**WRMA**
Walter R. McDonald & Associates, Inc.

*FINDINGS FROM THE*

# SERVICE AREA 8 – LONG BEACH / SOUTH BAY COMMUNITY FORUMS

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

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***Prepared for:***
**The Los Angeles County Department of Mental Health**

***Prepared by:***
**Walter R. McDonald and Associates, Inc.**
**EVALCORP Research & Consulting, Inc.**
**Laura Valles & Associates, LLC**

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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 stakeholder 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 8 – Long Beach/South Bay. 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 275 community members attended the two community forums held in Service Area 8 and represented a diverse array of community sectors. Of the 275 participants, 22 percent represented mental health providers, 21 percent represented parents and families of consumers, and 13 percent represented health. Between 1 and 10 percent represented education (9%); social services (7%), underserved communities (7%); consumers (4%), law enforcement (1%), and community family resource centers (1%). Thirty 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 8. 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 | Total |
|---|---|---|---|---|---|---|---|
| Carson | 28 | 32 | 33 | 28 | 21 | 23 | 165 |
| | | | | 19 | | | 19 |
| Long Beach | 6 | 18 | 12 | 20 | 7 | 7 | 70 |
| | | | 21 | | | | 21 |
| Total by Group | 34 | 50 | 66 | 67 | 28 | 30 | 275 |

**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 8 SUMMARY

Two community forums were held in Service Area 8 – Long Beach/South Bay. The first was held on October 15, 2008 from 3:00 pm to 7:00 pm at the Carson Community Center, and the second one was held on October 18, 2008 from 9:00 am to 1:00 pm at Cal State University Long Beach.

A total of 14 age- and language-specific breakout sessions/groups were conducted in Service Area 8; of them, 12 were age-specific and represented the five CDMH age categories. The two additional groups were Spanish-language. It is important to note that within each of the Spanish 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** | | |
| **October 15, 2008 Carson, CA (28*)** | 1. Children/Youth in Stressed Families (13) | Increasing the types of culturally appropriate mental health treatment and supportive services |
| | 2. Underserved Cultural Populations (7) | Educating community members on mental health, health assessments and diagnosis, as well as the location of supportive services |
| **October 18, 2008 Long Beach, CA (6)** | 1. Children/Youth in stressed families (2) | More mother/caregiver and child bonding programs |
| | 2. Underserved Cultural Populations (3 after tie-breaker vote taken) | Early education and mandatory pre-kindergarten for all income levels that include mental health and early intervention services to address behavioral issues |
| **Children 6-15 Years** | | |
| **October 15, 2008 Carson, CA (32)** | 1. Children/Youth in Stressed Families (15) | Integrated approaches/collaboration |
| | 2. Underserved Cultural Populations (7) | Non-traditional approaches, such as community organizing and activities that involve families and reduce social isolation |
| **October 18, 2008 Long Beach, CA (18)** | 1. Underserved Cultural Populations (7) | Increasing and utilizing networks, tapping into community agencies, schools etc., providing services where children/youth are |
| | 2. Children/Youth in Stressed Families (6) | Provide awareness raising trainings to children, youth, parents and teachers |

| AGE GROUP | PRIORITY POPULATION | PRIORITY STRATEGY |
|---|---|---|
| **Transition-Age Youth 16-25 Years** | | |
| **October 15, 2008 Carson, CA (33)** | 1. Children/Youth at Risk of or Experiencing Juvenile Justice Involvement (11) | More community- and/or faith-based programs |
| | 2. Underserved Cultural Populations (10) | Community-based services, including services in schools, homes, faith-based organizations, and alternative sites (e.g., WIC, childcare facilities, etc.) |
| **October 18, 2008 Long Beach, CA Group #1 (12)** | 1. Children/Youth in Stressed Families (4) | More community and school based programs, including after school, extracurricular, mentoring and parenting programs |
| | 2. Children/Youth At-Risk for School Failure (4) | School-based strategies which include more school, after school, and extra-curricular activities that are culturally relevant and support linguistic, nutritional, and other individual needs |
| **October 18, 2008 Long Beach, CA Group #2 (21)** | 1. Underserved Cultural Population (9) | Meeting youth where they are at (local, accessible) |
| | 2. Individuals Experiencing Onset of Serious Psychiatric Illness (4) | Increased services at local sites that include more hospital beds, evaluation teams, urgent services, expeditious processes, and transitional and permanent housing |
| **Adults 26-59 Years** | | |
| **October 15, 2008 Carson, CA Group # 1 (28)** | 1. Underserved Cultural Populations (19) | Culturally relevant services and staff |
| | 2. Trauma Exposed (6) | Training for paraprofessionals |
| **October 15, 2008 Carson, CA Group # 2 (19)** | 1. Underserved Cultural Populations (8) | Outreach |
| | 2. Individuals Experiencing Onset of Serious Psychiatric Illness (8) | Coordinated Care |
| **October 18, 2008 (20)** | 1. Underserved Cultural Populations ((10) | "One-stop shop" that would allow consumers to get multiple resources in one location. This concept is linked to the co-location of PEI support services with other resources in places people regularly go, such as schools, primary medical care offices, etc. |
| | 2. Trauma Exposed (9) | Integrated behavioral health as a model for PEI services |
| **Older Adults 60+ Years** | | |
| **October 15, 2008 Carson, CA (21)** | 1. Individuals Experiencing Onset of Serious Psychiatric Illness (13) | Providing services where the client is (i.e., localized in communities, etc.) |
| | 2. Trauma-Exposed (5) | Train and utilize peer advocates |

| AGE GROUP | PRIORITY POPULATION | PRIORITY STRATEGY |
|---|---|---|
| **October 18, 2008 Long Beach, CA (7)** | 1. Underserved Cultural Populations (3) | Reducing the stigma associated with the loss of independence by providing services and outreach through a peer Train the Trainer model that assures high quality and culturally and linguistically sensitive care. Conduct public events such as health fairs and town hall meetings to inform the community about mental health issues |
| | 2. Trauma–exposed (2) | **D**evelopment of support services for trauma exposed older adults that include in home services, support groups and immediate intervention when there is a critical incident in the community |
| **Spanish-Speaking Group** | | |
| **October 15, 2008 Carson, CA (23)** | TAY-Ages 16-25 (13) | |
| | 1. Underserved Cultural Populations (17) | Spanish stigma reduction media campaign on PEI services |
| | Adults-Ages 26 to 59 (4) | |
| | 1. Underserved Cultural Populations (15) | Spanish stigma reduction media campaign on PEI services |
| **October 18, 2008 Long Beach, CA (7)** | TAY-Ages 16 -25 (3) | |
| | 1. Children/Youth in Stressed Families (4) | Universal health insurance or medical for the undocumented population that includes mental health treatment and medication |
| | Children-Ages 6 -15 (2) | |
| | 1. Children/Youth in Stressed Families (5) | Family resource centers that can provide on-site mental health services to children and their parents |

## 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 8.

In Table 3, each priority population selected by an age-specific breakout group is indicated by a check mark (✓). A denotation of "S" in the table indicates the priorities specified by the Spanish-language breakout sessions/groups.

**Table 3.**
**Top Two Priority Populations by Age Group (N=14 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 | ✓✓ | ✓ ✓ | ✓✓ S | ✓✓✓S | ✓ |
| Individuals experiencing onset of serious psychiatric illness | | | ✓ | ✓ | ✓ |
| Children and youth in stressed families | ✓✓ | ✓✓ S | ✓ S | | |
| Trauma-exposed | | | | ✓✓ | ✓✓ |
| Children at-risk of school failure | | ✓ | ✓ | | |
| Children/youth at-risk of or experiencing juvenile justice involvement | | | ✓ | | |

* This group had a tie in the voting process when selecting their top priority populations.

The two sessions/groups representing Children 0 to 5 selected Underserved cultural populations and Children and youth in stressed families. The two sessions/groups representing Children 6 to 15 selected Underserved cultural populations, Children and youth in stressed families, and Children at-risk for school failure as their top priorities.

Demonstrating a wider variety in responses, the three sessions/groups representing Transition-Age Youth (16-25) selected Underserved cultural populations, Individuals experiencing onset of serious psychiatric illness, Children and youth in stressed families, Children at-risk for school failure, and Children/youth hat-risk of or experiencing juvenile justice involvement as their top priority populations. The three sessions/groups representing Adults (26-59) voted Underserved cultural

populations, Individuals experiencing onset of serious psychiatric illness, and Trauma-exposed individuals as their top priority populations. Similarly, participants in the two sessions/groups representing Older Adults (60 plus) chose these same three priority populations: Underserved cultural populations, Individuals experiencing onset of serious psychiatric illness, and Trauma-exposed individuals.

Voting by participants attending the Spanish-language sessions/groups identified the following priorities: Children 6-15 (Children and youth in stressed families); Transition-Age Youth age 16-25 (Underserved cultural populations and Children and youth in stressed families); and Adults 26-59 (Underserved cultural populations).

# 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.** There were two breakout groups for children ages 0-5 years. Table 4 shows how many groups and the total 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 populations.

**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 | % of Votes Received |
|---|---|---|---|---|
| Children and Youth in Stressed Families | 2 | 15 | 34 | 44% |
| Underserved Cultural Populations | 2 | 10 | 34 | 29% |

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

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

| Priority Populations | Sub-populations | |
|---|---|---|
| | Group 1 (N=28) | Group 2 (N=6) |
| Children and Youth in Stressed Families | • Children in the foster care system; in out-of-home care/ kinship care; living in overcrowded homes or unsafe neighborhoods; or with disabilities/chronic illnesses.<br>• Prenatal drug-exposed children.<br>• Older siblings whose problems impact children aged 0-5.<br>• Single-parent households.<br>• Parents who are incarcerated or depressed.<br>• Parents and families with a history of substance abuse, trauma, or mental illness; who do not qualify for Medi-Cal, are uninsured, or underinsured; with young children who fear formal services; living in poverty; in domestic violence situations; who do not know how to access services; who are non-English speaking.<br>• Women with post-partum depression.<br>• Caregivers/grandparents who care for other people's children. | • African-American males/boys.<br>• Children living in poverty.<br>• Abused/neglected children, either sexually or physically, by extended family members, which then impacts the financial and emotional state of the family (e.g., arrested abuser leads to decreased family income).<br>• Developmental delays such as autism, speech or visual impairments, or physical disabilities such as being born without arms or ear lobes.<br>• Unidentified dual diagnosis or drug exposure during pregnancy.<br>• Teenage mothers.<br>• Depression among mothers, which may result in poor parent-child bonding, self- medication due to guilt if child has been harmed by someone else, and increased levels of poverty or poor economic situations.<br>• Post-traumatic stress disorder (PTSD) as a result of community violence, domestic violence, and self-inflicted abuse. |
| Underserved Cultural Populations | • Children in out-of-home care or kinship care outside of LA County DCFS involvement; or who are physically and developmentally disabled.<br>• Single parents and grandparents of children aged 0-5; or non-English speaking parents, especially those with autistic children.<br>• Families experiencing social and economic barriers, and those who do not qualify economically (too rich or too poor) for medical insurance or mental health services; or who do not seek traditional mental health services, such as Latinos, Native Americans, Asian Pacific Islanders, homeless, and transient households. | • Children not participating in pre-kindergarten programs due to working-poor income status or ethnic/cultural differences (e.g., Cambodian and Latino families may prefer to have grandparents raise children, rather than attend pre-kindergarten program).<br>• Misdiagnosed ADHD or conduct disorders, especially for African-American boys, who may be experiencing post-traumatic stress disorder.<br>• Spanish-speaking populations, particularly undocumented, monolingual Spanish-speakers, and the uninsured. |

**STRATEGIES.** The two to three top strategies selected by the two breakout 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=28) | Increase the types of culturally appropriate mental health treatment and supportive services (n=15). | Educate community members on mental health, health assessments and diagnosis, as well as the location of mental health supportive services (n=3). | Educate professionals that interact with children, such as working with community partners (n=1). |
| | 2 (N=6) | More mother/caregiver and child bonding programs (n=5). | Greater collaboration between medical and mental health providers (n=1). | N/A |
| Underserved Cultural Populations | 1 (N=28) | Educate community members on mental health, health assessments and diagnosis, as well as the location of mental health supportive services (n=10). | Increase outreach efforts, especially when utilizing the community health worker or "Promotora" model (n=6). | Increase culturally competent, linguistically appropriate, destigmatizing therapy, and support services (n=2). |
| | 2 (N=6) | Early education and mandatory pre-kindergarten for all income levels to address behavioral issues (n=6). | N/A | N/A |

## CHILDREN, 6 TO 15 YEARS

**PRIORITY POPULATIONS.** There were three breakout groups for Children 6 to 15. In addition, Children 6 to 15 was selected as a priority age category in one of the Spanish-speaking breakout groups. These three groups representing Children 6 to 15 identified three priority populations. As mentioned, there was a tie among two priority populations in one of the breakout sessions/groups.

Table 7 shows the distribution of groups by priority population and the number of participants in the groups who voted for each of the top 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 |
|---|---|---|---|---|
| Children And Youth In Stressed Families | 3 | 26 | 57 | 46% |
| Underserved Cultural Populations | 2 | 14 | 50 | 28% |
| Children At-Risk Of School Failure | 1* | 7 | 32 | 22% |

*This priority population tied for second place with Children and youth in stressed families in one of the breakout sessions.

**SUB-POPULATIONS.** Table 8 displays the sub-populations for Underserved cultural populations, Children and youth in stressed families, and Children at-risk of 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=32) | Group 2 (N=18) | Group S (N=7) |
| Children and Youth in Stressed Families | • Children living in poverty; children of incarcerated parents' or, DCFS involved children in foster care or adoption.<br>• Low-income children with health issues.<br>• Homeless children.<br>• Children in families with history of mental illness or substance abuse; with domestic violence<br>• Children experiencing child abuse or neglect.<br>• Immigrant families with language/cultural issues.<br>• Single- or grandparent-headed homes. | • Children/youth separated from undocumented parents (i.e., deportation or immigration); parents due to drug use.<br>• Sexually abused boys and girls.<br>• Kids in the child welfare system.<br>• Children at risk of joining gangs (African-American, Latino, Cambodian).<br>• Homes where children witness/experience domestic violence.<br>• Pregnant minority teen-age girls, especially those at- risk for substance abuse. | • Undocumented and uninsured families.<br>• Children with special needs; living with substance abuse and domestic violence; or, at risk of failing school.<br>• Low income and monolingual families. |

| Priority Populations | Group 1 (N=32) | Group 2 (N=18) |
|---|---|---|
| Underserved Cultural Populations | • Children with disabilities; children with dual diagnoses; children questioning their sexual identity.<br>• Homeless children of transient or homeless parents.<br>• Undocumented immigrants: APIs, Cambodian children.<br>• African-American children and youth experiencing depression.<br>• African-American women with disabilities.<br>• Fathers.<br>• Hispanics and other minority populations experiencing stigma.<br>• Unidentified dysfunctional families. | • Kids/youth of color who are part of the child welfare system.<br>• Youth with physical or developmental disabilities.<br>• Immigrant children/youth, specifically Cambodian and Latino.<br>• Youth who are in need of an Individual Education Plan (IEP) program in the public school system.<br>• African-American and Latino males at-risk of gang affiliation, suicide, and academic challenges.<br>• African-American young males with incarcerated parents.<br>• Lesbian, Gay, Bi-sexual, Trans-gendered, Queer (LGBTQ) youth. |

| Priority Populations | Group 1 (N=32) | |
|---|---|---|
| Children at-risk of School Failure | • Children with developmental/learning disabilities; with co-morbid chronic illnesses.<br>• Neglected children raising themselves; or, emotionally disturbed children (diagnosed and undiagnosed).<br>• Children living in poverty; or, children who are bullied.<br>• Probation and at-risk youth.<br>• Teen parents.<br>• High school drop-outs. | • Gang-involved, "wanna-be", and children of gang-involved parents.<br>• Children of parents with mental disorders; who are socially isolated;<br>• Children whose parents have substance abuse problems; or, are illiterate in native language and English.<br>• Children in families that move frequently.<br>• Ethnic minorities, especially immigrants.<br>• All sub-populations identified under "Children/Youth from stressed families" priority population. |

**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 |
|---|---|---|---|---|
| Children and Youth in Stressed Families | 1 (N=32) | Integrated approaches and/or collaboration (n=17). | Serve the entire family (n=7). | Community-based approaches (n=5). |
| | 2 (N=18) | Provide awareness-raising trainings to children, youth, parents, and teachers (n=15). | Increase funding and utilization of pre-existing multi-disciplinary collaborations (i.e., one stop wellness/resource centers) (n=2). | Not identified. |
| | S (N=7) | Family resource centers that can provide on-site mental health services to children and their parents (n=3). | Collaboration among organizations and institutions; integrating services and resources in order to provide comprehensive treatment to families in local communities (n=2). | Not identified |
| Underserved Cultural Populations | 1 (N=32) | Non-traditional approaches, such as community organizing and activities that involve families and reduce social isolation (n=12). | Cross-training and integrated services that include mental health services (n=7). | Community-led outreach and education efforts (n=6). |
| | 2 (N=18) | Increase and utilize networks, tapping into community agencies, schools, etc., providing services where children/youth are at (n=13). | Outreach via media (youth focused channels, social networks sites, etc.) (n=3). | Increase outreach using culturally and linguistically appropriate approaches (n=1). |
| Children and Youth at-risk of School Failure* | 1 (N=32) | Non-traditional services, education, and training based in schools and homes that involve teacher and parents (available before, during, and after school). (n=7) | Not identified. | Not identified. |

*This priority population tied for second place with Children and youth in stressed families in one of the breakout sessions/groups and became a third priority population.

## TRANSITION-AGE YOUTH, 16 TO 25 YEARS

**PRIORITY POPULATIONS.** There were three breakout groups for Transition-Age Youth (TAY). In addition, two Spanish-language breakout groups selected Transition-Age Youth as a priority age category. Each of the Spanish-language breakout groups also selected one priority population within each age category selected (refer back to Table 2 for a visual representation of the breakout group priority population selections). Table 10 displays the distribution of 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 |
|---|---|---|---|---|
| Underserved Cultural Populations | 3 | 36 | 77 | 47% |
| Children and Youth in Stressed Families | 2 | 8 | 19 | 42% |
| Children at Risk of School Failure | 1 | 4 | 12 | 33% |
| Children and Youth At Risk of or Experiencing Juvenile Justice Involvement | 1 | 11 | 33 | 33% |
| Individuals Experiencing the Onset Of Serious Psychiatric Illness. | 1 | 4 | 21 | 19% |

**SUB-POPULATIONS.** Table 11 displays the sub-populations for the five 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 | | |
|---|---|---|---|
| | Group 1 (N=33) | Group 3 (N=21) | Group S (N=23) |
| Underserved Cultural Populations | • Lesbian, gay, bisexual teens at risk of gangs, drugs, homelessness, prostitution, graffiti, and selling drugs.<br>• Transgendered individuals.<br>• Undocumented immigrants who do not seek help.<br>• People with developmental disabilities and dual diagnosis, representing all ethnic and other subpopulations.<br>• Asian, Filipino, Korean, Vietnamese, Cambodian Vietnamese, and Cambodian youth.<br>• Pacific Islanders (Samoans and Tongans); Native Americans; Indians; African Americans; Latinos; Mexicans | • Children of parents with mental health needs.<br>• Deaf and hearing-impaired youth.<br>• Economically impoverished youth without healthcare; uninsured youth; or, transition-age youth who have been exposed to trauma.<br>• LGBTQI, includes ethnic LGBTQI (Lesbian, Gay, Bi-Sexual Transgender, Questioning, Intersexual).<br>• Latinos entering community college; Asian-American communities, particularly Cambodian; or, African-Americans.<br>• Undocumented; homeless and mentally ill homeless; or, HIV/AIDS population | • Latino youth and families.<br>• Undocumented and uninsured families.<br>• Mentally ill youth and adults.<br>• Low income and monolingual families.<br>• Incarcerated youth. |
| Priority Populations | Group 2 (N=12) | | Group S (N=21) |
| Children and Youth in Stressed Families | • Children/youth born addicted to substances; high school drop-outs or uneducated youth; or, youth in foster families.<br>• Teen parents and single parents.<br>• Newly immigrated and undocumented TAY and their families.<br>• Gay/lesbian youth and/or their parents in the process of coming out.<br>• Youth and/or their families with physical/medical challenges and/or economic challenges or, substance abuse or mental illness among youth, their parents and families/multigenerational families.<br>• Ethnic minorities; homeless; gang-involved or -affected individuals; individuals receiving inadequate services from mental health professionals, which may include those who are undiagnosed, misdiagnosed, or over-medicated; or, victims of sexual abuse or incest. | | • Latino high school and college youth with mental health problems.<br>• Undocumented and uninsured youth.<br>• Youth in gangs.<br>• Low income and monolingual youth.<br>• Incarcerated youth. |

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

| Priority Populations | Sub-populations |
|---|---|
| Group 2 (N=12) | |
| Children at risk of School Failure | • All of the sub-populations listed under children/youth in stressed families also apply and contribute to children/youth at risk of school failure.<br>• Children lacking parental care, supervision, and engagement; parental involvement and support in education and learning.<br>• Overprotective parents.<br>• Families faced with economic challenges, including lack of resources and materials.<br>• Children neglected by medical and school personnel; or, children without access to mental health professionals in schools.<br>• Undiagnosed learning disorders; or, individuals with autism and/or developmental disabilities.<br>• Children and youth caught in the cultural and generational divide in which they are not understood by their parents. |
| Priority Populations | Group 1 (N=33) |
| Children and Youth at risk of or Experiencing Juvenile Justice Involvement | • Mono-lingual youth, living at home, who are involved in the criminal justice system (not all youth are on probation but may be at risk) with family or domestic violence issues.<br>• Youth experiencing difficulties in school; using alcohol or other drugs; youth exposed to violence and other trauma; or, youth who have limited access to mental health services.<br>• Foster care youth ("black and brown are over-represented").<br>• Cambodian youth experiencing cultural issues, language barriers, and transportation issues; Hispanic/Latino youth experiencing acculturation issues.<br>• Youth living in single parent families; or, youth living in fear, who do not speak English and are involved in gangs.<br>• Vulnerable individuals with developmental disabilities.<br>• Undiagnosed individuals.<br>• Youth with a parent or grandparent who is or was incarcerated. |
| Priority Populations | Group 3 (N=21) |
| Individuals Experiencing the Onset of Serious Psychiatric Illness | • Drop-outs/incarcerated youth; or probation youth.<br>• Youth in group homes; Youth using/abusing methamphetamine/crack cocaine; or, with psychosis/depression.<br>• Young people unaware about mental health and unaware that they may have a problem because they feel they are normal.<br>• Youth 16 – 18 in families with authoritarian parents unaware that their child is ill, and uneducated about existing information and resources.<br>• Youth with long term sexually transmitted diseases or HIV/AIDS.<br>• School/college populations; or, with substance abuse history.<br>• Females; or single, un-wed mothers.<br>• Victims of intimate partner violence.<br>• Veterans (we now have very young veterans). |

**STRATEGIES.** The two to three top strategies corresponding to the priority populations listed above and representing 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 |
|---|---|---|---|---|
| Underserved Cultural Populations | 1 (N=33) | Community-based services, including services in schools, homes, faith-based organizations, and alternative sites (e.g., WIC, childcare facilities, etc.) (n=19). | Mobile services (n=11). | More networking and collaboration (n=2). |
| | 3 (N=21) | Meeting youth where they are at (local, accessible places) (n=10). | Training for educators, law enforcement, TAY, and families (n=6). | Culturally relevant services (education/ outreach/trainings) (n=4). |
| | S (N=23) | Spanish media campaign on PEI services and on stigma reduction (n=6). | Support groups and advocacy training for parents (n=3). | Mental health services and hospitalization beds for the uninsured and undocumented population (n=3). |
| Children and Youth in Stressed Families | 2 (N=12) | More community- and school-based programs, including after school, extracurricular, mentoring and parenting programs (n=7). | More education and training for mental health professionals and school personnel (n=2). | Structured services for families (n=1). |
| | S (N=7) | Universal health insurance or medical for the undocumented population including mental health treatment and medication (n=4). | Required courses in high schools and colleges on mental health education and stigma (n=2). | Not identified. |
| Children and Youth at risk of School Failure | 2 (N=12) | School-based strategies which include more school, after school, and extra-curricular activities that are culturally relevant and support linguistic, nutritional, and other individual needs (n=5). | Needs-based tutoring and mentoring programs (n=4). | Increased parental education and awareness (n=2). |
| Children and Youth at risk of or Experiencing Juvenile Justice Involvement | 1 (N=33) | More community- and/or faith-based programs (n=10). | School-based programs, including after-school, mentoring, and vocational training linked to placement and employment (n=7). | Integrated, comprehensive, and collaborative services (n=6). |
| Individuals Experiencing the Onset of Serious Psychiatric Illness | 3 (N=21) | Increased services at local sites that include more hospital beds, evaluation teams, urgent services, expeditious processes, and transitional and permanent housing (n=9). | Training for educators, law enforcement, families, providers, and youth and community (n=6). | Advocates with similar experiences to serve as mentors, provide linkages and resources, and follow-up (n=6). |

## ADULTS, 26 TO 59 YEARS

**PRIORITY POPULATIONS.** Three breakout groups were conducted representing Adults. In addition, one Spanish breakout group selected Adults as a priority age category and one corresponding priority population. Table 13 shows the distribution of breakout groups by priority population as well as the number of participants in the groups who voted for the priority populations most important to Adults. 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 |
|---|---|---|---|---|
| Underserved cultural populations | 4 | 52 | 90 | 58% |
| Individuals experiencing the onset of serious psychiatric illness | 1 | 8 | 19 | 42% |
| Trauma-exposed | 2 | 15 | 48 | 31% |

**SUB-POPULATIONS.** Table 14 displays the Adult sub-populations for the three priority populations identified above.

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

| Priority Populations | Sub-populations | | | |
|---|---|---|---|---|
| | Group 1 (N=28) | Group 2 (N=19) | Group 3 (N=20) | **Group S (N=23)** |
| Underserved Cultural Populations | • Cambodians (adults, war survivors, etc.); Pacific Islanders (recent immigrants); Vietnamese (recent immigrants, ethnic Chinese, etc.); Latino (recent immigrants mainly from Mexico in the South Bay); or Middle Eastern (recent immigrants).<br>• LGBTQ communities. | • Poor people; or, gay and lesbian.<br>• Individuals seeking medical care for psychiatric disorders.<br>• Middle class<br>• Minorities.<br>• Spanish-speakers; or, non-native language speakers.<br>• Veterans; homeless; parolees; or, undocumented.<br>• Cambodian. | • API: Koreans, Cambodians, Filipinos; African Americans; Samoans; American Indians; or, Latinos.<br>• Parolees; veterans; deaf/hard of hearing; homeless or transitional housing adults;<br>• Caregivers.<br>• LBTQ community.<br>• Adults with co-occurring/co-morbid disorders.<br>• Those with developmental, physical challenges, or disabilities (e.g., blindness). | • Latino youth and families.<br>• Undocumented and uninsured families.<br>• Mentally ill youth and adults.<br>• Low income and monolingual families.<br>• Incarcerated youth. |
| Priority Populations | Group 2 (N=19) | | | |
| Individuals Experiencing the Onset of Serious Psychiatric Illness | • Foster children.<br>• Parents who have lost a child to death; or new parents.<br>• Individuals who come in contact with law enforcement; stressed individuals; individuals with health issues; or individuals with bipolar disorders, anxiety disorders, and dementia.<br>• Permanently disabled, developmentally and/or physically disabled, and/or chronically mentally ill<br>• Caregivers or siblings of individuals who are mentally ill.<br>• Uneducated individuals having difficulty retaining or getting a job and are stressed about money<br>• Middle class individuals, stressed due to economic issues; or, substance abusers. | | | |

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

| Priority Populations | Sub-populations | |
|---|---|---|
| | Group 1 (N=28) | Group 3 (N=20) |
| Trauma-exposed | • Individuals dealing with addiction (gambling, substance abuse, etc.).<br>• Homeless (highly addicted, depressed population, etc.).<br>• Victims of family violence (partner/spousal abuse); victims of crime (strong arm theft, violent crime, etc.); victims of war trauma (violence, loss of loved ones, depression, etc.); or, victims and perpetrators of gang violence (local gangs such as Longos, Wilmas, TRG, Asian Boys, etc.). | • Victims of hate crimes; sexual, physical, verbal, physical, emotional, or financial abuse; domestic violence; elder abuse; incest; agoraphobia; internet-related crimes; natural disasters; rumors; gang violence; rape, specifically female survivors; or, disabled victims abused by their caregivers.<br>• New Immigrants; veterans; homeless persons; or, those involved in the criminal justice system, such as parolees.<br>• Adult gang members; adult survivors of child abuse; adults who grew up in the foster care system; adults recently diagnosed with HIV; adults who report physical symptoms/ailments that may be connected to mental illness; adults diagnosed with life-threatening illnesses.<br>• Single parents experiencing a lack of financial support.<br>• Persons/families experiencing addictive behaviors.<br>• People who were raised in “broken homes”, specifically homes where parents were divorced; or, those who experienced “dysfunctional families.”<br>• Families that have experienced loss, specifically “military families” who have lost someone through war.<br>• Families with adult children (or adult children) who have “come out” as LGBT. |

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

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

| Priority Populations | Group | Strategy #1 | Strategy #2 | Strategy #3 |
|---|---|---|---|---|
| Underserved Cultural Populations | 1 (N=28) | Culturally relevant services and staff (n=16). | Local community services (=7). | Not identified. |
| | 2 (N=19) | Outreach (n=8). | Access to services, information, resources, education, trainings (n=7). | Training across disciplines (n=2). |
| | 3 (N=20) | One-stop shop that would allow consumers to get multiple resources in one location (n=7). | Utilize innovative outreach strategies that connect DMH and PEI services with ethnic and/or non-English monolingual media as well as partnerships with ethnic and/or monolingual non-English CBOs and service providers (n=4). | Build upon current community services and resources such as support provided by faith-based organizations and mobile outreach vans (n=2). |
| | S (N=23) | Spanish media campaign on PEI services and on stigma reduction (n=6). | Support groups and advocacy training for parents (n=3). | Mental health services and hospital beds for the uninsured and undocumented population (n=3). |
| Individuals Experiencing the Onset of Serious Psychiatric Illness | 2 (N=19) | Coordinated care (n=10). | Invest in primary intervention (n=5). | Training and networking (n=1). |
| Trauma-Exposed | 1 (N=28) | Training for paraprofessionals (n=13). | Reduce the stigma surrounding mental health (n=8). | Wellness groups (n=1). |
| | 3 (N=20) | Integrated behavioral health as a model for PEI services (n=10). | Increase the peer-to-peer support. Utilize trusted peers of consumers who have similar experiences to consumers (n=5). | Increasing the amount of available support services, resources, and facilities (n=2). |

## OLDER ADULTS, 60+ YEARS

**PRIORITY POPULATIONS.** There were two breakout groups conducted representing Older Adults. Table 16 shows the distribution of Older Adult breakout groups by priority population, as well as the number of participants in the groups who voted for the respective 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 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 |
|---|---|---|---|---|
| Individuals experiencing the onset of serious psychiatric illness | 1 | 13 | 21 | 62% |
| Underserved cultural populations | 1 | 3 | 7 | 42% |
| Trauma-exposed | 2 | 7 | 28 | 25% |

**SUB-POPULATIONS.** Table 17 displays the Older Adult sub-populations for the three priority populations identified above.

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

| Priority Populations | Sub-populations | |
|---|---|---|
| | Group 1 (N=21) | |
| Individuals Experiencing the Onset of Serious Psychiatric Illness | • Older adults with physical ailments/chronic illness and ongoing depression; with co-occurring disorders; or experiencing social isolation.<br>• Non-English speaking/limited English speaking seniors experiencing isolation.<br>• Elders experiencing abuse; experiencing grief resulting from the loss of a loved one; experiencing self-neglect; or experiencing dementia.<br>• Elders without extended support networks;<br>• Latino seniors experiencing depression and health issues.<br>• Adults diagnosed with a mental illness who are "aging up" into senior status.<br>• Older adult care-givers (i.e., adult children, grandchildren, etc.) who neglect own health.<br>• Older, monolingual, immigrant adults (APIs, Spanish speaking individuals, etc.). | |
| | Group 2 (N=7) | |
| Underserved Cultural Populations | • Frail, chronically ill, and those living with chronic pain.<br>• Disabled, especially those who have mobility issues and/or are vision impaired.<br>• Latino; or non English speakers, including elders from the Cambodian community.<br>• LGBQT.<br>• Elderly living alone and isolated; under the care of adult protective services.<br>• Veterans. | |
| | Group 1 (N=21) | Group 2 (N=7) |
| Trauma-exposed | • Victims of elder abuse (inflicted by adult children and caregivers).<br>• Homeless older adults.<br>• Seniors who witness/live with violence in high crime areas.<br>• Older adults who have had their life connections stripped away (multiple losses such as war, refugees, etc.); experiencing Post Traumatic Stress Disorder (PTSD); experiencing depression due to loss of adult children; experiencing loss of independence.<br>• Veterans who have repressed trauma or no previous access to services.<br>• "Survivors" who experienced the Holocaust or war. | • Older adults at risk of suicide; who are financially, psychologically and physically abused; experiencing the stress of being caregivers for their sons, daughters, and/or grandchildren, as well as when those in their care may be involved with substance abuse.<br>• Older adults who have recently become disabled; with new symptoms.<br>• LGBQT older adults that often suffer from neglect and isolation. |

**STRATEGIES.** The two to three top strategies corresponding to the priority populations listed above and representing Older Adults 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 |
|---|---|---|---|---|
| Individuals Experiencing the Onset of Serious Psychiatric Illness | 1 (N=21) | Provide services where the client is located (localize services in communities) (n=8). | Collaborate with local agencies (n=6). | Build partnerships with non-traditional providers (n=3). |
| Underserved Cultural Populations | 2 (N=7) | Reduce stigma associated with the loss of independence by providing services and outreach through a peer Train the Trainer model that assures high quality and culturally and linguistically sensitive care. Conduct public events such as health fairs and town hall meetings to inform the community about mental health (n=5). | Conduct multilingual social marketing campaigns that involve mainstream media including public service announcements on television (n=2). | Not identified. |
| Trauma-Exposed | 1 (N=21) | Train and utilize peer advocates (n=16). | Deliver services where clients are located (n=2). | Use less obvious approaches to gain access (n=1). |
| | 2 (N=7) | Develop support services for trauma exposed older adults, including in home services, support groups and immediate intervention when there is a critical incident in the community (n=6). | Improve case management and development of specialists in the coordination of long-term care (n=1). | 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 group.

| ADDITIONAL NEEDS OR POPULATIONS | |
|---|---|
| Children (0 to 5) | • Educate professionals that interact with children (teachers, primary care doctors, day-care providers, school administrators) on mental health.<br>• Build off the community health clinic model of community friendly, culturally sensitive, linguistically appropriate, health, and support services.<br>• Locate mental health services in community-friendly and community-centered sites.<br>• Help community members, especially grandparents caring for their grandchildren, locate and navigate the mental health service system.<br>• Understand which underserved cultural populations utilize specific media (such as using telenovelas with the Latino population) and target that media with mental health messages and service locations.<br>• Communicate about mental health in a de-stigmatizing way.<br>• Develop ethnically-sensitive and appropriate screening and assessment tools.<br>• Remind clients (families) to focus on family dinnertime, as it has been shown to have long-term benefits.<br>• Combine everything: Find creative innovative ways to educate/entertain families.<br>• Offer bonding and conflict resolution education for parents via a collaboration between doctors/nurses and DMH.<br>• Provide free transportation with educational billboards on buses traveling to healthcare appointments and nature/recreational areas. |
| Children (6 to 15) | • Provide mental health services and programs to youth returning to or formerly incarcerated (i.e., re-entry, recidivism).<br>• Pay attention to children and youth who have developmental delays or physical disabilities/challenges.<br>• Launch Spanish media campaigns on PEI services.<br>• Offer self-esteem workshops for all age groups.<br>• Increase policing on school campuses. |
| Transition Age Youth (16-25) | • Address the needs of the following populations:<br>o Uninsured persons, especially women and those with milder to moderate illness.<br>o High school dropouts.<br>o Emancipated foster youth.<br>o Unemployed youth.<br>o Dually diagnosed youth involved with DCFS or schools.<br>o Missing persons and support for their families.<br>o Homeless youth difficult to define, find, and help.<br>o Students with disabilities.<br>o Victims of school bullying, in the community and online. |

| ADDITIONAL NEEDS OR POPULATIONS | |
|---|---|
| | o Youth with problems and issues not severe enough to be diagnosed.<br>o Developmentally delayed and developmentally disabled (paralyzed).<br>o Deaf and hard of hearing.<br>o Under-insured.<br>• Provide transitional programs [for homeless and foster youth].<br>• Consider technical assistance grants for new providers serving youth.<br>• Support persons with disabilities (additional supports to help cover costs of living, food, clothing, books).<br>• Provide support services for parents.<br>• Offer nutrition education and physical activities.<br>• Support developmental transitions for different age groups.<br>• Provide low cost or free services, as youth often do not have insurance coverage.<br>• Identify mental health needs for school aged children, making clear what age and why.<br>• Ensure quality assurance of mental health programs and services.<br>• Train youth and adults on early detection of mental illness and access to services.<br>• Provide cultural and linguistic sensitivity trainings for service providers in understanding the Latino community.<br>• Reduce barriers/criteria for the uninsured and undocumented population.<br>• Launch Spanish media campaigns on PEI services.<br>• Offer self-esteem workshops for all age groups.<br>• Increase policing on school campuses. |
| Adults (26-59) | • Increase access to mental health services for the uninsured.<br>• Provide more culturally appropriate and bilingual drug and alcohol referrals/services.<br>• Provide services for co-occurring disorders such as HIV and substance abuse.<br>• Offer evidence-based trauma treatment.<br>• Identify other unidentified populations such as those with Autism or the severe mentally disabled.<br>• Maintain incentives for clients seeking services.<br>• Increase suicide prevention services.<br>• Address job stress and the stigma linked to seeking support.<br>• Address The Lazarus effect among the HIV-positive population.<br>• Address the needs of people experiencing economic oppression, such as those persons who are facing foreclosure.<br>• Train youth and adults on early detection of mental illness and access to services.<br>• Conduct cultural and linguistic sensitivity trainings for service providers in understanding the Latino community.<br>• Reduce barriers/criteria for the uninsured and undocumented population. |
| Older Adults (60 Plus) | • Inform service providers and the public at large about evidence-based practices in working with older adults with mental health concerns.<br>• Conduct more research and communication regarding evidence-based and promising practices for older adults who are trauma exposed and/or part of underserved cultural groups. |