
	Group 1 (N=34)
<p>Children and Youth in Stressed Families</p>	<ul style="list-style-type: none"> • Children of substance abusing parents; youth in homes where parents are active drug users; children of incarcerated parents; TAY children of parents who live with chronic illness; children living with parents who have mental health issues; youth in homes where parents suffer from mental illness; children living in juvenile justice camps or group homes; or, children being raised by their grandparents. • Foster youth; foster care students who have been expelled from school; emancipating foster youth; or, emancipated foster youth who are at risk for becoming homeless. • Single parent families; or, teenage and transition-age youth parents (TAY). • Gang-involved youth, particularly those from families with intergenerational gang patterns; or, youth raised in environments and neighborhoods where gangs and substance abuse are prevalent • Families where physical and/or emotional abuse is present. • Children/families living in poverty, including families with unemployed and underemployed parents; or, families/youth who are homeless. • TAY and their families who are returning from military service. • Youth with mental health issues who may not be appropriately served (e.g., undiagnosed bipolar disorder; youth with learning disabilities whose parents are unable or unwilling to advocate on behalf of their children; or, youth with low self-esteem issues that can lead to suicide). • African-American and Latino youth. • LGBTQ youth.
	Group 1 (N=34)
<p>Children/Youth at risk for School Failure</p>	<ul style="list-style-type: none"> • All of the sub-populations mentioned under children and youth in stressed families above. • Children raised in homes where parents are LGBTQ. • Youth in homes with parents who are uneducated and/or demonstrate low levels of involvement; or, youth in homes where the parents lack basic life skills and are unable to teach their children basic skills. • Young adults facing peer pressure to drop out of middle or high school; students who are 18 years old but are behind in school credits; or, children who are advanced to next school grade before they are ready.

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| | <ul style="list-style-type: none">• Children who are engaging in risky behavior (e.g., sexual promiscuity, substance abuse, truancy, and/or street racing); children who have been expelled; or, students with a high truancy record.• Children from homes where parents are unaware of mental health signs, issues, and the affects on kids/youth; children of parents who are absent due to work responsibilities or distance, and as a result may lack parental supervision (parents working "down below" or south of Antelope Valley); youth who have relocated from a large populated city to a small town; or, children from immigrant families with acculturation issues.• Children who have a physical or developmental disability but have not been assessed; youth who lack mental health awareness and education.• Kids who are subjected to bullying.• Children raised in families where a "culture of violence" exists.• Substance abusing youth. |
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STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing the group advocating for Transition-Age Youth are presented in Table 12.

Table 12. Top Strategies by Priority Population: Transition-Age Youth, 16-25

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Children and Youth in Stressed Families	1 (N=34)	School and community-based education programs regarding substance abuse, mental health, and life skills (n=13).	Increased communication and collaboration among service systems (n=5).	More mentoring programs (n=4).
Children/ Youth at risk for School Failure	1 (N=34)	Increased capacity of community-based organizations to provide a variety of services, including tutoring, mentoring, counseling and one-on-one support (n=8).	More mentoring programs (n=5).	More TAY drop-in centers (n=3).

ADULTS, 26 TO 59 YEARS



PRIORITY POPULATIONS. One breakout group was conducted representing Adults. This group identified two priority populations: Trauma-exposed individuals and Children and youth in stressed families. Table 13 shows the number of participants who voted for the priority populations selected in relation to the total number of participants in the Adults breakout group. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 13. Percentage of Participants Who Selected the Top Priority Populations for Adults, 26 to 59

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Trauma-exposed	1	6	14	43%
Children and youth in stressed families	1	5	14	36%

SUB-POPULATIONS. Table 14 displays the Adults sub-populations for the two priority populations identified above.

Table 14. Priority Population Sub-populations: Adults

Priority Populations	Sub-populations
	Group 1 (N=14)
<p>Trauma-exposed</p>	<ul style="list-style-type: none"> • Victims of violent crimes; or, adults who experience sexual, physical, and emotional abuse. • Adults with drug abuse issues. • Adults with Post Traumatic Stress Disorder (PTSD), including those who have suffered a traumatic car accident. • Immigrants dealing with acculturation trauma, including those who immigrated due to trauma in their native countries. • Adults who experience discrimination based on legal status, language and/or ethnic background. • Veterans from war. • Adults who isolate themselves.
	Group 1 (N=14)
<p>Children and Youth in Stressed Families</p>	<ul style="list-style-type: none"> • Single parent families. • Families receiving services from the Department of Children and Family Services (DCFS). • Families with substance abuse issues. • Families exposed to or living in domestic violence situations; or, families exposed to sexual, physical, and emotional abuse. • Families involved with gangs. • Families living under the poverty level. • Families with children having social and/or academic difficulties in school.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing one group advocating for Adults are presented in Table 15.

Table 15. Top Strategies by Priority Population: Adults, 26 to 59

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Trauma-exposed	1 (N=14)	Public education about existing mental health resources and mental health issues, such as domestic violence, substance abuse, co-occurring disorders, physical abuse, sexual abuse, and emotional abuse. These efforts are to be linguistically and culturally sensitive (n=9).	Crisis mobile unit services for trauma-exposed individuals and the high-risk adult population (n=2).	A 12-step support group model for victims of domestic violence and gang violence (n=1). <u>Additional Strategies Tied for 3rd Place</u> Increased funding for treatment centers (n=1). Transportation for people accessing services (n=1).
Children and Youth in Stressed Families	1 (N=14)	Low-cost or no-cost early intervention counseling services for DCFS birth parents, couples, families, and individuals who may not have a diagnosis in-home or in non-traditional settings. These services are to be linguistically and culturally sensitive (n=10).	Utilization of the family resource center model for providing comprehensive services (n=2).	Parent education on the developmental stages of children (n=1). <u>Additional Strategy Tied for 3rd Place</u> Faith-based collaborations to provide prevention and early intervention gang reduction services (n=1).

OLDER ADULTS, 60+ YEARS



PRIORITY POPULATIONS. One age-specific breakout group was conducted representing Older Adults. Table 16 shows the number of participants who voted for the priority populations selected in relation to the total number of participants in the Older Adults breakout group. In order to show the relative weight among the priority populations selected, the table includes the percentage of votes each priority population received in relation to the total number of participants in the group.

Table 16. Percentage of Participants Who Selected the Top Priority Populations for Older Adults, 60 Plus

Top Priority Populations Selected	# of Groups	# Votes Received	Total # of Participants	Percentage of Votes Received
Trauma-exposed	1	6	12	50%
Individuals experiencing onset of serious psychiatric illness	1	3	12	25%

SUB-POPULATIONS. Table 17 displays the Older Adults sub-populations for the two priority populations identified above.

Table 17. Priority Population Sub-populations: Older Adults, 60 Plus

Priority Populations	Sub-populations
Trauma-exposed	Group 1 (N=12)
	<ul style="list-style-type: none"> • Grandparents as parents/care-givers. • Female older adults. • Disabled persons; or, homeless. • Older adults who are geographically isolated; or, older adults who lack access to services, with barriers such as transportation. • Seniors who have been financially abused; or, persons experiencing physical/emotional elder abuse. • Seniors experiencing technological isolation and/or do not understand technological changes such as email, etc. • Seniors dealing with major health issues; or, seniors dealing with a loss of medical services and/or benefits. • Persons on fixed income; or, seniors experiencing financial difficulties, poverty, loss of income, death of spouse, or other types of loss/grief. • Seniors experiencing transitional change and loss of independence.
Individuals Experiencing Onset of Serious Psychiatric Illness	Group 1 (N=12)
	<ul style="list-style-type: none"> • All of the sub-populations mentioned under the trauma-exposed priority population. • Seniors experiencing cognitive impairments and/or co-occurring disorders; or, seniors experiencing bi-polar disorder or schizophrenia. • Seniors experiencing depression or isolation; or, seniors having suicidal thoughts. • Hoarding seniors. • Seniors abusing substances, including prescription and non-prescription drugs, and/or alcohol. • Seniors who lack awareness of geriatric issues.

STRATEGIES. The two to three top strategies corresponding to the priority populations selected by the participants in the Older Adults breakout group are presented in Table 18.

Table 18. Top Strategies by Priority Population: Older Adults, 60 Plus

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
Trauma-exposed	1 (N=12)	Increased access to mental health services (n=10).	More outreach and education for the community (n=1).	Not identified.
Individuals Experiencing Onset of Serious Psychiatric Illness	1 (N=12)	Increased access to services (n=7).	More outreach and education for the community (n=4).	Not identified.

VI. RECOMMENDATIONS FOR ADDITIONAL NEEDS OR POPULATIONS

At the end of the breakout session, participants were asked to identify any additional needs or populations that were not addressed during the discussion around priority population strategies. The suggestions offered are presented below by age and language groups.

ADDITIONAL NEEDS OR POPULATIONS	
Children (0 to 5)	<ul style="list-style-type: none"> ● Address the following service needs: <ul style="list-style-type: none"> ○ More early start group programs for parents and their children. ○ Continued services through regional centers for children 3 to 5 years of age. ○ Expanded services through regional center programs. ○ Preventative strategies in schools. ○ Fatherhood program expansion, support groups, and financial literacy education. ● Address the following populations: <ul style="list-style-type: none"> ○ Trauma exposed war veterans and their families. ○ Fathers, brothers, any male caregivers in the child's life.
Children (6 to 15)	<ul style="list-style-type: none"> ● No additional needs or populations were identified.
Transition Age Youth (16-25)	<ul style="list-style-type: none"> ● Address the following additional needs: <ul style="list-style-type: none"> ○ Quality networking for youth. ○ Outreach to parents. ○ Greater access to health insurance. ○ Make available a 211 auditory line. ○ Updated resource directories. ○ Family-friendly outreach. ○ Youth-friendly media that sends positive messages and information regarding services through the use of text messages, blogs, etc. ○ Outreach to lesbian, gay, bi-sexual, transgender communities in the Antelope Valley to reduce stigma, which can reduce drug abuse and mental health issues. ○ Grief and loss services. ○ Collaboration and access to L.A. County mental health, children and family services, and probation systems. ● Additional comments: <ul style="list-style-type: none"> ○ Service Planning Area 1 is not just Palmdale, but includes many other communities.
Adults (26-59)	<ul style="list-style-type: none"> ● Additional comments ; The location of the community forum was too far for some of the Spanish-speaking community members who reside in the Palmdale area; and, transportation services were not available through DMH to attend the event.
Older Adults (60 Plus)	<ul style="list-style-type: none"> ● Address the following additional populations: <ul style="list-style-type: none"> ○ Seniors ineligible for services because of strict criteria. ● Address the following additional needs: <ul style="list-style-type: none"> ○ Funds for Meals on Wheels program. ● Acknowledge the increasing older adult population.