APPENDIX II

KEY INDIVIDUAL INTERVIEWS

FINDINGS FROM THE

AREA 1 KEY INDIVIDUAL INTERVIEWS
Santa Clara Valley
(Fillmore, Piru, Santa Paula)

CONDUCTED AS PART OF THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN DEVELOPMENT PROCESS
IN VENTURA COUNTY

April 2009

Prepared for:
The Ventura County Behavioral Health Department

Prepared by:
EVALCORP Research & Consulting, Inc.

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Special thanks and acknowledgement go to the Ventura County Behavioral Health Department (VCBH) PEI staff, the VCBH PEI Planning Committee, and to those participating in the Area 1 Key Individual Interviews. We greatly appreciate the willingness among each of the interviewees to share with us their time and perspectives. The wealth of information provided during each of the interviews was invaluable to the formation of this report.

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I. Introduction

The Ventura County Behavioral Health Department (VCBH) is taking a comprehensive community-based approach to the development of the County's Prevention and Early Intervention (PEI) Plan. This effort is funded through the Mental Health Services Act (MHSA), an act providing funds for services and supports to help people feel socially and emotionally stable.

The MHSA has defined mental health *prevention* as reducing risk factors and building protective factors in order to keep mental health issues from occurring. Mental health *early intervention* refers to short, low-intensity services to improve mental health problems and avoid the need for more extensive treatment.

The approach to developing the PEI plan is multi-faceted and utilizes the collection of quantitative data, key individual interviews, focus groups, and community forums to assess the mental health needs, priority populations, and needed services across five geographic areas of Ventura County. VCBH contracted with Evalcorp Research & Consulting, Inc. to spearhead the PEI data collection process. The data gathered by Evalcorp will be analyzed and synthesized to inform Ventura County's Prevention and Early Intervention Plan.

This report presents findings from the Key Individual Interviews that were conducted in Area 1, representing the Santa Clara Valley, including Fillmore, Piru, and Santa Paula. The purpose of these interviews was to collect data on the mental health issues and needs in the communities served by the interviewees.

II. Methodology

Participants

During the first phase of the PEI Planning Process, 25 key individual interviews were conducted across five geographic areas of Ventura County; five interviews in each Area. A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention.

VCBH, with guidance from Evalcorp Research & Consulting, Inc., identified interviewees based on geographic representation and representation within the following MHSA categories: age group, community sector, priority populations, and key prevention and early intervention community mental health needs. Key individual interviewees were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for prevention and early intervention.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals across five geographic Areas of Ventura County. Key individuals were initially identified by VCBH. Evalcorp provided consultation on the process and helped to finalize the list of invited participants, ensuring representation across requisite criteria specified by the MHSA.

Evalcorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A formal Letter of Invitation and Confirmation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions. A copy of the Key Individual Interview Questions can be found in the **Appendix**.

A majority of the key individual interviews were conducted by telephone, and others in-person. The interviews each took about one hour to complete. During the interviews, participants were asked about community and mental health needs, age group priorities and priority populations, existing and needed prevention and early intervention services, and recommendations for providing effective prevention and early intervention services. The interviews were audio recorded with the consent of the interviewee. Once the interviews were complete, participants received a thank-you letter acknowledging their participation.

A transcript was prepared for each key individual interview conducted, summarizing each participant's responses by question. Information from each interview was then coded so that the data could be content analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Services Provided, and Communities Served

Demographics

Five key individuals participated in the Area 1 interviews. Selected to represent a diverse set of mental health prevention and early intervention stakeholders, interview respondents represented different, and, in some cases, multiple community sectors including law enforcement (n=1), education (n=1), social services (including the faith-based community) (n=3), mental health service providers (n=1), and individuals with serious mental illness and/or their families (n=1).

All interviewees who chose to report their ethnicity selected Latino/Hispanic (n=4), two of whom identified specifically as Mexican.[1] The interviewee sample included two males and three females. Three individuals were between the ages of 26 and 59, whereas two respondents were older adults over the age of 60. All five respondents reported speaking both Spanish and English fluently.

Services Provided and Communities Served

Interviewees completed a participant profile as a means of gathering additional information on their backgrounds in terms of the communities they serve and their frame of reference with respect to prevention and early intervention mental health services. Additionally, key individual interview participants were asked at the beginning of each interview to clarify and elaborate on services provided by the individual and his/her organization. As displayed in **Table 1** below, basic needs such as food, housing, and clothing, and programs for youth and/or adults were cited most often as types of services their organizations provide.

[1] One interviewee respondent did not indicate his/her ethnicity.

Table 1: Services Provided by the Interviewee or His/Her Organization
(n=5)

Services	Number of Mentions
Basic needs	5
Programs for youth and/or adults	5
Law enforcement	2
Case management	2
Community awareness programs	1
Community liaison	1
Total:	16

Additional organizational information gathered from the participant profiles is presented in **Tables 2 through 5** below. **Table 2** indicates that the majority of interviewees represent Area 1, the Santa Clara Valley, which includes Fillmore, Piru, and Santa Paula. As displayed, interviewees also represented Areas other than Area 1.

Table 2: **Geographic Area of Ventura County Served By Interviewees**
(n=5)

Geographic Area	Number of Participants
Area 1: Fillmore, Piru, Santa Paula	4
Area 2: Ojai, Ventura	1
Area 3: Camarillo, Oxnard, Port Hueneme	1
Area 4: Thousand Oaks, Newbury Park, Westlake Village	0
Area 5: Moorpark, Simi Valley	1

As displayed in **Table 3**, **i**nterviewees also were most likely to serve Latino/Hispanic individuals (n=5), which includes the Mexican, Mixteco, and Zapoteco communities, in addition to the homeless (n=4)

Table 3: Underserved/Unserved Populations Represented By Interviewees
(n=5)

Underserved/Unserved Populations	Number of Participants
Latino/Hispanic	5
Mexican	5
Mixteco	2
Zapoteco	1
Homeless	4
LGBT/Questioning Individuals	3
Migrant Farm Workers	3
Co-occurring Disorders	2
African-American	1
American Indian	1
Asian/Pacific Islander	1
Eastern European/Middle Eastern	1
Refugees	1
Veterans	1
Deaf, Hard of Hearing and/or Blind	1

Children and youth in stressed families (n=4) or Children and youth at-risk of or experiencing involvement in the juvenile justice system (n=4) were being served by almost all the interviewees (see **Table 4**).

Table 4: Priority Populations Served/Represented By Interviewees
(n=5)

Priority Populations	Number of Participants
Children/Youth in Stressed Families	4
Children/Youth at Risk of or Experiencing the Juvenile Justice System	4
Trauma-Exposed Individuals	3
Children at Risk for School Failure	3
Underserved Cultural Populations	3
Individuals Experiencing Onset of Serious Psychiatric Illness	2

All but one interviewee reported providing services to Transition-age youth, and three of five interviewees serve Children and Adults, as displayed in Table 5.

Table 5: Age Groups Served By Interviewees
(n=5)

Age Groups	Number of Participants
Transition-age Youth (TAY) (18-25)	4
Children (6-17)	3
Adults (26-59)	3
Prenatal to Pre-K (0-5)	1
Older Adults (60+)	1

IV. Knowledge of the VCBH PEI Planning Process

To document the interviewees' knowledge of the VCBH PEI planning process, each interviewee was asked to indicate his or her level of knowledge on a three-point scale ranging from "not at all knowledgeable" to "very knowledgeable." The five interviewees in Area 1 identified themselves as either "not at all" (n=3) or "somewhat" (n=2) knowledgeable of the process.

When asked to qualify their answers, two of the three respondents without any prior knowledge of the PEI planning process indicated that they first learned about PEI when they were invited to participate in the interview. The third reported gaining a very limited understanding of the process through his job role.

Those who were "somewhat knowledgeable" of the process (n=2) were informed through different sources. One interviewee gained knowledge of VCBH and its proposed programs when the Department contacted him requesting information about the local community. The other interviewee stated that she was aware of *"the purpose but not the process."* She reported having been involved in the first round of the Community Services and Supports (CSS) component of the MHSA planning process, which led to the establishment of the One-Step Center in her community. However, regarding prevention and early intervention, she felt out of the loop and shared her

concerns about the lack of connection between local community organizations and county mental health providers.

V. Mental Health Needs

Greatest Mental Health Needs

In order to address and help prioritize unmet community mental health needs, interviewees were asked to identify the greatest mental health needs in their communities. A variety of responses were offered, but services for marginalized populations (n=5), stigma reduction to increase the use of mental health services (n=3), and outreach (n=3) were the needs identified most often (**Table 6**).

Marginalized populations identified by the interviewees included undocumented workers, farm workers, impoverished families, and the homeless. With regards to the social stigma associated with mental health services, respondents indicated that Hispanic families and families from small towns are often hesitant to utilize services – at times, waiting until mental health issues require emergency room attention before seeking help. The recommendation that providers *"get out into the community"* to schools, homes, and work locations underscored a need to increase community outreach as a means of raising awareness and reducing the social stigma associated with mental health.

Table 6: Greatest Mental Health Needs
(n=5)

Mental Health Needs	Number of Mentions
Services for marginalized populations	5
Stigma reduction	3
Outreach	3
Increased access	2
Services for youth	2
Communication and collaboration among service providers	1
Culturally appropriate services	1
Total:	**17**

Impact of the Greatest Mental Health Needs

When invited to describe how mental health needs were impacting their communities, responses were specific and targeted (**Table 7**). Respondents described how tensions within struggling families spill over into the community in the form of gang and criminal activity or drug use. They expressed concerns that those receiving assistance were often stigmatized for their mental health needs, causing them to experience shame, to minimize serious diagnoses, or to avoid assistance that would be noticeable by friends or neighbors (e.g., home visitation from county service providers). Cultural and social isolation, lack of transportation, and limited facilities for specific groups (especially youth) also present a barrier to service access for those who would benefit from services.

Table 7: The Impact of Mental Health Needs on Interviewees' Communities
(n=5)

Impact of Mental Health Needs	Number of Mentions
Struggling families	4
Stigma	3
Limited access	3
Negative mental health outcomes	2
Total:	**12**

Ranking MHSA Mental Health Needs

Building upon interviewees' discussion about the mental health needs in the community and the impact of those needs, each of the five interviewees was presented a list of five California Department of Mental Health (CDMH) MHSA mental health needs and asked to rank order those needs from highest to lowest need. The five mental health needs are: 1) At-risk children, youth, and young adult populations; 2) Stigma and discrimination; 3) Disparities in access to mental health services; 4) Psycho-social impact of trauma; and, 5) Suicide risk. **Table 8** below displays the interviewees' rankings.

All five respondents ranked At-risk children, youth, and young adult populations and Stigma and discrimination within the top three mental health needs in their communities. Disparities in access to mental health services were also important to four respondents who ranked it as the second highest community mental health need. Suicide risk and the Psycho-social impact of trauma were ranked fourth and fifth by the majority of the respondents (n=4). Explanations for the three most popular rankings are presented below the table.

Table 8: Rank Ordered Mental Health Needs
(n=5)

Mental Health Needs	1st	2nd	3rd	4th	5th
At-risk children, youth, and young adult populations	**2**	**1**	**2**	--	--
Stigma and discrimination	**2**	**1**	**2**	--	--
Disparities in access to mental health services	--	4	1	--	--
Psycho-social impact of trauma	--	--	1	2	2
Suicide risk	1	--	--	1	3

<u>At-Risk Children, Youth, and Young Adult Populations</u>

- These populations are the most impacted and, as a result, are vulnerable to and dependent upon an adult support system, "*at the mercy of their family and neighborhood conditions*."
- Without access to needed services, youth drink or do drugs to cope
- Unaddressed mental health needs may ultimately lead to serious mental illness and consequences

<u>Stigma and Discrimination</u>

- Those who need help do not like others to be aware of their situation, or do not want to identify certain symptoms for cultural reasons

- Important to address among youth (especially recent arrivals and special needs children) because they are under pressure to fit in and therefore do not seek help
- Leads to disparities in access, which then leads to other mental health needs

Disparities in Access to Mental Health Services

- Especially acute for farm workers and the undocumented
- Clients think there is only one route to get help and when the process takes too long many give up

Community Strengths

In an effort to build upon existing assets in Area 1, interviewees were asked to describe the strengths or protective factors currently available in their communities that could help address the top mental health needs identified in the previous question (**Table 9**). Programs and activities for youth, such as the Boys and Girls Clubs, ASPIRE, and One-Step Center youth programs, were mentioned most often (n=5). Faith-based programs and youth groups were also noted (n=3). Collectively, programs and activities for youth and faith-based programs including church youth groups comprise over half of the mentions regarding community strengths.

Table 9: Community Strengths/Protective Factors
(n=5)

Strengths/Protective Factors	Number of Mentions
Programs/activities for youth	5
Faith-based programs (for youth)	3
Community-based programs	2
Sports/recreation programs	2
Programs for children 0-5	1
Resource centers for basic needs	1
School partnerships	1
Total:	**15**

VI. Priority Age Groups

Prevention

Mental health prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders. To document interviewees' opinions about the age groups in greatest need of prevention services within their communities in Area 1, the following five age groups were presented for rank ordering: 1) Prenatal to Pre-K, 0 to 5; 2) Children, 6 to 17; 3) Transition-age Youth (TAY), 18 to 25; 4) Adults, 25 to 59; and 5) Older Adults, 60+. The resulting responses are displayed in **Table 10** below. As shown, four of five interviewees identified Children, 6 to 17, and Transition-age youth, 18 to 25, as high-priority age groups (i.e., ranked first or second). Representative examples of respondents' reasons for prioritizing those groups are listed below the table.

Table 10: Rank Ordered Age-Groups for Prevention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	1	--	1	1	2
Children, 6 to 17	**3**	**1**	--	1	--
Transition-age Youth (TAY), 18 to 25	--	**4**	1	--	--
Adults, 26 to 59	1	--	--	3	1
Older Adults, 60+	--	--	3	--	2

Children, 6 to 17

- Children who act out because of problems happening in the home will benefit from prevention
- Children are more impressionable, and therefore more susceptible to positive interventions, guidance and support services
- Children have hormonal confusion and developmental problems and are looking to establish their self-identity at this age

Transition-age Youth, 18 to 25

- They have many questions about decisions that need to be made as they transition from dependence to independence, and are at-risk of making poor choices

Two respondents indicated that they identified Children and/or Transition-age youth as high priorities for prevention services because those age groups were the focus of their work in the community, while another identified Adults as a top priority for the same reason. One interviewee ranked the various age groups from youngest to oldest in accordance with a belief that the earlier the prevention, the more effective and least costly.

Early Intervention

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse. Similar to the previous question about prevention services, interviewees were asked to rank order the same age groups according to the level of need for early intervention mental health services in Area 1.

As displayed in **Table 11**, interviewees' prioritizations varied across age groups. However, Children and Transition-age youth tended to receive higher rankings, compared to Prenatal to pre-K children, Adults and Older Adults.

Table 11: Rank Ordered Age-Groups for Early Intervention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	1	--	1	--	3
Children, 6 to 17	**1**	**2**	**1**	1	--
Transition-age Youth, 18 to 25	**1**	**2**	**2**	--	--
Adults, 26-59	1	--	1	3	--
Older Adults, 60+	1	1	--	1	2

When asked to explain their rankings, several interviewees (n=3) indicated that their reasoning was similar to that for identifying priority age groups for prevention services. Examples of more specific explanations offered by interviewees for the top age groups cited are provided below.

Children, 6 to 17

- Now seeing *"mental health issues at a younger age than ever before"*
- Young adults becoming parents at younger ages
- This is when AD/HD usually starts

Transition-age Youth, 18-25

- High incarceration rates at this age
- *"Mental illness starts at this age"*

VII. Priority Populations

The California State Department of Mental Health (CDMH) MHSA has identified the following six priority populations for PEI: [2] 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children/youth in stressed families; 4) Trauma-exposed individuals; 5) Children at-risk for school failure; and, 6) Children and youth at-risk of or experiencing involvement with the Juvenile Justice System. To determine which priority populations the interviewees identified as most in need of prevention and/or early intervention services in Area 1, they were asked to rank order them from highest to lowest. As displayed in **Table 12** below, four of five interviewees identified Underserved cultural populations as the priority population most in need of prevention or early intervention services in their communities. One respondent pointed out that regardless of which population one selects, all of the mental health conditions associated with the priority populations listed exist among the low-income, minority populations, or among the underserved. Explanations for this ranking included:

Underserved Cultural Populations

- The community of Santa Paula and its environs is 70 percent Hispanic, a group that is generally unaware of, or unwilling to access mental health services, primarily for cultural reasons
- Confusing, bureaucratic service systems, complicated eligibility criteria, and language barriers limit access for Hispanics
- Do not receive equal education or the opportunities that are available to others
- For cultural reasons, *"Hispanics/Latinos [can be] close-minded on mental health"*
- This is the overarching priority population and all others should be considered subsets

All respondents considered Children and youth in stressed families among the top three ranks (see **Table 12**). The only respondent who offered an explanation for ranking this population at the top indicated that parents may not know where to go for help and do not approach problems proactively.

[2] Definitions for each priority population can be found in the Key Individual Interview Questions contained in the **Appendix**.

Table 12: Rank Ordered Priority Populations
(n=5)

Priority Populations	1st	2nd	3rd	4th	5th	6th
Underserved cultural populations	**4**	--	--	1	--	--
Individuals experiencing the onset of serious psychiatric illness	--	1	--	--	1	3
Children and youth in stressed families	**1**	**2**	**2**	--	--	--
Trauma-exposed individuals	--	--	1	1	2	1
Children at risk for school failure	--	1	2	1	--	1
Children and youth at risk of or experiencing involvement with the Juvenile Justice System	--	1	--	2	2	--

VIII. Existing PEI Services

Following the interviewees' rankings of the CDMH priority populations, the interviewer asked the five interviewees to identify existing prevention and/or early intervention services in Area 1 that were currently serving their top ranked priority population – in this case, Underserved cultural populations.

Two interviewees were unable to identify any existing prevention or early intervention services in their local communities. Responses offered by the other three participants that address the needs of Underserved cultural populations are listed below in alphabetical order. The One-Step Center was the only service identified as an "Evidence-based Program." One interviewee suggested that maybe the Boys and Girls Club might be evidence-based given their long history serving youth. None were identified as "Promising Practices."

- ASPIRE
- Boys and Girls Club (n=2)
- Churches (n=2)
- First 5 Family Resource Center
- Mental Health Clinic
- One-Step Center
- Schools refer children/families
- Sports Programs
- Weed and Seed

IX. Needed PEI Services

Conversely, interviewees were also asked to recommend needed prevention and/or early intervention services that could address the mental health needs of the priority population they ranked number one. The interviewee who identified Children and youth in stressed families as the top priority suggested that youth and family retreats be offered, and that schools be utilized more often to identify issues with children. This individual also cited the benefits of removing individuals from stressful situations, *"even if it is for a day."*

Recommendations for programs and services that would benefit Underserved cultural populations highlighted a perceived need for outreach and community education, and to offer services where they are most accessible:

- Information dissemination via community fairs and festivals
- Community-based outreach by trained paraprofessionals to raise awareness of available services; *"They put a face on the service agencies and this will help break down the barriers associated with going to 'esa clinica' (that clinic!)"*
- Community education and the creation of flyers and books to increase awareness of the signs and symptoms of mental health issues
- Service provision at schools, churches, and in the workplace (i.e., *"going into the fields"*)

X. Service Access and Delivery

In addition to a lack of needed services, barriers to service access can also pose a challenge. As displayed in **Table 13** below, interviewees identified social stigma, whether it be the prevalence of negative attitudes toward mental health needs and services within the Hispanic community in particular, or the provision of mental health services at stigmatized facilities, as the greatest mental health service access barrier (n=4). Language was mentioned three times, addressing the need for providers to offer services in their clients' primary language.

Table 13: Service Access Barriers
(n=5)

Barriers	Number of Mentions
Stigma	4
Language	3
Transportation	2
Homelessness	1
Lack of awareness	1
Lack of communication and collaboration among service providers (about consumers)	1
Social isolation	1
Time to get an appointment	1
Total:	**14**

When asked to suggest strategies to increase access**, Table 14** shows that interviewees were most likely to stress the importance of offering culturally appropriate services that are provided by culturally competent, bilingual staff with whom clients can easily communicate and identify (n=4). Providing services in accessible and *"natural community settings"* such as schools, or in settings that resemble consumer's home environments, was also stressed (n=3).

Table 14: Strategies to Decrease Access Barriers
(n=5)

Strategy	Number of Mentions
Culturally competent/bilingual/bicultural staff	4
Accessible settings/location-based services	3
Conduct a community needs assessment	1
Education and outreach (door-to-door)	1
Communication and collaboration among service providers (about consumers)	1
Maintain confidentiality	1
Total:	**11**

As a follow up to the previous question, interviewees were asked to identify the best ways to provide effective, culturally appropriate prevention and early intervention services in their communities (see **Table 15**). Almost half of interviewees' recommendations addressed culturally competent service provision by bilingual, culturally competent providers. In fact, one interviewee recommended that cultural competence training be provided to all public service employees. Providing services at community centers or schools was also recommended as a means of increasing accessibility; as was conducting various forms of outreach through the church, via flyers, or by gathering community members to participate in a community forum.

Table 15: Ways to Provide Culturally Appropriate and Effective Services
(n=5)

Recommendation	Number of Mentions	Percentage of Mentions
Culturally competent/bilingual/bicultural staff	6	46%
Accessible settings/location-based services	4	31%
Outreach, education, and awareness	3	23%
Total:	**13**	100%

XI. Outreach, Education, Awareness

Finally, recommendations to better educate and inform their communities about mental health prevention and early intervention were solicited from interviewees, as displayed in **Table 16**. Their responses fell into two categories: information dissemination (n=4) and strategic outreach/public promotion (n=2). Examples of interviewees' specific recommendations are presented below on the following page.

Table 16: Recommendations to Educate and Inform the Community about PEI
(n=5)

Recommendation	Number of Mentions
Information dissemination	4
Strategic outreach/public promotion	2
Total:	**6**

Strategic Outreach/Public Promotion of PEI

- You cannot expect the community to utilize services that they do not know exist or have information about them
- VCBH should be present at every event in town and "market" its products/services
- VCBH should be present anywhere groups gather for social activities (e.g., at schools, at sports fields, at churches and other community events)

Information Dissemination

- A letter about PEI should be sent home from school with all students
- Distribute pamphlets that spell out what it is that defines certain disorders with statements such as *"Do you have bi-polar?"* or *"This is what depression feels like"*
- Announce PEI services at Catholic church/mass
- Disseminate brochures (in Spanish) at all contact points for the community: doctor's office, health clinics, neighborhood stores, and at block parties and other community celebrations

XII. Additional Comments

When asked if they had any additional comments to offer regarding PEI or to share with VCBH, interviewees expressed a need to go beyond information collection to service provision, to improve and expand upon existing services, and to increase the level of follow-up that is conducted with mental health service recipients. One interviewee shared her personal experience in the mental health system, describing how funding cutbacks have affected her brother's level of care and emphasizing the value of individual attention. She pointed out, *"It has been an uphill battle. When there was funding they would come out to pick him up. Then there were cutbacks. Now Santa Paula Mental Health Services has really been working with him and that has helped. The caseworker came out to talk with him individually, showed a personal interest, which is really cool."*

Other comments included:

- *"I'm impressed that VCBH is making an effort to inform the community about services but it needs to go beyond information-gathering to establishing programs and implementing strategies. Even if these are pilot programs, at least services will be getting to the community and we'll be learning how to serve the community more effectively."*
- *"We need to expand the One-Step Center and create others that are more centrally located, integrated and collaborative, and that target all the various prevention and early intervention needs of community members."*
- *"There is a great need for follow-up. Underserved populations are not known for coming back so mental health staff must understand that they must put forth their best effort the first time they serve a client and must be prepared to be persistent with follow-up contacts again and again. This will indicate interest and will help develop a relationship of trust and caring."*

XIII. Implications and Observations

Though diverse in their backgrounds and awareness of the VCBH PEI planning process, data collected from the key individual interviews produced clear trends. Respondents related that, despite community strengths such as programs for youth and church-based programs, mental health issues faced by struggling individuals and families has resulted in deleterious community impacts. Gang involvement, drug use, and a tendency to resist service use due to the social stigma attached to mental illness were mentioned as the most prevalent negative community impacts resulting from limitations on mental health service availability and use.

Generally, interview participants agreed that children and youth should be the primary focus of prevention and early intervention services, in addition to gearing service provision toward underserved cultural populations that typically experience disparities in quality of care and access. In order to increase awareness of and access to mental health services, it was recommended that barriers such as the social stigma associated with mental health services and a shortage of culturally competent services be addressed. Community education in the form of flyers, brochures, books, and community events was suggested. It was also recommended that mental health agencies be staffed by bilingual staff members who are trained to offer culturally competent services. Provision of services at schools and community centers may also assist in VCBH's effort to increase accessibility to individuals and families in need.

APPENDIX

Informant's Organizational Affiliation

1. Briefly describe the types of services you or your organization provides.

Knowledge Regarding PEI

2. How knowledgeable are you about Ventura County Behavioral Health's Prevention and Early Intervention (PEI) planning process?

   __ Very Knowledgeable

   __ Somewhat Knowledgeable

   __ Not at all Knowledgeable

   2a. Please qualify/explain why you responded very or somewhat knowledgeable? (e.g., How did you become very knowledgeable/somewhat knowledgeable?)

Community Mental Health Needs

3. Overall, what are the greatest mental health needs in your community?

   3a. How do you see these needs impacting your community?

4. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Please rank order the

following mental health needs with 1 representing what you believe is the highest need in your community.

__ Disparities in access to mental health services

__ Psycho-social impact of trauma

__ At-risk children, youth, and young adult populations

__ Stigma and discrimination

__ Suicide risk

4a. Please explain your ranking.

4b. What strengths or protective factors exist in your community that could help address the top mental health needs you identified? (e.g., opportunities for youth involvement in the schools; strong faith-based organizations in the area; lots of support services for at-risk youth; strong family or other support networks, etc.)

Priority Age Groups—Prevention Services

Prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders.

5. Please rank order the following age groups with 1 representing the age group most in need of **prevention** services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

5a. Please explain your ranking.

Priority Age Groups—Early Intervention Services

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse.

6. Please rank order the following age groups with 1 representing the age group most in need of **early intervention** mental health services in your community?

   __ Prenatal to Pre-K (0-5)

   __ Children (6-17)

   __ Transition-age Youth (TAY) (18-25)

   __ Adults (26-59)

   __ Older Adults (60+)

   6a. Please explain your ranking.

Priority Populations

7. The California State Department of Mental Health has identified six priority populations for PEI. (*The state definition for each priority population is found on the last page of this interview guide). Please rank order the list below with 1 representing the priority population most in need of **prevention** and/or **early intervention** services in your community.

   __Underserved cultural populations

   __Individuals experiencing the onset of serious psychiatric illness

   __Children/youth in stressed families

   __Trauma-exposed individuals

   __Children at risk for school failure

   __Children/youth at risk of or experiencing involvement with the Juvenile Justice System

   7a. Please explain your ranking.

Existing and Needed PEI Services

8. Do you know of any existing **prevention** and/or **early intervention** services that currently address the mental health needs of your number one ranked priority population from Question 7? If yes, please identify? If no, please skip to Question 9.

*8a. Of the existing programs and services you just listed, do you know if any of them are considered *evidence-based programs (EBP), promising practices (PP), or community-defined evidence practices (CDEP)*? (*The definitions for each type of research-based practice can be found on the last page of this interview guide.)

8b. If yes, which ones? (Please identify whether EBP, PP, or CDEP.)

9. What **prevention** and/or **early intervention** services are needed to address the mental health needs of the priority population you ranked number one, _____? (Insert the top ranked priority population from Question 7.)

Service Access and Delivery

10. What barriers do people encounter accessing mental health services in the communities

you serve?

11. What types of strategies would help people get the mental health services they need in the communities you serve?

12. What are the best ways to provide effective, culturally appropriate **prevention** and **early intervention** services in your community?

Outreach, Education, and Awareness

13. What recommendations do you have to better educate/inform your community about

mental health **prevention** and **early intervention**?

Additional Comments

14. Is there anything else you would like to add or you would like Ventura County Behavioral Health to know?

*Q7 Priority Population Definitions

Underserved Cultural Populations. PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, veterans, deaf and blind, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Individuals Experiencing Onset of Serious Psychiatric Illness. Those identified by providers,

including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth in Stressed Families. Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-exposed. Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at-Risk for School Failure. At-risk due to unaddressed emotional and behavioral problems.

Children/Youth at-Risk of or experiencing Juvenile Justice Involvement. Those with signs of behavioral/emotional problems who are at-risk or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Service Supports.

*Q8a Research-based Practice Definitions

Evidence-Based Programs include programs that have been evaluated and show positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness.

Promising Practices include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.

Community-defined Evidence Practices include programs that have been identified by local unserved and/or underserved communities and have demonstrated effectiveness in local communities.

EVALCORP
Research & Consulting

AREA 2 KEY INDIVIDUAL INTERVIEWS
Ojai, Ventura

CONDUCTED AS PART OF THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN DEVELOPMENT PROCESS
IN VENTURA COUNTY

April 2009

Prepared for:
The Ventura County Behavioral Health Department

Prepared by:
EVALCORP Research & Consulting, Inc.

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TABLE OF CONTENTS

I. Introduction

The Ventura County Behavioral Health Department (VCBH) is taking a comprehensive community-based approach to the development of the County's Prevention and Early Intervention (PEI) Plan. This effort is funded through the Mental Health Services Act (MHSA), an act providing funds for services and supports to help people feel socially and emotionally stable.

The MHSA has defined mental health *prevention* as reducing risk factors and building protective factors in order to keep mental health issues from occurring. Mental health *early intervention* refers to short, low-intensity services to improve mental health problems and avoid the need for more extensive treatment.

The approach to developing the PEI plan is multi-faceted and utilizes the collection of quantitative data, key individual interviews, focus groups, and community forums to assess the mental health needs, priority populations, and needed services across five geographic areas of Ventura County. VCBH contracted with Evalcorp Research & Consulting, Inc. to spearhead the PEI data collection process. The data gathered by Evalcorp will be analyzed and synthesized to inform Ventura County's Prevention and Early Intervention Plan.

This report presents findings from the Key Individual Interviews that were conducted in Area 2, representing Ojai and Ventura. The purpose of these interviews was to collect data on the mental health issues and needs in the communities served by the interviewees.

II. Methodology

Participants

During the first phase of the PEI Planning Process, 25 key individual interviews were conducted across five geographic areas of Ventura County; five interviews in each Area. A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention.

VCBH, with guidance from Evalcorp Research & Consulting, Inc., identified interviewees based on geographic representation and representation within the following MHSA categories: age group, community sector, priority populations, and key prevention and early intervention community mental health needs. Key individual interviewees were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for prevention and early intervention.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals across five geographic Areas of Ventura County. Key individuals were initially identified by VCBH. Evalcorp provided consultation on the process and helped to finalize the list of invited participants, ensuring representation across requisite criteria specified by the MHSA.

Evalcorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A formal Letter of Invitation and Confirmation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions. A copy of the Key Individual Interview Questions can be found in the **Appendix**.

A majority of the key individual interviews were conducted by telephone, and others in-person. The interviews each took about one hour to complete. During the interviews, participants were asked about community and mental health needs, age group priorities and priority populations, existing and needed prevention and early intervention services, and recommendations for providing effective prevention and early intervention services. The interviews were audio recorded with the consent of the interviewee. Once the interviews were complete, participants received a thank-you letter acknowledging their participation.

A transcript was prepared for each key individual interview conducted, summarizing each participant's responses by question. Information from each interview was then coded so that the data could be content analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Services Provided, and Communities Served

Demographics

Five key individuals participated in the Area 2 interviews. Selected to represent a diverse set of mental health prevention and early intervention stakeholders, interview respondents represented different, and, in some cases, multiple community sectors including social services (n=3), education (n=2), mental health service providers (n=1), health, (n=1), community family resource centers (n=1), and employment (n=1).

Most of the interviewees reported their ethnicity as Caucasian (n=4). One interviewee identified as Latino/Hispanic and, more specifically, as Mexican. The interviewee sample included three males and two females. All individuals were between the ages of 26 and 59. All five respondents reported speaking English, with four reporting that they also spoke Spanish.

Services Provided and Communities Served

Interviewees completed a participant profile as a means of gathering additional information on their backgrounds in terms of the communities they serve and their frame of reference with respect to prevention and early intervention mental health services. Additionally, key individual interview participants were asked at the beginning of each interview to clarify and elaborate on services provided by the individual and his/her organization. As displayed in **Table 1** below, programs for youth and/or adults, and mental health services were cited most often as types of services their organizations provide.

Table 1: Services Provided by the Interviewee or His/Her Organization
(n=5)

Services	Number of Mentions
Programs for youth and/or adults	5
Mental Health	3
Crisis intervention	2
Health	2
Case management	1
Community advocacy	1
Community awareness programs	1
Resource referral	1
Total:	16

Additional organizational information gathered from the participant profiles is presented in **Tables 2 through 5** below. **Table 2** indicates that all of the interviewees represent Area 2, which includes Ojai and Ventura. As displayed, interviewees also represented Areas other than Area 2.

Table 2: **Geographic Area of Ventura County Served By Interviewees**
(n=5)

Geographic Area	Number of Participants
Area 1: Fillmore, Piru, Santa Paula	2
Area 2: Ojai, Ventura	5
Area 3: Camarillo, Oxnard, Port Hueneme	2
Area 4: Thousand Oaks, Newbury Park, Westlake Village	2
Area 5: Moorpark, Simi Valley	1

As displayed in **Table 3** interviewees also were most likely to serve Latino/Hispanic individuals (n=5), which includes the Mexican, Mixteco, and Zapoteco communities, in addition to the African-American community (n=2), and homeless (n=2).

Table 3: Underserved/Unserved Populations Represented By Interviewees
(n=5)

Underserved/Unserved Populations	Number of Participants
Latino/Hispanic	5
Mexican	4
Mixteco	1
Zapoteco	1
African-American	2
Homeless	2
American Indian	1
Asian/Pacific Islander	1
LGBT/Questioning Individuals	1

Children and youth in stressed families (n=3) or Children at risk for school failure (n=3) were being served by a majority of the interviewees (see **Table 4**).

Table 4: Priority Populations Served/Represented By Interviewees
(n=5)

Priority Populations	Number of Participants
Children/Youth in Stressed Families	3
Children at Risk for School Failure	3
Underserved Cultural Populations	2
Trauma-Exposed Individuals	1

Three of five interviewees serve each of the five age categories as displayed in **Table 5**.

Table 5: Age Groups Served By Interviewees
(n=5)

Age Groups	Number of Participants
Prenatal to Pre-K (0-5)	3
Children (6-17)	3
Transition-age Youth (TAY) (18-25)	3
Adults (26-59)	3
Older Adults (60+)	3

IV. Knowledge of the VCBH PEI Planning Process

To document the interviewees' knowledge of the VCBH PEI planning process, each interviewee was asked to indicate his or her level of knowledge on a three-point scale ranging from "not at all knowledgeable" to "very knowledgeable." The five interviewees in Area 2 identified themselves as either "not at all" (n=2) , "somewhat" (n=2), or "somewhat/very" (n=1) knowledgeable of the process.

When asked to qualify their answers, the two respondents without any prior knowledge of the PEI planning process indicated that they first learned about PEI when they were invited to participate in the interview.

Those who were "somewhat knowledgeable" of the process (n=2) were informed through different sources. One interviewee gained knowledge of VCBH and its proposed programs when Dr. Gabino Aguirre contacted him about the process, and also by reading promotional publications. The other interviewee stated that she was aware of the process through her involvement in and attendance at various meetings and activities in the county. Additionally, she was involved in the first round of the Community Services and Supports (CSS) component of the MHSA.

The interviewee who was "somewhat/very knowledgeable" about the process (n=1) stated that he has observed some of the planning meetings, and that most of the information he receives comes from a director in his organization who is a member of the Ventura County PEI Planning Committee.

V. Mental Health Needs

Greatest Mental Health Needs

In order to address and help prioritize unmet community mental health needs, interviewees were asked to identify the greatest mental health needs in their communities. A variety of responses were offered, but services for family issues (n=5) and increased access (n=5) were the needs identified most often (**Table 6**).

Specific services for family issues identified by the interviewees included those that: help parents work with their children effectively, assist perinatal substance abusing mothers and their children, relate to relationship/partner/marriage issues, and address end-of-life issues. With regards to increased access to mental health services, respondents indicated that not only is there an overall lack of access to mental health services in general, but also that where there are services it is difficult to find assistance because many facilities are short-staffed.

Table 6: Greatest Mental Health Needs
(n=5)

Mental Health Needs	Number of Mentions
Services for family issues	5
Increased access	5
Interagency communication	2
Overcome powerlessness	2
Services for marginalized populations	2
Overcome isolation	1
Prevention/early intervention services	1
Stigma reduction	1
Suicide risk reduction	1
Total:	**20**

Impact of the Greatest Mental Health Needs

When invited to describe how mental health needs were impacting their communities, responses were specific and targeted (**Table 7**). Respondents expressed concern that negative mental health outcomes result from people not getting treated, or being treated inappropriately, sometimes with those needing the most help ending up in jail. Other issues leading to negative mental health outcomes include physicians not being able to consult with other doctors or mental health professionals to determine the best course of treatment for individuals, and children who enter preschool with behavior and disciplinary problems, and/or stunted personal growth. Limited access is the result of care needs not being met, transportation problems and mental health service delivery not matching the needs of the community. They described how tensions within struggling families affect children's ability to learn, which ultimately, can lead to truancy, expulsions, poor academic outcomes, or even involvement with the Juvenile Justice system. One of the interviewees stated that these unmet needs affect the entire community by *"holding us back from attaining the highest goals and objectives."*

Table 7: The Impact of Mental Health Needs on Interviewees' Communities
(n=5)

Impact of Mental Health Needs	Number of Mentions
Negative mental health outcomes	5
Limited access	4
Struggling families	3
Stigma	2
Loss to society	1
Total:	**15**

Ranking MHSA Mental Health Needs

Building upon interviewees' discussion about the mental health needs in the community and the impact of those needs, each of the five interviewees was presented a list of five California Department of Mental Health (CDMH) MHSA mental health needs and asked to rank order those needs from highest to lowest need. The five mental health needs are: 1) At-risk children, youth, and young adult populations; 2) Stigma and discrimination; 3) Disparities in access to mental health services; 4) Psycho-social impact of trauma; and, 5) Suicide risk. **Table 8** below displays the interviewees' rankings.

Four respondents ranked At-risk children, youth, and young adult populations within the top two mental health needs in their communities. Disparities in access to mental health services and the Psycho-social impact of trauma were also important to four respondents who ranked each category as one of their top three choices. The five respondents each ranked Stigma and discrimination first through fifth. Suicide risk was ranked fifth by the majority of the respondents (n=4). Explanations for the three most popular rankings are presented below the table.

Table 8: Rank Ordered Mental Health Needs
(n=5)

Mental Health Needs	1st	2nd	3rd	4th	5th
At-risk children, youth, and young adult populations	**2**	**2**	--	1	--
Disparities in access to mental health services	**2**	**1**	**1**	1	--
Psycho-social impact of trauma	--	**1**	**3**	1	--
Stigma and discrimination	1	1	1	1	1
Suicide risk	--	--	--	1	4

<u>At-Risk Children, Youth, and Young Adult Populations</u>

- These populations are the most impacted because an increasing number of youth are involved in violence and crimes, feeling isolated, and acting out in nonproductive activities
- There is value in starting services when people are young and getting everyone together on the same team behind an individual
- Families living in poverty or under severe financial distress would benefit from prevention and early intervention
- At-risk youth are often stigmatized and it is important that they not be labeled as sick or ill

Disparities in access to mental health services

- The top need due primarily to socioeconomic circumstances and lack of insurance or limited insurance
- There is not enough access to mental health services that are appropriate, especially for the homeless
- There are few organizations offering needed services to the LGBT community
- Immigrant families do not have an understanding of the benefits of mental health services or how to access them

Psycho-social impact of trauma

- Especially true when the definition of trauma is broadened to encompass domestic and community violence
- There are a *"lot of people who are so shell-shocked that they are not functioning"*
- People are traumatized by a lack of resources for health care and services overall
- Those in poverty are in a perpetual state of trauma

Community Strengths

In an effort to build upon the existing assets in Area 2, interviewees were asked to describe the strengths or protective factors currently available in their communities that could help address the top mental health needs identified in the previous question (**Table 9**). Community-based programs, counseling/mental health services, faith-based programs, and schools/school partnerships were each mentioned three times comprising over three-fourths of the mentions regarding community strengths. The Coalition to End Family Violence and the Partnership for Safe Families & Kids were the specific community-based programs mentioned. Planned Parenthood and Jewish Family Services were listed as places where the community members could receive counseling and mental health services. The Clergy Council received praise as a faith-based program. It was noted that there is grief counseling in schools, while Ventura High School received recognition for its "Hate Free Zone" program and the Ventura Unified School District was identified as a proactive district that partners with communities, including Behavioral Health, to meet the needs of children.

Table 9: Community Strengths/Protective Factors
(n=5)

Strengths/Protective Factors	Number of Mentions
Community-based programs	3
Counseling/mental health services	3
Faith-based programs	3
Schools/school partnerships	3
County services	1
Family resource center	1
Programs/activities for the whole family	1
Programs/activities for youth	1
Total:	**16**

VI. Priority Age Groups

Prevention

Mental health prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders. To document interviewees' opinions about the age groups in greatest need of prevention services within their communities in Area 2, the following five age groups were presented for rank ordering: 1) Prenatal to Pre-K, 0 to 5; 2) Children, 6 to 17; 3) Transition-age Youth (TAY), 18 to 25; 4) Adults, 25 to 59; and 5) Older Adults, 60+. The resulting responses are displayed in **Table 10** below. As shown, all five interviewees identified Children, 6 to 17, as a high-priority age group (i.e. ranked first or second). Additionally, three of the five gave a high priority to Prenatal to Pre-K, 0 to 5. Representative examples of respondents' reasons for prioritizing those groups are listed below the table.

Table 10: Rank Ordered Age-Groups for Prevention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	**3**	--	--	--	2
Children, 6 to 17	**2**	**3**	--	--	--
Transition-age Youth (TAY), 18 to 25	1	1	3	--	--
Adults, 26 to 59	--	--	1	4	--
Older Adults, 60+	--	--	1	1	3

<u>Children, 6 to 17</u>

- Prevention is necessary with children because it impacts their school performance and life skills
- If there are problems due to family abuse, it is better to address prevention early on rather than later
- Youth are coming to terms with their sexuality at an earlier age due in part to the internet and easier access to issues of sexual awareness

<u>Prenatal to Pre-K, 0 to 5</u>

- This age group is a top priority from a public health perspective
- The earlier the prevention, the better

One respondent indicated that they identified Transition-age youth as a high priority for prevention services because that age group experiences stress by needing to find a job or career combined at a time when these youth are coming to terms with their sexuality or gender identification. Another ranked TAY second because youth this age tend to deny and hide mental health issues and disorders. One interviewee ranked the various age groups from youngest to oldest in accordance with a belief that the earlier the prevention, the more effective and least costly.

Early Intervention

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse. Similar to the previous question about prevention services, interviewees

were asked to rank order the same age groups according to the level of need for early intervention mental health services in Area 2.

As displayed in **Table 11**, interviewees' prioritizations varied across age groups. All five of the interviewees marked Children, 6 to 17 as a high priority (i.e., ranked this group first or second). Three out of five marked Prenatal to Pre-K, 0 to 5 and Transition-age Youth, 18 to 25, as a high priority.

Table 11: Rank Ordered Age-Groups for Early Intervention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	**1**	**2**	--	--	2
Children, 6 to 17	**4**	**1**	--	--	--
Transition-age Youth, 18 to 25	**1**	**2**	2	--	--
Adults, 26-59	--	--	1	4	--
Older Adults, 60+	--	--	1	1	3

When asked to explain their rankings, several interviewees (n=3) indicated that their reasoning was similar to that for identifying priority age groups for prevention services. Examples of more specific explanations offered by interviewees for the top age groups cited are provided below.

Children, 6 to 17

- Necessary with children because it impacts their school performance and life skills
- It is better to address problems early on rather than later
- This age group would benefit substantially from counseling, support, and general early intervention services
- Greater opportunity for impact, particularly by reaching students in elementary and middle schools

Prenatal to Pre-K, 0 to 5

- Need to ensure that children's mental health needs are addressed at a young age before those needs become exacerbated

Transition-age Youth, 18-25

- There is a need for individual and group counseling for this age group
- This group is not yet inured to a particular lifestyle

VII. Priority Populations

The California State Department of Mental Health (CDMH) MHSA has identified the following six priority populations for PEI: [3] 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children/youth in stressed families; 4) Trauma-exposed individuals; 5) Children at-risk for school failure; and, 6) Children and youth at-risk of or experiencing involvement with the Juvenile Justice System. To determine which priority populations the interviewees identified as most in need of prevention and/or early intervention services in Area 2,

[3] Definitions for each priority population can be found in the Key Individual Interview Questions contained in the **Appendix**.

they were asked to rank order them from highest to lowest. As displayed in **Table 12** below, each of the five interviewees chose a different priority population as most in need of services. However, three of five interviewees identified Underserved cultural populations or Children and youth in stressed families as the first or second highest priority population most in need of prevention or early intervention services in their communities. Explanations for these rankings included:

Underserved Cultural Populations

- Most in need of service because *"they do not have a strong voice"*
- Even though there is a large Hispanic/Latino population in the county, there are not services specifically marked for this group
- There are increased immigrant, indigenous populations like the Mixtecos who are marginalized and underserved

Children and Youth in Stressed Families

- There is a high need for PEI services and a general lack of access to mental health services
- With many stressed families and the lack of services, children are going to fail out of school
- This group does *"not have a strong voice"* similar to Underserved cultural populations
- This factor shows up in young people who have been kicked out of their home and are now wondering where they will live

The interviewee who chose Individuals experiencing the onset of serious psychiatric illness stated that based upon experiences in his medical practice, prevention is definitely a need for patients with minor and major depression. One interviewee stated that Trauma-exposed individuals was the highest priority because if the trauma is less than one year away, there could be a lot of success getting over that hurdle. The interviewee who chose Children/youth at risk of or experiencing involvement with the Juvenile Justice system explained that is because these youth often fall through the cracks and are in high need of assistance with education and job development.

Table 12: Rank Ordered Priority Populations
(n=5)

Priority Populations	1st	2nd	3rd	4th	5th	6th
Underserved cultural populations	**1**	**2**	**1**	--	--	1
Children and youth in stressed families	**1**	**2**	**1**	1	--	--
Individuals experiencing the onset of serious psychiatric illness	1	1	1	--	1	1
Trauma-exposed individuals	1	--	--	2	1	1
Children and youth at risk of or experiencing involvement with the Juvenile Justice System	1	--	--	2	1	1
Children at risk for school failure	--	--	2	2	1	--

VIII. Existing PEI Services

Following the interviewees' rankings of the CDMH priority populations, the interviewer asked the five interviewees to identify existing prevention and/or early intervention services in Area 2 that were currently serving their top ranked priority population.

Responses offered by the participants that address their chosen top-ranked need are listed in alphabetical order. El Concilio, Popular Power, and school-based after school programs were identified as "Evidence-based Programs." Additionally, El Concilio was identified as a "Promising Practice." First 5 and the Public Health Nursing Program were both thought to be "Evidence-based programs" and "Promising Practices," however, the interviewees were not certain that this was true.

- Arts for Action
- Catholic Family Services
- El Concilio
- First 5 funded behavioral services
- Grief Counseling in Schools
- Interface counselors
- Jewish Family Services
- Kids and Families Together
- Midnight basketball
- Mixteco Project (MICOP) (n=2)
- Non-profits
- Popular Power
- Private practice social workers, mental health providers, psychiatrists
- Public Health Nursing Program
- School-based after school programs
- Services united
- Ventura County Hospital
- Vista del Mar private mental health hospital

IX. Needed PEI Services

Conversely, interviewees were also asked to recommend needed prevention and/or early intervention services that could address the mental health needs of the priority population they ranked number one. As there are five different top-ranked populations, each interviewee's comments are listed below.

Recommendations for programs and services that would benefit Underserved cultural populations highlighted a perceived need for resources and accessibility:

- More money be made available, although the interviewee stated that he did not think that would happen
- Make services more accessible to the general public by cutting through the red tape

Recommendations for programs and services that would benefit Individuals experiencing the onset of serious psychiatric illness also highlighted a perceived need for accessible services:

- Provide available and accessible services
- Use a clearinghouse or directory to increase awareness of available services among providers and the public
- Provide a mix of outpatient services such as group and individual counseling

- Provide services to meet the needs of Transitional-age youth, such as young girls dealing with eating disorders

Recommendations for programs and services that would benefit Children and youth in stressed families highlighted a perceived need for prevention and early intervention services:

- Provide in-home counseling for children age 0 to 5
- Provide school-based counseling for elementary and middle school children

Recommendations for programs and services that would benefit Trauma-exposed individuals included suggestions of following up with a client when that person does not have the strength to do so:

- Caseworker or contact would be automatically assigned to the person who suffered the trauma based on the police or doctor report.
- When experiencing trauma, it is hard to have the wherewithal to find help on one's own, so it would be helpful to have someone with mental health knowledge seek out these individuals

The recommendation for Children and youth at risk of or experiencing involvement with the Juvenile Justice system was to provide:

- Vocational and job skills training along with vocational mentorship.

X. Service Access and Delivery

In addition to a lack of needed services, barriers to service access can also pose a challenge. As displayed in **Table 13** below, interviewees identified transportation problems as the greatest mental health service access barrier (n=4). Stigma ranging from the community's perception of mental health clinics, behavioral barriers and family resistance to take children to a clinic was mentioned three times. Additionally, financial barriers because of no health insurance or because a worker may be undocumented were also mentioned three times.

Table 13: Service Access Barriers
(n=5)

Barriers	Number of Mentions
Transportation	4
Stigma	3
Financial	3
Lack of cultural understanding	2
Lack of awareness	2
Language	2
Limited access	2
Patient (Barrier to oneself)	1
Red tape	1
Total:	**20**

When asked to suggest strategies to increase access**, Table 14** shows that interviewees were most likely to stress the importance of offering services that are accessible and based in trusted and frequented locations such schools and community resource settings (n=6). Additionally, comprehensive county planning was stressed (n=3), which would include a coordination of services and referrals, a hotline for providers so they can have assistance in assessing patients' needs, and reinstituting Psychiatric Evaluation Teams (PET) that would come out in crisis situations.

Table 14: Strategies to Decrease Access Barriers
(n=5)

Strategy	Number of Mentions
Accessible settings/location-based services	6
Comprehensive county planning	3
Employ non-traditional methods	2
Training for families	2
Communication and collaboration among service providers (about consumers)	1
Culturally competent/bilingual/bicultural staff	1
Education and outreach	1
Increased funding	1
Training for public workers	1
Total:	**18**

As a follow up to the previous question, interviewees were asked to identify the best ways to provide effective, culturally appropriate prevention and early intervention services in their communities (see **Table 15**). Half of the interviewees' recommendations addressed culturally competent service provision by bilingual, culturally competent providers. One interviewee stated that *"you may understand the language, but if you don't understand the culture, you are going to create an uncomfortable atmosphere."* Services provided by those who know the individuals, families, and community was recommended as a means of increasing accessibility, as was utilizing community organizations that employ staff from the community.

Table 15: Ways to Provide Culturally Appropriate and Effective Services
(n=5)

Recommendation	Number of Mentions
Culturally competent/bilingual/bicultural staff	6
Accessible settings/location-based services	2
Training for families	2
Comprehensive county planning	1
Outreach, education, and awareness	1
Total:	**12**

XI. Outreach, Education, Awareness

Finally, recommendations to better educate and inform their communities about mental health prevention and early intervention were solicited from interviewees, as displayed in **Table 16**. Their responses fell into six categories with information dissemination (n=10) and strategic outreach/public promotion (n=5) most often mentioned. Examples of interviewees' specific recommendations are presented below the table.

Table 16: Recommendations to Educate and Inform the Community about PEI
(n=5)

Recommendation	Number of Mentions
Information dissemination	10
Strategic outreach/public promotion	5
Communication and collaboration among organizations and county	2
Comprehensive county planning	1
Family training	1
Provider training	1
Total:	**20**

Strategic Outreach/Public Promotion of PEI

- Publicize to a broad audience
- Mount a stronger marketing campaign
- Use technology, internet and text messages to reach youth
- Be visible in the community
- Provide outreach in the community

Information Dissemination

- Use public service announcements and advertise on buses, TV and radio
- Communicate through the Housing Rights seminar that is offered on a quarterly basis
- Utilize trusted individuals such as teachers, providers and community members to encourage others to access PEI services
- Establish face-to-face contact
- Provide positive, pro-social mental health messages in the community to get people talking
- Introduce awareness through "back door" methods, such as at school meetings where parents are required to attend
- Agencies should continually talk about mental health programs and PEI
- Talk to youth at a young age about HIV/AIDS
- Talk to youth who are in at-risk situations about self-esteem
- Use Spanish language radio

XII. Additional Comments

When asked if they had any additional comments to offer regarding PEI or to share with VCBH, interviewees expressed a need to go beyond information collection to service provision, to

understand that many populations can be considered underserved, and to look at a countywide picture and plan for the future to improve and expand understanding of mental health services by the community. One interviewee shared his personal concerns about funding resources drying up in Ventura County and in California. Two interviewees openly praised the efforts of VCBH. Selected comments are offered below:

- *"Veteran services are another area that is increasing in need. There are a lot of veterans in Ventura County who are coming home with Post-traumatic Stress Disorder which is manifesting in job loss, domestic violence and mental health issues. Veterans are becoming an underserved population. Better coordination of veterans services is needed, such as the "Veteran's Project" in Los Angeles in which providers volunteer to assist veterans in need."*
- *"I know that whenever I call and try to get help [at VCBH], and I can get a hold of somebody, they all try to be very helpful. But, everyone is too short-staffed, and overworked. It is really hard. There are so many horrible cases that some cases don't get seen because they are not quite as bad. If you are not a danger to yourself or others, does that mean you don't need help?"*
- *"We really have to address what we do from a larger systems perspective. I think we have to look at the workforce and how we empower that population to be the future providers as opposed to just seeing them as a population whose needs we need to meet, but instead see them as contributors to the system: How do we engage the underserved populations we are trying to reach in the mental health system?"*
- *"I have seen the work that Behavioral Health does, and they do a lot for a very little [money]."*
- *"Compared to Los Angeles County, VCBH stacks up very well. I think we do a good job. I am concerned about the budget cuts. To see those dollars dry up means we're going to have to find a way to be really creative, and I am not sure what that is."*

XIII. Implications and Observations

Though diverse in their backgrounds and awareness of the VCBH PEI planning process, data collected from the key individual interviews produced clear trends. Respondents related that, despite community strengths such community- and faith-based organizations, school programs and available mental health services, they still see negative mental health outcomes in their communities. Those who could use services are not getting treated appropriately and sometimes end up in jail rather than getting help. Children enter pre-school with behavior and disciplinary problems leading to them not being able to learn, and in many cases leading these youth to become involved with the Juvenile Justice system. It is also difficult for providers because there is not a comprehensive countywide method for physicians to consult with other doctors or mental health professionals to determine the best course of treatment. Limited access to comprehensive mental health care occurs when needs are not met and delivery of services does not match the needs of the community.

Generally, interview participants agreed that children and youth should be the primary focus of prevention and early intervention services, followed closely by those in the 0 to 5 range and transition-age youth. Each interviewee ranked a different priority population as the highest individual priority; however, Undeserved cultural populations, and Children and youth in stressed

families were seen as the most important when taking into account populations ranked second and third. In order to increase awareness of and access to mental health services, it was recommended that barriers such as transportation, the social stigma associated with mental health services and financial issues be addressed. Community education in the form of radio/TV/bus advertisements, at places where parents and potential clients congregate, and using trusted individuals such as teachers, providers, and community members to encourage others to access PEI services was suggested. It was also recommended that mental health agencies be staffed by bilingual staff members who are trained to offer culturally competent services. Provision of services at schools and community centers and training for families may also assist in VCBH's effort to increase accessibility to individuals and families in need.

APPENDIX

Informant's Organizational Affiliation

15. Briefly describe the types of services you or your organization provides.

Knowledge Regarding PEI

16. How knowledgeable are you about Ventura County Behavioral Health's Prevention and Early Intervention (PEI) planning process?

__ Very Knowledgeable

__ Somewhat Knowledgeable

__ Not at all Knowledgeable

2a. Please qualify/explain why you responded very or somewhat knowledgeable? (e.g., How did you become very knowledgeable/somewhat knowledgeable?)

Community Mental Health Needs

17. Overall, what are the greatest mental health needs in your community?

3a. How do you see these needs impacting your community?

18. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Please rank order the following mental health needs with 1 representing what you believe is the highest need in your community.

__ Disparities in access to mental health services

__ Psycho-social impact of trauma

__ At-risk children, youth, and young adult populations

__ Stigma and discrimination

__ Suicide risk

4a. Please explain your ranking.

4b. What strengths or protective factors exist in your community that could help address the top mental health needs you identified? (e.g., opportunities for youth involvement in the schools; strong faith-based organizations in the area; lots of support services for at-risk youth; strong family or other support networks, etc.

Priority Age Groups—Prevention Services

Prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders.

19. Please rank order the following age groups with 1 representing the age group most in need of **prevention** services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

5a. Please explain your ranking.

Priority Age Groups—Early Intervention Services

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse.

20. Please rank order the following age groups with 1 representing the age group most in need of **early intervention** mental health services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

6a. Please explain your ranking.

Priority Populations

21. The California State Department of Mental Health has identified six priority populations for PEI. (*The state definition for each priority population is found on the last page of this interview guide). Please rank order the list below with 1 representing the priority population most in need of **prevention** and/or **early intervention** services in your community.

__Underserved cultural populations

__Individuals experiencing the onset of serious psychiatric illness

__Children/youth in stressed families

__Trauma-exposed individuals

__Children at risk for school failure

__Children/youth at risk of or experiencing involvement with the Juvenile Justice System

7a. Please explain your ranking.

Existing and Needed PEI Services

22. Do you know of any existing **prevention** and/or **early intervention** services that currently address the mental health needs of your number one ranked priority population from Question 7? If yes, please identify? If no, please skip to Question 9.

*8a. Of the existing programs and services you just listed, do you know if any of them are considered *evidence-based programs (EBP), promising practices (PP), or community-defined evidence practices (CDEP)*? (*The definitions for each type of research-based practice can be found on the last page of this interview guide.)

8b. If yes, which ones? (Please identify whether EBP, PP, or CDEP.)

23. What **prevention** and/or **early intervention** services are needed to address the mental health needs of the priority population you ranked number one, _____? (Insert the top ranked priority population from Question 7.)

Service Access and Delivery

24. What barriers do people encounter accessing mental health services in the communities

you serve?

25. What types of strategies would help people get the mental health services they need in the communities you serve?

26. What are the best ways to provide effective, culturally appropriate **prevention** and **early intervention** services in your community?

Outreach, Education, and Awareness

27. What recommendations do you have to better educate/inform your community about mental health **prevention** and **early intervention**?

Additional Comments

28. Is there anything else you would like to add or you would like Ventura County Behavioral Health to know?

***Q7 Priority Population Definitions**

Underserved Cultural Populations. PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, veterans, deaf and blind, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Individuals Experiencing Onset of Serious Psychiatric Illness. Those identified by providers,

including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth in Stressed Families. Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-exposed. Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at-Risk for School Failure. At-risk due to unaddressed emotional and behavioral problems.

Children/Youth at-Risk of or experiencing Juvenile Justice Involvement. Those with signs of behavioral/emotional problems who are at-risk or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Service Supports.

*Q8a Research-based Practice Definitions

Evidence-Based Programs include programs that have been evaluated and show positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness.

Promising Practices include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.

Community-defined Evidence Practices include programs that have been identified by local unserved and/or underserved communities and have demonstrated effectiveness in local communities.

FINDINGS FROM THE

AREA 3 KEY INDIVIDUAL INTERVIEWS
Camarillo, Oxnard, Port Hueneme

CONDUCTED AS PART OF THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN DEVELOPMENT PROCESS
IN VENTURA COUNTY

April 2009

Prepared for:
The Ventura County Behavioral Health Department

Prepared by:
EVALCORP Research & Consulting, Inc.

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TABLE OF CONTENTS

I. Introduction

The Ventura County Behavioral Health Department (VCBH) is taking a comprehensive community-based approach to the development of the County's Prevention and Early Intervention (PEI) Plan. This effort is funded through the Mental Health Services Act (MHSA), an act providing funds for services and supports to help people feel socially and emotionally stable.

The MHSA has defined mental health *prevention* as reducing risk factors and building protective factors in order to keep mental health issues from occurring. Mental health *early intervention* refers to short, low-intensity services to improve mental health problems and avoid the need for more extensive treatment.

The approach to developing the PEI plan is multi-faceted and utilizes the collection of quantitative data, key individual interviews, focus groups, and community forums to assess the mental health needs, priority populations, and needed services across five geographic areas of Ventura County. VCBH contracted with Evalcorp Research & Consulting, Inc. to spearhead the PEI data collection process. The data gathered by Evalcorp will be analyzed and synthesized to inform Ventura County's Prevention and Early Intervention Plan.

This report presents findings from the Key Individual Interviews that were conducted in Area 3, representing the Camarillo, Oxnard and Port Hueneme. The purpose of these interviews was to collect data on the mental health issues and needs in the communities served by the interviewees.

II. Methodology

Participants

During the first phase of the PEI Planning Process, 25 key individual interviews were conducted across five geographic areas of Ventura County; five interviews in each Area. A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention.

VCBH, with guidance from Evalcorp Research & Consulting, Inc., identified interviewees based on geographic representation and representation within the following MHSA categories: age group, community sector, priority populations, and key prevention and early intervention community mental health needs. Key individual interviewees were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for prevention and early intervention.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals across five geographic Areas of Ventura County. Key individuals were initially identified by VCBH. Evalcorp provided consultation on the process and helped to finalize the list of invited participants, ensuring representation across requisite criteria specified by the MHSA.

Evalcorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A formal Letter of Invitation and Confirmation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions. A copy of the Key Individual Interview Questions can be found in the **Appendix**.

A majority of the key individual interviews were conducted by telephone, and others in-person. The interviews each took about one hour to complete. During the interviews, participants were asked about community and mental health needs, age group priorities and priority populations, existing and needed prevention and early intervention services, and recommendations for providing effective prevention and early intervention services. The interviews were audio recorded with the consent of the interviewee. Once the interviews were complete, participants received a thank-you letter acknowledging their participation.

A transcript was prepared for each key individual interview conducted, summarizing each participant's responses by question. Information from each interview was then coded so that the data could be content analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Services Provided, and Communities Served

Demographics

Five key individuals participated in the Area 3 interviews. Selected to represent a diverse set of mental health prevention and early intervention stakeholders, interview respondents represented different community sectors including law enforcement (n=1), education (n=2), health (n=1), and community family resource centers (n=1).

Respondents were asked to identify ethnicity and were invited to mark all that applied to them. Three marked Latino/Hispanic, one of whom identified specifically as Mexican. Additionally, there was one response each for American Indian, Asian/Pacific Islander, and Caucasian. The interviewee sample included three males and two females. All five individuals were between the ages of 26 and 59. All five respondents reported speaking English and four marked that they spoke Spanish.

Services Provided and Communities Served

Interviewees completed a participant profile as a means of gathering additional information on their backgrounds in terms of the communities they serve and their frame of reference with respect to prevention and early intervention mental health services. Additionally, participants were asked at the beginning of each interview to clarify and elaborate on services provided by the individual and his/her organization. As displayed in **Table 1**, programs for youth and/or adults, law enforcement, and community advocacy were cited most often as types of services their organizations provide.

Table 1: Services Provided by the Interviewee or His/Her Organization
(n=5)

Services	Number of Mentions
Programs for youth and/or adults	6
Law enforcement	3
Community advocacy	3
Health	2
Education	2
Crisis intervention	2
Mental health services	1
Community awareness programs	1
Case management	1
Total:	**21**

Additional organizational information gathered from the participant profiles is presented in **Tables 2 through 5** below. **Table 2** indicates that all interviewees represent Area 3, which includes Camarillo, Oxnard, and Port Hueneme. As displayed, interviewees also represented Areas other than Area 3.

Table 2: **Geographic Area of Ventura County Served By Interviewees**
(n=5)

Geographic Area	Number of Participants
Area 1: Fillmore, Piru, Santa Paula	2
Area 2: Ojai, Ventura	2
Area 3: Camarillo, Oxnard, Port Hueneme	5
Area 4: Thousand Oaks, Newbury Park, Westlake Village	1
Area 5: Moorpark, Simi Valley	1

As displayed in **Table 3** interviewees also were most likely to serve Latino/Hispanic individuals (n=5), which includes the Mexican, Mixteco, and Zapoteco communities, migrant farm workers (n=5), and LGBT/questioning individuals (n=4).

Table 3: Underserved/Unserved Populations Represented By Interviewees
(n=5)

Underserved/Unserved Populations	Number of Participants
Latino/Hispanic	5
Mexican	4
Mixteco	3
Zapoteco	2
Migrant Farm Workers	5
LGBT/Questioning Individuals	4
Homeless	3
African-American	3
American Indian	3
Asian/Pacific Islander	3
Co-occurring Disorders	2
Eastern European/Middle Eastern	1
Deaf, Hard of Hearing and/or Blind	1
Veterans	1

Children and youth in stressed families (n=4), Children and youth at-risk of or experiencing involvement in the Juvenile Justice system (n=4), and Underserved cultural populations (n=4) were being served by almost all of the interviewees (see **Table 4**).

Table 4: Priority Populations Served/Represented By Interviewees
(n=5)

Priority Populations	Number of Participants
Children/Youth in Stressed Families	4
Children/Youth at Risk of or Experiencing the Juvenile Justice System	4
Underserved Cultural Populations	4
Children at Risk for School Failure	3
Trauma-Exposed Individuals	2
Individuals Experiencing Onset of Serious Psychiatric Illness	1

All interviewees provide services to Children, and four of five interviewees serve Transition-age youth and Adults, as displayed in **Table 5**.

Table 5: Age Groups Served By Interviewees
(n=5)

Age Groups	Number of Participants
Children (6-17)	5
Transition-age Youth (TAY) (18-25)	4
Adults (26-59)	4
Prenatal to Pre-K (0-5)	3
Older Adults (60+)	3

IV. Knowledge of the VCBH PEI Planning Process

To document the interviewees' knowledge of the VCBH PEI planning process, each interviewee was asked to indicate their level of knowledge on a three-point scale ranging from "not at all knowledgeable" to "very knowledgeable." Most of the five interviewees in Area 3 identified themselves as "somewhat" knowledgeable (n=4) and one marked "not at all" knowledgeable about the process.

When asked to qualify their answers, the respondent without any prior knowledge of the PEI planning process indicated that she first learned about PEI when she was invited to participate in the interview. She stated that she had looked on the County's website to gain more knowledge, but could not find additional information about the process for gathering input from stakeholders or when meetings were scheduled.

Those who were "somewhat knowledgeable" of the process (n=4) were informed through different sources. Two interviewees gained knowledge of VCBH and its proposed programs by knowing someone who is on the Ventura County PEI Planning Committee or sitting in on meetings. Another interviewee was involved with the state mental health association and worked on the MHSA before it became an Act; however, his knowledge was at the state rather than county level. The fourth

interviewee who stated he was "somewhat knowledgeable" learned of the process as a participant on the Ventura County Mental Health Board and also from his time of service on the Juvenile Detention Alternative Initiative.

V. Mental Health Needs

Greatest Mental Health Needs

In order to address and help prioritize unmet community mental health needs, interviewees were asked to identify the greatest mental health needs in their communities. A variety of responses were offered, but increased access (n=4), culturally appropriate services (n=2), prevention/early intervention services (n=2), and services for youth (n=2) were the needs identified most often (**Table 6**).

The interviewees identified a lack of mental health service providers at high schools and in the city of Camarillo, as areas in which access could be increased. With regards to culturally appropriate services, respondents indicated that there is a lack of access to culturally competent programs and that providers should hire more bilingual staff. More prevention and early intervention services would help address the perception that only extremely ill people need mental health services. Services for youth are needed in schools to address problems other than academics. One respondent stated there was a need to reach out to youth as well as older adults and create activities in which both groups can engage simultaneously.

Table 6: Greatest Mental Health Needs
(n=5)

Mental Health Needs	Number of Mentions
Increased access	4
Culturally appropriate services	2
Prevention/early intervention services	2
Services for youth	2
Financial access	1
More resources	1
Empowerment of individuals	1
Outreach	1
Services for marginalized populations	1
Services for older adults	1
Services for those in crisis/have been traumatized	1
Total:	**17**

Impact of the Greatest Mental Health Needs

When invited to describe how mental health needs were impacting their communities, responses were specific and targeted (**Table 7**). Respondents described how tensions within struggling families spill over into the community in the form of gang and criminal activity or drug use, and domestic violence. Children and youth get *"knocked off the path"* after experiencing trauma, violence or bullying. The interviewees expressed concerns about negative mental health outcomes when youths' emotional needs are not being met, and issues are not resolved. This leads to rising rates of

disorders among teens such as cutting, eating disorders, alcohol and other drug use, and sexual abuse. One respondent stated that *"get tough"* policies worsen the mental health of youth.

Table 7: The Impact of Mental Health Needs on Interviewees' Communities
(n=5)

Impact of Mental Health Needs	Number of Mentions
Struggling youth/families	7
Negative mental health outcomes	6
Limited access	3
Involvement with Justice system	1
Total:	**17**

Ranking MHSA Mental Health Needs

Building upon interviewees' discussion about the mental health needs in the community and the impact of those needs, each of the five interviewees was presented a list of five California Department of Mental Health (CDMH) MHSA mental health needs and asked to rank order those needs from highest to lowest need. The five mental health needs are: 1) At-risk children, youth, and young adult populations; 2) Stigma and discrimination; 3) Disparities in access to mental health services; 4) Psycho-social impact of trauma; and, 5) Suicide risk. One respondent added another priority population as his fourth priority, which was not offered as a choice during the interview: At-risk families/parents of at-risk youth. **Table 8** below displays the interviewees' rankings.

Three of five respondents ranked Disparities in access to mental health services as the top mental health need, with another interviewee ranking it as the second priority. All five ranked At-risk children, youth, and young adult populations as either the first or second priority. The Psycho-social impact of trauma was within the top three mental health needs for four of the respondents. Suicide risk and Stigma and discrimination were ranked fourth and fifth. Explanations for the three most popular rankings are presented below the table

Table 8: Rank Ordered Mental Health Needs
(n=5)

Mental Health Needs	1st	2nd	3rd	4th	5th	6th
Disparities in access to mental health services	**3**	**1**	--	--	1	--
At-risk children, youth, and young adult populations	**1**	**4**	--	--	--	--
Psycho-social impact of trauma	1	--	3	--	1	--
Suicide risk	--	--	2	1	1	1
Stigma and discrimination	--	--	--	3	2	--
At-risk families/parents of at-risk youth	--	--	--	1	--	--

<u>Disparities in Access to Mental Health Services</u>

- There are 65,000 farm workers and their families, and 20,000 Mixtecos in the county
- Disparities in access addresses such issues as access to mental health facilities, information about mental health, and issues surrounding ability to pay
- Marginalized youth often lack the ability to pay for services and also deal with language and stigma barriers to services
- Services are very limited and not specialized to help young people who are mentally ill, potentially mentally ill, and/or at-risk of acting out

At-risk Children, Youth, and Young Adult Populations

- This group gets the least amount of attention, and help for this population could have the most impact
- This group is most at-risk of not succeeding in their lives and they are highly affected by the unhealthy emotional state of their parents or other adults in their lives
- Children often inherit mental illness form their parents and deal with cultural stigmas

Psycho-social Impact of Trauma

- Especially acute for students who are exposed to difficult living situations and are depressed
- Youth experience violence in their homes, have abusive boyfriends or girlfriends, and have friends or family who have been killed due to gang violence or involvement in other unhealthy situations
- Trauma comes in many forms and can be manifested when one is displaced in the country or is displaced from one's culture

Community Strengths

In an effort to build upon the existing assets in Area 3, interviewees were asked to describe the strengths or protective factors currently available in their communities that could help address the top mental health needs identified in the previous question (**Table 9**). Community-based programs, such as the KEYS Leadership Academy and a center for transitional-age youth that address the disparities and provides services for at-risk youth, were mentioned most often (n=3). Faith-based programs (n=3) such as Catholic Charities and county services such as the 211 helpline (n=2) were also noted. Collectively, community-based programs and faith-based programs comprise two-thirds of the mentions regarding community strengths.

Table 9: Community Strengths/Protective Factors
(n=5)

Strengths/Protective Factors	Number of Mentions
Community-based programs	3
Faith-based programs	3
County services	2
Family resource center	1
Total:	**9**

VI. Priority Age Groups

Prevention

Mental health prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders. To document interviewees' opinions about the age groups in greatest need of prevention services within their communities in Area 3, the following five age groups were presented for rank ordering: 1) Prenatal to Pre-K, 0 to 5; 2) Children, 6 to 17; 3) Transition-age Youth (TAY), 18 to 25; 4) Adults, 25 to 59; and 5) Older Adults, 60+. The resulting responses are displayed in **Table 10** below.

As shown, four of five interviewees identified Children, 6 to 17, as the highest priority. Additionally, four of five respondents agreed that Transition-age youth, 18 to 25, was the second highest priority. Representative examples of respondents' reasons for prioritizing those groups are listed below the table.

Table 10: Rank Ordered Age-Groups for Prevention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	1	--	2	2	--
Children, 6 to 17	**4**	**1**	--	--	--
Transition-age Youth (TAY), 18 to 25	**--**	**4**	1	--	--
Adults, 26 to 59	--	1	1	3	--
Older Adults, 60+	--	--	1	--	4

Children, 6 to 17

- It is important to educate these youth earlier about ways to prevent the onset of mental health issues
- Prevention for children is important because of parenting, abuse and learning issues, plus these services could possibly prevent gang involvement
- There is a high rate of suicide attempts and suicides at the high school level
- Children and youth are dealing with anger and violence and are *"walking time bombs"*
- When services are offered for the younger age groups, the parents are also involved, which is beneficial to the whole family

Transition-age Youth, 18 to 25

- They need to learn how to deal with their own emotional well-being in order to raise healthy and successful children
- This group is often forgotten and a hard-to-reach group
- Many in this group have health needs that have gone undetected, and new mental health needs can occur after graduating from high school

One interviewee ranked the various age groups from youngest to oldest in accordance with a belief that the earlier the prevention, the more effective and least costly.

Early Intervention

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse. Similar to the previous question about prevention services, interviewees were asked to rank order the same age groups according to the level of need for early intervention mental health services in Area 3.

As displayed in **Table 11**, all five of the interviewees ranked Children as the highest priority, and four of the five stated that Transition-age youth were the second highest priority for early intervention services.

Table 11: Rank Ordered Age-Groups for Early Intervention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	--	--	2	2	1
Children, 6 to 17	**5**	--	--	--	--
Transition-age Youth, 18 to 25	--	**4**	**1**	--	--
Adults, 26-59	--	--	2	3	--
Older Adults, 60+	--	1	--	--	4

When asked to explain their rankings, several interviewees (n=4) indicated that their reasoning was similar to that for identifying priority age groups for prevention services. Examples of more specific explanations offered by interviewees for the top age groups cited are provided below.

Children, 6 to 17

- This is the age group where the greatest impact can be made
- Children represent the future of society and they need to be emotionally healthy in order to lead successful and happy lives
- There are broken children/youth in the community who are already violent and hurting themselves

Transition-age Youth, 18-25

- Many in this age group do not know what services are available to them nor how to access them once they are living on their own
- *"This is where we are getting a lot crime in our community"*

VII. Priority Populations

The California State Department of Mental Health (CDMH) MHSA has identified the following six priority populations for PEI: [4] 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children/youth in stressed families; 4) Trauma-exposed individuals; 5) Children at-risk for school failure; and, 6) Children and youth at-risk of or experiencing involvement with the Juvenile Justice System. To determine which priority populations the interviewees identified as most in need of prevention and/or early intervention services in Area 3, they were asked to rank order them from highest to lowest. As displayed in **Table 12** below, four of five interviewees identified Children and youth in stressed families as the priority population most in need of prevention or early intervention services in their communities. The other respondent ranked Children and youth in stressed families as the second highest priority. One interviewee stressed several of the categories are intertwined and are all an immediate priority. Explanations for Children and youth in stressed families included:

Children and youth in stressed families

- There is a general lack of services for this population
- Stressors in families can come from inadequate jobs or income, adaptive disorders and cultural changes
- This group needs PEI services in order for them to become healthy and successful adults

[4] Definitions for each priority population can be found in the Key Individual Interview Questions contained in the **Appendix**.

- Youth have mental health issues that are compounded through the years
- Youth need help to deal with transitions to young adulthood and mental instabilities
- Families who are solid and strong add to the resiliency of children – without that resiliency, everything that follows is going to be a challenge for those who have grown up in stressed families

The interviewee who selected Underserved cultural populations as the highest priority stated that this is because there are several large populations that are not being served, especially in their language.

Four of the five respondents listed Children at-risk for school failure as one of the top three highest priorities. Even though none selected this category as the highest priority it is interesting to note the specific explanations:

- The list of issues that impact learning include such situations as children who are homeless, those living in group homes, or in unsettled or violent homes, all of which can affect academic learning
- It is such a "*critical item that children not fail school, that we need them in society*"
- Children at-risk for school failure are also at-risk for involvement with the Juvenile Justice system

Table 12: Rank Ordered Priority Populations
(n=5)

Priority Populations	1st	2nd	3rd	4th	5th	6th
Children and youth in stressed families	**4**	**1**	--	--	--	--
Underserved cultural populations	1	1	--	--	3	--
Children at risk for school failure	--	**2**	**2**	--	--	1
Children and youth at risk of or experiencing involvement with the Juvenile Justice System	--	1	1	3	--	--
Individuals experiencing the onset of serious psychiatric illness	--	1	--	1	1	2
Trauma-exposed individuals	--	--	2	1	1	1

VIII. Existing PEI Services

Following the interviewees' rankings of the CDMH priority populations, the interviewer asked the five interviewees to identify existing prevention and/or early intervention services in Area 3 that were currently serving their top ranked priority population, which in this case is Children and youth in stressed families (n=4) and Underserved cultural populations (n=1).

Responses offered by the five participants that address the needs of Children and youth in stressed families and Underserved cultural populations are listed below in alphabetical order. Clinicas was identified as a "Community-defined Evidence Practice" with some programs that are considered as "Evidence-based Programs". KEYS Leadership Academy was identified as a "Promising Practice".

- The 800 and 211 24-hour help line
- Adult Protective Services in Camarillo
- Casa Pacifica

- Clinicas (n=2)
- Drug and alcohol treatment facility
- Faith-based organizations (n=4) including:
  - Interfaith services
  - The Family Ministry and Church
- High school
- Interface
- KEYS Leadership Academy
- Mental health services in Conejo Valley
- School districts with psychologists
- Short-term shelters
- Ventura County Behavioral Health
- Ventura County Medical Center
- Youth Probation Department

IX. Needed PEI Services

Conversely, interviewees were also asked to recommend needed prevention and/or early intervention services that could address the mental health needs of the priority population they ranked number one. The interviewee who identified Underserved cultural populations as the top priority suggested that more school-based sites be instituted in order to interact with children and to screen those children who could benefit from some home visits to deal with abuse or adjustment issues adding that *"If you are going to go do early intervention, you have to go where the children are. And, where they are going to be is in day care and elementary schools."*

Recommendations for programs and services that would benefit Children and youth in stressed families highlighted a perceived need for outreach through schools and other community centers, as well as offering services that could meet the basic needs of those families under stress, and to follow up with continuity of care:

- A part-or full-time on-site therapist at the high school
- Offer anger management program, outreach programs and services
- More Community Real Clinics should be available, especially in the lower socio-economic areas of Ventura County
- Offer transitional housing and employment plans for homeless and group home children, youth, and their families
- Offer easily accessible, culturally competent services at low or limited cost and have those services available around the clock
- Provide continuity of care, services, and medication realizing that it is important to provide initial services and follow through until consumer is well again
- Once a child or family is referred to a program, counselors should come out to the home immediately

X. Service Access and Delivery

In addition to a lack of needed services, barriers to service access can also pose a challenge. As displayed in **Table 13** below, interviewees identified the lack of bilingual, bicultural services, whether it be the lack of culturally competent staff or the fact that children are the link to parents

for mental health services because of language issues as the greatest health service access barrier (n=8). Inconvenient operating hours and lack of available services were mentioned as concerns relating to limited access (n=4), as was the stigma associated with the fear of *"coming out"* to receive mental health services, especially among those within the Latino community (n=4).

Table 13: Service Access Barriers
(n=5)

Barriers	Number of Mentions
Lack of bilingual/bicultural services	8
Limited access	4
Stigma	4
Lack of awareness	3
Financial	2
Lack of communication and collaboration among service providers (about consumers)	1
Limited resources	1
Transportation	1
Total:	**24**

When asked to suggest strategies to increase access**, Table 14** shows that interviewees were most likely to emphasize the importance of education and outreach, making sure that a *"culturally sensitive educational campaign"* is utilized and to go to where the people are because "*to bring them in, they have to be found*" (n=6). Providing transportation whether with mobile units or through free services was also stressed (n=3).

Table 14: Strategies to Decrease Access Barriers
(n=5)

Strategy	Number of Mentions
Education and outreach (including bilingual/bi-cultural outreach)	6
Provide transportation	3
Increased funding	2
Accessible settings/location-based services	2
Culturally competent/bilingual/bicultural staff	2
Services tailored to the needs of each group	1
Reduce stigma	1
Total:	**17**

As a follow up the previous question, interviewees were asked to identify the best ways to provide effective, culturally appropriate prevention and early intervention services in their communities (see **Table 15**). About a third of interviewees' recommendations addressed culturally competent outreach and education to the community to provide awareness about mental health services (n=5). Suggestions included hosting neighborhood groups, disseminating information in places that community members frequent progressively over time, and developing a mental health campaign that equates accessing mental health services with medical services when one has a cold or flu. It is also important to these interviewees that culturally competent staff are available for those who seek help (n=3), and that a

concerted effort is mounted to increase communication and collaboration among organizations and the county (n=3).

Table 15: Ways to Provide Culturally Appropriate and Effective Services
(n=5)

Recommendation	Number of Mentions
Outreach, education, and awareness (bilingual/bicultural)	5
Culturally competent/bilingual/bicultural staff	3
Communication/collaboration among organizations and county	3
Accessible settings/location-based services	2
Programs for children/youth	1
Provide transportation	1
Reduce stigma	1
Total:	**16**

XI. Outreach, Education, Awareness

Finally, recommendations to better educate and inform their communities about mental health prevention and early intervention were solicited from interviewees, as displayed in **Table 16**. Most of their responses fell into two categories: information dissemination (n=8) and strategic outreach/public promotion (n=6). Examples of interviewees' specific recommendations are presented below the table.

Table 16: Recommendations to Educate and Inform the Community about PEI
(n=5)

Recommendation	Number of Mentions
Information dissemination	8
Strategic outreach/public promotion	6
Communication/collaboration among organizations and county	2
Culturally competent/bilingual/bicultural staff	1
Education for county workers	1
Total:	**18**

<u>Strategic Outreach/Public Promotion of PEI</u>

- Make sure the public relations effort is continuous
- Provide information in places and at times accessible to community members
- A comprehensive, long-term, culturally-sensitive, educational campaign is required
- Be more welcoming
- Conduct more outreach to specific populations
- Try to be as inclusive as possible, using innovative methods to reach out to various populations

<u>Information Dissemination</u>

- Radio announcements in Mixteco, similar to what Clinicas does
- Place public notices in the entry/exit ways of public places
- Engage county and agency workers to promote PEI
- Conduct a public awareness campaign through the Spanish language newspapers

- Mental health education in the classrooms following methods of the Tobacco Prevention and Education program
- Conduct a public awareness campaign tied in with educational materials delivered over the radio, especially on Spanish speaking stations
- A mobile unit committed to raising awareness about mental health and mental health services

XII. Additional Comments

When asked if they had any additional comments to offer regarding PEI or to share with VCBH, interviewees expressed a need to improve and expand upon existing services. There seems to be a realization that mental health needs of the community are inextricably linked with VCBH and how that department will plan for the future. One interviewee offered the support and use of his program's facilities to assist with the PEI planning process in any way needed. Selected examples of comments are included below:

- *"I can just see that the future is getting better. I see PEI as really having an impact on the high school. I hope we have some creative programs and things that do happen."*
- *"Services should be accessible. Mental health care should be available for everyone and no one should be turned away."*
- *"They [VCBH] have a tough job and they are doing the best they can. Law enforcement is definitely willing to work however we can, it's a problem we share together. We want them to be successful."*
- *"They [VCBH] need to share these funds as prescribed by the act with community health centers. And, they also need to have more minorities within their staff as the lack affects the integrity of their program."*

XIII. Implications and Observations

Though diverse in their backgrounds, data collected from the key individual interviews produced clear trends. Respondents related that, despite community strengths such as programs for youth and church-based programs, mental health issues faced by struggling individuals and families had resulted in deleterious community impacts. Gang involvement, drug use, teen disorders, and *"at-risk youth who are like time bombs"* were mentioned as the most prevalent negative community impacts resulting from limitations on mental health service availability and use.

Generally, interview participants agreed that children and youth should be the primary focus of prevention and early intervention services, in addition to gearing service provisions toward Children and youth in stressed families to help create support systems that are solid, strong and resilient. In order to increase awareness of and access to mental health services, it was recommended that barriers such as a shortage of culturally competent services, limited access to services, and the social stigma associated with mental health issues be addressed. It was suggested that bilingual and bicultural community education and outreach should be disseminated at community events, slowly and progressively over time. Additionally, VCBH was urged to use all kinds of bilingual media such as radio, TV, newspaper, and bus advertisements to get the word out about mental health. It was also recommended that transportation be offered whether in the form of a mobile unit coming out to the community, or through free public access. Increased communication and collaboration among

and across organizations and the county may also assist in VCBH's effort to increase accessibility to individuals and families in need.

APPENDIX

Informant's Organizational Affiliation

29. Briefly describe the types of services you or your organization provides.

Knowledge Regarding PEI

30. How knowledgeable are you about Ventura County Behavioral Health's Prevention and Early Intervention (PEI) planning process?

    __ Very Knowledgeable

    __ Somewhat Knowledgeable

    __ Not at all Knowledgeable

    2a. Please qualify/explain why you responded very or somewhat knowledgeable? (e.g., How did you become very knowledgeable/somewhat knowledgeable?)

Community Mental Health Needs

31. Overall, what are the greatest mental health needs in your community?

3a. How do you see these needs impacting your community?

32. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Please rank order the following mental health needs with 1 representing what you believe is the highest need in your community.

__ Disparities in access to mental health services

__ Psycho-social impact of trauma

__ At-risk children, youth, and young adult populations

__ Stigma and discrimination

__ Suicide risk

4a. Please explain your ranking.

4b. What strengths or protective factors exist in your community that could help address the top mental health needs you identified? (e.g., opportunities for youth involvement in the schools; strong faith-based organizations in the area; lots of support services for at-risk youth; strong family or other support networks, etc.)

Priority Age Groups—Prevention Services

Prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders.

33. Please rank order the following age groups with 1 representing the age group most in need of **prevention** services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

5a. Please explain your ranking

Priority Age Groups—Early Intervention Services

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse.

34. Please rank order the following age groups with 1 representing the age group most in need of **early intervention** mental health services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

6a. Please explain your ranking.

Priority Populations

35. The California State Department of Mental Health has identified six priority populations for PEI. (*The state definition for each priority population is found on the last page of this interview guide). Please rank order the list below with 1 representing the priority population most in need of **prevention** and/or **early intervention** services in your community.

__Underserved cultural populations

__Individuals experiencing the onset of serious psychiatric illness

__Children/youth in stressed families

__Trauma-exposed individuals

__Children at risk for school failure

__Children/youth at risk of or experiencing involvement with the Juvenile Justice System

7a. Please explain your ranking.

Existing and Needed PEI Services

36. Do you know of any existing **prevention** and/or **early intervention** services that currently address the mental health needs of your number one ranked priority population from Question 7? If yes, please identify? If no, please skip to Question 9.

*8a. Of the existing programs and services you just listed, do you know if any of them are considered *evidence-based programs (EBP), promising practices (PP), or community-defined evidence practices (CDEP)*? (*The definitions for each type of research-based practice can be found on the last page of this interview guide.)

8b. If yes, which ones? (Please identify whether EBP, PP, or CDEP.)

37. What **prevention** and/or **early intervention** services are needed to address the mental health needs of the priority population you ranked number one, _____? (Insert the top ranked priority population from Question 7.)

Service Access and Delivery

38. What barriers do people encounter accessing mental health services in the communities

you serve?

39. What types of strategies would help people get the mental health services they need in the communities you serve?

40. What are the best ways to provide effective, culturally appropriate **prevention** and **early intervention** services in your community?

Outreach, Education, and Awareness

41. What recommendations do you have to better educate/inform your community about

mental health **prevention** and **early intervention**?

Additional Comments

42. Is there anything else you would like to add or you would like Ventura County Behavioral Health to know?

*Q7 Priority Population Definitions

Underserved Cultural Populations. PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, veterans, deaf and blind, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Individuals Experiencing Onset of Serious Psychiatric Illness. Those identified by providers,

including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth in Stressed Families. Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-exposed. Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at-Risk for School Failure. At-risk due to unaddressed emotional and behavioral problems.

Children/Youth at-Risk of or experiencing Juvenile Justice Involvement. Those with signs of behavioral/emotional problems who are at-risk or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Service Supports.

*Q8a Research-based Practice Definitions

Evidence-Based Programs include programs that have been evaluated and show positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness.

Promising Practices include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.

Community-defined Evidence Practices include programs that have been identified by local unserved and/or underserved communities and have demonstrated effectiveness in local communities.

AREA 4 KEY INDIVIDUAL INTERVIEWS
Thousand Oaks, Newbury Park, Westlake Village

CONDUCTED AS PART OF THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN DEVELOPMENT PROCESS
IN VENTURA COUNTY

April 2009

Prepared for:
The Ventura County Behavioral Health Department

Prepared by:
EVALCORP Research & Consulting, Inc.

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TABLE OF CONTENTS

I. Introduction

The Ventura County Behavioral Health Department (VCBH) is taking a comprehensive community-based approach to the development of the County's Prevention and Early Intervention (PEI) Plan. This effort is funded through the Mental Health Services Act (MHSA), an act providing funds for services and supports to help people feel socially and emotionally stable.

The MHSA has defined mental health *prevention* as reducing risk factors and building protective factors in order to keep mental health issues from occurring. Mental health *early intervention* refers to short, low-intensity services to improve mental health problems and avoid the need for more extensive treatment.

The approach to developing the PEI plan is multi-faceted and utilizes the collection of quantitative data, key individual interviews, focus groups, and community forums to assess the mental health needs, priority populations, and needed services across five geographic areas of Ventura County. VCBH contracted with Evalcorp Research & Consulting, Inc. to spearhead the PEI data collection process. The data gathered by Evalcorp will be analyzed and synthesized to inform Ventura County's Prevention and Early Intervention Plan.

This report presents findings from the Key Individual Interviews that were conducted in Area 4, representing Thousand Oaks, Newbury Park and Westlake Village. The purpose of these interviews was to collect data on the mental health issues and needs in the communities served by the interviewees.

II. Methodology

Participants

During the first phase of the PEI Planning Process, 25 key individual interviews were conducted across five geographic areas of Ventura County; five interviews in each Area. A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to mental health prevention and early intervention.

VCBH, with guidance from Evalcorp Research & Consulting, Inc., identified interviewees based on geographic representation and representation within the following MHSA categories: age group, community sector, priority populations, and key prevention and early intervention community mental health needs. Key individual interviewees were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for prevention and early intervention.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals across five geographic Areas of Ventura County. Key individuals were initially identified by VCBH. Evalcorp provided consultation on the process and helped to finalize the list of invited participants, ensuring representation across requisite criteria specified by the MHSA.

Evalcorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A formal Letter of Invitation and Confirmation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions. A copy of the Key Individual Interview Questions can be found in the **Appendix**.

A majority of the key individual interviews were conducted by telephone, and others in-person. The interviews each took about one hour to complete. During the interviews, participants were asked about community and mental health needs, age group priorities and priority populations, existing and needed prevention and early intervention services, and recommendations for providing effective prevention and early intervention services. The interviews were audio recorded with the consent of the interviewee. Once the interviews were complete, participants received a thank-you letter acknowledging their participation.

A transcript was prepared for each key individual interview conducted, summarizing each participant's responses by question. Information from each interview was then coded so that the data could be content analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Services Provided, and Communities Served

Demographics

Five key individuals participated in the Area 4 interviews. Selected to represent a diverse set of mental health prevention and early intervention stakeholders, interview respondents represented different, and, in some cases, multiple community sectors including health (n=3), social services (including the faith-based community) (n=3), and mental health service providers (n=1).

Three of five interviewees selected Caucasian as their ethnicity, one marked Asian/Pacific Islander and one chose Latino/Hispanic. The interviewee sample included one male and four females. Three individuals were between the ages of 26 and 59, whereas two respondents were older adults over the age of 60. All five respondents reported speaking English, two marked that they speak Spanish, and one each who speaks Farsi and Japanese.

Services Provided and Communities Served

Interviewees completed a participant profile as a means of gathering additional information on their backgrounds in terms of the communities they serve and their frame of reference with respect to prevention and early intervention mental health services. Additionally, participants were asked at the beginning of each interview to clarify and elaborate on services provided by the individual and his/her organization. As displayed in **Table 1**, community awareness programs, programs for youth and/or adults, health services and mental health services were cited most often as types of services their organizations provide.

Table 1: Services Provided by the Interviewee or His/Her Organization
(n=5)

Services	Number of Mentions
Community awareness programs	4
Programs for youth and/or adults	4
Health services	3
Mental health services	3
Community liaison	2
Crisis intervention	1
Cultural awareness	1
Resource referral	1
Social services	1
Total:	**20**

Additional organizational information gathered from the participant profiles is presented in **Tables 2 through 5** below. **Table 2** indicates that all of the interviewees represent Area 4, which includes Thousand Oaks, Newbury Park, and Westlake Village. As displayed, interviewees also represented Areas other than Area 4.

Table 2: **Geographic Area of Ventura County Served By Interviewees**
(n=5)

Geographic Area	Number of Participants
Area 1: Fillmore, Piru, Santa Paula	1
Area 2: Ojai, Ventura	2
Area 3: Camarillo, Oxnard, Port Hueneme	3
Area 4: Thousand Oaks, Newbury Park, Westlake Village	5
Area 5: Moorpark, Simi Valley	4

As displayed in **Table 3** interviewees were most likely to serve Latino/Hispanic individuals (n=3), which includes the Mexican, Mixteco, and Zapoteco communities, in addition to the Asian/Pacific Islander community (n=3).

Table 3: Underserved/Unserved Populations Represented By Interviewees
(n=5)

Underserved/Unserved Populations	Number of Participants
Latino/Hispanic	3
Mexican	2
Mixteco	1
Zapoteco	1
Asian/Pacific Islander	3
Homeless	2
African-American	2
American Indian	2
Eastern European/Middle Eastern	2
Refugees	2
Migrant Farm Workers	1
Co-occurring Disorders	1
Veterans	1

Children and youth in stressed families (n=4) and Underserved cultural populations (n=4) were being served by almost all the interviewees (see **Table 4**).

Table 4: Priority Populations Served/Represented By Interviewees
(n=5)

Priority Populations	Number of Participants
Children/Youth in Stressed Families	4
Underserved Cultural Populations	4
Children at Risk for School Failure	2
Children/Youth at Risk of or Experiencing the Juvenile Justice System	1
Trauma-Exposed Individuals	1
Individuals Experiencing Onset of Serious Psychiatric Illness	1

All but one interviewee provides services to Older adults, and three of five interviewees serve Children, Transition-age youth, and Adults, as displayed in Table 5.

Table 5: Age Groups Served By Interviewees
(n=5)

Age Groups	Number of Participants
Older Adults (60+)	4
Children (6-17)	3
Transition-age Youth (TAY) (18-25)	3
Adults (26-59)	3
Prenatal to Pre-K (0-5)	1

IV. Knowledge of the VCBH PEI Planning Process

To document the interviewees' knowledge of the VCBH PEI planning process, each interviewee was asked to indicate their level of knowledge on a three-point scale ranging from "not at all knowledgeable" to "very knowledgeable." The five interviewees in Area 4 identified themselves as either "not at all" (n=3) or "somewhat" (n=2) knowledgeable of the process.

When asked to qualify their answers, the three respondents without any prior knowledge of the PEI planning process indicated that they first learned about PEI when they were invited to participate in the interview.

Those who were "somewhat knowledgeable" of the process (n=2) were informed through different sources. One interviewee gained knowledge of VCBH and its proposed programs through reading about it in the paper and hearing about it at National Alliance on Mental Illness (NAMI) classes for providers. The other interviewee stated that she has served on many mental health committees within the county at which there are discussions about gaps in services and the need for more services. She has learned about PEI through these conversations and has a general knowledge about the process.

V. Mental Health Needs

Greatest Mental Health Needs

In order to address and help prioritize unmet community mental health needs, interviewees were asked to identify the greatest mental health needs in their communities. A wide variety of responses were offered, but services for marginalized populations (n=3) and alcohol and other drug prevention/intervention were the needs identified most often (**Table 6**).

Marginalized populations identified by the interviewees include undocumented workers who try not to draw attention to themselves and Hispanic families. Without appropriate services, many turn to alcohol and drug use/abuse resulting in deleterious effects on families and the community. One interviewee stressed how all of these needs coalesce to affect parents, and as a result the whole family. She stated that *"if you can impact the parents, you are going to impact the children."*

Table 6: Greatest Mental Health Needs
(n=5)

Mental Health Needs	Number of Mentions
Services for marginalized populations	3
Alcohol and other drug prevention/intervention	2
Culturally appropriate services	1
Communication and collaboration among service providers	1
Financial access	1
Increased access	1
Isolation reduction	1
Prevention/early intervention services	1
Services for family issues	1
Services for older adults	1
Services for youth	1
Suicide risk reduction	1
Total:	**15**

Impact of the Greatest Mental Health Needs

When invited to describe how mental health needs were impacting their communities, responses were specific and targeted (**Table 7**). Respondents described how tensions within struggling families result in poor academic performance, youth who make inappropriate decisions, and with grandparents often needing to assume responsibility for their grandchildren. Problems in families spill over into the community in the form of gang and criminal activity or drug use. They expressed concerns that there are negative mental health outcomes when patients' needs are unaddressed and children with behavioral problems are not helped. Cultural and social isolation, social stigma, and being a member of a marginalized population also present a barrier to service access for those who would benefit from services.

Table 7: The Impact of Mental Health Needs on Interviewees' Communities
(n=5)

Impact of Mental Health Needs	Number of Mentions
Struggling families	7
Negative mental health outcomes	4
Stigma	1
Isolation	1
Involvement with justice system	1
Marginalized populations	1
Struggling older people	1
Total:	**16**

Ranking MHSA Mental Health Needs

Building upon interviewees' discussion about the mental health needs in the community and the impact of those needs, each of the five interviewees was presented a list of five California Department of Mental Health (CDMH) MHSA mental health needs and asked to rank order those needs from highest to lowest need. The five mental health needs are: 1) At-risk children, youth, and young adult populations; 2) Stigma and discrimination; 3) Disparities in access to mental health services; 4) Psycho-social impact of trauma; and, 5) Suicide risk. **Table 8** below displays the interviewees' rankings.

Four of five respondents ranked At-risk children, youth, and young adult populations and Disparities in access to mental health services within the top three mental health needs in their communities. Stigma and discrimination and Suicide risk were ranked as the highest three priorities by three out of five interviewees. The Psycho-social impact of trauma was ranked fourth or fifth by the majority of the respondents (n=4). Explanations for the three most popular rankings are presented below the table.

Table 8: Rank Ordered Mental Health Needs
(n=5)

Mental Health Needs	1st	2nd	3rd	4th	5th
At-risk children, youth, and young adult populations	**2**	**2**	--	1	--
Disparities in access to mental health services	**2**	**1**	**1**	1	--
Stigma and discrimination	**1**	--	**2**	--	2
Suicide risk	--	2	1	--	2
Psycho-social impact of trauma	--	--	1	2	2

<u>At-Risk Children, Youth, and Young Adult Populations</u>

- More and more young people are being seen for co-occurring disorders because there are not enough programs to deal with incidence of these diagnoses among youth
- It is critical to reach children early in order to prevent issues from developing or worsening
- This population suffers from social and dire economic conditions

Disparities in Access to Mental Health Services

- Due to eligibility criteria, it is very challenging to access mental health services making this group the top priority as it goes *"hand-in-hand"* with other mental health needs
- Once this community health need is taken care of, the other issues fall into place making this category the one to receive money as it could realize the greatest impact
- This becomes a big issue by middle school, especially if families do not have enough money to buy supplies for classes, access to the internet, or transportation to the library – teachers often think that these students do not care, when in reality these youth may not be able to financially meet the requirements that are necessary to succeed

Stigma and Discrimination

- There is often shame involved in receiving mental health services because many think *"I should be able to deal with it myself, [but] they can't deal with it themselves"*
- The stigma surrounding mental health is a barrier to accessing cervices for white, middle-class families, as well as Hispanic families in the community

Community Strengths

In an effort to build upon the existing assets in Area 4, interviewees were asked to describe the strengths or protective factors currently available in their communities that could help address the top mental health needs identified in the previous question (**Table 9**). Three categories each had three mentions: community-based programs, programs and activities for youth, and faith-based programs. Community-based programs noted were Kids and Company and the Japanese American Citizen League, while programs and activities for youth mentioned were booster clubs, organizations that can provide stipends for youth to participate, and summer camps, especially where older siblings can run the camps with younger siblings participating. The Hispanic Ministry, Oxnard Buddhist Temple and the Japanese American Christian Chapel were the three faith-based programs mentioned. Collectively, community-based programs, programs and activities for youth and faith-based programs comprise over half of the mentions regarding community strengths.

Table 9: Community Strengths/Protective Factors
(n=5)

Strengths/Protective Factors	Number of Mentions
Community-based programs	3
Programs/activities for youth	3
Faith-based programs	3
County services	2
Families	2
Referral service	1
Role models/advocates	1
School partnerships	1
Sports/recreation programs	1
Total:	**17**

VI. Priority Age Groups

Prevention

Mental health prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders. To document interviewees' opinions about the age groups in greatest need of prevention services within their communities in Area 1, the following five age groups were presented for rank ordering: 1) Prenatal to Pre-K, 0 to 5; 2) Children, 6 to 17; 3) Transition-age Youth (TAY), 18 to 25; 4) Adults, 25 to 59; and, 5) Older Adults, 60+. The resulting responses are displayed in **Table 10** below. As shown, each of the five interviewees selected a different category to represent the highest priority. However, four of five interviewees identified Adults, 26-59, Transition-age youth, 18 to 25, and Children, 6-17 as high-priority age groups (i.e., ranked first, second or third). Representative examples of respondents' reasons for prioritizing those groups are listed below the table.

Table 10: Rank Ordered Age-Groups for Prevention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	1	--	--	3	1
Children, 6 to 17	**1**	**1**	**2**	1	--
Transition-age Youth (TAY), 18 to 25	**1**	**2**	**1**	--	1
Adults, 26 to 59	**1**	**2**	**1**	1	--
Older Adults, 60+	1	--	1	--	3

<u>Adults, 26-59</u>

- This is where the largest gap in service is and this is the age group that ultimately impacts the other age groups, having a particularly serious impact on their kids (i.e., all of the prevention and early intervention that is offered for youth is lost when youth go home to parents who do not know effective parenting strategies)
- This age group is affected by the closure of out-patient clinics in the county due to funding
- The current economic recession has resulted in many adults losing their homes and jobs and having a very difficult time leading to depression, or perhaps suicide

<u>Transition-age Youth, 18 to 25</u>

- More youth in this age group, especially if widened to include 14 to 25 year olds are being seen because of meth-induced psychosis in particular and co-occurring disorders in general
- This is the group that will be parents soon, and prevention services will help them be better parents

<u>Children, 6-17</u>

- The best prevention is that which comes earlier, especially for school aged youth
- The earlier the prevention the better, as it impacts the trajectory of everyone's life

One respondent stated that while the Prenatal to Pre-K age group is important, she believes that *"First Five is doing a fabulous job funding mental health services, early intervention and screening."* She also listed Older adults as the fifth priority not because this group is not important, but trying to think of where money spent might get its best return.

Early Intervention

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse. Similar to the previous question about prevention services, interviewees were asked to rank order the same age groups according to the level of need for early intervention mental health services in Area 4.

As displayed in **Table 11**, all five interviewees chose a different age group as the highest priority. However, all five ranked Children as one of the top three priorities and four of five placed Transition-age youth in the top three priorities.

Table 11: Rank Ordered Age-Groups for Early Intervention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	1	--	2	2	--
Children, 6 to 17	**1**	**3**	**1**	--	--
Transition-age Youth, 18 to 25	**1**	**1**	**2**	1	--
Adults, 26-59	1	1	--	2	1
Older Adults, 60+	1	--	--	--	4

When asked to explain their rankings, one interviewee indicated that her reasoning was similar to that for identifying priority age groups for prevention services. Another thought that Prenatal to Pre-K was the most important age group, but listed them as fourth because she believes that the First Five organization is doing a great job. One interviewee ranked the various age groups from youngest to oldest in accordance with a belief that the earlier the intervention, the more effective and least costly. Examples of more specific explanations offered by interviewees for the top age groups cited are provided below.

<u>Children, 6 to 17</u>

- Special education services are an important assessment, planning, and intervention tool for addressing school-related issues
- There is a correlation between alcohol and drug use in parents, and psychological issues seen in their young children
- Children do not have the skills to deal with society and do not have fully developed communication skills

<u>Transition-age Youth, 18-25</u>

- They will become parents soon
- The impact of drug usage (both illicit and prescription drugs) on their mental health and lives in general means that many are dropping out of school or are in continuation school and are remaining in the system on a long-term basis

VII. Priority Populations

The California State Department of Mental Health (CDMH) MHSA has identified the following six priority populations for PEI: [5] 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children/youth in stressed families; 4) Trauma-exposed individuals; 5) Children at-risk for school failure; and, 6) Children and youth at-risk of or experiencing involvement with the Juvenile Justice System. To determine which priority populations the interviewees identified as most in need of prevention and/or early intervention services in Area 4, they were asked to rank order them from highest to lowest. As displayed in **Table 12** below, three of five interviewees identified Children and youth in stressed families as the highest priority population (n=2) or second highest priority population (n=1) most in need of prevention or early intervention services in their communities. One respondent pointed out that the needs of Children and youth in stressed families contribute to all the other areas of need on the list. Explanations for this ranking included:

<u>Children and Youth in Stressed Families</u>

- The beginnings of mental health issues are seen in this population, such as depression, substance abuse, and violence within the family, *"there is a huge need for services here"*
- The earlier the prevention or intervention when young, then the better the outcome and their future life with a lessened possibility of school failure and /or involvement with the Juvenile Justice system
- Families need to be reached earlier to have the greatest impact and the cost benefit. If families are not reached early, there will be trauma-exposed individuals and children at at-risk for school failure or experiencing the Juvenile Justice system

Two respondents considered Underserved cultural populations as the highest priority population (see **Table 12**). Explanations for this ranking included:

<u>Underserved cultural populations</u>

- This is where the biggest gaps in service exist, and where the greatest impact at all levels can be achieved
- Service workers who are employed in hotels, cleaning people's homes and offices, etc. become a forgotten population
- As a member of a minority population, this is the group the interviewee is most familiar with

One interviewee put Individuals experiencing the onset of serious psychiatric illness as the highest priority explaining that mental illness needs to be addressed at the onset in order to help individuals function through the rest of their lives, whether the mental illness is genetic or drug-induced.

[5] Definitions for each priority population can be found in the Key Individual Interview Questions contained in the **Appendix**.

Table 12: Rank Ordered Priority Populations
(n=5)

Priority Populations	1st	2nd	3rd	4th	5th	6th
Children and youth in stressed families	**2**	**1**	--	2	--	--
Underserved cultural populations	**2**	--	**1**	1	--	1
Individuals experiencing the onset of serious psychiatric illness	1	--	--	--	1	3
Children at risk for school failure	--	2	1	1	1	--
Trauma-exposed individuals	--	2	--	--	2	1
Children and youth at risk of or experiencing involvement with the Juvenile Justice System	--	--	3	1	1	--

VIII. Existing PEI Services

Following the interviewees' rankings of the CDMH priority populations, the interviewer asked the five interviewees to identify existing prevention and/or early intervention services in Area 4 that were currently serving their top ranked priority population, which include Children and youth in stressed families, Underserved cultural populations, and Individuals experiencing the onset of serious psychiatric illness.

One interviewee was unable to identify any existing prevention or early intervention services in the local community. Responses offered by the other four participants that address the needs of highest priority populations are listed below in alphabetical order. Several programs or services were identified as both "Promising Practices" and "Community-defined Evidence Practices": CAUSE; City Impact; El Centrito; El Concilio; Head Start; and Strategies, a program through Interface. Additionally, two programs, Kids and Company, and Westminster Free Clinic, were identified as "Promising Practices".

- Bilingual person from Behavioral Health
- Blue Book, a referral service through Interface
- CAUSE
- CIRT
- City Impact
- El Centrito
- El Concilio
- First Five
- Head Start through Child Development Resources
- Kids and Company
- Neighborhoods for Learning
- Senior outreach and services program for older adults
- Strategies, a program through Interface
- Triad program between Children's Mental Health, Probation, and Children's Services
- Those with Medi-Cal have access through county programs
- Westminster Free Clinic

IX. Needed PEI Services

Conversely, interviewees were also asked to recommend needed prevention and/or early intervention services that could address the mental health needs of the priority population they ranked number one. The interviewee who identified Individuals experiencing the onset of severe psychiatric illness suggested education and increased public awareness of mental issues to reduce the stigma attached. Additionally, there should be increased access and more involvement for families of those experiencing the onset of mental illness.

Recommendations for programs and services that would benefit Children and youth in stressed families strongly pointed to education and outreach in the community:

- Important to communicate the same message across social workers, behavioral health, community resource centers and primary care physicians
- Educate and let the community know about all types of social services available
- Information regarding services must be pervasive throughout the community
- Prevention education should come from several sources including schools, clinics, and VCBH
- Disseminate prevention education for parents on how to raise healthy children including information on bonding, infant cues, child development, and mental health issues
- Information on services must be in an understandable language, especially Spanish

Recommendations for programs and services that would benefit Underserved cultural populations highlighted a perceived need for outreach and community education, and to offer services through others who have been trained in the community:

- Outreach to those who are unassimilated and impress upon them how important it is to learn English
- Paraprofessional training of parents who can train others in their community, "*We have found that it empowers the community, it helps them help themselves, it doesn't create stigmas, and because they are teachers they are changing the way they do things … that's a very, very effective approach*"
- Stress education and keep youth in school longer
- Youth must be taught to separate stereotypes from reality
- Parents must learn to give their children confidence in their abilities and futures
- Increase awareness of services to populations who do not know what is available

X. Service Access and Delivery

In addition to a lack of needed services, barriers to service access can also pose a challenge. As displayed in **Table 13**, interviewees identified financial barriers (n=4), which includes lack of money or not having insurance; and limited access (n=4), which includes the lack of available services in general, the lack of mental health services in this part of the county, and restrictive eligibility requirements as the top mentioned barriers. Additionally, issues of language, cultural stigmas, and transportation were each mentioned three times as barriers to those receiving the services needed.

Table 13: Service Access Barriers
(n=5)

Barriers	Number of Mentions
Financial	4
Limited access	4
Language	3
Stigma	3
Transportation	3
Lack of awareness	2
Lack of bilingual/bicultural services	1
Lack of communication and collaboration among service providers (about consumers)	1
Limited family involvement	1
Social isolation	1
Time to get an appointment	1
Total:	**24**

When asked to suggest strategies to increase access**, Table 14** shows that interviewees were most likely to stress the importance of education and outreach to the community, especially through appropriate bilingual/bicultural methods (n=9). Suggestions for education include outreaching to unserved populations, providing access to information in understandable vocabulary and appropriate language, increasing awareness of mental health services, developing community forums and focus groups, and relaying positive understanding about mental health issues to families and individuals.

Table 14: Strategies to Decrease Access Barriers
(n=5)

Strategy	Number of Mentions
Education and outreach (Including bilingual/bi-cultural outreach)	9
Culturally competent/bilingual/bicultural staff	2
Accessible settings/location-based services	2
Policy changes	2
Provide transportation	2
Reduce financial burden	2
Reduce stigma	2
Expand eligibility requirements	1
Increased funding	1
Prevention/early intervention	1
Total:	**24**

As a follow up to the previous question, interviewees were asked to identify the best ways to provide effective, culturally appropriate prevention and early intervention services in their communities (see **Table 15**). Mirroring the above responses, the most often mentioned recommendation (n=8) by the interviewees addressed outreach, education and awareness delivered in a culturally appropriate way. It was suggested to use celebratory events as vehicles for distributing information, while another respondent commented that support such as child care be provided at community meetings. Another

way identified to deliver PEI services included accessible settings/location-based services (n=4) such as working with the schools and having mental health professionals go to the community to overcome transportation barriers. The interviewees also thought it was important to have staff who are culturally competent (n=3) and to reduce stigma (n=3) attached to mental health care.

Table 15: Ways to Provide Culturally Appropriate and Effective Services
(n=5)

Recommendation	Number of Mentions
Outreach, education, and awareness (including bilingual/bicultural outreach)	8
Accessible settings/location-based services	4
Culturally competent/bilingual/bicultural staff	3
Reduce stigma	3
Communication and collaboration among organizations	1
Increased funding	1
Total:	**20**

XI. Outreach, Education, Awareness

Finally, recommendations to better educate and inform their communities about mental health prevention and early intervention were solicited from interviewees, as displayed in **Table 16**. Their responses fell into three categories: information dissemination (n=6), strategic outreach/public promotion (n=3), and communication and collaboration among organizations and the county. Interviewees' recommendations are presented below the table.

Table 16: Recommendations to Educate and Inform the Community about PEI
(n=5)

Recommendation	Number of Mentions
Information dissemination	6
Strategic outreach/public promotion	3
Communication and collaboration among organizations and county	3
Culturally competent bilingual/bicultural staff	1
Public education	1
Training	1
Total:	**15**

<u>Information Dissemination</u>

- Use public service announcements
- Fotonovelas are an excellent vehicle for educating the community as they represent cultural realities graphically and in the vernacular
- Develop a speaker's bureau
- Provide support groups for youth in middle schools and parents at all levels in order to disseminate information -- first through children, then through parents
- Provide collaborative presentations by schools, agencies, mental health systems at community locations that are marketed as health presentations instead of mental health to reduce stigma and increase access

<u>Strategic outreach/public promotion</u>

- Once these programs and individuals are educated, they will bring the information back to their community and bring people in for service
- Educational efforts that communicate in simple terms and a language understandable to the target communities
- Make sure Japanese seniors are aware of available services

Communication and collaboration among organizations and the county

- Build relationships with current programs, key individuals, grass roots organizations in the community
- Collaborate and partner with schools to have mental health professionals in schools to address needs and work together to reach those in the community
- Hire bilingual coordinators at schools who are friendly, respectful and approachable and who can make referrals as needed

XII. Additional Comments

When asked if they had any additional comments to offer regarding PEI or to share with VCBH, interviewees expressed a wide variety of suggestions. One interviewee mentioned how similar immigrants are across all groups. Another talked about how mental health services can help in a general sense, while another talked about a specific mental health law in Ventura County. Yet another interviewee thought long-range planning should incorporate training Latinos/Hispanics in the mental health field so that they would become the next generation of culturally competent providers in the county. One interviewee expressed her desire for additional PEI information and continued collaboration with this project. Selected comments are provided below:

- *"There is a lot of similarity in [all] immigrant groups. The things I touched on about the Japanese are true of all these other groups, especially the language and cultural things. There is a lot to overcome. Yet, I am glad to see that Ventura County is making some effort to find out what the problems are, how they can address them and how they can help the people because it's not going to get better, it's going to get worse."*
- *"Depression and stress are huge issues that cut across all cultures and socioeconomic statuses, often going undiagnosed and untreated. There is a need for prevention services to 'help smooth a life out' such as education on time management and coping skills … if mom is not healthy, how can children grow up to be healthy?"*
- *"Populations need to be empowered. I am so [glad] you are working on this, it is such a big need in the whole county. One of the reasons there is a lack of services isn't so much a lack of funding, but a lack of professionals who meet the qualifications I mentioned earlier such as cultural competency. I don't know how you would recruit new people into the county, or what could be done there in the short run. But, definitely in the long run we need to train people, especially in the Hispanic community. So if they are trained to be counselors, then I think they will stay in Ventura County even after they are trained."*
- *"We need to re-examine the Ventura County 5150 law regarding releasing patients from mental hospitals to live in the community. Some of the regulations were appropriate for when they were written; but not anymore. The DSM is evolving and including a lot of these new diagnoses, but the law has not changed."*

XIII. Implications and Observations

The interviewees had diverse backgrounds and not a lot of awareness regarding the VCBH PEI planning process. However, they had spent much time in their community working with mental health issues, gave a lot of thought to their responses, and came up with many, wide-ranging comments and suggestions about PEI. Respondents related that, despite strengths such as community-based, programs for youth and faith-based programs, there are a wide range of mental health needs in the community. The impact of these needs is seen most in struggling families and in negative mental health outcomes as evidence by poor academic performance and youth who make inappropriate decisions, which then spills over into the broader community in the form of drug use and criminal activity. A lack of access to mental health care often results in patients' needs not being addressed and children with behavioral problems not receiving help.

Generally, interview participants agreed that children and transition-age youth should be the primary focus of prevention and early intervention services, in addition to gearing service provision toward Children and youth in stressed families and Underserved cultural populations that typically experience disparities in quality of care and access. In order to increase awareness of and access to mental health services, it was recommended that barriers such as financial access including those with limited or no health insurance, and other access issues such as eligibility requirements and the lack of mental health services be addressed. The Area 4 interviewees also believes that issues of language, social and cultural stigmas, and lack of transportation are barriers to those who would benefit from mental health care. There was a strong agreement among the five interviewees that bilingual/bicultural public education, outreach, and awareness is a viable strategy to decrease access barriers, and that it is important to provide culturally appropriate and effective services. Community education in the form of fotonovelas, a speaker's bureau, support groups in schools, public service announcements, and presentations at community locations was suggested. It was also recommended that communication and collaboration among and across organizations and the county be increased. Provision of services at schools and community centers may also assist in VCBH’s effort to increase accessibility to individuals and families in need.

APPENDIX

Informant's Organizational Affiliation

43. Briefly describe the types of services you or your organization provides.

Knowledge Regarding PEI

44. How knowledgeable are you about Ventura County Behavioral Health's Prevention and Early Intervention (PEI) planning process?

__ Very Knowledgeable

__ Somewhat Knowledgeable

__ Not at all Knowledgeable

2a. Please qualify/explain why you responded very or somewhat knowledgeable? (e.g., How did you become very knowledgeable/somewhat knowledgeable?)

Community Mental Health Needs

45. Overall, what are the greatest mental health needs in your community?

3a. How do you see these needs impacting your community?

46. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Please rank order the following mental health needs with 1 representing what you believe is the highest need in your community.

__ Disparities in access to mental health services

__ Psycho-social impact of trauma

__ At-risk children, youth, and young adult populations

__ Stigma and discrimination

__ Suicide risk

4a. Please explain your ranking.

4b. What strengths or protective factors exist in your community that could help address the top mental health needs you identified? (e.g., opportunities for youth involvement in the schools; strong faith-based organizations in the area; lots of support services for at-risk youth; strong family or other support networks, etc.)

Priority Age Groups—Prevention Services

Prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders.

47. Please rank order the following age groups with 1 representing the age group most in need of **prevention** services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

5a. Please explain your ranking.

Priority Age Groups—Early Intervention Services

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse.

48. Please rank order the following age groups with 1 representing the age group most in need of **early intervention** mental health services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

6a. Please explain your ranking.

Priority Populations

49. The California State Department of Mental Health has identified six priority populations for PEI. (*The state definition for each priority population is found on the last page of this interview guide). Please rank order the list below with 1 representing the priority population most in need of **prevention** and/or **early intervention** services in your community.

__Underserved cultural populations

__Individuals experiencing the onset of serious psychiatric illness

__Children/youth in stressed families

__Trauma-exposed individuals

__Children at risk for school failure

__Children/youth at risk of or experiencing involvement with the Juvenile Justice System

7a. Please explain your ranking.

Existing and Needed PEI Services

50. Do you know of any existing **prevention** and/or **early intervention** services that currently address the mental health needs of your number one ranked priority population from Question 7? If yes, please identify? If no, please skip to Question 9.

*8a. Of the existing programs and services you just listed, do you know if any of them are considered *evidence-based programs (EBP), promising practices (PP), or community-defined evidence practices (CDEP)*? (*The definitions for each type of research-based practice can be found on the last page of this interview guide.)

8b. If yes, which ones? (Please identify whether EBP, PP, or CDEP.)

51. What **prevention** and/or **early intervention** services are needed to address the mental health needs of the priority population you ranked number one, _____? (Insert the top ranked priority population from Question 7.)

Service Access and Delivery

52. What barriers do people encounter accessing mental health services in the communities

you serve?

53. What types of strategies would help people get the mental health services they need in the communities you serve?

54. What are the best ways to provide effective, culturally appropriate **prevention** and **early intervention** services in your community?

Outreach, Education, and Awareness

55. What recommendations do you have to better educate/inform your community about mental health **prevention** and **early intervention**?

Additional Comments

56. Is there anything else you would like to add or you would like Ventura County Behavioral Health to know?

*Q7 Priority Population Definitions

Underserved Cultural Populations. PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, veterans, deaf and blind, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Individuals Experiencing Onset of Serious Psychiatric Illness. Those identified by providers,

including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth in Stressed Families. Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-exposed. Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at-Risk for School Failure. At-risk due to unaddressed emotional and behavioral problems.

Children/Youth at-Risk of or experiencing Juvenile Justice Involvement. Those with signs of behavioral/emotional problems who are at-risk or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Service Supports.

*Q8a Research-based Practice Definitions

Evidence-Based Programs include programs that have been evaluated and show positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness.

Promising Practices include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.

Community-defined Evidence Practices include programs that have been identified by local unserved and/or underserved communities and have demonstrated effectiveness in local communities.

AREA 5 KEY INDIVIDUAL INTERVIEWS
Moorpark, Simi Valley

CONDUCTED AS PART OF THE MENTAL HEALTH SERVICES ACT
PREVENTION AND EARLY INTERVENTION PLAN DEVELOPMENT PROCESS
IN VENTURA COUNTY

April 2009

Prepared for:
The Ventura County Behavioral Health Department

Prepared by:
EVALCORP Research & Consulting, Inc.

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TABLE OF CONTENTS

I. Introduction

The Ventura County Behavioral Health Department (VCBH) is taking a comprehensive community-based approach to the development of the County's Prevention and Early Intervention (PEI) Plan. This effort is funded through the Mental Health Services Act (MHSA), an act providing funds for services and supports to help people feel socially and emotionally stable.

The MHSA has defined mental health *prevention* as reducing risk factors and building protective factors in order to keep mental health issues from occurring. Mental health *early intervention* refers to short, low-intensity services to improve mental health problems and avoid the need for more extensive treatment.

The approach to developing the PEI plan is multi-faceted and utilizes the collection of quantitative data, key individual interviews, focus groups, and community forums to assess the mental health needs, priority populations, and needed services across five geographic areas of Ventura County. VCBH contracted with Evalcorp Research & Consulting, Inc. to spearhead the PEI data collection process. The data gathered by Evalcorp will be analyzed and synthesized to inform Ventura County's Prevention and Early Intervention Plan.

This report presents findings from the Key Individual Interviews that were conducted in Area 5, representing Simi Valley and Moorpark. The purpose of these interviews was to collect data on the mental health issues and needs in the communities served by the interviewees.

II. Methodology

Participants

During the first phase of the PEI Planning Process, 25 key individual interviews were conducted across five geographic areas of Ventura County; five interviews in each Area. A "key individual" is someone who is knowledgeable about a specific community, issue, or problem related to prevention and early intervention.

VCBH, with guidance from Evalcorp Research & Consulting, Inc., identified interviewees based on geographic representation and representation within the following MHSA categories: age group, community sector, priority populations, and key prevention and early intervention community mental health needs. Key individual interviewees were selected because they were knowledgeable about their constituency and had insight into community mental health needs and strategies for prevention and early intervention.

Procedures

The purpose of the key individual interviews was to conduct in-depth discussions with community leaders, gatekeepers, and other individuals across five geographic Areas of Ventura County. Key individuals were initially identified by VCBH. Evalcorp provided consultation on the process and helped to finalize the list of invited participants, ensuring representation across requisite criteria specified by the MHSA.

Evalcorp staff contacted the interviewees, explained the purpose of the interviews, invited them to participate, and worked closely with the interviewees to arrange dates, times, and locations for the interviews. Once the interviews were arranged, interviewees were provided the following documentation: A formal Letter of Invitation and Confirmation, a PEI Informational Brochure, Key Individual Profile, Key Individual Consent Form, and Key Individual Interview Questions. A copy of the Key Individual Interview Questions can be found in the **Appendix**.

A majority of the key individual interviews were conducted by telephone, and others in-person. The interviews each took about one hour to complete. During the interviews, participants were asked about community and mental health needs, age group priorities and priority populations, existing and needed prevention and early intervention services, and recommendations for providing effective prevention and early intervention services. The interviews were audio recorded with the consent of the interviewee. Once the interviews were complete, participants received a thank-you letter acknowledging their participation.

A transcript was prepared for each key individual interview conducted, summarizing each participant's responses by question. Information from each interview was then coded so that the data could be content analyzed in aggregate form and presented in summary format.

III. Demographics of Key Individual Interviewees, Services Provided, and Communities Served

Demographics

Five key individuals participated in the Area 5 interviews. Selected to represent a diverse set of mental health prevention and early intervention stakeholders, interview respondents represented different, and, in one case, multiple community sectors including education (n=3), social services (n=2), and employment (n=1).

When asked to report their ethnicity, two of the interviewees marked Caucasian, two marked Latino/Hispanic, and one marked Asian/Pacific Islander. All of the interviewees were females and all were between the ages of 26 and 59. All five respondents reported speaking English. In addition, four interviewees spoke Spanish, one spoke French, one spoke German, and one spoke Vietnamese.

Services Provided and Communities Served

Interviewees completed a participant profile as a means of gathering additional information on their backgrounds in terms of the communities they serve and their frame of reference with respect to prevention and early intervention mental health services. Additionally, participants were asked at the beginning of each interview to clarify and elaborate on services provided by the individual and his/her organization. As displayed in **Table 1**, crisis intervention, education, community liaison, and employment services were cited most often as types of services that interviewees' organizations provide.

Table 1: Services Provided by the Interviewee or Her Organization
(n=5)

Services	Number of Mentions
Crisis intervention	4
Education	4
Community liaison	2
Employment services	2
Basic needs	1
Mental health services	1
Programs for youth and /or adults	1
Resource referral	1
Total:	**16**

Additional organizational information gathered from the participant profiles is presented in **Tables 2 through 5** below. **Table 2** indicates that all of the interviewees represent Area 5, Moorpark and Simi Valley. As displayed, two interviewees also represented Area 4.

Table 2: **Geographic Area of Ventura County Served By Interviewees**
(n=5)

Geographic Area	Number of Participants
Area 1: Fillmore, Piru, Santa Paula	0
Area 2: Ojai, Ventura	0
Area 3: Camarillo, Oxnard, Port Hueneme	0
Area 4: Thousand Oaks, Newbury Park, Westlake Village	2
Area 5: Moorpark, Simi Valley	5

As displayed in **Table 3** interviewees also were most likely to serve Latino/Hispanic individuals (n=4), which includes the Mexican, Mixteco, and Zapoteco communities, in addition to the homeless (n=4) and migrant farm workers (n=4).

Table 3: Underserved/Unserved Populations Represented By Interviewees
(n=5)

Underserved/Unserved Populations	Number of Participants
Latino/Hispanic	4
Mexican	4
Mixteco	2
Zapoteco	1
Homeless	4
Migrant Farm Workers	4
African-American	3
Asian/Pacific Islander	3
Eastern European/Middle Eastern	3
LGBT/Questioning Individuals	2
American Indian	2
Co-occurring Disorders	1
Refugees	1
Veterans	1
Deaf, Hard of Hearing and/or Blind	1

Children and youth in stressed families (n=3) was the priority population most often cited as being served by interviewees, followed by Children/youth at-risk of or experiencing involvement in the juvenile justice system (n=2) and Children/youth at-risk for school failure (n=2) (see **Table 4**).

Table 4: Priority Populations Served/Represented By Interviewees
(n=5)

Priority Populations	Number of Participants
Children/Youth in Stressed Families	3
Children/Youth at-Risk of or Experiencing the Juvenile Justice System	2
Children at-Risk for School Failure	2
Trauma-Exposed Individuals	1
Underserved Cultural Populations	1
Individuals Experiencing Onset of Serious Psychiatric Illness	1

All of the interviewees provide services to Prenatal to pre-K, 0-5 and Children, 6-17, with three of the five providing services to Transition-age youth, 18-25, as displayed in **Table 5**.

Table 5: Age Groups Served By Interviewees
(n=5)

Age Groups	Number of Participants
Prenatal to Pre-K (0-5)	5
Children (6-17)	5
Transition-age Youth (TAY) (18-25)	3
Adults (26-59)	2
Older Adults (60+)	2

IV. Knowledge of the VCBH PEI Planning Process

To document the interviewees' knowledge of the VCBH PEI planning process, each interviewee was asked to indicate their level of knowledge on a three-point scale ranging from "not at all knowledgeable" to "very knowledgeable." The five interviewees in Area 5 had diverse levels of knowledge identifying themselves as "very" (n=2), "somewhat" (n=2), or "not at all" (n=1) knowledgeable about the process.

When asked to qualify their answers, the respondent without any prior knowledge of the PEI planning process indicated that she first learned about PEI when she was invited to participate in the interview.

Those who were "very knowledgeable" of the process (n=2) were informed through different sources. One interviewee gained knowledge of VCBH and its proposed programs due to her involvement with the department in her work capacity. The other learned about prevention and early intervention through her professional life, as well as through personal experience. Additionally, she has served as a member of the MHSA System as a city representative of the task Force on Homelessness.

Both of the interviewees who were "somewhat knowledgeable" of the process gained their knowledge of PEI by attending presentations. One interviewee gained additional knowledge by attending county meetings after being invited by a county liaison.

V. Mental Health Needs

Greatest Mental Health Needs

In order to address community mental health needs, interviewees were asked to identify the greatest mental health needs in their communities. A variety of responses were offered, but almost half of the answers touched on increasing access (n=11), which was followed by services for youth (n=4), services for marginalized populations (n=2), and transportation (n=2) as displayed in **Table 6**.

Issues of increased access include the month-long wait to get an appointment with VCBH, the hour it takes for a crisis team to arrive, services not open on the weekends, a lack of services in general, and particularly in Moorpark (n=2) and Simi Valley (n=1). The interviewees also noted the inadequate staffing and limited services at all levels of Behavioral Health in Area 5, with one noting that psychiatrists and counselors are so overloaded that clients receive inconsistent care.

The need for services for youth was indicated by such responses that there are no school-based counseling services, children/teenagers/young adults have the greatest mental health needs, and that youth and children need a special place or center where they can go to feel safe.

Table 6: Greatest Mental Health Needs
(n=5)

Mental Health Needs	Number of Mentions
Increased access	11
Services for youth	4
Services for marginalized populations	2
Transportation	2
Alcohol and other drug prevention/intervention	1
More prevention/early intervention services	1
Services for family issues	1
Services for those in crisis/have been traumatized	1
Total:	**23**

Impact of the Greatest Mental Health Needs

When invited to describe how mental health needs were impacting their communities, more than half of the responses centered on negative mental health outcomes (n=10) as seen in **Table 7**. Interviewees described how those who need an appointment and are not able to be seen for a month lose out because most people will not access services once the crisis has passed. Other comments focused on persons who need services and are screened out by gatekeepers who do not give proper information; ineffective services that leading to an overall sense of hopelessness; and the notion that a chain reaction is produced as behaviors are passed down within generations resulting in children with social, emotional, and behavioral problems.

They expressed concerns for struggling youth/families that result when a father leaves his family because of addiction, leaving a single mother to raise the children. Students do not attend or achieve in school when basic needs are not met with many students on academic probation whether formal or informal.

Table 7: The Impact of Mental Health Needs on Interviewees' Communities
(n=5)

Impact of Mental Health Needs	Number of Mentions
Negative mental health outcomes	10
Struggling families	4
Involvement with Juvenile Justice system	2
Limited access	2
Stigma	1
Total:	**19**

Ranking MHSA Mental Health Needs

Building upon interviewees' discussion about the mental health needs in the community and the impact of those needs, each of the five interviewees was presented a list of five California Department of Mental Health (CDMH) MHSA mental health needs and asked to rank order those needs from highest to lowest need. The five mental health needs are: 1) At-risk children, youth, and young adult populations; 2) Stigma and discrimination; 3) Disparities in access to mental health services; 4) Psycho-social impact of trauma; and, 5) Suicide risk. One interviewee added the category of At-risk families/parents of at-risk youth so that she had six rankings. **Table 8** below displays the interviewees' rankings.

Four of five respondents ranked Disparities in access to mental health services and At-risk children, youth, and young adult populations within the top two mental health needs in their communities. Stigma and discrimination was important to three respondents who ranked that category within the top three community mental health needs. Suicide risk was the highest priority for one respondent, but ranked fourth and fifth for the other four. The Psycho-social impact of trauma was ranked fourth and fifth by the majority of the respondents (n=3). At-risk families/parents of at-risk youth has only one ranking as that category was added by an interviewee. Explanations for the three most popular rankings are presented on the following page.

Table 8: Rank Ordered Mental Health Needs
(n=5)

Mental Health Needs	1st	2nd	3rd	4th	5th	6th
Disparities in access to mental health services	**2**	**2**	--	--	1	--
At-risk children, youth, and young adult populations	**1**	**3**	--	--	1	--
Stigma and discrimination	1	--	2	1	--	1
Suicide risk	1	--	--	3	1	--
Psycho-social impact of trauma	--	--	2	1	2	--
At-risk families/parents of at-risk youth	--	--	1	--	--	--

Disparities in Access to Mental Health Services

- This is the highest priority for East County because it is so far to get to services that are located in Ventura and Oxnard
- Families in lower socio-economic groups do not have the same access to care as do those in middle or upper classes because of lack of medical insurance, and transportation issues
- All of the issues related to disparities in access could be treated when access to mental health services is available to those who need it
- There are no services available in Moorpark

At-risk Children, Youth, and Young Adult Populations

- This is the need most often seen by the interviewee who is concerned about the lack of services for at-risk children and youth
- This group has deeply ingrained cultural beliefs and are very reluctant to *"to break the rules"* and seek services
- *"If we could help them then, they will become adults that don't have that many problems"*
- Economic stresses add to the pressures in this group, with many of the region's Hispanic families living in overcrowded conditions, contributing to more stress on the children because they have no outlet, or place to call their own

Stigma and Discrimination

- Individuals do not want to admit to the need for services for fear of being seen as crazy
- Many think that mental health services are *"only for the rich people who invent illnesses to get a vacation"*
- If issues arise, individuals want to resolve them within their families
- Many people think that dealing with mental health issues makes you a bad person

Community Strengths

In an effort to build upon the existing assets in Area 5, interviewees were asked to describe the strengths or protective factors currently available in their communities that could help address the top mental health needs identified in the previous question (**Table 9**). The interviewees were able to recount many service and programs that would be considered strengths. Schools/school partnerships, such as the support groups at the high school put on by one of the counselors, Cal Safe program for pregnant teens, school-based social workers in highs schools, and students required to complete a certain number of hours for community service, were mentioned most often (n=9). Programs/activities for youth (n=7), community-based programs (n=5), and services offered by the county (n=4) were also noted. Collectively, schools/school partnerships and programs for youth comprise about half of the total responses.

Table 9: Community Strengths/Protective Factors
(n=5)

Strengths/Protective Factors	Number of Mentions
Schools/school partnerships	9
Programs/activities for youth	7
Community-based programs	5
County services	4
Faith-based programs	2
Training (specified)	2
Community liaison	1
Counseling/mental health services	1
Total:	**31**

VI. Priority Age Groups

Prevention

Mental health prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders. To document interviewees' opinions about the age groups in greatest need of prevention services within their communities in Area 5, the following five age groups were presented for rank ordering: 1) Prenatal to Pre-K, 0 to 5; 2) Children, 6 to 17; 3) Transition-age Youth (TAY), 18 to 25; 4) Adults, 25 to 59; and, 5) Older Adults, 60+. The resulting responses are displayed in **Table 10**. As shown, all five interviewees identified Children, 6 to 17 as the highest priority age group. All ranked Transition-age youth, 18 to 25, as either the second or third priority. All respondents selected Older adults, 60+ as the fifth priority. Representative examples of respondents' reasons for prioritizing those groups are listed below the table.

Table 10: Rank Ordered Age-Groups for Prevention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	--	1	1	3	--
Children, 6 to 17	**5**	--	--	--	--
Transition-age Youth (TAY), 18 to 25	--	**3**	**2**	--	--
Adults, 26 to 59	--	1	2	2	--
Older Adults, 60+	--	--	--	--	5

<u>Children, 6 to 17</u>

- This is the age group in which signs of problems become apparent and can be addressed in the school environment
- Interviewee is responsible for this age group and where she sees the most need
- *"If we can help them, they will become better adults with not a lot of heavy baggage of mental health issues"*
- Because there are *"no services in Moorpark"* there are many more discipline issues

- There is a dearth of adequate in- and out-of-school programs, counseling or other positive programs for this age group

Transition-age Youth, 18 to 25

- This is the age where they may be more involved in gangs, become pregnant/have children, and be in violent relationships
- Once youth reach 18 years of age, *"they are on their own"* and not required to get help resulting in many who are not diagnosed and/or treated

Two respondents stated that there are services available for Prenatal to Pre-K through First Five, and one proffered that Simi Valley and surrounding communities are very responsive to the needs of older adults as reasons why they were ranked as lower priorities.

Early Intervention

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address them before they get worse. Similar to the previous question about prevention services, interviewees were asked to rank order the same age groups according to the level of need for early intervention mental health services in Area 5.

As displayed in **Table 11**, all interviewees ranked Children as the number one priority. Four of five ranked Transition-age youth as the second priority, with the other interviewee ranking TAY as the third highest priority. All respondents ranked Older adults as the lowest priority.

Table 11: Rank Ordered Age-Groups for Early Intervention Services
(n=5)

Age Groups	1st	2nd	3rd	4th	5th
Prenatal to Pre-K, 0 to 5	--	1	2	2	--
Children, 6 to 17	**5**	--	--	--	--
Transition-age Youth, 18 to 25	--	**4**	**1**	--	--
Adults, 26-59	--	--	2	3	--
Older Adults, 60+	--	--	--	--	5

When asked to explain their rankings, most of the interviewees (n=4) indicated that their reasoning was similar to that for identifying priority age groups for prevention services. Examples of more specific explanations offered by interviewees for the top age groups cited are provided below.

Children, 6 to 17

- This is the age span in which many youth experience problems such as hormonal changes, domestic violence, substance abuse, gangs, violent relationships and/or teen pregnancies
- Once children are in school, there are those who can see what is going on with those kids adding that *"parents don't know how to break the cycle they are in"*

Transition-age Youth, 18-25

- It is very important to educate TAY to instill healthy values and behaviors they can then use in raising their own families
- Many have not been successful in school, and when they become of age they do not have enough resources to help them learn how to *"get their life organized and understand what they need to do"*

VII. Priority Populations

The California State Department of Mental Health (CDMH) MHSA has identified the following six priority populations for PEI: [6] 1) Underserved cultural populations; 2) Individuals experiencing the onset of serious psychiatric illness; 3) Children/youth in stressed families; 4) Trauma-exposed individuals; 5) Children at-risk for school failure; and, 6) Children and youth at-risk of or experiencing involvement with the Juvenile Justice System. To determine which priority populations the interviewees identified as most in need of prevention and/or early intervention services in Area 5, they were asked to rank order them from highest to lowest. As displayed in **Table 12**, three of five interviewees identified Underserved cultural populations as the priority population most in need of prevention or early intervention services in their communities, one selected Children and youth in stressed families, and one chose Individuals experiencing the onset of serious psychiatric illness. One respondent pointed out that all of the priority populations were interconnected. Explanations for prioritizing Underserved cultural populations included:

- There is a large Mixteco population living in Moorpark that is desperately in need of services – this population suffers from isolation, loneliness, mistreatment, and discrimination and will not seek services because *"they do not have the luxury to get sick as they must work"*
- There is a need for culturally competent providers who understand a particular culture
- There is a stigma attached to mental health services in the Hispanic community, which is the primary ethnic group in Moorpark
- Something needs to be done to understand that it is not a stigma to access this type of care
- Within the Hispanic community many are living in poverty, which aggravates the stresses

The respondent who considered Children and youth in stressed families as the highest priority stated that from her experience in counseling this is the most common and most urgent population. The interviewee who ranked Individuals experiencing the onset of serious psychiatric illness responded that she is aware of prodromal intervention for early onset and believes that it will be very important to develop programs that can diagnose and intervene early with these individuals.

Table 12: Rank Ordered Priority Populations

[6] Definitions for each priority population can be found in the Key Individual Interview Questions contained in the **Appendix**.

(n=5)

Priority Populations	1st	2nd	3rd	4th	5th	6th
Underserved cultural populations	**3**	--	1	--	--	1
Children and youth in stressed families	**1**	**2**	**1**	1	--	--
Individuals experiencing the onset of serious psychiatric illness	1	--	2	--	1	1
Children at risk for school failure	--	1	1	1	1	1
Children and youth at risk of or experiencing involvement with the Juvenile Justice System	--	1	--	3	1	--
Trauma-exposed individuals	--	1	--	--	2	2

VIII. Existing PEI Services

Following the interviewees' rankings of the CDMH priority populations, the interviewer asked the five interviewees to identify existing prevention and/or early intervention services in Area 5 that were currently serving their top ranked priority population. In Area 5, Underserved cultural populations was most often ranked as the number one priority (n=3), followed by Children and youth in stressed families (n=1) and Individuals experiencing the onset of serious psychiatric illness (n=1).

Two interviewees were unable to identify any existing prevention or early intervention services in their local communities. Responses offered by the other three participants address the needs of the three priority populations identified above and are listed below in alphabetical order. Project Alert, Second Step, and the prevention education curricula used by Moorpark Unified School District Center were the only three services identified as "Evidence-based Programs." None were identified as "Promising Practices."

- Action Family Counseling
- Boys and Girls Club
- Catholic Social Services
- Child Health/Disability Prevention Program
- Child Protective Services
- CIRT
- Clinicas of Camino Real
- Community Pregnancy Clinic
- Counseling (PEI) offered at middle and high schools for some at-risk students
- First Five (n=2)
- Free clinic of Simi Valley, which offers health care for the homeless
- Hospice (including grief counseling)
- Human Services (Adult, Children and Family Services)
- Interfaith, 24 hour counseling and women's center
- Mobile Crisis Line through VCBH
- Moorpark Family Care
- National Alliance on Mental Illness (NAMI)
- Office of Education offers a homeless education project and countywide foster youth services program

- Prevention education curricula used by Moorpark Unified School District
- Project Alert
- Rainbow Alliance
- Salvation Army camp for troubled youth
- SARB (Teresa Cortes specifically mentioned)
- Second Step
- Simi Valley Unified School District (Homeless Liaison, Minor Parent Program, Student Support Services)
- Special Education Local Plan Area (SELPA)
- Special ED IEP process connects families to VCBH for counseling (present in elementary schools)
- United Parents advocacy Group for Children
- VCBH, Children Mental Health Services
- VCBH, Youth and Families division
- Ventura County Alcohol and Drug Programs
- YMCA

IX. Needed PEI Services

Conversely, interviewees were also asked to recommend needed prevention and/or early intervention services that could address the mental health needs of the priority population they ranked number one.

Recommendations for programs and services that would benefit Underserved cultural populations highlighted a need to offer services where they are most accessible, bringing in services to the community if necessary, using culturally competent service staff, and to partner with existing community organizations:

- Better understanding of differences across cultures/beliefs
- Bring services and resources into the community, such as guest speakers
- Build capacity amongst the community, teaching them to help others
- Deliver PEI services in town so residents would feel more comfortable accessing them
- Have one place where a multitude of services can be accessed, where a family can receive diagnoses, medical services and counseling
- Partner up with existing organizations within the community
- Provide bilingual/bi-cultural services that listen to the community
- Provision of services in language of client whether it be Vietnamese or Mixteco
- Work with schools, community agencies, and the community itself

Recommendations for programs and services that would benefit Children and youth in stressed families include:

- Offer school-based counseling that students could access during the school day, and include needs-based groups and individual counseling
- Work with families that are stressed by offering groups for families and children using a holistic approach

Recommendations for programs and services that would benefit Individuals experiencing onset of serious psychiatric illness include:

- Better IEP services and follow through in the schools
- Detox facilities and housing for youth
- Homeless advocates for behavioral health issues in Simi Valley
- Parent education and support groups
- In-home counselors for at-risk individuals providing ongoing supports
- Peer counseling, social skills groups to help those who experience issues
- Positive activities, such as after-school programs for children and youth with emotional issues
- Require all teachers to treat children with special needs in a humane way
- Require adequate training and support for those who work with emotionally disturbed and mentally ill
- Require principals, vice-principals, counselors to be trained by NAMI on what mental illness looks like early on, and how to refer to accessible services
- Advocates for youth whose parents cannot advocate because of their own issues

X. Service Access and Delivery

In addition to a lack of needed services, barriers to service access can also pose a challenge. As displayed in **Table 13** below, interviewees identified financial issues, whether it be the lack of money or health insurance, or intimidation over billing issues as the greatest mental health service access barrier (n=4). Language, lack of available services or limited access, cultural stigma, and transportation were each mentioned three times, conveying that barriers to access are many and widespread across several categories.

Table 13: Service Access Barriers
(n=5)

Barriers	Number of Mentions
Financial	4
Language	3
Limited access	3
Stigma	3
Transportation	3
Lack of continuity in care	2
Lack of communication and collaboration among service providers (about consumers)	2
Time to get an appointment	2
Alcohol and other drug use (masks MH issues)	1
Lack of awareness	1
No PEI (proactive assistance)	1
Total:	**25**

When asked to suggest strategies to increase access, **Table 14** shows that interviewees were most likely to emphasize the importance of offering services in accessible settings such as through the schools, during evening and weekend hours, in family-friendly settings perhaps providing child care, and by

bringing services into the community (n=7). Culturally appropriate education and outreach including teaching those who need services to understand the issues and having a panel of community members talk about mental health services to help others see it in a positive light, was also stressed (n=6).

Table 14: Strategies to Decrease Access Barriers
(n=5)

Strategy	Number of Mentions
Accessible settings/location-based services	7
Education and outreach (culturally appropriate)	6
Culturally competent/bilingual/bicultural staff	3
Cut red tape	1
Communication and collaboration among service providers (about consumers)	1
Reduce stigma	1
Total:	**19**

As a follow up to the previous question, interviewees were asked to identify the best ways to provide effective, culturally appropriate prevention and early intervention services in their communities (see **Table 15**). Half of interviewees' recommendations fell into two categories: culturally competent service provision by bilingual, culturally competent providers (n=4) and accessible settings or location-based services (n=4). One interviewee's suggestion for providing culturally competent staff was that these services need to come from bilingual organizations while another stated it was crucial that staff are trained on cultural issues. Bringing services into the community locally and in central locations, as well as making sure any mental health urgent care center can be reached by public transportation and be open around the clock were suggestions for increasing accessibility.

Table 15: Ways to Provide Culturally Appropriate and Effective Services
(n=5)

Recommendation	Number of Mentions
Culturally competent/bilingual/bicultural staff	4
Accessible settings/location-based services	4
Communication and collaboration among organizations	3
Outreach, education, and awareness (culturally appropriate)	2
Caring staff who can be advocates	2
Public education (ESL classes)	1
Total:	**16**

XI. Outreach, Education, Awareness

Finally, recommendations to better educate and inform their communities about mental health prevention and early intervention were solicited from interviewees, as displayed in **Table 16**. Three-quarters of the responses fell into two categories: information dissemination (n=4) and communication and collaboration among organizations and county (n=4). Examples of interviewees' specific recommendations are presented below the table.

Table 16: Recommendations to Educate and Inform the Community about PEI

(n=5)

Recommendation	Number of Mentions
Communication and collaboration among organizations and county	4
Information dissemination	4
Strategic outreach/public promotion	2
Volunteer advocates	1
Total:	**11**

Communication and Collaboration among organizations and county

- Work with the SARB, Juvenile Justice System and other agencies
- Collaborate with those who are already working with underserved populations and who have already earned trust such as Parent Project, First 5, and Catholic Charities
- Communicate with the community through Catholic Social Services, faith-based organizations and the schools
- Provide more education about the process through local schools, churches, community-based organizations, or anywhere people who need services congregate

Information Dissemination

- Building confidence and regaining trust can be accomplished by going into community members' homes, listening to and talking with them, building relationships , and working together
- Publish a directory of every single service that Behavioral Health funds and the exact name and phone number of who to talk with about what service (i.e., the directory would contain all information needed to access help)
- Brochures could serve as an abbreviated version of a resource directory
- Target different groups with perhaps one presentation in the spring and one in the fall (presentations would be the same, but repeated offerings reinforce the message – different charities could target different groups, and audiences could be directed to various organizations)

XII. Additional Comments

When asked if they had any additional comments to offer regarding PEI or to share with VCBH, interviewees expressed a strong need for services to be located specifically in Moorpark, and that the services be staffed by those who are culturally competent. One interviewee shared her belief that currently clients are not receiving early intervention and that this affects the level of care for everyone further into the future. Selected comments are provided below:

- *"I hope they hear that Moorpark, Simi Valley, Thousand Oaks, and Santa Paula are all part of the county and need resources. For many years, we have been the ugly duck and only get whatever is left over. We pay taxes. We must have our needs covered. We need services to come to our cities to help us resolve the problems."*
- *"We appreciate any and all increases in service that could be provided. We are facing the toughest years I will probably ever see in California schools. The fact that we are facing these kinds of economic issues has a huge impact on stresses on families, that we will end up*

seeing on kids. My need for mental health services for my children and families here is only going to get worse. We welcome any support or any way of working with you that we can."

- *"I know we have a need for more Spanish bilingual [people], even in the East County even though we think most of the bilingual need for services is in the Oxnard region or in Ventura, or in Santa Paula. But, here in the East County we also have that need, even though it is smaller than the Oxnard region, but we still have that need here. Also, for Vietnamese ... that is for the whole county, not just for the East County."*
- *"There are no county services of any kind in Moorpark. We have no behavioral health services here in town. The closest available is in Simi Valley, which is actually 1-1/2 hours on the bus. There are no career job centers her in town, no public health office. Moorpark has been in the process for the last eight years to build an under-one-roof service center where you could have county services. It has been eight years and it still has not been built."*
- *"I have great empathy for the overwhelming amount of work that they [VCBH] have been given to deal with, and I have great empathy for their honest attempts. But, I also think they are overwhelmed, and that access to their services is blocked by their systems. There are hundreds and thousands of youth who are not getting the help they need in early intervention – that would maybe stop some of the logjam of clients. If it is not effective, it is not doing the job."*

XIII. Implications and Observations

Though diverse in their backgrounds and awareness of the VCBH PEI planning process, data collected from the key individual interviews produced clear trends. A theme repeated was that there is very limited local access to mental health services for those who live in Area 5, along with long wait times for services in other parts of the county. This was mentioned as the greatest mental health need, resulting in negative mental health outcomes and struggling families as children develop social, emotional, and behavioral problems. In spite of these problems, respondents related a long list of community strengths such as partnerships with schools, programs and activities for youth, and other community-based programs.

All of the interviewees agreed that children should be the highest priority for prevention and early intervention services, with most agreeing that the second priority should be transition-age youth. Three of the respondents believe that service provisions should be geared toward underserved cultural populations that typically experience disparities in quality of care and access. In order to increase awareness of and access to mental health services, it was recommended that barriers such as financial issues, the social stigma associated with mental health services, a shortage of culturally competent service, and transportation issues be addressed. Communication and collaboration among organizations taking the form of working with organizations that have already earned the trust of community members, as well as working with schools and "*anywhere people who need services congregate*" were suggested as methods to better educate and inform communities. Community education in the form of a directory listing all services offered by VCBH, and targeting different groups with mental health presentations was recommended. It was also urged that mental health agencies be staffed by bilingual providers who are trained to offer culturally competent services, and that these services be offered in accessible settings within the local community. Provision of services at schools and community centers may also assist in VCBH's effort to increase accessibility to individuals and families in need.

APPENDIX

Informant's Organizational Affiliation

57. Briefly describe the types of services you or your organization provides.

Knowledge Regarding PEI

58. How knowledgeable are you about Ventura County Behavioral Health's Prevention and Early Intervention (PEI) planning process?

__ Very Knowledgeable

__ Somewhat Knowledgeable

__ Not at all Knowledgeable

2a. Please qualify/explain why you responded very or somewhat knowledgeable? (e.g., How did you become very knowledgeable/somewhat knowledgeable?)

Community Mental Health Needs

59. Overall, what are the greatest mental health needs in your community?

3a. How do you see these needs impacting your community?

60. The California State Department of Mental Health has identified five key community mental health needs that should be addressed in the PEI plan. Please rank order the following mental health needs with 1 representing what you believe is the highest need in

your community.

__ Disparities in access to mental health services

__ Psycho-social impact of trauma

__ At-risk children, youth, and young adult populations

__ Stigma and discrimination

__ Suicide risk

4a. Please explain your ranking.

4b. What strengths or protective factors exist in your community that could help address the top mental health needs you identified? (e.g., opportunities for youth involvement in the schools; strong faith-based organizations in the area; lots of support services for at-risk youth; strong family or other support networks, etc.)

Priority Age Groups—Prevention Services

Prevention generally involves services and programs that promote social and emotional well-being in order to reduce and/or prevent the onset of mental health issues and disorders.

61. Please rank order the following age groups with 1 representing the age group most in need of **prevention** services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

5a. Please explain your ranking.

Priority Age Groups—Early Intervention Services

Early intervention is defined as services of short duration (less than 1 year) and of relatively low intensity that help people identify early mental health warning signs so they can address

them before they get worse.

62. Please rank order the following age groups with 1 representing the age group most in need of **early intervention** mental health services in your community?

__ Prenatal to Pre-K (0-5)

__ Children (6-17)

__ Transition-age Youth (TAY) (18-25)

__ Adults (26-59)

__ Older Adults (60+)

6a. Please explain your ranking.

Priority Populations

63. The California State Department of Mental Health has identified six priority populations for PEI. (*The state definition for each priority population is found on the last page of this interview guide). Please rank order the list below with 1 representing the priority population most in need of **prevention** and/or **early intervention** services in your community.

__Underserved cultural populations

__Individuals experiencing the onset of serious psychiatric illness

__Children/youth in stressed families

__Trauma-exposed individuals

__Children at risk for school failure

__Children/youth at risk of or experiencing involvement with the Juvenile Justice System

7a. Please explain your ranking.

Existing and Needed PEI Services

64. Do you know of any existing **prevention** and/or **early intervention** services that currently address the mental health needs of your number one ranked priority population from Question 7? If yes, please identify? If no, please skip to Question 9.

*8a. Of the existing programs and services you just listed, do you know if any of them are considered *evidence-based programs (EBP), promising practices (PP), or community-defined evidence practices (CDEP)*? (*The definitions for each type of research-based practice can be found on the last page of this interview guide.)

8b. If yes, which ones? (Please identify whether EBP, PP, or CDEP.)

65. What **prevention** and/or **early intervention** services are needed to address the mental health needs of the priority population you ranked number one, _____? (Insert the top ranked priority population from Question 7.)

Service Access and Delivery

66. What barriers do people encounter accessing mental health services in the communities you serve?

67. What types of strategies would help people get the mental health services they need in the communities you serve?

68. What are the best ways to provide effective, culturally appropriate **prevention** and **early intervention** services in your community?

Outreach, Education, and Awareness

69. What recommendations do you have to better educate/inform your community about mental health **prevention** and **early intervention**?

Additional Comments

70. Is there anything else you would like to add or you would like Ventura County Behavioral Health to know?

***Q7 Priority Population Definitions**

Underserved Cultural Populations. PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, veterans, deaf and blind, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Individuals Experiencing Onset of Serious Psychiatric Illness. Those identified by providers, including but not limited to primary health care, as presenting signs of mental illness first break, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth in Stressed Families. Children and youth placed out-of-home or those in families where there is substance abuse or violence, depression or other mental illnesses or lack of caregiving adults (e.g., as a result of a serious health condition or incarceration), rendering the children and youth at high risk of behavioral and emotional problems.

Trauma-exposed. Those who are exposed to traumatic events or prolonged traumatic conditions including grief, loss and isolation, including those who are unlikely to seek help from any traditional mental health service.

Children/Youth at-Risk for School Failure. At-risk due to unaddressed emotional and behavioral problems.

Children/Youth at-Risk of or experiencing Juvenile Justice Involvement. Those with signs of behavioral/emotional problems who are at-risk or have had any contact with any part of the juvenile justice system, and who cannot be appropriately served through Community Service Supports.

***Q8a Research-based Practice Definitions**

Evidence-Based Programs include programs that have been evaluated and show positive outcomes AND have been subject to expert/peer review determining that the programs have a significant level of evidence of effectiveness.

Promising Practices include programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes.

Community-defined Evidence Practices include programs that have been identified by local unserved and/or underserved communities and have demonstrated effectiveness in local communities.