WRMA
Walter R. McDonald & Associates, Inc.

FINDINGS FROM THE

SERVICE AREA 4 – CENTRAL 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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Prepared by:
Walter R. McDonald and Associates, Inc.
EVALCORP Research & Consulting, Inc.
Laura Valles & Associates, LLC

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We greatly appreciate the assistance we received from the LACDMH PEI staff, the Service Area Advisory Committees, and the Community Forum Coordinators in coordinating the forums. We also extend special thanks to all the community forum participants for taking the time to engage in the community forums and for sharing with us their perspectives. The wealth of information provided during each of the breakout session discussions was invaluable to the formation of this report.

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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 two Community Forums conducted in Service Area 4 – Central. The purpose of the Community Forums 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 Forums 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 220 community members attended the two community forums held in Service Area 4 and represented a diverse array of community sectors. Of the 220 participants, 38 percent represented mental health providers, 20 percent represented the underserved, 16 percent represented social services, 13 percent represented consumers, and 12 percent represented health. Between less than 1 percent and 8 percent represented education (8%), parents and families of consumers (6%), community family resource centers (5%), law enforcement (1%), and employment and the media, both representing less than 1 percent of participants. Sixteen percent of participants did not indicate which sector they represented.

- A total of 14 age- and language-specific breakout sessions were held across the two community forums conducted in Service Area 4. A breakdown of the number of community participants in each breakout session/group by community forum 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+	Spanish	Korean	Total
Kyoto Grand Hotel Los Angeles	24	18	22	30	17	9	6	126
			19	14				33
Wilshire Plaza Hotel Los Angeles	5		8	24	7	17		61
								0
Total by Group	29	18	49	68	24	26	6	220

FORMAT. The community forums were organized and conducted in the same manner based on a three-hour or three-hour and fifteen minute time period. One of the two community forums in each Service Area was conducted on a weekday and the other on a Saturday, and took place either in the morning or in the late afternoon/early evening. Translators were available for mono-lingual speakers of various languages. 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- and language-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 4 SUMMARY

Two community forums were held in Service Area 4 – Central. The first was held on December 10, 2008 from 4:00 pm to 7:00 pm at the Kyoto Hotel in Los Angeles, and the second one was held on December 13, 2008 from 10:00 am to 1:00 pm at the Wilshire Plaza Hotel in Los Angeles.

A total of 14 age- and language-specific breakout sessions/groups were conducted in Service Area 4; of them, 11 were age-specific and represented the five CDMH age categories. Two additional groups were conducted in Spanish and one was conducted in Korean. It is important to note that within each of the language-specific breakout groups, participants were asked to prioritize two of the five age categories, as well as to prioritize one priority population under each age category.

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		
December 10, 2008 Los Angeles, CA (24)	1. Children/Youth in Stressed Families (12)	Integrated and coordinated services to be offered at schools, parks, centers, faith based organizations and institutions to include – wraparound, multi-disciplinary services, resources and activities, and case management co-located, social services, and mental health.
	2. Children/Youth at risk for School Failure (5)	Integrated and coordinated services such as mental health supports, school readiness, community and parental supports, stigma reduction, and children who do not qualify for special education programs and services provided by DMH and others in child care facilities, schools, day care centers for, and safe community centers.
December 13, 2008 Los Angeles, CA (Combined 0-5 and 6-15 age group) (5)	1. Children/Youth in Stressed Families (2)	Provide education for therapists, professionals, families, schools, and health providers that is integrated into professional programs or community based, with particular attention to working with ages zero to five.
	2. Children/Youth at risk for School Failure (2)	Improved accountability and communication between regional centers and schools in order to ensure timely and ongoing services for children.
Children 6-15 Years		
December 10, 2008 Los Angeles, CA (18)	1. Children/Youth in Stressed Families (10)	Provide school-based screenings, programs and education through private, charter, religious and ethnically diverse schools, with appropriate funding.

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
	2. Underserved Cultural Populations (5)	Increase public awareness through various programs, media campaigns, in waiting areas and other public outlets.
Transition Age Youth 16-25 Years		
December 10, 2008 Los Angeles, CA (22)	1. Children/Youth in Stressed Families (8)	Provide more mental health services where TAY are (community centers, faith based organizations, shopping malls, etc.).
	2. Trauma Exposed (6)	Provide additional psycho-education programs.
December 10, 2008 Los Angeles, CA (19)	1. Children/Youth in Stressed Families (7 after tie-break)	Address stigma associated with mental health issues at family and community levels via a "community mobilization model" using cultural organizations and institutions.
	2. Trauma Exposed (7 after tie-break)	Serve the undocumented TAY population in order to build their capacity via programs and strategies such as community involvement and engagement, community and cultural activities.
December 13, 2008 Angeles, CA (8)	1. Underserved Cultural Populations (2)	Utilize TAY peer-to-peer based support and campaigns.
	2. Children/Youth in Stressed (2)	Utilize TAY peer-to-peer outreach.
	3. Trauma Exposed (2)	Providers and school personnel trained on trauma signs/symptoms/events that can be traumatic.
Adults 26-59 Years		
December 10, 2008 Los Angeles, CA (30)	1. Trauma Exposed (12)	Outreach and public education, such as through DMH treatment teams, that is culturally competent, neighborhood-based, in comfortable settings that promote mental health messages.
	2. Underserved Cultural Populations (10)	Outreach and public education campaign that is culturally appropriate in key community locations.
December 10, 2008 Los Angeles, CA (14)	1. Trauma Exposed (7)	Collaboration and partnership between the Department of Mental Health and community-based non-profit organizations and networks in order to increase the Departments' understanding of specific issues and learn from direct providers' experiences.
	2. Underserved Cultural Populations (6)	Improve access to services in underserved neighborhoods (convenient site locations, access for uninsured clients, and non-traditional services).
December 13, 2008 Los Angeles, CA (24)	1. Underserved Cultural Populations (10)	Collaboration and partnership to provide mental health education and services through community based locations such as a "wellness club", to non-English speaking, monolingual, undocumented and uninsured individuals that is culturally and linguistically appropriate.
	2. Trauma Exposed (9)	Increased training for CBOs and law enforcement regarding trauma response for individuals and those with psychiatric symptoms.

AGE GROUP	PRIORITY POPULATION	PRIORITY STRATEGY
Older Adults 60+ Years		
December 10, 2008 Los Angeles, CA (17)	1. Underserved Cultural Populations (12)	Develop culturally and linguistically appropriate community outreach and PEI services, which includes the training of providers to be more culturally and linguistically appropriate.
	2. Trauma Exposed (5)	Build partnerships with existing neighborhood-based agencies.
December 13, 2008 Los Angeles, CA (7)	1. Underserved Cultural Populations (5)	Collaborate with non-mental health agencies and trusted community agencies to identify early signs, refer to services, or provide PEI services.
	2. Trauma Exposed (6 after tie-break)	Tap in to existing and create new evidence-based strategies, specifically using participatory research.
Spanish-Speaking Group		
December 10, 2008 Los Angeles, CA (9)	Adults-Ages 26-59(4)	
	1. Trauma Exposed (6)	Media campaigns locally and nation-wide regarding mental illness and stigma. Campaigns to focus on messages of "hope". Spanish education/messages to be aired on television/radio during prime time; bill-boards with educational messages and contact information on mental health; strategic outreach in bars and clubs about mental health issues such as alcohol and drug prevention.
	Children-Ages 6-15 (3)	
	2. Trauma Exposed (4)	Education/training to school personnel, parents, foster/adoption parents, youth and children on mental illness, early identification of symptoms, child abuse prevention and stigma. Training to be mandatory for parents and foster/adoptive parents in collaboration with the school district.
December 13, 2008 Los Angeles, CA (17)	Children-Ages 6-15 (8)	
	1. Children/Youth in Stressed Families (5)	Utilize the Promotoras Comunitarias model to inform/educate community on mental health.
	TAY-Ages 16-25 (4)	
	2. Individuals Experiencing Onset of Serious Psychiatric Illness (9 after tie-break) (19)	Provide education on mental illness, symptoms, stigma, and personal development for parents, foster parents and TAY. Education to be provided via conferences, classes, and educational campaigns. Training and education to be culturally and linguistically appropriate
Korean-Speaking Group		
December 10, 2008 Los Angeles, CA (6)	Transition Age Youth-Ages 16-25(3)	
	1. Underserved Cultural Populations (2)	Dedicated community center that provides both mental and physical exercise in one location.
	Adults-Ages 26 - 59 (3)	
	2. Trauma Exposed (6 after tie-break)	Dedicated community center that provides both mental and physical exercise in one location.

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 (✓). The denotations "S" and "K" in the table indicate the priorities specified by the Spanish- and Korean-language breakout sessions/groups.

Table 3.
Top Two Priority Populations by Age Group
(N=13 Breakout Sessions)

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		✓	✓K	✓✓✓	✓✓
Individuals Experiencing Onset Of Serious Psychiatric Illness			S		
Children And Youth In Stressed Families	✓✓	✓S	✓✓✓		
Trauma-Exposed		S	✓✓✓	✓✓✓S K	✓✓
Children At-Risk Of School Failure	✓✓				
Children/Youth At-Risk Of Or Experiencing Juvenile Justice Involvement					

*One age-specific breakout group had a three-way tie. A revote was conducted, resulting in the same three-way tie and one additional priority population.

The two sessions/groups representing Children 0 to 5 both selected Children and youth in stressed families, and Children at-risk of school failure. The one session/group representing Children 6 to 15 selected Underserved cultural populations and Children and youth in stressed families as their priority populations. The three sessions/groups representing Transition-Age Youth (16-25) selected three of the six priority populations as their top priorities: Underserved cultural populations, Children and youth in stressed families, and Trauma-exposed. The three sessions/groups representing Adults (26-59) voted Underserved cultural populations and Trauma-exposed individuals as their top priority populations.

Lastly, the two sessions/groups representing Older Adults (60+) chose Underserved cultural populations and Trauma-exposed individuals.

Participants attending the two Spanish-language sessions/groups identified the following priorities: Children 6-15 (Children and youth in stressed families and Trauma-exposed individuals); Transition-Age Youth, 16-25 (Individuals experiencing the onset of serious psychiatric illness); and, Adults 26-59 (Trauma-exposed). Participants in the Korean-language sessions/groups voted Transition-Age Youth, 16-25 (Underserved cultural populations) and Adults, 26-59 (Trauma-exposed) as their top priorities.

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. Two age-specific breakout sessions/groups were conducted representing Children 0 to 5. These two groups identified two priority populations: Children and youth in stressed families and Children and youth at-risk for school failure. Table 4 shows the distribution of groups by priority population and the number of participants in the groups 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 groups representing each priority population.

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	2	14	29	48%
Children And Youth At-Risk For School Failure	2	7	29	24%

SUB-POPULATIONS. Table 5 displays how participants defined the sub-populations for Children and youth in stressed families and Children and youth at-risk for school failure.

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

Priority Populations	Sub-populations	
	Group 1 (N=24)	Group 2 (N=5)
Children and Youth in Stressed Families	• Children experiencing domestic violence. • Children experiencing community and/or gang violence. • Children of single parent families or families with marital problems. • Children who are homeless or living in poverty. • Children in the child welfare system. • Children whose mothers are depressed or struggling with other mental health issues. • Children of undocumented immigrants or children living in mono-lingual language homes. • Families of children with developmental disabilities.	• Children whose parents are mentally ill. • Children of teen mothers/fathers or in single parent households. • Children in families where substance abuse is multi-generational. • Children who are homeless; children in families where homelessness is multi-generational; or, children living in poverty. • Children in families where physical and emotional abuse is multi-generational; children who have been sexually abused; or, children that experience domestic violence in their family. • Children with special needs that require regional center services; or, families with children who have physical disabilities. • Foster children who have had multiple placements; or, adopted foster children with special needs. • Children with undiagnosed mental health issues who are labeled "bad kids" and parents viewed as "bad parents;" or, passive parents whose children, ages two to three, are aggressive and hit their parents; • Children who have had multiple suspensions from school; or, children with ADHD. • Children of immigrant parents who fear deportation. • Families and children in Echo Park and around University of Southern California areas.
	Group 1 (N=24)	Group 2 (N=5)
Children and Youth at-Risk of School Failure	• All sub-populations noted above also apply to this priority population. • Children being raised by grandparents; children of teen parents;	• Children who are being raised by grandparents. • Children living in poverty. • Children who are substance abusers.

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

Priority Populations	Sub-populations	
	or, children who lack quality child care. • Children in the foster care system; or, children who are homeless. • Children of under-represented populations where education is not seen as a priority; or, children living in mono-language speaking homes. • Children who are uninsured and whose families do not qualify for Medi-Cal programs. • Children whose parents are incarcerated; or, children of parents who have experienced untreated trauma. • Children at risk of learning and behavioral problems that do not meet program eligibility criteria – resulting in their falling behind in school; or, children in unsupportive classrooms; children who are extremely quiet and "invisible." • Children with special needs and undiagnosed special needs or who suffer from chronic illness. • Children with attachment disorders; or, children exhibiting aggressive behavior such as biting. • Children with learning delays related to speaking a language other than English; children with low literacy in the family; or, children with different learning styles.	• Children who have received improper diagnosis and whose untreated condition worsens overtime; or, children who are misdiagnosed as developmentally delayed. • Children in families who are isolated due to language barriers and cannot read or speak English; children whose parents are under-educated; or, children who cannot read and do not have anyone in the home that can help them with homework. • Children who are quiet and overlooked; or, children who have been suspended or expelled. • Children in families experiencing domestic violence; children of incarcerated parents; or, children of mentally ill parents; Children in families where there is multi-generational gang influence. • Children separated from parents due to deportation; children who are separated from parent when he/she migrates to the United States without them, but are then sent for several years later and they experience culture shock and have no bond with parents. • Children in families who value working over education. • Children in families where there is no structure or daily routines or are unsupervised after school hours).

STRATEGIES. The two to three top strategies selected by the two breakout sessions/groups 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=24)	Integration and coordination of services to be offered at schools, parks, centers and faith based organizations and institutions to include: wrap-around, multi-disciplinary services, resources and activities; case management; and co-located mental health and social services (n=11).	Supports to include Mommy & Me, Daddy & Me, child bonding/infant massage, breast feeding and affordable entertainment (n=6).	Increased services and programs that promote well-being and empathy; activities and programs for the whole family; affordable infant care; crisis services; nurseries; and affordable housing (n=3).
	2 (N=5)	Education for therapists, professionals, families, schools, and health providers that are integrated into professional programs or community- based programs, with particular attention to working with ages zero to five (n=3).	Stigma reduction of mental health by creating programs in the community (e.g., for pregnant women and after birth with child using Wellness Model) (n=1).	Incentives to hospitals and organizations to work with the zero to five population (n=1).
Children and youth at-Risk for School Failure	1 (N=24)	Partnership, integration, and coordination of services (e.g., mental health supports in child care facilities, support for existing children's initiatives, services for children who do not qualify for special education programs or services, community and parental supports in safe community centers, school-based activities and programs that reduce mental health stigma, and programs and activities at daycare centers that educate parents regarding school readiness) (n=15).	Training and education for child care providers regarding mental health screenings; training for mental health workers on the specific needs of children 0-5; parent education offered at pre-schools on identifying mental health issues and the difference between abuse and discipline (n=3).	Universal screening for children in pre-school and children of parents in the mental health system (n=3).
	2 (N=5)	Improved accountability and communication between regional centers and schools in order to ensure timely and ongoing services for children (n=3).	Programs for middle school children and their parents regarding mental health prevention and early intervention, including information on bullying, self-esteem, parent-child interactions, and relationships (n=2).	

CHILDREN, 6 TO 15 YEARS

PRIORITY POPULATIONS. One age-specific breakout session/group was conducted representing Children 6 to 15. In addition, Children 6 to 15 was selected as a priority age category in both of the Spanish-language breakout groups. These three groups representing Children 6 to 15 identified three priority populations: Underserved cultural populations, Children and youth in stressed families, and Trauma-exposed.

Table 7 shows the distribution of groups by priority population and 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 across the groups electing the respective priority populations.

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
Trauma-exposed	1	4	9	44%
Children and youth in stressed families	2	15	35	43%
Underserved cultural populations	1	5	18	28%

SUB-POPULATIONS. Table 8 displays the sub-populations for Trauma-exposed individuals, Children and youth in stressed families, and Underserved cultural populations 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 S (N=9)	
Trauma-exposed	• Children/youth in gangs; children/youth living in domestic violence; or, children youth living in dysfunctional homes (e.g., sexual abuse, pornography etc.). • Children/youth living with single parents. • Pregnant teens. • Newly arrived immigrants experiencing culture clash.	
	Group 1 (N=18)	Group S (N=17)
Children and Youth in Stressed Families	• Immigrant families: Filipino, Latino including undocumented immigrants; or, Indian immigrants from Mexico or Latin America who are non-Spanish speaking. • Older siblings/children filling parent roles; pre-adolescent children acting as caregivers for other children and parents; or, teens acting as caregivers for substance abusing parents. • Children whose parents or siblings are absent due to incarceration; or, families in domestic violence situations. • Acculturating immigrant youth. • Girls exhibiting anxiety and low self esteem. • Grieving children, due to the loss of a parent or caregiver. • Households with limited adult supervision, due to adults working long hours and/or multiple jobs; children who are socially isolated, in school and in the community; or, children in families with low educated parents. • Children living with parents or siblings who suffer from mental illness and are not receiving treatment. • Children who are part of the Department of Children and Family Services (DCFS); or, children within the Juvenile Justice system.	• Children/youth who are undocumented. • Children diagnosed with learning disabilities due to speaking a different language. • Children with mental illness. • Children living with divorced parents. • Children exposed to trauma within their family unit.

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

Priority Populations	Sub-populations
	Group 1 (N=18)
Underserved Cultural Populations	• Latino children of non-English speaking parents; indigenous Mayan immigrants from Mexico and Guatemala; undocumented single Filipino fathers without medical coverage; Latino, Armenian, Iranian, Afro-American, Filipino and Orthodox Jewish families for whom stigma is a barrier; East Asian and South East Asian refugees for whom traditional western strategies regarding mental health do not work; or, undocumented communities, from diverse backgrounds. • Lesbian, gay, bisexual, trans-gender, questioning youth with immigrant parents or families; or, lesbian, gay, bisexual, trans-gender, questioning families and trans-gendered Latinos who are not recognized as "families" and are subsequently ineligible for assistance. • Parents/single parents with lack of transportation and multiple children. • Residents of densely populated housing projects including multi-family households; multi-generational families living in the same household; or, working class or low income families who are ineligible for medical coverage.

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing three breakout groups advocating for Children 6 to 15 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
Trauma-exposed	S (N=9)	Education and training for school personnel, parents, foster/adoption parents, and youth and children on the following: mental illness, early identification of symptoms, child abuse prevention and stigma. Training to be mandatory for parents and foster or adoption parents in collaboration with the school district (n=8).	Recreational sport activities and tournaments for all children with no access or cost criteria (n=1).	N/A.
Children and Youth in Stressed Families	1 (N=18)	School-based screenings, programs, and education, available in private, charter, religious, and ethnically diverse schools, with appropriate funding (n=9).	Community-based artistic, faith-based activities and services, offered in various locations (n=5).	Increased awareness, education, and universal screenings at the community level (n=1).
	S (N=17)	Utilization of the Promotoras Comunitarias model to inform/educate community on mental health (n=9).	Training and education for school personnel, parents, and institutions on early identification of mental illness and symptoms, discrimination, and how to support individuals with mental illness. Education to be provided through flexible, linguistically appropriate activities and with no access criteria (n=6).	Media campaign in multiple languages and settings on mental health education and surrounding stigma (n=1).
Underserved Cultural Populations	1 (N=18)	Increase public awareness through various programs, media campaigns, in waiting areas and other public outlets (n=9).	Provide culturally specific programs and services for youth and their families that are community-centered (n=5).	Create comprehensive family centers (n=1).

TRANSITION-AGE YOUTH, 16 TO 25 YEARS

PRIORITY POPULATIONS. Three age-specific breakout groups were conducted representing Transition-Age Youth. In addition, one Spanish-language group selected Transition-Age Youth as a priority age category, as did the Korean-language group. Table 10 displays the distribution of the five breakout groups by priority population as well as the number of participants in the groups who voted for the priority populations most important for Transition-Age Youth. 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 groups selecting each priority population.

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
Individuals Experiencing Onset Of Serious Psychiatric Illness	1	9	17	53%
Children And Youth In Stressed Families	3	17	49	35%
Trauma-Exposed	3	15	49	31%
Underserved Cultural Populations	2	4	14	29%

*An unbreakable three-way tie occurred among Underserved cultural populations, Children and Youth in Stressed Families, And Trauma-Exposed in one of the groups, resulting in one additional priority population.

SUB-POPULATIONS. Table 11 displays the sub-populations for the four priority 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		
Individuals Experiencing Onset of Serious Psychiatric Illness	Group S (N=17)		
	• Children/youth who are uninsured or have limited medical coverage. • Children/youth rejected by family members for having a mental illness. • Children/youth who are using illicit drugs for self medication purposes. • Children/youth in denial of their mental illness.		
	Group 1 (N=22)	Group 2 (N=19)	Group 3 (N=8)
Children and Youth in Stressed Families	• Undocumented immigrants; immigrant families; or, impoverished families. • Single parent families; or, teen families. • LGBTQ individuals. • Teens that live in gang infested communities; African American, Latino, and Asian teens that live in gang infested communities; or, teens with family members that have been shot. • Teens witnessing domestic violence in their families; youth in families where there is cultural conflict between the generations; or, children where their parents are having marital problems. • Teens who have mental disorders and their parents are unaware of the problem; or, children with family members dealing with substance abuse or mental illnesses. • Teens who lack parental supervision due to: limited education, work, incarceration,	• TAY students that are pregnant or parenting. • LGBT TAY and LGBT TAY that have been displaced. • Unaccompanied immigrant TAY that are victims of abuse/violence, abandonment and neglect; families with dependent TAY, especially those that have experienced traumatic economic loss; or, TAY that are under pressure to join gangs and/or become part of a tagging crew. • Families with TAY that are very low income in downtown area and are linguistically isolated. • Homeless TAY; homeless TAY with children; or, homeless families with dependent TAY. • Undocumented families with TAY; or, TAY that are members of underserved cultural populations; or, immigrant TAY and TAY of recent immigrants. • TAY where families are substance abusers.	• Single-parent families; TAY parents; or, multigenerational families. • Low-income families; or, unemployed TAY. • New immigrants. • TAY and/or their families in unstable housing. • TAY with relatives in gangs; or, TAY who live in unsafe communities (e.g., gang activity). • Families where a parent has a mental illness, substance abuse issues, or developmental delays. • Emancipated TAY.

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

Priority Populations	Sub-populations		
	substance abuse, literacy issues; teens in families where there is multi-generational substance abuse; or, children exposed to substance abuse. • Incarcerated youth transferring back into communities; homeless youth who still have relationships with their families; and, children in foster care. • Faith-based families where the parents' views have a negative impact on children. • Children who experience academic pressure. • Teens on probation; or, isolated and/or bullied youth.	• TAY in disintegrated families.	
	Group 1 (N=22)	Group 2 (N=19)	Group 3 (N=8)
Trauma-exposed	• Teens that have dealt with immigration in their families, feel alienated from their families because of cultural differences, or have experienced the process of coming to the United States because of problems in their homeland. • Teens that have experienced hate and/or racism; youth who have experienced racial profiling; or, teens that have been bullied. • Teens that have witnessed domestic violence/abuse in homes; teens that have experienced sexual abuse outside of their homes; rape victims; or, youth exposed to dating violence. • Victims of crime; victims of discrimination/bias; or, victims of natural	• TAY or those with loved ones who have recently been diagnosed with HIV and other serious/traumatic illnesses. • TAY who witness or are victims of domestic or relationship abuse; or, TAY who experience sexual abuse as children; or, TAY who are victims of slavery or human trafficking. • TAY with negative engagement with law enforcement and criminal justice system; TAY who live in violent neighborhoods; TAY who have lost family members prematurely; TAY who have witnessed murder. • TAY who experience institutionalized discrimination (i.e., job discrimination, education discrimination, religious	• TAY who have been abused; or, TAY exposed to bullying, racism, or homophobia. • Victims/witnesses of violent crimes or gang activity; or, youth wounded by gunshots. • Youth not living with their biological parents. • TAY veterans. • Homeless TAY. • TAY recovering from a traumatic illness. • Youth involved in sex trafficking. • Youth exposed to incarceration. • Youth exposed to extreme dysfunction of a parent.

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

Priority Populations	Sub-populations		
	disasters. • Homeless youth. • Teens that have experienced pregnancy/child birth; or, teen prostitutes. • Teens that have experienced chronic poverty, lack resources; or, teens that have experienced multiple placements due to poverty and foster care. • Teens that have experienced grief/loss due to violence (gunshots, stabbings, death) to family members; or, witnesses of community violence. • Children who live in gang communities; or, teens who have been incarcerated or live in juvenile detention centers. • Children of divorced parents; teens whose parents have marital conflict or are divorced; children who have been abandoned by their parents and/or lack a relationship with their parents; teens who lack role models; or, children forced to take parental roles. • TAY with mental illness and/or serious trauma.	discrimination, LGBT discrimination). • TAY with recent family disruption (i.e., incarcerated care givers, removal of siblings or removed themselves). • TAY with family who are substance abusers. • TAY with LGBTQ-phobic parents. • Homeless TAY. • TAY war veterans with PTSD. • TAY lacking leadership or surrounded by individuals with low self-esteem.	• Youth impacted by natural disasters.
	Group 3 (N=8)	Group K (N=6)	
Underserved Cultural Populations	• Hispanic community; African-American community; or, non-English speaking families. • Homeless populations. • Those who are homeless during the transition from the juvenile justice system back into mainstream society. • Undocumented families; or, recent immigrants. • LGBTQ TAY.	• Sub-populations were not identified in this breakout session/group.	

STRATEGIES. The two to three top strategies corresponding to the priority populations listed above and representing the five groups 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
Individuals Experiencing Onset of Serious Psychiatric Illness	S (N=17)	Training and/or education on mental illness, symptoms, stigma, and personal development, for parents, foster parents and TAY. Education to be provided via conferences, classes, and educational campaigns. Training and education to be culturally and linguistically appropriate (n=15)	Services and/or programs that provide psychiatric services for TAY at all schools, and develop and/or expand mentoring programs for TAY that include recreational activities (n=2).	N/A.
Children and Youth in Stressed Families	1 (N=22)	More mental health services where TAY spend time (community centers, faith-based organizations, shopping malls, etc.) (n=15).	More peer counseling support groups (n=3).	More outreach efforts to de-stigmatize mental health (n=2).
	2 (N=19)	Address stigma associated with mental health issues at family and community levels via a "community mobilization model" using cultural organizations and institutions (n=6).	Peer-to-peer or paraprofessional counseling at TAY locations, peer run facilities and programs (n=4).	Mental health outreach, education and referrals at schools that provide access to available services via the internet, 24 hour hotline, etc. (n=3).
	3 (N=8)	Utilize TAY peer-to-peer outreach (n=4).	Outreach to parents and provide mental health education to parents (n=3).	Allow TAY to access to mental health services without parent consent (n=2).
Trauma-exposed	1 (N=22)	Additional psycho-education programs (n=11).	Training staff, stakeholders, and teen navigators about trauma (n=6).	Increased funding for existing services (n=2). <u>Additional Strategy Tied for 3rd Place</u>: Services for families and friends (n=2).
	2	Build TAY's capacity via: programs	Build capacity of first responders	Mental health outreach and

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

Priority Populations	Group	Strategy #1	Strategy #2	Strategy #3
	(N=19)	and strategies; community involvement; and, community and cultural activities. Address undocumented TAY (n=8).	(e.g., CBO's, shelters, clinics, etc.) via formal collaborations with mental health services and peer advocates (n=4).	education through technology; partnerships with existing organizations; and, culturally appropriate services (n=3).
	3 (N=8)	Training for providers and school personnel on trauma signs, symptoms, and/or events that can be traumatic (n=4).	DMH partner with the Veterans Administration Service Centers (n=3).	Allow TAY to access PEI services without parent consent (n=3).
Underserved Cultural Populations	3 (N=8)	Utilization of TAY peer-to-peer based support and campaigns (4).	Cross-training DMH and youth-serving CBOs and providers (n=2).	Development of a strategy and/or theme of conducting outreach to community members using local media and/or ethnic media (n=1). <u>Additional Strategy Tied for 3rd Place</u>: Educating youth on gang risk factors (n=1).
	K (N=6)	Dedicated community center that provides both mental and physical exercise in one location (n=3).	Inform public by advertising on Korean Television network (public service announcements) (n=1).	Educate and work with local faith leaders to understand early prevention (n=1). <u>Additional Strategy Tied for 3rd Place</u>: Funded vocational training opportunities (n=1).

ADULTS, 26 TO 59 YEARS

PRIORITY POPULATIONS. Three age-specific breakout groups were conducted representing Adults. In addition, Adults 26-59 was selected as a priority age category in one of the Spanish-language breakout groups and among the participants in the Korean-language group. Five groups representing Adults 26 to 59 identified two priority populations: Underserved cultural populations and Trauma-exposed individuals. Table 13 shows the number of participants who voted for the priority populations selected in relation to the total number of participants in the five Adults breakout groups. 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 groups selecting each priority population.

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	5	38	83	46%
Underserved cultural populations	3	26	68	38%

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

Table 14. Priority Population Sub-populations: Adults 26-59*

Priority Populations	Sub-populations			
	Group 1 (N=30)	Group 2 (N=14)	Group 3 (N=24)	Group S (N=9)
Trauma-exposed	• Homeless; low income; undocumented immigrants; uninsured; veterans; LGBTQ; or, disabilities. • Persons with head injuries; people with early signs of dementia; or, people with signs of mental retardation; • People coming out of transitional housing, jail, rehabilitation, or other institutions. • Victims of domestic violence; victims of abuse; or, female/male victims of rape. • Individuals with high stress; or, suicide risk. • Witnesses of violence, death, crime; or, individuals experiencing loss (natural disaster, etc.). • People receiving services through a mental health agency/clinic. • Those who do not seek services out of fear/stigma. • Mental health social services staff working in the field. • Persons with HIV/AIDS.	• Non-custodial parents. • Immigrant parents; or, immigrant communities, specifically refugees. • LGBTQ individuals. • Returning military veterans. • Individuals experiencing homelessness, either short or long term; people who have lost their home. • People who have experienced job loss. • Victims of violent crimes, such as rape; or, people who are exposed to domestic violence, including verbal, emotional and physical abuse. • People diagnosed with HIV; or, people experiencing chronic illness and their partners. • Those with disabilities (mental and/or physical) who have been abused.	• Eastern European and Middle Eastern populations. • LGBTQ individuals. • Domestic violence survivors and individuals living with domestic violence. • Homeless individuals; or, individuals living with inadequate housing conditions. • Individuals coming out of the military (veterans) • Formerly incarcerated individuals. • Individuals with co-occurring disorders that do not have any social supports • Individuals that have been traumatized by drugs or violence in their communities; victims of hate crimes; individuals that have witnessed traumatic or violent events	• Individuals living in domestic violence. • Individuals with physical disabilities due to tragic accidents. • Individuals who are discriminated against due to not speaking English. • War veterans. • Individuals whose children are removed due to their own or caregivers' mental illness. • Families living in high crime/violent communities; or, individuals exposed to violence.

Table 14. Priority Population Sub-populations: Adults 26-59*

Priority Populations	Sub-populations			
		• Parents of children at-risk for gang involvement or drug use; or, people who are addicted to substances and their partners. • Mothers or fathers who are separated from their children. • Survivors of homicide, including relatives and friends of homicide victims.	• Individuals whose lives have been disrupted due to traumatic events such as job loss, eviction, fires and/or other natural disasters. • Individuals that do not meet DMH's target population criteria.	
	Group 1 (N=30)	Group 2 (N=14)	Group 3 (N=24)	
Underserved Cultural Populations	• Homeless; veterans; uninsured; under-insured; undocumented immigrants. • HIV/AIDS; head injuries; people with early signs of dementia; or, people with signs of mental retardation. • Russian; Pacific Islander; people with primary language other than English/Spanish (Tagalog/Mezo-American). • Individuals with low literacy rates (under-educated). • Victims of domestic violence; victims of abuse; or, female/male victims of rape. • Witnesses of violence, death, crime; young witnesses of violence; or, youth associated with gang related culture.	• Linguistically isolated families; people experiencing a language barrier, due to limited English language skills; or, people who are foreign born. • The lesbian, bisexual, gay, transgender and questioning community. • Persons who are deaf or hearing impaired. • Immigrants and refugees; or undocumented immigrants. • The uninsured. • Those who are low income or experiencing poverty; or, homeless individuals. • Ex-offenders (formerly incarcerated). • Those with mental health conditions. • Individuals who have been trafficked for the purposes of the sex trade.	• Individuals from religious communities. • Populations who are ethnically (or racially) diverse; populations or communities who are linguistically isolated; or, monolingual individuals from various communities. • Undocumented immigrants; or, recent immigrants and first generation immigrants. • Individuals that are mentally or physically disabled. • Individuals who have been incarcerated. • Individuals living in poverty; individuals who are at-risk of being homeless; or, homeless individuals	

Table 14. Priority Population Sub-populations: Adults 26-59*

Priority Populations	Sub-populations		
	• Low income; or, homeless African American men. • People coming out of transitional housing, jail, rehabilitation, or other institutions; • Those who do not seek services out of fear/stigma. • Individuals experiencing loss (natural disaster, etc.). • Individuals with high stress. • Those at-risk of suicide. • People receiving services through a mental health agency/clinic; people with physical mental health symptoms; or, individuals who do not identify as having a mental illness. • Mental health social services staff working in the field.		who do not have access to resources for mental health services. • Eastern European and Middle Eastern populations; individuals who are African American, African, Cuban, Jamaican or Belizean. • LGBTQ. • Individuals living in environments that have a “gang culture”.

*Sub-populations were not identified in the Korean-language breakout session.

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

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

Priority Population	Group	Strategy #1	Strategy #2	Strategy #3
Trauma-exposed	1 (N=30)	Outreach and public education: culturally competent, neighborhood-based outreach provided in comfortable settings that promote positive mental health messages, including DMH treatment teams (n=13).	Downtown urgent care mental health center (n=5).	Multi-disciplinary training of providers, police, community partners, and university educators to improve cultural competency. Use non-stigmatizing mental health messages. Training should foster collaboration with other sectors (n=4).
	2 (N=14)	Collaboration and partnership with the Department of Mental Health and community-based non-profit organizations and networks in order to increase the department's understanding of specific issues and learn directly providers' experiences (n=10).	Increased access to services and permanent funding, including increased quantity of services and broadened eligibility for individuals and non-profit organizations (n=2).	Not identified (it was noted that two participants left the session early).
	3 (N=24)	Increased training for CBOs and law enforcement regarding response to trauma exposed individuals and those with psychiatric symptoms (n=12).	Training individuals and Promotoras to provide peer support groups, life coaching, and outreach (n=6).	Multi-disciplinary teams to work with and provide services to special populations in community friendly environments (churches, community centers, health fairs, emergency rooms, CBOs and directly operated contract centers) (n=4).
	S (N=9)	Media campaigns locally and nation-wide regarding mental illness and stigma. Campaigns to focus on messages of "hope". Spanish education/messages to air on television/radio during prime time; billboards with educational messages and contact information on mental health; strategic outreach (i.e., in bars, clubs) about mental health issues such as alcohol and drug prevention (n=3).	Mandatory training for service providers, professionals, and DMH personnel on effective treatment modalities for people with mental illness (n=2).	Recreational/informative activities that promote family unity (e.g., exercise, meditation, play therapy) (n=2).

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

Priority Population	Group	Strategy #1	Strategy #2	Strategy #3
	K (N=6)	Dedicated community center that provides both mental and physical exercise in one location (n=3).	Independent living facilities and more Section-8 housing (n=2).	Service extenders program (n=1).
Underserved Cultural Populations	1 (N=30)	Outreach and public education campaigns that are culturally appropriate in key community locations (n=10).	Train providers, partners, universities, front-desk staff in culturally competent, linguistic and appropriate non-stigmatizing information on mental health (n=5).	Peer to peer, culturally competent/linguistically appropriate mental health information (n=4).
	2 (N=14)	Improving access to services in underserved neighborhoods, including convenient site locations, access for uninsured clients, and non-traditional services (n=7).	Culturally, ethnically, and linguistically sensitive staff who are comparably paid (n=2).	DMH to collaborate with existing experienced service providers and engage with the community itself (n=2).
	3 (N=24)	Mental health education and services to non-English speaking, monolingual, undocumented and uninsured individuals that are culturally and linguistically appropriate at community based locations such as a “wellness club”(n=10).	Support services to homeless individuals, including those with pending eligibility cases (n=8).	Peer-operated crisis support centers and training for peer advocates (n=3).

OLDER ADULTS, 60+ YEARS

PRIORITY POPULATIONS. Two age-specific breakout groups were 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 two Older Adults breakout groups. 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 groups selecting each priority population.

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
Underserved cultural populations	2	17	24	71%
Trauma-exposed	2	11	24	46%

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	
	Group 1 (N=17)	Group 2 (N=7)
Underserved Cultural Populations	• Armenians; Russians; Hispanics; Farsi-speaking populations; or, API community. • LGBT Older Adults. • Non-English speaking; non-English speaking homeless persons; or, undocumented persons. • Disabled persons, including deaf, autistic, blind, developmentally disabled. • Individuals with severe medical or mental health issues who are unable to leave their homes. • Uninsured and underinsured; veterans; or, religious minorities. • Homeless persons; or, impoverished persons.	• LGBTQ. • Linguistically-isolated; Hispanic community; API community; African American; Armenians; American Indians; Southeast Asian; or, South Asian. • Immigrants and undocumented workers; parents of first generation students. • Illiterate persons or those with language barriers. • Un/Underemployed; or, uninsured or underinsured. • Home-bound; or, socially isolated and/or introverted. • Homeless, including those at-risk for homelessness; or, living in residential care; or, multiple families in crowded living conditions. • Handicapped; economically challenged; have chronic medical conditions; or, forced to work longer later in life and not by choice. • Violent, anti-social; just released from jail, also including those arrested and released but not charged with any crime; or, unemployable due to felonies, lack of education, etc. • Caregivers.
	Group 1 (N=17)	Group 2 (N=7)
Trauma-exposed	• Non-English speaking persons; or, undocumented persons. • Immigrants; or, immigrants who experience trauma pre-immigration, such as refugees. • Victims and witnesses of crimes; or, victims of domestic violence. • People experiencing loss and bereavement; those experiencing separation anxiety; those at risk of suicide; or, those experiencing poverty. • Those who experience stress related to being a	• Those experiencing stigma from cultural differences and would not likely seek services or would be fearful to admit mental health needs. • Those experiencing loss, including death of a loved one, home, and independence; those experiencing loss of ADLs (Activities of Daily Living) and IADLs (Instrumental Activities of Daily Living); those experiencing loss of transportation options; or, those experiencing financial loss and the related compound stressors. • Those who are isolated due to ideology and value systems; those isolated in their homes due to gang and community violence; those in transition to residential care facilities; or, forced to relocate to another state or country.

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

	Sub-populations	
	caregiver, especially those providing care to a spouse with dementia; those experiencing caregiver or family neglect; or, those experiencing abuse in assisted living facilities. • Those experiencing unexpected lifestyle changes, such as fire, natural disaster, financial changes; or, those in transition, especially those transitioning into retirement. • Those experiencing cardiovascular disease (African-American and Armenian population specifically named); amputees; or, people who have experienced medical trauma.	• Those hospitalized for health conditions; or, who experience deteriorating health. • Older adults who had trauma early in life that is reoccurring in older adulthood; victims of abandonment and neglect; or, those exhibiting suicidal ideation and depression. • Older adults experiencing domestic terrorism or someone monopolizing control over household; those experiencing elder abuse; those misrepresented by caregivers and providers; victims of ageism; or, those not valued or recognized. • Those who are misguided, misdiagnosed, or misinformed; do not have access to a continuum of care; impacted by the growing cost of living; or, experiencing court-ordered evictions. • Those with a spouse or other loved one with cognitive disorders/illness. • Stressed older adult caregivers.

STRATEGIES. The two to three top strategies corresponding to the priority populations selected by the participants in the two Older Adults breakout groups 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
Underserved Cultural Populations	1 (N=17)	Develop culturally and linguistically appropriate community outreach and PEI services, which includes the training of providers to be more culturally and linguistically appropriate (n=8).	Increase partnership and funding to Adult Protective Services, adult day care centers, and to older-adult serving agencies (n=3).	Build partnerships with existing neighborhood-based agencies to provide PEI services (n=2).
	2 (N=7)	Collaborate with non-mental health agencies and trusted community agencies to identify early signs, refer to services, or provide PEI services (n=5).	Provide training to mental health staff and gate-keepers (n=2).	N/A.
Trauma-exposed	1 (N=17)	Build partnerships with existing neighborhood-based agencies (n=8).	Offer culturally and linguistically appropriate community outreach and PEI services (n=5).	Increased supports such as a warm line, respite care, and support groups (n=1).
	2 (N=7)	Tap in to existing and create new evidence-based strategies, specifically using participatory research (n=4).	Train and utilize seniors as part of peer-based support services (n=2).	Provide trainings, education, and collaborative opportunities for gate-keepers (n=1).

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)	Address the following: • Develop a media public awareness campaign on how to help children 0-5 who are at risk for school failure and living with stressed out families. • Provide services for pregnant women with mental illness (i.e., help link them to bonding and attachment related services after delivery). • Cultivate a trauma childcare workforce grounded in strength-based prevention and focused on social skills, emotion and behavior regulation, and parent engagement as a means of supporting children's early learning.
Children (6 to 15)	Address the following: • Implement early identification and prevention at the various levels of community, including schools, faith-based organizations and places of worship. • Create a strong system of accountability to ensure that funding and programs are being implemented and utilized to their maximum potential. • Increase awareness through education for the general population.
Transition Age Youth (16-25)	Address the following: • Victims of sexual abuse. • LGBT youth seeking mental health services should not have to seek help in another SPA due to stigma. • Individuals exhibiting onset symptoms of serious psychiatric illness should receive priority over lower-risk individuals. • Pregnant/parenting teens are at risk for abuse, neglect, behavior issues, school failure, learning difficulties, and, juvenile justice involvement, etc. • Socially isolated TAY's that are not being reached at schools or other organizations in the community. • Pregnant teens in all service areas, especially in SAAC 4, with a focus on the Latino population. • Veterans; "DMH should partner with the Veterans Administration and create VA service centers." • Isolated, homebound, and home-school TAY. • Ensure hospitalization services for adolescents. • Promote physical exercise, conscious relaxation, yoga classes, and meditation practices for holistic well-being. • People should be able to receive services that are congruent with their ethnic cultural traditions, with an emphasis on empowerment and health promotion. • Let peers develop their own facilities and programs as well as run them. • Conduct post-partum depression screenings.

ADDITIONAL NEEDS OR POPULATIONS	
	• Focus on grief/trauma for TAY among different ethnic populations (e.g. Native-American, African American, Latin American, Asian American, etc.). • Conduct peer-to-peer based support and campaigns that normalize mental health and PEI and also help the community see the benefits of PEI and mental wellness. • Expand workforce development. • "All strategies must have DMH funding flexibility to implement. The current funding model will not work and will stop any and all strategies." • "Tackle the issue of institutional racism."
Adults (26-59)	Address the following: • Individuals that are in debt from loans, bills and collections agencies. • Families that have been effected by gang violence. • Families of gang affiliated youth. • Victims of crimes (non hate crimes). • "Use tele-mental health technology to address specialty shortages, dignity and access issues for people placed on 5150 hold that are taken to the emergency room for evaluation." • Offer mental health services at non-DMH contractor community-based programs. • "The Department of Mental Health needs to prioritize efforts that transcend the artificial divisions we have established. For example, underserved cultural populations that are trauma-exposed and experiencing onset of psychiatric illness. This happens at the community based organization level and the client level, but not at the DMH programmatic or funding level."
Older Adults (60 Plus)	Address the following: • Housing needs. • Employment for seniors. • Underinsured. • Recognize age diversity among older adults. • Coalesce common interests.
Korean-language Group	Address the following: • Educational programs to educate Korean families about raising children and understanding how to recognize mental health issues at a younger age, including providing a certificate of healthy child development for parents before actually having a child. • Need for centers to be more than just medical treatment facilities. Each center must be equipped to handle healthy living, including physical fitness.
Spanish-language Group	Address the following: • Older adult population whose mental health needs are ignored or neglected. • Grandparents who are raising their grandchildren, ages zero to five. • Adults 26 to 59 who are uninsured. • Youth released from jail. • Newly arrived immigrants who may experience trauma due to culture and language differences. • Underserved cultural populations, specifically the indigenous community who is linguistically and culturally marginalized. • Utilize a peer advocate model when providing mental health education to parents and youth. • Provide mandatory training for DMH personnel on customer service and available resources.