MONTEREY COUNTY
BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

# COMMUNITY PROGRAM PLANNING PROCESS
# FY 2023-2024
# COMMUNITY FOCUS GROUP SUMMARY

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Measuring What Matters℠

# TABLE OF CONTENTS

# INTRODUCTION

In 2004, California voters passed the Mental Health Services Act (MHSA) through Proposition 63, which designated funding to improve mental health service systems throughout the state. To ensure effective utilization of these funds, the Mental Health Services Oversight and Accountability Commission (MHSOAC) requires counties receiving MHSA funds to develop a comprehensive Three-Year Program and Expenditure Plan outlining how funds will be used. This plan must be created in partnership with local stakeholders and community members through the Community Program Planning (CPP) Process.

Monterey County Behavioral Health Bureau (MCBH) contracted with EVALCORP, a professional evaluation company, to support an assessment of behavioral and mental health needs in communities throughout Monterey County. To gather comprehensive insights across the County, EVALCORP, engaged both Community Members (individuals from the community who may benefit from behavioral health services) and Stakeholders (those providing or facilitating access to services) in a mixed-methods approach including listening sessions, focus groups, and surveys. The purpose of these assessments, which are a part of the CPP Process, was to gather valuable insights from stakeholders and community members to enhance the effectiveness of behavioral health services in Monterey County, ensuring they meet the diverse needs of all communities.

This Community Health Survey report describes the needs, barriers to care, and gaps in behavioral health services identified by Community Members residing in Monterey County. Findings from other CPP Process data collection activities are also available:

- Community Member Focus Groups Summary of Findings
- Community Member Listening Sessions Summary of Findings
- Stakeholder Focus Groups Summary of Findings
- Stakeholder Survey Summary of Findings

MCBH will use this data to inform resource allocation and prioritization of programs, strategies, and initiatives funded under the Mental Health Services Act.

# METHODOLOGY

## Recruitment

The community focus groups were designed to gather perspectives on the current state of mental and behavioral health services in Monterey County for underserved and underrepresented populations in the county. Focus group participants were recruited through MCBH system partners across Monterey County. Ultimately, eight key populations were identified: 1) Unhoused, 2) African American Males, 3) Veterans, 4) LGBTQ+, 5) Individuals affected by the 2023 floods, 6) Early childhood caregivers, 7) individuals who live in South County, and 8) the Indigenous community.

Through coordinating with contacts at MCBH system partners, seven community focus groups were organized that ensured representation from each of the above priority populations. Four of the focus groups were facilitated in English, two in Spanish, and one in Triqui.

## Data collection

For each focus group, participants were hosted in person by a system partner, such as a community based organization. Four focus groups were facilitated virtually by a facilitator and three were facilitated in-person. A notetaker was present in each focus group and each group was recorded to verify the contents of the notes taken.

Focus groups lasted between 30 and 60 minutes. Demographic data were collected from consenting participants at the beginning of each focus group. Participants were each provided with a $40 gift card as an expression of appreciation for their time.

## Data Analysis

All qualitative data were cleaned and prepared for analysis, which flowed through two phases. The first phase began with a content analysis for prominent themes. In the second phase of the analysis, results were synthesized within and across different focus groups to achieve a greater depth of understanding. Demographic data were analyzed for descriptive statistics.

# RESPONDENT PROFILE

One hundred twenty-eight Community Members participated across the seven focus groups. Below represents a snapshot of demographic and background characteristics of participants:

- 70% were Hispanic/Latino, 16% were African American, and 11% were White (N=116)
- 64% were female (N=125)
- When asked what language they spoke most at home, 44% spoke Spanish and 35% spoke English (N=124)
- 85% were heterosexual or straight (N=87)
- 59% were covered by Medi-Cal, 24% were covered by Medicare, and 18% did not have insurance (N=114)

Table 1 provides a list of all the additional information participants wished to share about themselves.

**Table 1. Additional Participant Information**

| Situation | Percentage* |
|---|---|
| Parent or Caregiver | 51% |
| Veteran | 13% |
| Individual Living with a Disability | 12% |
| Individual with a Serious Mental Illness | 11% |
| Family Member of an Individual with a Serious Mental Illness | 10% |
| Unhoused | 9% |
| Undocumented | 7% |
| Individual with a Substance Use Disorder | 6% |
| Caregiver of Adult | 2% |

*Percentages may sum to more than 100% because participants were able to choose more than one option. N=128

# FINDINGS

The focus groups were conducted in order to answer the following essential questions concerning mental health language, primary contributing factors to mental illness, experiences accessing and receiving services, suggestions for outreach, and suggestions for community engagement. The findings section will delve into the focus group findings for each topic. A conclusion will follow that synthesizes the findings at the end of the report.

## The Language of Mental Health

Understanding the language that community members use when discussing mental health is foundational to creating effective, equitable, and supportive mental health environments and messaging that empowers individuals to seek care, reduce stigma, and promote overall well-being in the community. To explore how the community currently understands mental health, focus group participants were asked to talk about what the term meant to them. Conversations revealed a diverse range of perceptions of mental health and the varying language people use to talk about it. Many participants associated mental health with severe, negative states, encompassing emotional, cognitive, or physical distress. Conversely, others described mental health in positive terms, associating it with feelings of emotional well-being and physical relaxation. While a few participants recognized the integral link between mental health and overall health, the majority of the language reflected strong predispositions, casting mental health in either a distinctly positive or negative light. Multiple conversations also noted the difference in how service providers within the mental health continuum of care talk about mental health differently than how they, the community, understand it. These variations in understanding and language point to the need for clearer communication and education around mental health to foster a more unified and neutral perspective.

## Primary Contributing Factors to Poor Mental Health

Uncovering the factors that contribute to poor mental health within the community from the perspective of the community can help the County pinpoint areas of need and better tailor interventions to meeting the nuanced and complex needs of residents. Findings reveal a variety of factors that stretch across psychological, environmental, and social influences that all affect the mental health of individuals within the County. The findings below offer insights into the mental health landscape of the community through lived experiences and observations of its members.

**Psychological Factors**

When asked about the issues that contribute to poor mental health outcomes in their community, groups brought up various stress-related conditions that many residents find themselves in. These various psychological states of mind pose a serious risk for individuals to develop severe mental health issues, if not addressed. For instance, financial strain was a common theme across several focus groups with conversations noting job insecurity, student loans, caregiving responsibilities, and the price of housing as a constant source of anxiety for many in the community. Additionally, attitudes against talking about mental health within minority populations were also identified as an issue that contributes to poor mental health. Focus group conversations noted that, within the African American and Hispanic cultures, there has been pressure to be strong and independent, causing a reluctance to openly discuss mental health issues. This reluctance, on top of a mistrust in the government and the medical community from historical neglect, can greatly impede the general willingness individuals in the

community might have to talk openly about mental health, good or bad, and to seek early intervention services to prevent severe and disabling conditions. These psychological stressors that persist in the community, compounded by the loss of trust in the system, are important considerations for the County when expanding services and conducting community outreach. Notably, efforts to engage individuals in services should seek to understand the additional stressors an individual might be experiencing to provide a holistic form of care. Additionally, services may require additional efforts to hire individuals from minority populations and additional time that allows service providers to engage in trust building activities with and for minority populations. Such services would do well to collaborate with cultural organizations that are strongly connected to the communities of color to ensure services are culturally relevant and reflective of the community's beliefs, understandings, and values.

**Environmental Factors**

In discussing the impact of environmental factors on mental health, focus group participants notably highlighted the significant role of natural disasters, particularly emphasizing the psychological aftermath of floods in Monterey County. These conversations shed light on how experiences with natural disasters, such as the recent flooding, directly contribute to mental health challenges, including symptoms of anxiety and depression. For instance, a participant from the Flood Impacted Community focus group vividly illustrated the severe emotional toll, stating that the ordeal necessitated psychological intervention and medication to cope with the stress and anxiety induced by the disaster. Such personal accounts underlined the profound stress and ongoing anxiety about future disasters among the affected individuals. These findings from the community highlight the need to coordinate emergency relief efforts with immediate mental health services. Additionally, findings point to a need for long-term mental health services that continue even after the emergency services cease to help community members cope with the ongoing anxiety caused by the environmental trauma.

**Social Factors**

Community Members revealed several social factors that impact behavioral health outcomes in their communities, including social isolation, factors associated with migration, structural racism, and financial strain.

Discussing the impact that social factors have on mental health, community members highlighted the role of social isolation. Community members shared how different elements of social isolation, such as lack of social support, geographic isolation, experiencing loneliness, or being socially excluded can lead to poor mental health. For example, a participant shared the experience of how not having family made the holiday season difficult emotionally and wished there were "mental health barrier breakers" like concerts and community events to help combat the stress of being isolated during the holiday season. Other community members described the stress and anxiety they experienced that came with the social isolation of living in geographically remote areas. These findings suggest the need that community members have for support with expanding their social networks to combat feelings of isolation that contribute to poor mental health, particularly for those in geographically remote areas.

Members of multiple focus groups stressed that those who had migrated struggled with mental health issues because of factors linked to migration, such as migration status, not speaking English, and being away from friends and family in their home country. This conversation shed light on how experiences associated with migration can be risk factors for, or can exacerbate, community members' struggle with mental health issues. Community members described how undocumented people and non-English

speakers, including migrants who speak Indigenous languages, were particularly at risk for mental health issues, such as depression and anxiety. These findings show a demand for services in Indigenous languages and the desire for further outreach to Indigenous communities. Community members also revealed the nuance of mental health needs of migrants, which could potentially be addressed through support groups tailored to the mental health issues that arise during the migration process. For example, a variety of support groups could be developed that are specific to the mental health needs of migrants, including not only stress, but also sadness that comes from missing friends and family.

Participants shared negative feelings from what they considered to be structural racism within the community. Particularly, participants attributed mental health concerns they or their community experienced to institutional practices, cultural representations, and other norms that perpetuate racial and ethnic inequities. Participants described how their communities were "hurting" due to "systemic racism" and described a number of mental health issues that were associated with these negative experiences, such as trauma. These findings reveal an opportunity to develop outreach programs and culturally sensitive services designed to help combat the negative impacts that structural racism has on individuals from these vulnerable racial and ethnic communities.

Community members provided a window into their mental health by opening up about the financial strain they faced, such as unemployment and lack of job opportunities. This discussion shed light on how financial strain can, in the eyes of community members, cause poor mental health. For instance, a participant explained that "financial issues" were linked to causing depression, anxiety, or poor mental health in their eyes. The participant described how "living in a shelter when you're growing up, always worrying about whether you will have a home" was a major contributor to poor mental health. These results echo the 2022-2023 CPPP report, which show community survey results and provider survey results in which "Financial stress, unemployment, or lack of job opportunities" and "Homelessness" were two of the three "Top Contributing Major Factors to Mental and Behavioral Problems" for both data sources. Taken together, these findings show that financial strain continues to impact behavioral health outcomes in the County and that services may need to extend beyond traditional behavioral health assistance to include employment assistance, housing stability programs, and accessible educational opportunities.

## Accessing and Engaging Services

Understanding how community members access and engage with mental health services can help the County improve community members' experiences and increase access to services. Concerning accessing services, findings revealed that some community members did not consider themselves to be knowledgeable enough to access services and preferred to receive information through sources with which they had a personal connection. Community members also showed that they preferred local clinics. When talking about engagement with services, community members discussed how they valued cultural proficiency and timeliness of services, and preferred engagement strategies built on trust and relatability. These results help shed light on potential issues in the screening, assessment, and connection process, as well as provide ideas for how to engage unreached individuals and populations.

**Accessing Services**

In sharing their perceptions and experiences with the mental health care system, it was clear that many focus group participants lacked knowledge about available services and how to access services. When focus group participants spoke about not knowing about what services are available or how to access

services, the conversation would turn to a resource sharing conversation where other participants would openly share about the resources they knew about. In these conversations, it was clear that participants wanted to know more and, for those that knew of services, that their experiences with the system were very positive.

Throughout several focus groups, community members highlighted the importance that mobile clinics could play in helping to provide services to unreached localities. The extent to which participants from different focus groups could travel to services varied. For example, many community members provided examples of how they could only walk or take the bus to mental health clinics. However, community members were hopeful that local clinics and mobile clinics could help them begin the process of seeking care. This reveals the interest that some community members have in using mobile clinics for their mental health care that would allow the County to reach geographically isolated populations.

Community members also underscored their desire to access knowledge about mental health services through sources they trust. For many participants, community-based organizations were an example of the type of source they trusted for information distribution. Participants discussed a variety of community based organizations that they engaged with and shared their positive experiences, revealing a special form of trust with caseworkers that they did not typically share with other providers. Additionally, participants talked about how schools and could be used to provide additional information about services in the community. The use of community-based organizations and schools reflects a need from community members to receive information from sources they trust and have established personal connections with. This underscores how important the relationship with the community is for outreach and education efforts to be successful.

**Engaging Services**

In discussing their experiences connecting with mental health services, community members described the importance of cultural proficiency. Participants discussed how cultural proficiency played a major role in determining whether they had a positive or negative experience. Participants shared the importance of different elements of cultural proficiency in their experience, such as seeing personal representation of themselves in staffing, being respected, and being offered services in their native languages, such as Spanish and Indigenous languages. One participant shared the importance of not only providing services in their own language, but also being sensitive of cultural norms in how services were provided. Community members across cultures also shared how empathy in service delivery was a critical element for engaging with a particular provider. Many community members wanted to feel understood and expressed that getting services from someone with comparable life experiences would help them feel understood. Participants' discussions of the need for cultural proficiency spanned race, ethnicity, and economic status, with the primary thread being the importance of having access to providers who empathize with, and relate to, their experiences. Findings demonstrate that cultural proficiency does not only concern race, ethnicity, or nationality, but revolves around life experience and relatability.

Community members also expressed a high value for timeliness of services. Conversations showed a sense of frustration with perceived "long" waiting times for services. These frustrations over timeliness also reflect the participants' desire to receive services and their enthusiasm to connect with mental health service providers.

When asked for recommendations on how MCBH can best engage with individuals who need mental health services, focus group participants encouraged continued outreach via community based

organizations. In the trust and comfort that the participants described having with community-based organizations, community members revealed that there was already a successful open dialogue between community-based organizations and community members. A similar dialogue emerged for youth engaged in mental health services provided through programs in schools. Participants stressed the importance of providing safe spaces for the youth and educating them about mental health services. A peer outreach program was another key suggestion that emerged from the focus groups for establishing trust and comfort with unreached populations. For example, a participant shared their experience of fighting stigma around receiving mental health services in their community by doing presentations to share their story. Taken together, these findings show that community members value engagement strategies built on trust that create positive experiences with the community and provide safe spaces for everyone, and especially for vulnerable populations. These findings are important because they show that community members value engagement that is relatable and allows people to connect based on personal experiences.

### Engagement Suggestions

Participants relayed preferences for more personal ways of community engagement:

1. *Outreach in Schools*
2. *Engagement through Community Based Organizations*
3. *Peer Engagement*

# CONCLUSION

Community members shared an array of insights. Concerning the language of mental health, there is a distinct opportunity to engage with the community as more community members understand mental health terminology and use this terminology to describe their own conditions. The variation in language used reveals not only the progress that has been made in terms of behavioral health education, but also the need for a unified message about mental in various outreach and education events within the County.

In talking about factors that contribute to poor mental health, participants continually emphasized the role of social factors. Though the conversation, these social factors intersected within other social factors and other environmental or psychological factors. For example, those who are socially isolated can be more vulnerable to poor mental health when problems arise, such as natural disasters or stress from financial strain. The key takeaway here is that these factors often intersect and often cannot be treated in isolation. Services could be tailored to handle multiple factors and be sensitive to ways in which these factors compound their effects to more aggravated mental health issues.

For experiences accessing and receiving services, community members provided key insights into their desire to receive mental health services. Some participants discussed barriers that arose during their experiences of receiving or attempting to receive services, while others shared their perspectives on opportunities to overcome these barriers. However, across the board, participants were passionate about their mental health experiences. This passion provides evidence of community members' desire to receive services and their continued need for these services.

# APPENDIX

**Table 2. Hispanic vs. Non-Hispanic**

| Hispanic vs. Non-Hispanic | Percentage |
|---|---|
| Hispanic/Latino | 76% |
| Non-Hispanic/Non-Latino | 24% |

N=113

**Table 3. Race and Ethnicity**

| Race and Ethnicity | Percentage |
|---|---|
| Latino/Hispanic | 70% |
| Black or AA | 16% |
| White | 11% |
| Mixed Race | 2% |
| Asian | 1% |

N=116

**Table 4. Gender**

| Gender | Percentage |
|---|---|
| Female | 64% |
| Male | 29% |
| Genderqueer | 2% |
| Questioning/unsure of gender identity | 2% |
| Transgender | 2% |
| Another | 1% |

N=125

**Table 5. Language Most Spoken at Home**

| Language | Percentage* |
|---|---|
| Spanish | 44% |
| English | 35% |
| Another | 19% |
| Both English and Spanish | 11% |

N=124

*Percentages may sum to more than 100% because participants were able to choose more than one option.

**Table 6. Sexual Orientation**

| Sexual Orientation | Percentage |
|---|---|
| Heterosexual or Straight | 85% |
| Bisexual | 6% |

| | |
|---|---|
| Another | 5% |
| Queer | 2% |
| Questioning | 2% |

N=87

**Table 7. Additional Participant Identification**

| Situation | Percentage* |
|---|---|
| Parent or Caregiver | 51% |
| Veteran | 13% |
| Individual Living with a Disability | 12% |
| Individual with a Serious Mental Illness | 11% |
| Family Member of an Individual with a Serious Mental Illness | 10% |
| Unhoused | 9% |
| Undocumented | 7% |
| Individual with a Substance Use Disorder | 6% |
| Caregiver of Adult | 2% |

*Percentages may sum to more than 100% because participants were able to choose more than one option.
N=128

**Table 8. Participant Insurance Status**

| Insurance Status | Percentage* |
|---|---|
| Medi-Cal | 59% |
| Medicare | 24% |
| None | 18% |
| Private | 8% |

*Percentages may sum to more than 100% because participants were able to choose more than one option.
N=114

**Table 9. Zip Code of Participants**

| Zip Code | Percent |
|---|---|
| 95076 | 44% |
| 93933 | 17% |
| 93927 | 13% |
| 93905 | 8% |
| 93955 | 6% |
| 93901 | 3% |
| 93906 | 2% |
| 93907 | 2% |
| 9576 | 2% |
| 92927 | 2% |
| 93921 | 1% |

N=125