Yolo County

Prevention and Early Intervention (PEI)

Community Planning Process

Narrative Report of Findings

Submitted by California Institute for Mental Health (CiMH)

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I. Introduction: The Information Gathering Process

In support of Yolo County efforts to plan for Prevention and Early Intervention services utilizing MHSA funding, a community engagement and data collection process was initiated to collect input and information from a variety of sources.

Compiled Data:

"Data Brief": A data brief was compiled for use in framing the issues pertinent to the Yolo County region and constituents. Dr. Sarah Taylor initially compiled this brief, with M. Anne Powell, MSW, PhD Candidate and Will Rhett-Mariscal, PhD (CiMH) on March 10th. An updated version on April 28th, 2008 was informed by a community stakeholder meeting on April 7th and by data sources shared by stakeholders within Yolo County *(See Attachment One, "Data Brief - Revised April 28, 2008"; Attachment Two, "Yolo County Probation Department 2008/2008 Comprehensive Multiagency Juvenile Justice Plan).*

New Data:

Key Informant Interviews (KII) – Twenty-five (25) key informant interviews were conducted, including: Eighteen (18) service providers, six (6) community members or entities (includes education), and one (1) target population (LGBT) respondent.

Focus Groups – Four (4) focus groups were conducted reaching a total of fifty (50) individuals, with ten (10) to fourteen (14) attendees per group. Focus groups were conducted in community settings to facilitate outreach and engagement of targeted ethnic and cultural communities, as well as consumers and family members (African American adult and elders community; Russian elders and Russian adult support group [AOD]; and NAMI).

Target Population Survey – One survey was conducted in Esparto at the farmers' market to outreach to the Latino community and a total of nine (9) respondents participated.

Target Populations – KIIs, Focus Groups and Surveys yielded input from specific ethnic, racial and cultural communities including: Russian; African American; Asian; tribal; LGBT. Additionally, interviewees represented homeless; TAY; adults; older adults and faith-based communities.

Methods - Interviews were conducted in person and through telephone interviews, as well as facilitating surveys distribution and receipt via fax or email, to suit the convenience of the interviewee and to maximize response rate. A survey tool was developed and used to collect data, and adapted for use with community *(see Attachment Three, Key Informant Interview-Community),* service

providers *(Attachment Four, Key Informant Interview-Service Provider),* and target populations *(Attachment Five, Key Informant Interview-Target Population).*

Community Stakeholder Meetings – A total of eight community meetings have been held to date (through May 14, 2008), with a ninth scheduled for May 21, 2008. These meetings were open to the public, held between 5pm-8pm in county facilities in community room settings.

Three initial informational meetings were conducted in February 2008 in Woodland, Davis and West Sacramento to facilitate community awareness of the PEI planning process underway in Yolo County. These locations represent the three major cities in Yolo County. Subsequent meetings addressed: Initial Needs Assessment Reporting (March 10, 2008); Needs Assessment Update (March 27, 2008); Education on PEI Strategies and Programs (April 7, 2008); Summary of Input: PEI Strategies (April 22, 2008); and Discussion of PEI Strategies (May 5, 2008). The meeting scheduled for May 21, 2008 will address: Summary of Input; Facilitation and Consensus *(See Attachment Six, Yolo County PEI Meeting Schedule).*

II. Findings

The community input process (see Part I. above) yielded the following identified Barriers; Existing Resources and Community Strengths; Preliminarily Recommended Strategies to address barriers; Other Concerns.

a. Barriers

Isolation – There were a number of factors indicating actual or potential isolation of individuals in Yolo County who may benefit from access to services related to PEI. General barriers included: Rural geographic areas; Poverty; Limited or lack of transportation in urban and rural areas. For the elderly, in particular, there was an identified lack of health coverage for hearing aides that impacts some individuals' ability to communicate with others or to ask for help. Barriers directly related to mental health care and needs included stigma and fear of labeling related to mental illness (thereby limiting ability to access services without a diagnosis). For youth, in particular, there was acknowledgement that some youth are able to access counseling through school settings; however, are limited outside of school due to fear of "being out" (LGBT), lack of insurance (youth without family insurance, living with friends or on their own) and the requirement of parental consent for counseling services.

Funding – Two themes emerged around funding issues: Discussion of limitations to funding, both locally (e.g. for TAY) and statewide for mental health care and regarding concerns about individuals and families ability to access care due to "funding issues". For individuals and families, it was identified that some people do not meet criteria for funded services. As well, some people either have private insurance that is not comprehensive (thereby excluding needed services) or lack insurance entirely. Alternatively, there are people who may qualify for public services (e.g. Section 8), but those funds or services are "closed to applications" due to system funding limitations.

Service Delivery – According to the data, two chronic concerns related to service delivery included: Difficulty accessing services and shortage of providers.

Access barriers to services included: Lack of transportation, specifically related to public transportation in remote areas and poor frequency of transportation; Lack of awareness of existing mental health or related services, as well as poor understanding about process to access services; Stigma related to asking for assistance; Insufficient community based services; Cultural norms precluding getting "mental health" help (e.g. Latino community); Ethnic and cultural groups not feeling welcomed by existing services; and fear of repercussions to seeking formal services, specifically around "documentation" issues.

Barriers related to providers included: Lack of providers to meet specific needs, such as psychiatrists to work with geriatric community issues ("only one Medicare psychiatrist" per one KII); Inadequate referral resources in communities

to meet needs; Fragmentation of existing services, with poor communication between providers; and a sense of people who could benefit from services *not* being identified for services (i.e. maternal depression impacting care of infants, but no treatment offered).

Lack of Services - Additional barriers identified were related to families with children. Specifically, low-income, new immigrants and those families with generational gang involvement were of concern to those providing community input.

An absence of providers to provide prevention and early intervention services to families with infants and young children "at risk" - or for those young children experiencing psycho/social/behavioral problems who may benefit from early childhood mental health services at onset – was identified. Outreach to parents of such children also was felt to be absent. Engagement of school staff, counselors and administrators in being "at the table" for planning mental health care was considered critical as schools are ready points of access for reaching children in need. It was also noted that children exhibiting behavioral issues tended to be the primary beneficiaries of school-based services (e.g. truancy programs) and there was a lack of community resources to refer all children to outside of school.

In particular, transition-age youth (TAY) programs were felt to be lacking among community-based organizations. There was also reported to be an absence of mental health services, one-on-one counseling, substance abuse counseling and intervention, family / parent counseling, counseling related to gang involvement and depression. The absence of such services was believed to contribute to an increased likelihood that youth will enter the juvenile justice system or that their mental health problems would intensify.

Other notable concern – It was a noted concern that the community perceives Probation as Law Enforcement; thereby impacting community trust in and reliance on probation.

Need for Culturally Relevant Services – Language barriers posed a large cultural barrier for individuals and families. Specifically, challenges identified included: Difficulty "finding" (employ, enlist help of) individuals who speak the language of those seeking help; Need for children to interpret for parents with providers; and a need to provide interpreter training and quality assurance.

Immigration and refugee issues also were identified as cultural concerns, particularly related to the Post-Traumatic Stress Disorder (PTSD) experienced by many individuals in refugee or immigrant communities.

Ethnic- and cultural-specific services were also reported as necessary (e.g. Drug treatment for Latinos, group homes for Russians, LGBT youth).

b. Existing Resources / Community Strengths

Following is an inventory of: Agencies; Programs; Strategies; Funding sources; Staffing and Training assets existing within Yolo County. These were reported by stakeholders and may be considered for leveraging future services.

Agencies

Family Service Agency
CASA
Communicare
Yolo Family Resource Center (with bilingual, bicultural staff)
Esparto Family Practice
First 5 Yolo Children and Families Commission
Yolo County Children's Alliance
Yolo ADMH
Winters Healthcare Foundation
RIZE, Inc.
Yolo Crisis Nursery
Suicide Prevention Agency
FamiliesFirst, Inc.

Programs

DESS – ILP for TAY
Youth MIOCR program
The Gay-Straight Alliance (GSA) clubs in all large high schools except West Sacramento – create supportive environment for lesbian, gay, bisexual, transgender and allied youth at school.
Teaching Tolerance curriculum from Southern Poverty Law Center – provides good activities for school sites to teach respect for all youth.Same is true of Gay-Straight Alliance (GSA) Network in SF.
"Adopt a social worker" (and their caseload!) happens in some churches.
NAMI "Beginnings" newsletter for children and families.
UC Davis
Sacramento City College - has satellite campuses in Yolo County.
Woodland Community College
Faith Communities
Grace In Action
Families and Self Help in West Sacramento
Older Adult Mobile Access Team
Older Adult Program
Eleanor Roosevelt Circle
Rehab House in Russian Community in West Sacramento
Wellness Center
Collings Teen Center, West Sacramento (not a program, but could serve as an access point for services)
Slavic Parents Association
School District Mental Health Services-

Special Education

School District Mental Health Services (continued)

Outreach for truancy and substance abuse
Counseling at one school through partnership with CSUS
Parenting and substance abuse classes
Access to Counseling without parental consent while on school (k-12) campuses
Prevention Program in school
Parenting classes: Parent Project through Davis Police Department and FRCs; Court-mandated for parents (FSA and Families First); Communicare; FRC (Plan to lead, Pi, Mega skills, Teen Parent classes; County (Nurturing Parenting, Making Parenting a Pleasure).
Woodland Truancy Mediation referred to FRC
Davis Truancy Program

Existing Strategies

Partnerships with community-based organizations (CBOs)
People use church for help in crises
Probation case-management with youth
Probation now doing mental health screen on every referral who could go to juvenile hall
Parent-Child Interactional Therapy (PCIT)
Good rapport of agency with schools, police departments and hospitals
Parent groups, information groups, 24/7 crisis lines for suicide prevention/intervention.

Funding Sources

First 5 Children and Families Commission
Access to SSI, MediCal, Medicare
Individual community donations fund Christmas program.
Child Protective Services (CPS) and other resources have received grants to support auxiliary services for families.
Davis Community Foundations
United Way
Winters Healthcare Foundation

Staff

Public Health Nurses, Nurses with mental health expertise
Student volunteer for services
Bilingual/Bicultural staff at Family Service Agency and Family Resource Center.

Training

UCD infant mental health training (from Napa)
NAMI Provider Training Program

Migrant education for children, emancipated youth and parents; health and social welfare services, capacity building focus.
CAARES Providers Training – UCD

c. Strategies

Outreach – Recommended outreach provided in the stakeholder process revolved around the concept of outreach to "where people are, instead of having them come to you." Ideas for successful outreach included home visits; use of community-based outreach workers; stationing of staff in rural areas; development of school-based services for youth and parents; and noted adolescents and college-age youth are most important for establishing improved ways to outreach, demystify and de-stigmatize asking for help.

Additionally, integration of mental health care into primary health care settings and use of the UCD PCIT training

Engagement in Services – Stakeholders provided the following recommendations relative to engagement of individuals, families and communities in mental health services: Use of relation-based approaches, family centered services, building rapport with consumers. Case-management services and peer support groups in communities were suggested vehicles for engaging people in care, as well as potential partnerships with ADMH and community agencies with Probation. Important nuances in how services are delivered to increase engagement addressed the need to "be there when people ask for help" and to provider for "walk-ins". Promotoras in Winters was also specified as important for engagement.

Providing training and education related to Stigma – In order to reduce the stigma experienced by those seeking, receiving or who may benefit from services, the following recommendations were made: Have education ready for families of children and for children with identified needs; Provide data and statistics to further community education; Provide education to reduce harassment of LGBT youth beginning in grade school, through high school; and Providing education via health fairs and community events.

Training of non-mental health professionals – The need for training in a variety of settings underscored the relevance of various disciplines and professions to be poised to refer those in need of mental health care. Schools, childcare settings teachers, school counselors, psychologists, foster parents, special education teachers and parents were initially identified. Additional targeted professionals for training to recognize mental health symptoms included: Primary care physicians, pediatricians, nurses and home visitors. Promotoras was, again, specified as a critical method to be utilized.

Provision of Culturally Appropriate Services – This area of concern addressed needs for culturally relevant services. Specifically: Interpreters for Russian

speaking, Pakistani, Urdu/Punjab communities; Support groups for LGBT youth and adults; Social acceptance of LGBT community members and organizations; Rural-specific design of rural services; and community-based cultural competence were recommended strategies.

Recommended Types of Services - Recommendations included One-Stop services; Evidence-based practices (EBP); Non-literacy based services; After school programs; Strength-based care; and Adult Protective Services workers who could assist when older adults are exploited to decrease risk of exploitation and prevent elder abuse.

System-level Recommendations – Stakeholders encouraged the development of relations, collaborations and coordination between agencies and schools, as well as between agencies and community. Provision of local services, flexible services and tapping into existing agency expertise was also promoted. A practical first step for the stakeholders, themselves, was for the county to share the roster of attendees in the planning process to facilitate networking.

Additional Strategies to leverage funding, partnerships and programs included: Leveraging MHSA money with First 5 funds; Working with transportation programs to coordinate services among special needs populations; Linking EDAP with UC Davis; Transferring two (2) CSS programs into the PEI category (Older Adults and early detection of depression) and use CSS funds for employment services; and considering prevention services for children who reside in RCL 14 and below.

d. Other Considerations related to Strategies - The following questions and concerns were also posed in the stakeholder process related to strategies:

- Probation not funded under Yolo CSS.
- Will CBOs really have a chance to receive funding under MHSA PEI?
- Parentification of children is a big contributing factor to "infant, children and youth in stressed families" and can lead to behavior issue for youth.
- Increased resources needed to help people learn English.
- Employment needs of community.
- Imperative to take resources into account when planning mental health services.
- Need for LGBT-affirming youth development opportunities.

III. Synthesis of Findings

a. Key Community Needs

Community members, community organizations and service providers all identified the following needs in the same order of priority: Disparities in Access; Stigma and Discrimination (Mental Health); Psychosocial impact of Trauma; At-risk infants, children and youth and TAY; Suicide Risk.

b. Age Focus of Key Community Needs

Community members, community organizations and service providers all identified the following age groups:

Community Members and Organizations:
TAY (16-25 years)
Infant, children and youth (0-15)
Adults (26-59)
Older Adults (60+)

Service Providers:
Infant, children and youth (0-15)
TAY (16-25 years)
Adults (26-59)
Older Adults (60+)

c. Priority Populations

Community members, community organizations and service providers all identified the following priority populations:

- Children, youth and TAY at risk for/experiencing juvenile justice involvement
- Children, youth and TAY at risk for school failure
- Individuals exposed to Trauma
- Infants, children and youth in stressed families
- Individuals with First Onset of Serious Psych. Illness
- Underserved Cultural Populations

Age groups for the Priority Populations were identified as:

- TAY (16-25)
- Infants, children and youth (0-15)
- Adults (26-59)
- Older Adults (60+)

IV. Summary Key Needs and Priority Populations

Based upon the community input and needs assessment conducted in the community planning process the following Top Key Community Mental Health Needs were identified to be:

- Disparities in Access (Rural areas; Lack of insurance; Lack of transportation; Lack of awareness of services; Lacking services, providers and staff);
- Stigma and Discrimination (within cultural communities [Russian, Latino, LGBT] as well as mental health); and
- Psychosocial impact of Trauma (victims of assault, child and elder abuse; domestic violence, refugees).

Based upon the community input and needs assessment conducted in the community planning process the following Primary Age Groups were identified relative to the Community Mental Health Needs: TAY (16-25 years) and Infants, children and youth (0-15).

In summary, priority populations were found to be:

- "Children, youth and TAY at risk for /experiencing juvenile justice involvement" that include youth experiencing behavioral and substance abuse problems and not getting help;
- "Children, youth and TAY at risk for school failure" that include those requiring services not available at school or in the community;
- "Individuals exposed to Trauma" which includes victims of assault, child and elder abuse, domestic violence, refugees;
- "Infants, children and youth in stressed families" including those lacking prevention services, within isolated families experiencing stress and those with parents who are currently receiving mental health treatment or otherwise "in the system";
- Individuals with First Onset of Serious Psych. Illness, noting those without access to medical care who are less likely to have their symptoms of mental illness recognized;
- Underserved Cultural Populations, noting families and individuals unaware of services and those needing mental health education.

The age groups are, as previously noted, prioritized to be TAY (16-25) and Infants, children and youth (0-15).