

Community Mental Health Needs Assessment

Ventura County
Behavioral Health

March 29, 2019

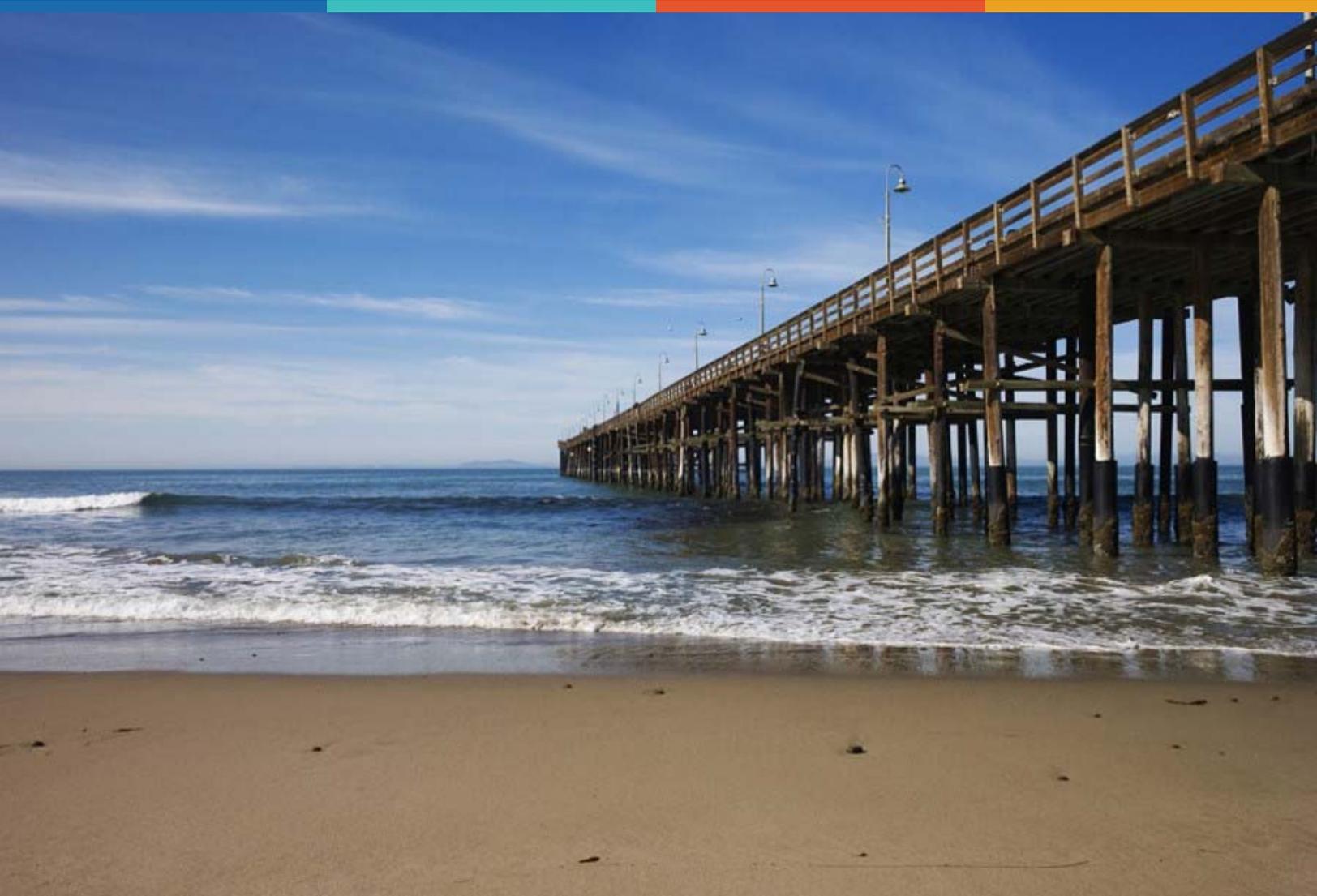




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Executive Summary

From March 2018 through February 2019, Ventura County Behavioral Health (VCBH) engaged Harder+Company Community Research to conduct a Community Mental Health Needs Assessment (CMHNA) to inform VCBH's Mental Health Services Act (MHSA) three-year plan. The CMHNA was designed with the goal of creating accessible ways for a wide range of community stakeholders, including community members and providers, to share their perceptions on mental health needs for Ventura County residents, and to identify the most urgent mental health needs among unserved and underserved populations in the county.

Process and Methods

Throughout the CMHNA, Harder+Company, along with VCBH and EVALCORP Research & Consulting, collected data to inform Ventura County's mental health needs through the following methods:

1. A review of existing **secondary data** on Ventura County's demographics and mental health indicators
2. A **community survey**, which reached nearly 5,000 residents, to directly assess demographic factors, mental health indicators, and feedback on mental health services among community members
3. Several **community focus groups**, reaching over 100 participants, in order to seek input from underserved or unserved priority populations in the county
4. A **provider survey**, with input from nearly 700 respondents, to seek input on the quality of existing mental health services from a wide range of county, private, and non-profit agencies that work with populations in need of mental health services

Key Findings

While this CMHNA demonstrated wide variation in perceived mental health needs between community members and providers, as well as between regions of the county and selected priority populations, there was broad agreement on four urgent community mental health needs, namely:

1. **Lack of access to needed mental health services:** 26% of community survey respondents who said they had needed mental health services in the past year did not receive them, while 35% of them said the same of a close family member. Respondents cited various barriers to access, including lack of health insurance or limited health insurance; inconvenient timing of services; services requiring too much travel; fear of provider mistreatment; and a lack of culturally or linguistically appropriate services. Many priority populations reported high rates of experiences of culturally inappropriate services, while homeless and Asian/Pacific Islander individuals reported a lack of linguistic appropriateness in higher proportions than other groups.
2. **Depression as a major mental health illness:** 52% of community

survey respondents indicated they had been diagnosed with depression by a healthcare provider in the past. About 29% of survey respondents also indicated that they had ever thought about or attempted suicide. Diagnosis of depression was fairly uniform across most priority groups, but notably higher among homeless (65%) and LGBTQ+ (62%) individuals, who both indicated having been diagnosed with depression in higher proportions than overall. Suicidal ideation did differ substantially across priority populations, with homeless individuals (56%) and LGBTQ+ individuals (49%) indicating past suicidal ideation or attempts in higher proportion than all other groups. Asians/Pacific Islanders, Blacks/African-Americans, and TAY also reported higher-than-overall rates of suicidal ideation or attempts (39-42%).

- 3. The homeless population as a priority in group in particular need of mental health services:** 40% of community survey respondents and 60% of provider survey respondents felt that homelessness was one of the top mental health issues in their community, while about 4% of survey respondents indicated they were actually homeless. During Ventura County's most recent point-in-time homeless count, in 2018, there were about 1,299 homeless individuals, and about 28% of them had mental health problems, while 26% were substance users. The community survey found that homeless individuals reported *worse mental health outcomes than every other priority population* across several key factors, including: (1) self-rated mental health status, (2) substance use, (3) suicidal ideation or attempts, and receiving mental health services that were either (4) culturally or (5) linguistically inappropriate. Homelessness is also unevenly distributed across Ventura County. The 2018 point-in-time homeless count showed that two thirds of homeless individuals were living in the cities of Oxnard and Ventura, the county's largest urban centers.
- 4. Substance abuse as a major co-morbidity impacting mental health status:** While about 15% of survey respondents indicated they had used a drug other than alcohol or tobacco in the past 12, certain priority populations reported use in substantially higher proportions. For example, 41% of homeless respondents to the community survey indicated recent substance use, compared to 29% for LGBTQ+ respondents, 28% for TAY respondents, and 25% for Asian/Pacific Islander respondents.

Recommendations

This CMHNA sought community input on the findings in this report in order to develop recommendations about potential services or systems that could help address the top four mental health needs identified through the community and provider surveys. Key recommendations are briefly outlined below, by topic area:

Access to Mental Health Services

1. Creation of a mental health navigation service that would serve as a "one-stop shop" for education, messaging, and stigma reduction about behavioral health issues, available mental health services and affordability
2. Coordination among county-wide service providers to ensure that all clients were triaged to appropriate and timely services regardless of their entry point to services, similar to what is referred to as a "no wrong door" policy
3. Delivering additional education to mental health providers (including

county agency and non-profit staff) and law enforcement on cultural and linguistic competency

Depression

1. Developing programs for education and outreach on depression in K-12 schools in Ventura County
2. Focused depression services for low income and homeless individuals, as well as older adults, and LGBTQ+ individuals, since these populations may suffer disproportionately from depression or other mental health conditions

Homelessness

1. Conduct further research to better understand homeless subpopulations (chronically homeless, transitionally homeless, dually diagnosed) and their mental health needs, as well as their geographic distribution across the county
2. Early intervention services for transitionally homeless individuals, providing needed supports for individuals at risk for chronic homelessness
3. An triage system to allow law enforcement agencies to link homeless individuals to appropriate mental health providers when mental healthcare is a more suitable responder

Substance Use

1. Conduct further research to better understand substance use subpopulations (by type of substance: e.g. cannabis, opioids, etc.) and their mental health needs
2. Focused substance use services for low income and homeless individuals

Additionally, Harder+Company recommends continuation of community engagement in assessing mental health needs through periodic, long-term community and provider surveys and focus groups.

Background

Purpose of Mental Health Services Act

The Mental Health Services Act (MHSA), formerly known as California Proposition 63, passed in November 2004 with the aim of providing increased funding, personnel and other resources to support county mental health programs spanning the continuum of prevention, early intervention and service needs.¹ MHSA's vision statement and guiding principles stress improvement of California's mental health systems through cultural competency, improved access, service efficacy, and the reduction of stigma against those with mental illness.² The letter of the MHSA itself outlines the act's five key intents as follows:³

1. To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.
2. To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.
3. To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.
4. To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.
5. To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.

Additionally, the MHSA is intended to address the mental health needs of unserved or underserved populations, and take into account age-appropriate services, particularly for children (under 18), Transition-Aged Youth (TAY, 16 to 25) and older adults (60 and over).

In order to access MHSA funds, California counties must submit documentation of their Three-Year Program and Expenditure Plans that includes, among other things, a Community Program Planning (CPP) process involving community stakeholders. The CPP must also solicit extensive input from diverse stakeholders, including consumers, caregivers, providers and the public at large.

¹ California Department of Health Care Services, Mental Health Services Act Website (12/28/2018) https://www.dhcs.ca.gov/services/mh/Pages/MH_Prop63.aspx

² California Department of Mental Health (DMH) Vision Statement and Guiding Principles for DMH Implementation of the Mental Health Services Act (2/16/2005) https://www.dhcs.ca.gov/services/MH/Documents/Vision_and_Guiding_Principles_2-16-05.pdf

³ Mental Health Services Oversight & Accountability Commission, Mental Health Services Act (1/29/2019) <http://mhsoac.ca.gov/file/3598/>

Approach to Community Mental Health Needs Assessment

This Community Mental Health Needs Assessment (CMHNA) is one component of Ventura County Behavioral Health's (VCBH) CPP, and was designed with the goal of creating accessible ways for a wide range of community stakeholders to share their perceptions on mental health needs for Ventura County residents. To that end, VCBH has partnered with Harder+Company Community Research to carry out the CMHNA and develop this report on the CMHNA's findings.

This CMHNA is focused on addressing the needs of (1) children and adolescents with severe emotional disturbance (SED), (2) adults with severe and persistent mental illness (SPMI), as well as those individuals considered to be (3) unserved or (4) underserved with regards to mental health services. There are numerous definitions of these four terms both in national and state statute, some of which are outlined below:

- (1) The California Welfare & Institutions Code (WIC) defines *seriously emotionally disturbed children or adolescents* as minors under the age of 18 who have a mental disorder other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. As a result of the mental disorder, the child has substantial impairment in self-care, school functioning, family relationships, or ability to function in the community.
- (2) WIC defines *severe and persistent mental illness* as a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders.
- (3) According to MHSA regulations, *unserved* means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency crisis-oriented contact with and/or services from the county may be considered unserved.
- (4) *Underserved* means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to:
 - a. Those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences;
 - b. Members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services;
 - c. Those in rural areas, Native American rancherias and/or reservations who are not receiving sufficient services.

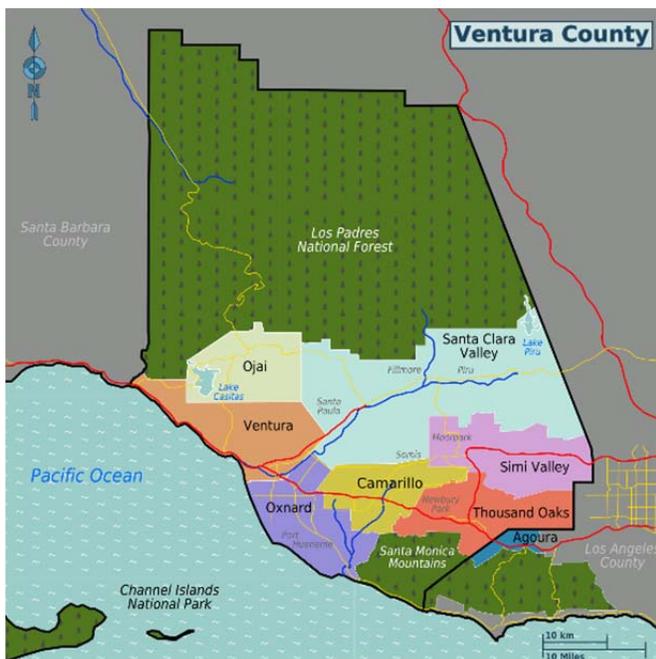
In order to determine potentially unserved or underserved populations, this CMHNA solicited feedback from the CMHNA's Advisory Group⁴ and community leaders at input sessions to identify the *priority populations* most in need of mental health services. In addition to considering the age groups defined by MHSR regulations (children, TAY and older adults), and Hispanics/Latinxs⁵ (who constitute a threshold population in Ventura County), the CMHNA input sessions generated the following priority groups:

- African-American
- Asian and Pacific Islander (API)
- Homeless
- LGBTQ+
- Mixteco

Advisory Group members and community leaders were also interested in whether mental health needs varied across various regions of the county, and if they did, to what extent. As a result, this CMHNA sub-divided Ventura County into seven geographic regions. This geographic division is especially salient given the mixed urban and rural nature of Ventura County, and MHSR regulation's inclusion of rural residents as potentially unserved or underserved. The seven geographic regions include (Exhibit 1):

- **Camarillo** (including the cities of Camarillo and Somis)
- **Conejo Valley** (including the cities of Newbury Park and Thousand Oaks in Ventura County proper, and the cities of Agoura Hills and Westlake Village in Los Angeles County)
- **Ojai**
- **Oxnard** (including the cities of Oxnard and Port Hueneme)
- **Santa Clara Valley** (including the cities of Fillmore, Piru and Santa Paula)
- **Simi Valley** (including the cities of Moorpark and Simi Valley)
- **Ventura**

Exhibit 1. Map of Ventura County CMHNA regions



* Note that Thousand Oaks and Agoura were combined into Conejo Valley, and that the Somis was included in the Camarillo region.

⁴ The Advisory Group is composed of around 21 staff from other Ventura County agencies, service providers, non-profits and community groups [see Acknowledgments for a list of Advisory Group members].

⁵ Throughout this report, the term Latinxs is used as a gender-inclusive form of the words Latina or Latino; the exceptions to this is when data are drawn from sources that use different terminology (for example, census data uses the term Hispanic/Latino).

This CMHNA sought to describe the overall mental health needs of the county, along with explicit consideration of individual mental health needs among the various age groups, priority populations and geographic regions outlined above. ✚

Needs Assessment Partners

The Community Mental Health Needs Assessment (CMHNA) was made possible through extensive collaboration among numerous agencies and organizations:

- **Ventura County Behavioral Health** provided review and oversight of the CMHNA and coordinated the outreach and implementation of the community survey and community focus groups
- **Harder+Company Community Research** led the overall CMHNA design and data analysis, particularly for the secondary data review, community survey and community focus groups
- **EVALCORP Research & Consulting** led the design, data collection, and analysis of the provider survey, as well as support in the analysis of English-language community focus groups
- **Advisory Group and community leaders**, drawing from various stakeholders, including Ventura County agencies, non-profits and consumers, submitted secondary data sources for review, provided input on priority population identification, and in some cases hosted community focus groups

Process and Methods

Harder+Company and EVALCORP Research & Consulting carried out the research design and analysis for the various data collection methods employed in the CMHNA. The data collection was divided into two categories: secondary and primary data.

Secondary data includes existing, publicly available data, and involves collecting and inventorying data that was generated outside of the CMHNA process (such as census data, county agency reports, state and local surveys).

Primary data is data that was generated specifically for this CMHNA, which did not exist previously. This includes both quantitative data, such as that obtained from surveys, and qualitative data, such as that obtained from focus groups. For purposes of this CMHNA, Harder+Company and EVALCORP Research & Consulting carried out three separate primary data collection efforts: (1) a community survey, (2) community focus groups, and (3) a provider survey.

Each of these primary and secondary data collection methods are described in the section below.

An overview of all data collection activities and key milestones of the CMHNA process is described in Exhibit 2 below.

Exhibit 2. Timeline of Ventura County CMHNA process



Data Collection Methods

Secondary Data Review

Harder+Company carried out the secondary data review of key demographics and mental/behavioral health status indicators primarily using U.S. Census Bureau data at the county (and sometimes, city) level, with California demographics for comparison. In some cases, where census data was unreliable or unavailable, data developed specifically by other national, state and local agencies were used. This data was presented to the Advisory Group and community stakeholders on May 16, 2018 and June 6, 2018, respectively. Only the most relevant and up-to-date data from this original set is presented in this report, since additional 2017-2018 data became available since the first Community Input Session. However, the full set of original indicator data from the first Community Input Session is provided in the Appendices.

Additionally, during the first Advisory Group meeting and community input session [see the *Community Engagement Process* section below], Harder+Company requested sources of additional county-level data from attendees to address perceived gaps and identify priority populations to be considered in the collection of primary data.

While demographic characteristics do not in and of themselves determine mental/behavioral health outcomes, factors such as socioeconomic status, housing and education are strongly linked to mental health. Demographic characteristics were also of interest in order to examine whether mental health outcomes in Ventura County might differ by characteristics such as age, gender and race/ethnicity.

The demographic factors under the “Ventura County Profile” section of this report set the context for examining outcomes related to mental/behavioral health. These data draw primarily from U.S. Census data, which allow for comparisons of Ventura County and state statistics. In some cases, state data was consulted (e.g. the California Health Interview Survey and the California Healthy Kids Survey), as well as local data (e.g. Ventura County Coroner’s Office).

A further intent of the CMHNA was to complement existing secondary data available for Ventura County with original data that could be examined at the regional level, as well as by race/ethnicity, sexual orientation, homeless status, etc. The need for this type of granular data was a primary impetus for the community survey described below.

Community Survey

VCBH and Harder+Company conducted a survey of the general, adult public (including consumers of mental health services, as well as their caregivers or family members) related to their experiences with mental and behavioral health services in Ventura County (i.e. personal and family members’ history with mental health illness and experiences accessing behavioral/mental health services). The survey was available in paper copy or online, as well as in English and Spanish. [See the *appendices for the community survey questionnaires.*] Both paper and online surveys were collected from August 22 to October 30, 2018.

VCBH intended for county-wide reach or penetration of the survey. In order to achieve this, both online and paper surveys were conducted, in order to ensure accessibility with varying audiences, and in order to provide respondents with multiple options for submitting their feedback. In addition, VCBH carried out extensive community outreach throughout the community survey collection period, including:

- A survey launch meeting on August 22, 2018 in order to engage county agencies and community groups in distributing paper surveys or disseminating the online survey link, and in returning paper surveys to VCBH for data entry;
- Distribution to MHSA contractors;
- On-demand delivery and collection of paper surveys to various agencies and community groups across the county;
- Tabling at various agencies and community groups, as well as public events;
- One-one-one assistance to agency and community group staff on explaining and administering the survey; and

- Live monitoring of the locations (ZIP codes, municipalities and regions) from which surveys were being received, in order to expand outreach efforts in locations with lower response numbers.

As a result of these extraordinary efforts by VCBH, the number of surveys received far exceeded the initial goal of 500-1000 surveys. In total, 4,772 surveys (3,697 paper and 805 online) were received.

The online and paper surveys were merged and cleaned to prepare the data set for descriptive analysis. In addition to analyzing the overall survey data, the resulting data set was also analyzed by dividing it by several regional and priority population groups.

Based on survey respondents' reported ZIP code of residence, respondents were divided into the following seven regions in order to analyze variations in survey responses by geographic location (respondents could be included in only one region):

- **Camarillo** including the cities of Camarillo and Somis
- **Conejo Valley** (including the cities of Newbury Park and Thousand Oaks in Ventura County proper, and the cities of Agoura Hills and Westlake Village)
- **Ojai**
- **Oxnard** (including the cities of Oxnard and Port Hueneme)
- **Santa Clara Valley** (including the cities of Fillmore, Piru and Santa Paula)
- **Simi Valley** (including the cities of Moorpark and Simi Valley)
- **Ventura**

Additionally, based on survey respondents' answers to various demographic questions, respondents were also divided into one or more of the following priority populations, based on groups within Ventura County that advisors and community stakeholders identified as likely to be unserved or underserved (respondents could be included in more than one priority population):

- African American
- Asian & Pacific Islander
- Hispanic/Latinx
- Homeless
- LGBTQ+
- Mixteco
- TAY
- Older Adults

Key results of the community survey are presented in this report and the full databook for the community survey is included in the appendices.

Community Focus Groups

Focus groups were conducted with specific priority groups identified by the CMHNA's advisors and community stakeholders. This approach was selected in recognition that quantitative data on certain priority groups may be difficult to obtain due to (1) the lack of existing data, (2) the small size of the priority populations being considered, and (3) the barriers certain priority groups might face in filling out a survey (due to language, location, access to the internet, or other factors).

Several factors were considered when determining the makeup and location of the focus groups, including:



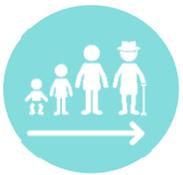
Geographic Coverage

- Ensuring that focus groups were held throughout the county; in the case of certain priority groups whose members were found in higher numbers in certain regions, focus groups were coordinated within those areas.



Unserved and Underserved Focus

- The priority groups identified by the CMHNA advisors and community stakeholders were those most likely to not receive needed mental health services; these groups included:
 - African Americans
 - Hispanics/Latinxs (English and Spanish speakers)
 - LGBTQ+
 - Homeless
 - Mixteco



Age

- While only adults were recruited for focus groups, this CMHNA sought to ensure the needs of children and youth were voiced through their adult caregivers and family members, as well as honoring MHA regulations' intent to reach all consumer age groups; these groups included:
 - Parents of children diagnosed with mental health diagnoses (English and Spanish speakers)
 - TAY
 - Older adults



Availability of Community Hosts

- In order to improve the accessibility of the focus groups, VCBH coordinated hosts throughout Ventura County, where possible by agencies that provided services or outreach to the priority populations identified.

Harder+Company developed the focus group protocol, which was modified iteratively through feedback from VCBH and other community stakeholders. Harder+Company then developed a training for all focus group facilitators, which included Harder+Company staff and two contracted experienced, bilingual independent facilitators. In total, 15 focus groups were conducted involving a total of 116 participants. The focus groups were conducted from October to December, 2018. Audio of the focus groups were recorded and then transcribed (and, where necessary, translated) for qualitative analysis. EVALCORP Research & Consulting also provided support with analysis of a subset of English-language focus groups.

Key results of the community focus groups are presented in the key findings section of this report.

Provider Survey

EVALCORP worked in collaboration with VCBH to develop and administer an online provider survey designed for organizations that intersect or serve populations experiencing mental health symptoms and/or are in need of mental health services. The purpose of the survey was to obtain providers' perspectives and experiences

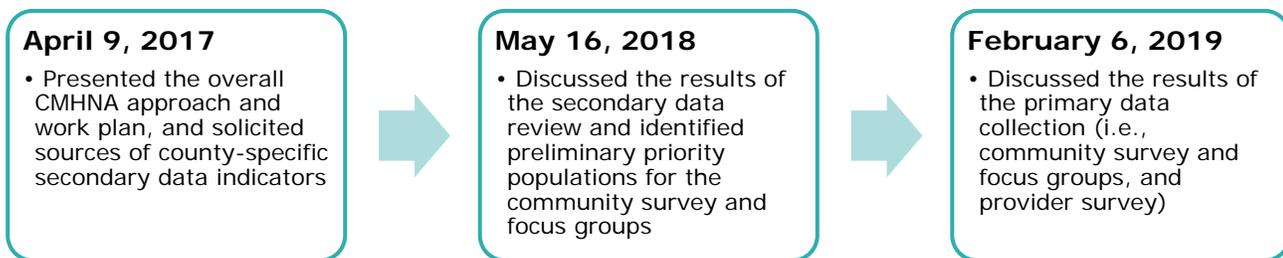
regarding the availability and provision of mental health services countywide. The survey also collected recommendations for improving mental health service delivery from providers.

The survey was distributed in October 2018 to a wide range of county, private, and non-profit agencies, including VCBH, law enforcement, education systems, public health, etc. During the three-week survey administration timeframe, a total of 690 individuals responded. For analysis purposes, respondents were asked to indicate the type of organization they represented, their role within that organization, and the geographic region of Ventura County that they served.

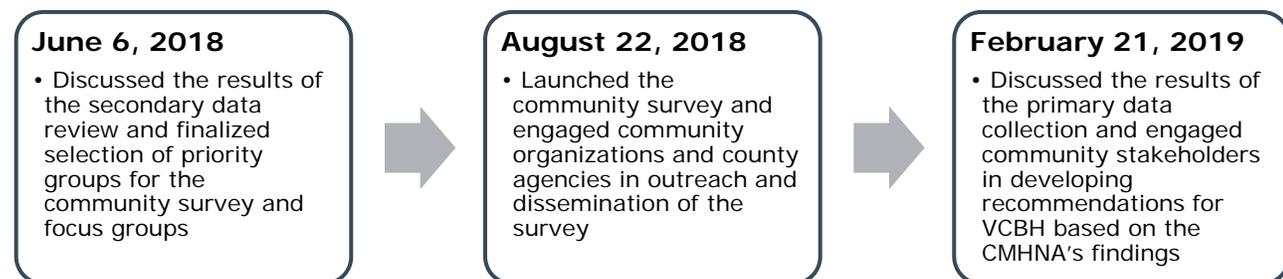
Key results of the provider survey are presented in this report and the full report from EVALCORP is included in the appendices.

Advisory Group and Community Stakeholder Input

In order to oversee and provide input to the CMHNA, VCBH convened an **Advisory Group** composed of around 20 staff from other Ventura County agencies, service providers, non-profits and community groups [see *Acknowledgments for a list of Advisory Group members*]. The Advisory Group came together during three sessions at key points in the CMHNA process, namely:



Community input was also instrumental to the design and recommendations of the CMHNA, in keeping with the spirit of MHSR regulations and the Community Program Planning process, which require engagement from consumers, caregivers and family members. To this end, three community input sessions were held, at which community leaders and interested parties were invited to provide feedback on various elements of the CMHNA, including cultural and linguistic competency. Attendance at the community input sessions ranged from 40 to 60 people representing various stakeholders and regions within the county. The three **community input sessions** took place as follows: #



Ventura County Profile

Overall, Ventura County's indicators on employment, socioeconomic status, housing and education are on par or better than for California as a whole, as are indicators related to mental/behavioral health.⁶ However, due to Ventura County's racially/ethnic diversity (e.g. there is no racial/ethnic majority in the county) and its regional variation (including urban, suburban and rural areas across more than 2,000 square miles), aggregate data may mask stark disparities within the county. Nevertheless, important differences can be discerned across lines of race/ethnicity and sexual orientation, particularly regarding mental/behavioral health outcomes.

Demographics

Overall population

The U.S. Census Bureau estimates that the overall population of Ventura County was just under 848,000 as of its latest five-year estimates (2013-2017), ranking 13th among California's 58 counties in terms of population. Most of Ventura County's population is concentrated in its largest urban centers, the cities of Oxnard and Ventura.

Age

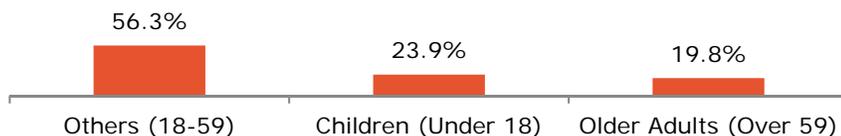
Note that MHPA regulations take into account several, overlapping age groups, including:

- Children (Under 18)
- TAY (16-25)
- Adults (18 and over)
- Older Adults (60 and over)

However, the structure of census data does not allow stratification into the TAY range above, so the best fit for the available data was used, which stratifies TAY as 16-24. Also note that the age ranges for other age groups listed throughout this section may also vary depending on the availability of data, and this is specified where it is the case.

There are just over 202,000 children (under 18) in Ventura County, accounting for about 24% of the population. Older adults (60+) number nearly 168,000, accounting for about 20% of the population. TAY (16-24), which overlap with the children's age category, number about 107,000, accounting for about 13% of the population. (Exhibits 3 and 4)

Exhibit 3. A majority of Ventura County's population is between the ages of 18 and 59. (n=847,834)



⁶ Source for data in this section, unless otherwise stated: U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimates

County Overview

Ventura County is a diverse, mid-sized Southern California county. Among the county's roughly 848,000 residents, no racial/ethnic group constitutes a majority, although Whites (46%) and Hispanics/Latinxs (42%) comprise substantial proportions of the county's population.

Ventura County's demographic and mental health indicators compare favorably with overall California figures. However, these indicators mask significant disparities within the county. These disparities manifest themselves both regionally and along the lines of race/ethnicity and sexual orientation, gender identity and gender expression.

Exhibit 4. TAY make up 13% of Ventura County's population. (n=847,834)

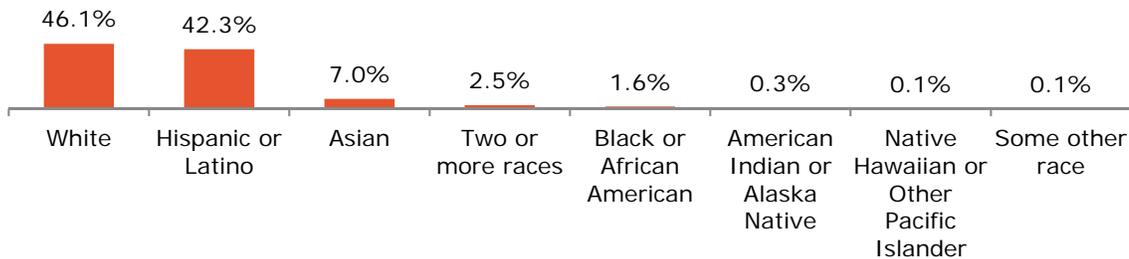


Race/ethnicity

While race and ethnicity alone do not determine mental health outcomes, disparities in factors such as income, employment and housing may manifest themselves across racial and ethnic lines. Since these factors are known to drive mental health outcomes, racial and ethnic disparities may directly or indirectly influence mental health outcomes.

No one racial or ethnic group holds a majority in Ventura County. The largest racial/ethnic groups, according to U.S. Census labels, include Whites (over 391,000 or about 46.1% of the population) and Hispanics or Latinos (over 358,000 or about 42.3% of the population). Asians numbered about 59,000 (or about 7.0% of the population) and Blacks or African Americans numbered over 13,000 (or about 1.6% of the population). American Indians or Alaska Natives, Native Hawaiians and other Pacific Islanders, and people identifying as some other race each constitute very small proportions of the population of Ventura County (less than half a percentage each). People identifying with multiple races numbered just over 21,000 (or about 2.5% of the population). (Exhibit 5)

Exhibit 5. Ventura County's population is mostly White and Hispanic/Latino (n=847,834)

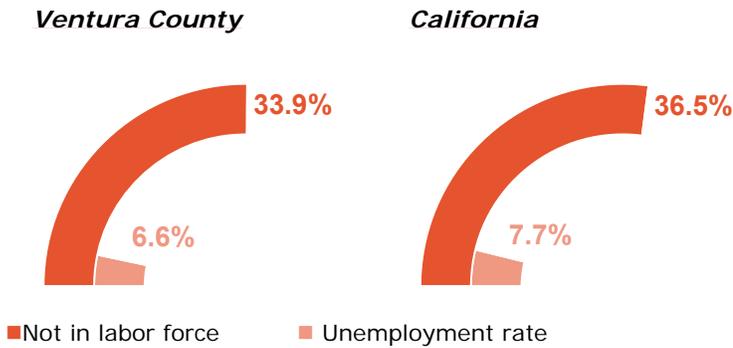


Employment

Employment is an important factor that may lead to differing mental health outcomes, since lack of employment may be a major stressor (especially among low income individuals), and since the majority of people in California obtain health insurance through their employer. Thus, employment may affect both mental health outcomes, and the ability to access mental health services.

Ventura County has a nearly 7% unemployment rate, while a third of the population is not in the labor force, which could mean that the respondents were students, retired, work in the home, or other statuses (both figures apply to those 16 and over only). By comparison, California has a slightly higher unemployment rate (8%) and percentage of the population not in the labor force (37%). (Exhibit 6)

Exhibit 6. Compared to California, Ventura County has a slightly lower unemployment rate and percentage not in the labor force.



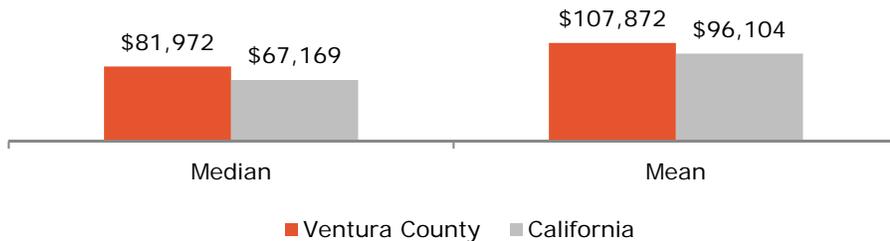
Income

As previously mentioned, employment and income may drive mental health outcomes in a variety of ways. Low income individuals and families may be subjected to stressors that lead to mental illness as a result of low income or poverty, and may be less able to afford mental health prevention or treatment services, or other amenities that may be protective against mental illness.

The median household income in Ventura County is approximately \$82,000 per year, and the mean yearly household income is approximately \$108,000 per year. By comparison, California has a substantially lower median (\$67,000) and a moderately lower mean (\$96,000) yearly household income. (Exhibit 7)

In terms of variation of income across the county, the highest median yearly household income is in Thousand Oaks (\$104,000), while the lowest is in Santa Paula (\$55,000), a substantial difference of about \$49,000 a year across the two municipalities. This difference across geographic regions suggests a great degree of income disparity across the county, as well as wide variation between the lowest and highest income residents in the county.

Exhibit 7. Ventura County's median and mean income is higher than California's.

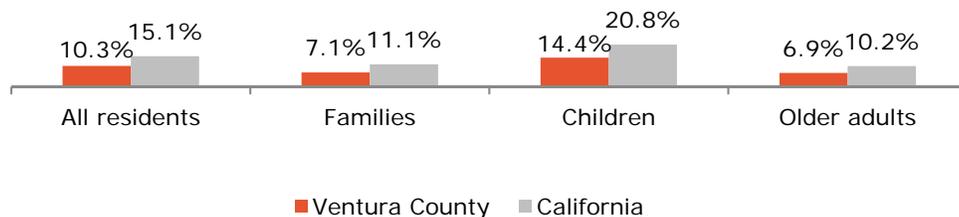


Poverty

Poverty is tightly linked with income and income disparity. However, household income alone does not determine poverty or wealth, since the experience of poverty will depend on various factors, such as household size and local cost of living. While federal poverty level guidelines do not take local conditions into account (although they do take household size into account), they may be illustrative for comparison purposes.

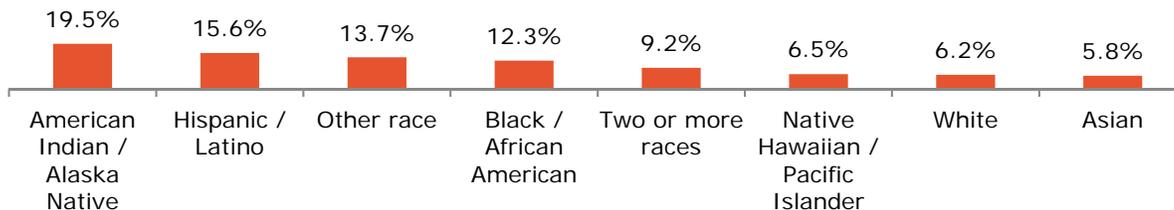
Approximately 7.1% of all Ventura County families and 10.3% of the total population live below the federal poverty level; the latter includes about 14.4% of all children (under 18) and 6.9% of older adults (65+) in the county. By comparison, in California, 11.1% of families and 15.1% of the total population live below the federal poverty level, a substantially higher percentage for each. Likewise, the percentage of children (20.8%) and older adults (10.2%) living below the poverty level in California is also substantially higher than for Ventura County. (Exhibit 8)

Exhibit 8. Ventura County has lower poverty rates than California overall across all demographics.



Poverty level also varies substantially by race and ethnicity, with 19.5% of Ventura County’s American Indians and Alaska Natives living below the federal poverty level, while Asians had the lowest rate at 5.8%. Hispanics or Latinos (15.6%), people of some other race (13.7%) and Blacks or African Americans (12.3%) also had higher poverty rates than for the county overall. (Exhibit 9)

Exhibit 9. American Indians / Alaska Natives, Hispanics/Latinos and Blacks/African Americans have higher poverty rates than the overall population of Ventura County.

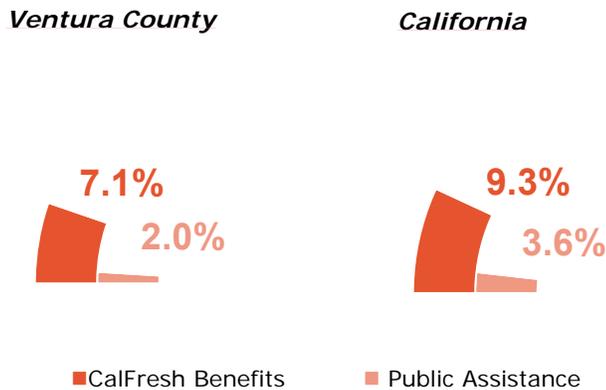


Public assistance

Individuals that rely on public assistance represent groups that are very low income and/or unable to work. As mentioned above, income and employment are linked to mental health outcomes.

About 2.0% of the county’s residents receive cash public assistance, and about 7.1% receive CalFresh (“food stamps”) benefits. By comparison, a somewhat higher percentage of all Californians receive cash public assistance (3.6%) of CalFresh benefits (9.3%). (Exhibit 10)

Exhibit 10. A lower proportion of Ventura County's residents receive public assistance compared to California overall.



Housing Costs and Homelessness

Housing instability and unaffordability of rent are major stressors that may influence the ability of individuals and families to maintain good mental health. As a basic need, issues related to housing may take precedence over seeking out care for mental health services, and the lack of stable housing may be an impediment to maintaining ongoing mental health care.

The median monthly gross rent in Ventura County is \$1,643, about 21% higher than for California (\$1,358). On average, Ventura County residents spend about 33.1% of their household income on rent (on par with California's rate, which is 33.8%).

The U.S. Department of Housing and Urban Development (HUD) considers families to be rent burdened when they pay more than 30% of their income on housing.⁷ By this definition, 55.3% of Ventura County renters are rent burdened (on par with California's figure, which is 53.1%).

High rent burden is one of various factors that may contribute to housing instability and homelessness. According to the Ventura County Continuum of Care Alliance's Homeless Count and Subpopulation Survey,⁸ there were 1,299 adults and children who were homeless during the 2018 point-in-time count, a 13% increase from 2017 to 2018. This is the first increase in the homeless point-in-time count since 2009.

Of the 1,299 homeless people counted in 2018:

- The majority (66%) were located in Ventura County's largest urban centers, the cities of Oxnard and Ventura
- 39% were unsheltered
- 32% were Hispanic or Latino
- 28% had been released from prison or jail in the past 12 months
- 28% had mental health problems
- 26% were substance users
- 18% were homeless for the first time that year
- 9% were children (under 18)
- 4% were children (under 18) and unsheltered

⁷ U.S. Department of Housing and Urban Development, Affordable Housing Website (Undated)

https://www.hud.gov/program_offices/comm_planning/affordablehousing/

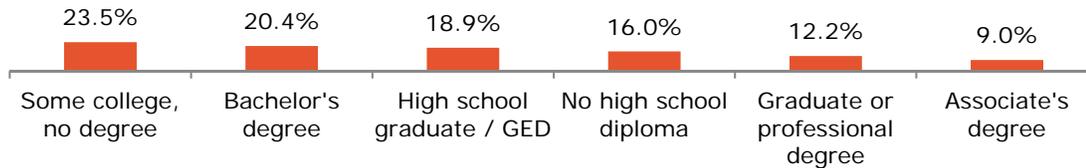
⁸ Ventura County Continuum of Care Alliance, 2018 Homeless Count and Subpopulation Survey (4/2018)

http://www.venturacoc.org/Images/VC_2018_Homeless_Count_and_Survey_Final_Report.pdf

Education

Among Ventura County residents 25 and over, 16.0% have no high school degree, while, in contrast, 32.6% have a bachelor's degree or higher (Exhibit 11). By comparison, in California, the percentage of people over 25 who have no high school degree (17.5%) was negligibly different from Ventura County, while the percentage of people with a bachelor's degree or higher (32.6%) was the same.

Exhibit 11. Nearly a quarter of Ventura County residents (25 and over) have a higher education degree, compared to 16% of residents with no high school diploma.



Mental/Behavioral Health Status

Access to health insurance

Affordability of healthcare (or mental health care) may be another stressor or barrier to initiating or continuing mental health services. As such, access to health insurance is a strong driver of access to mental health services. While some mental health services may be free of charge, the perception of high cost for services may prevent some individuals from accessing needed care.

According to census data from 2013-2017, 10.8% of Ventura County residents have no health insurance coverage, including 5.3% of children (under 19). These figures roughly correlate with those for California as a whole, where 10.5% of all residents and 4.7% of children have no health insurance coverage. (Exhibit 12)

Exhibit 12. Ventura County's population has a similar proportion of uninsured individuals compared to California overall.



Mental health status

The demographic factors outlined above have a major influence on mental health outcomes, outlined below.

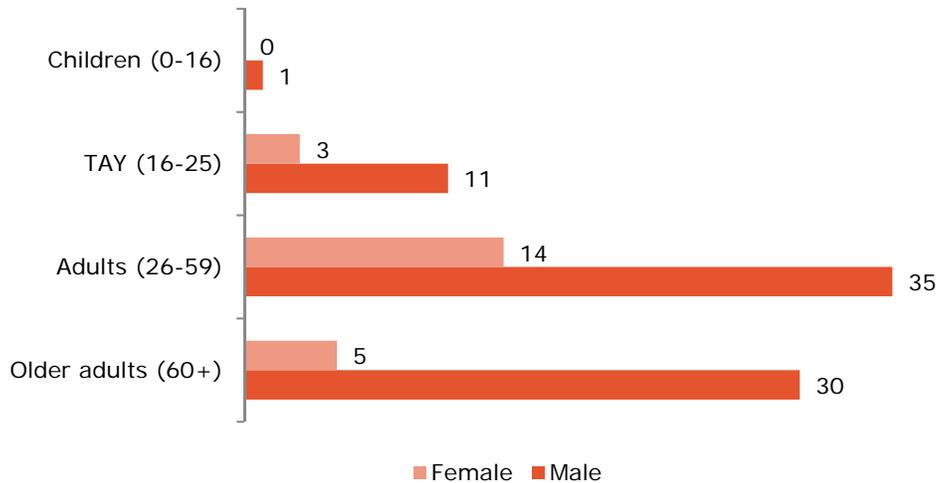
In 2017,⁹ 19.5% of Ventura County adults reported needing help for mental health problems (slightly higher than California's figure of 18.5%), while 8.0% reported serious psychological distress (also slightly lower than California's figure of 10.0%) and 7.3% had ever thought about committing suicide (lower than California's figure of 11.6%).

⁹ UCLA Center for Health Policy Research, California Health Interview Survey (2017) http://askchisne.ucla.edu/ask/_layouts/ne/dashboard.aspx

In 2017, there were 99 suicides in Ventura County.¹⁰ Overall, 3.5 times as many males died by suicide than females in Ventura County in 2017, and the majority of deaths by suicides were among adults 26 and over. (Exhibit 13)

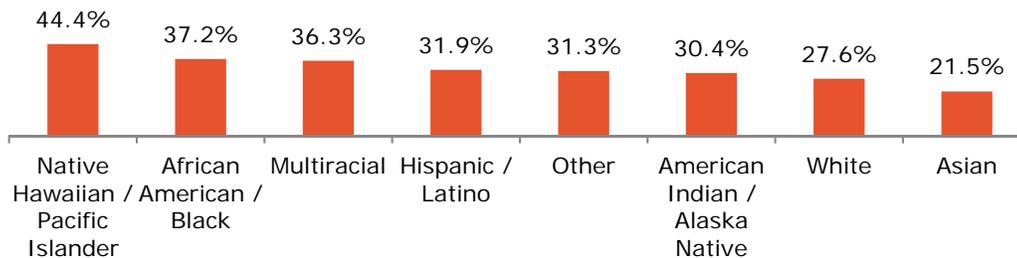
Depression, which places people at higher risk of suicide, is a highly prevalent issue in Ventura County, particularly among youth. Among Ventura County public school students in grades 7, 9, 11 and non-traditional programs from 2013-2015,¹¹ depression-related feelings varied by both race/ethnicity and sexual orientation.

Exhibit 13. Adults and older adults accounted for the majority of suicide-related deaths in Ventura County in 2017.



The groups most likely to have depression-related feelings included Native Hawaiians / Pacific Islanders (44.4%), African American/Black (37.2%), and multiracial students (36.3%), while Asians reported depression-related feelings the least (21.5%). (Exhibit 14)

Exhibit 14. Native Hawaiians / Pacific Islanders, African Americans / Blacks and multiracial students in Ventura County had higher rates of depression than their peers (2013-2015)



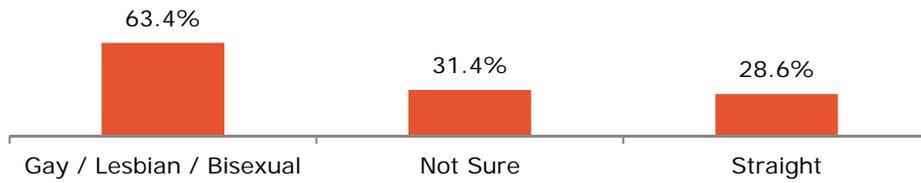
Lesbian, gay and bisexual (LGB) students were substantially more likely to have depression related feelings (63.4%) than their straight counterparts (28.6%). (Exhibit 15)

¹⁰ Ventura County Medical Examiner’s Office

¹¹ California Department of Education, California Healthy Kids Survey (7/2017)

<https://kidsdata.org>

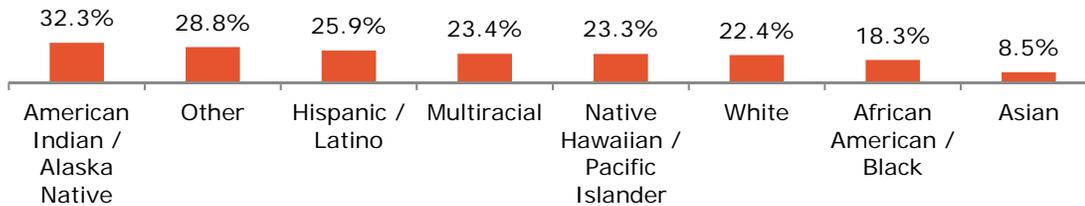
Exhibit 15. LGB students were more likely to have depression-related feelings than their counterparts (2013-2015)



Alcohol and drug use

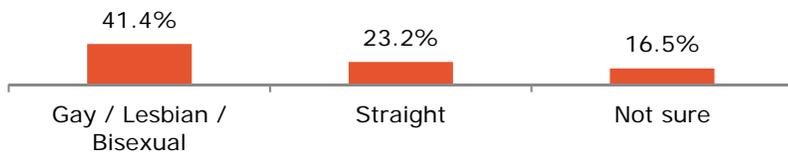
Alcohol and drug use followed similar trends to depression-related feelings among public school students,¹² with reported rates varying by race/ethnicity and sexual orientation. By racial/ethnic lines, American Indians / Alaska Natives reported the highest alcohol and drug use (32.3%), while Asians reported the least (8.5%). (Exhibit 16)

Exhibit 16. American Indian / Alaska Native students in Ventura County reported the most drug use, while Asians reported the least (2013-2015)



LGB students reported alcohol and drug use in substantially greater proportion (41.4%) than their straight counterparts (23.2%). (Exhibit 17)

Exhibit 17. LGB students in Ventura County reported higher alcohol and drug use than their counterparts (2013-2015)



¹² California Department of Education, California Healthy Kids Survey (7/2017) <https://kidsdata.org>

Key Findings

Key Findings across the primary data collection methods (community survey, provider survey, and community focus groups) are presented below. For complete community and provider survey findings, see the appendices.

Overall Community Survey Findings

In total, 4,772 survey responses were received. In the data that follows, the sample size (n) for specific survey items is noted (since some respondents may not have answered every item in the questionnaire, or some items may not have applied to them).

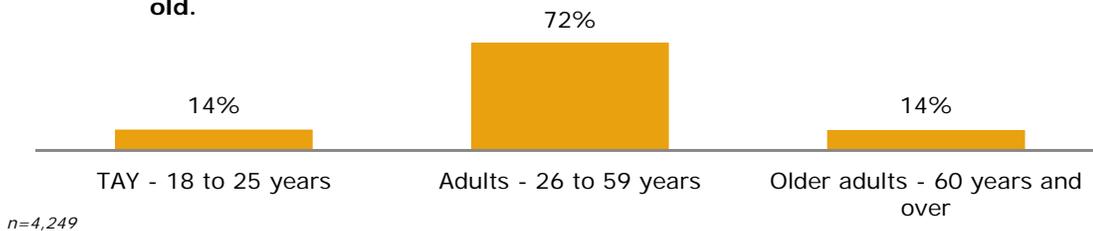
Demographics

The survey was intended for adults only (18 and over). Given this fact, respondents were stratified into the following age categories:

- **TAY** – 18-25
- **Adults** – 26 to 59
- **Older adults** – 60 and over

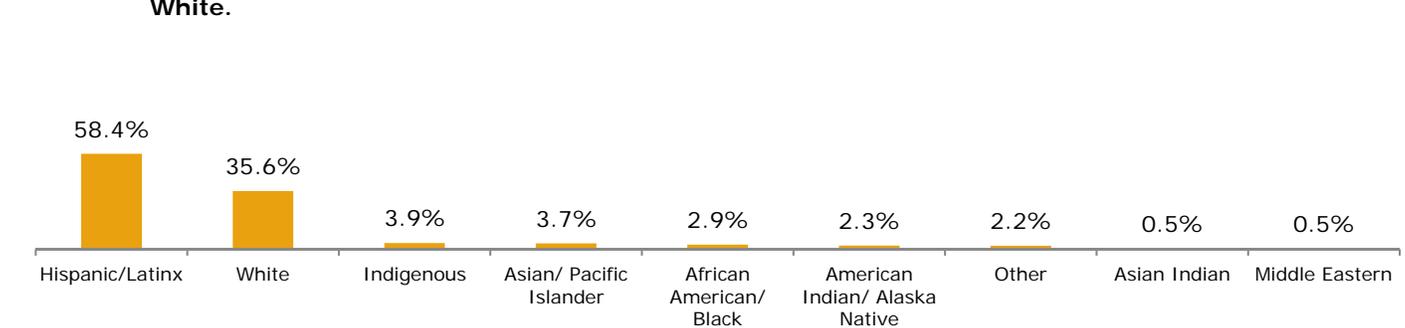
The vast majority of respondents that specified their age fell within the adult category, with equal proportions of TAY and older adults (Exhibit 18).

Exhibit 18. Most respondents were between the ages of 26 and 59 years old.



In terms of race and ethnicity, the majority of respondents were Hispanic/Latinx (58.4%), with Whites making up the second-largest proportion (35.6%). All other racial/ethnic categories accounted for a range in proportion from 3.9% down to 0.5% of the total sample. (Exhibit 19)

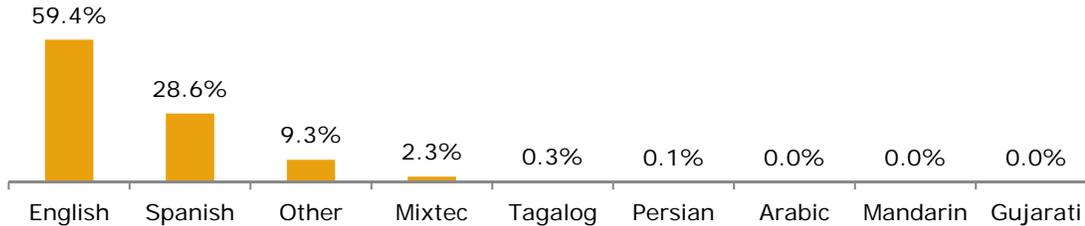
Exhibit 19. The vast majority of respondents were Hispanic/Latinx or White.



n=4,208
 Note: multiple choices possible; may not add up to 100%

In terms of primary language spoken at home, the majority of respondents preferred English (59.4%), while a substantial proportion preferred Spanish (28.6%) or some other language (9.3%, write-in responses typically indicated the respondent was multilingual or spoke Zapotec). All other languages ranged in proportion from 2.3% to 0.0%. (Exhibit 20)

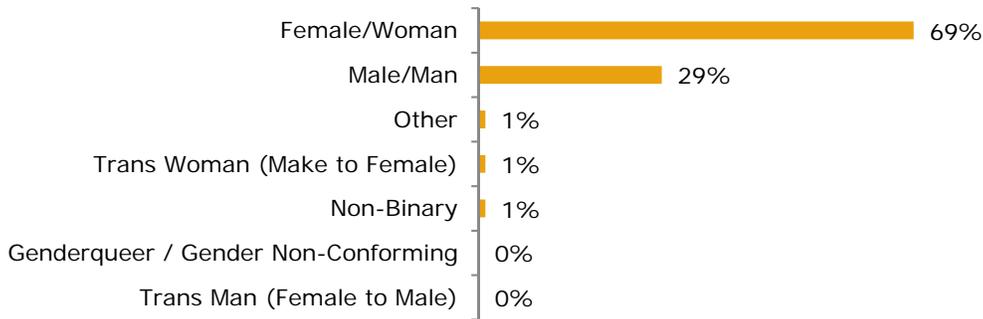
Exhibit 20. English and Spanish were the most common home languages among respondents.



n=4,229
 Note: multiple responses possible; may not add up to 100%

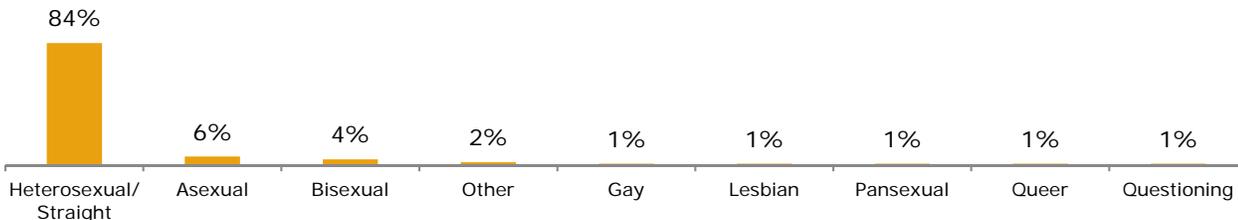
In terms of sexual orientation, 2-3% of respondents identified outside of the male/female binary, and 16-17% of respondents identified as asexual or LGBTQ+. Also note that, a much higher proportion of survey respondents identified as female (69%) than male (29%). (Exhibits 21 and 22)

Exhibit 21. About 2-3% of respondents identified outside of the male/female binary.



n=4,038
 Note: multiple choices possible; may not add up to 100

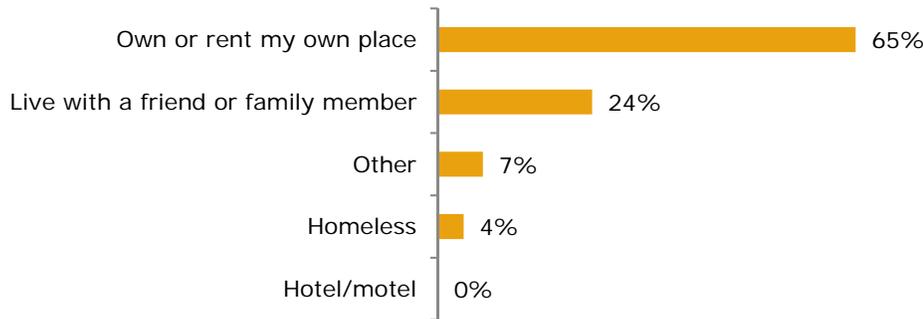
Exhibit 22. About 16% of respondents were LGBTQ+.



n=3,553
 Note: multiple choices possible; may not add up to 100%

Since the CMHNA advisors and community stakeholders identified homeless people as a group that may be particularly at risk of being unserved and underserved, the community survey also fielded a question about living situation. About 4% of survey respondents indicated that they were currently homeless (Exhibit 23). Furthermore, over half of respondents that said they were currently homeless, indicated that they had been homeless for a year or more.

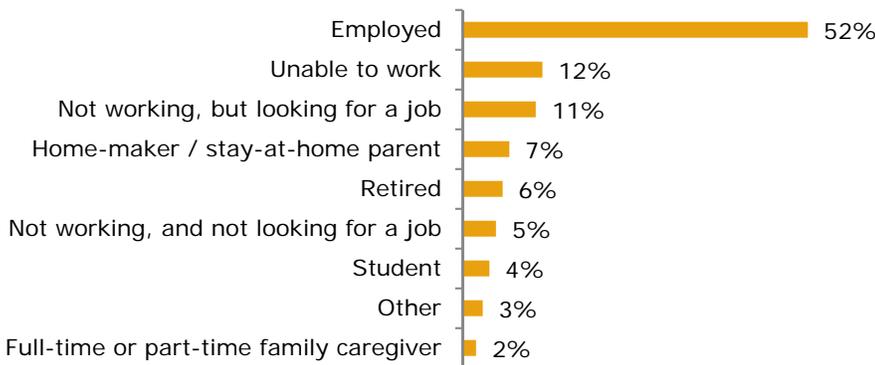
Exhibit 23. About 4% of respondents were homeless, either living on the streets or in shelters.



n=4,103

Overall, respondents were in a wide variety of employment situations. 52% of respondents indicated they were employed (either by an outside employer or self-employed). 11% indicated they were not working, but looking for a job (the category considered “unemployed”, Exhibit 24). Among the 52% of respondents that indicated they were employed, they reported a median income of \$35,000/year.

Exhibit 24. About 11% of survey respondents were unemployed (looking for a job).



n=4,054

Note: multiple choices possible; may not add up to 100%

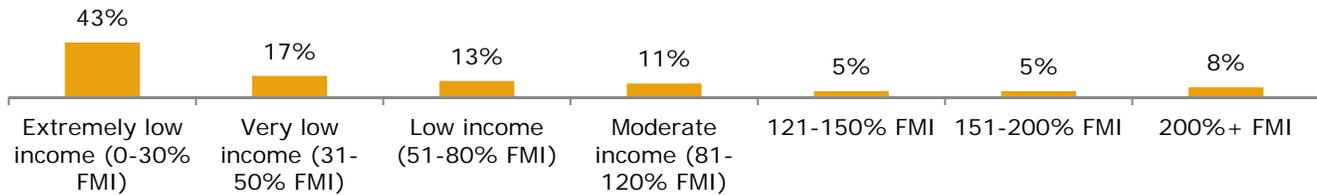
Which households were considered “low income” was determined based on household income, household size, and Ventura County-specific income levels determined by HUD that are calculated based on the percentage of the median family income (MFI) in Ventura County under which a specific family falls.

For reference, in Ventura County, the MFI for a household of four was \$96,000/year. The following are cutoffs for the various “low income” categories for Ventura County for a household of four:

- Low income (51-80% FMI) - \$81,100
- Very low income (31-50% FMI) - \$50,700
- Extremely low income (0-30% FMI) - \$35,300

Based on these levels, 73% of respondents are considered low, very low, or extremely low income (Exhibit 25). These income breakdowns, paired with the relatively high median household income in Ventura County, point to a large disparity in income within the county.

Exhibit 25. The majority of respondents were low to extremely low income.



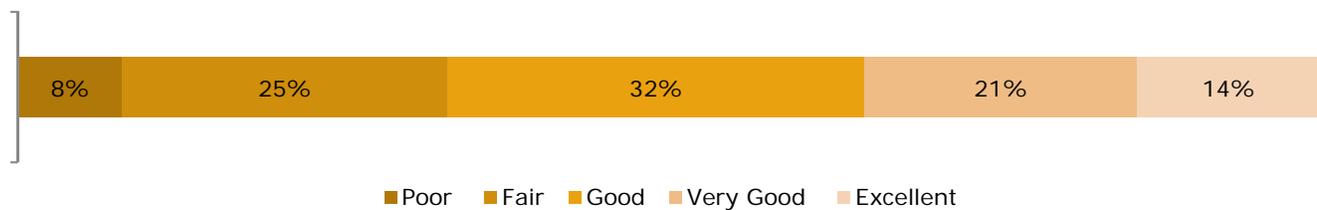
n=2,158

Mental Health Status

As with the results of the demographic questions in the community survey, the results for mental health status below are not an exhaustive accounting of all questions in the survey. Rather, they are key, salient highlights from the overall findings. For the complete community survey databook, see Appendix.

Respondents were asked to assess their own overall mental health on a five-point scale from poor to excellent. 67% of respondents rated themselves as having good, very good, or excellent overall mental health, while the remaining 33% rated their overall mental health as fair or poor. Few respondents rated themselves at the extremes of this scale, with only 8% rating their overall mental health as poor and 14% as excellent. (Exhibit 26)

Exhibit 26. About a third of respondents indicated they had fair or poor mental health.

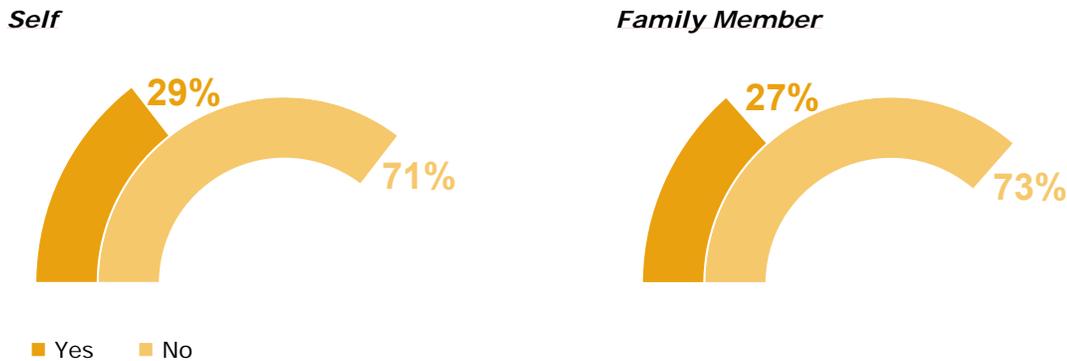


n=3,856

In contrast to the generally positive findings regarding overall mental health rating, survey respondents indicated in rather high proportions that they had ever thought about or attempted suicide, with 29% of respondents indicating they had done so, and 27% indicating that a close family member had done so (Exhibit 27). These figures stand in contrast to our secondary data review, which found that 7.3% of Ventura County residents that responded to the California Health Interview Survey (CHIS) said they had thought about suicide. The much greater proportion of respondents with suicidal ideation in the community survey may be due to the

sample, which included a large proportion of consumers of mental health services in Ventura County.

Exhibit 27. A substantial proportion of survey respondents said they (29%) or a close family member (27%) had ever thought about or attempted suicide.

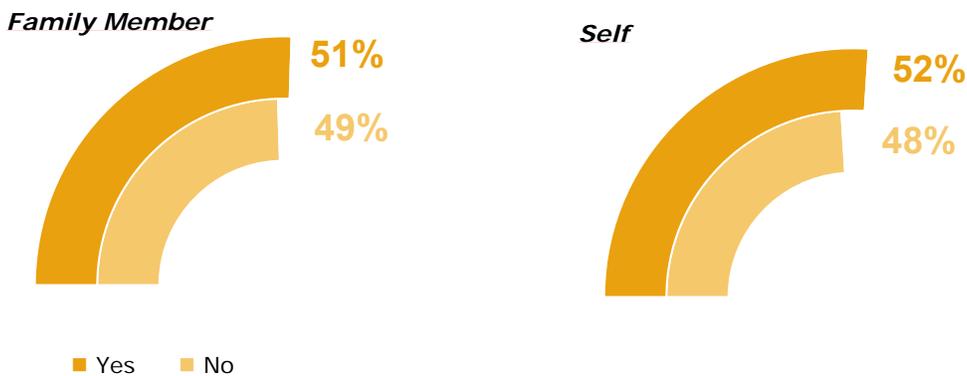


*n*_{self}=3,623, *n*_{family}=3,129

In the community survey, respondents were asked whether they or a close family member had *needed* mental services in the past 12 months, and if so, whether they had *received* those services. Therefore, mental health care access was loosely defined as *whether or not an individual received the mental health care they needed*.

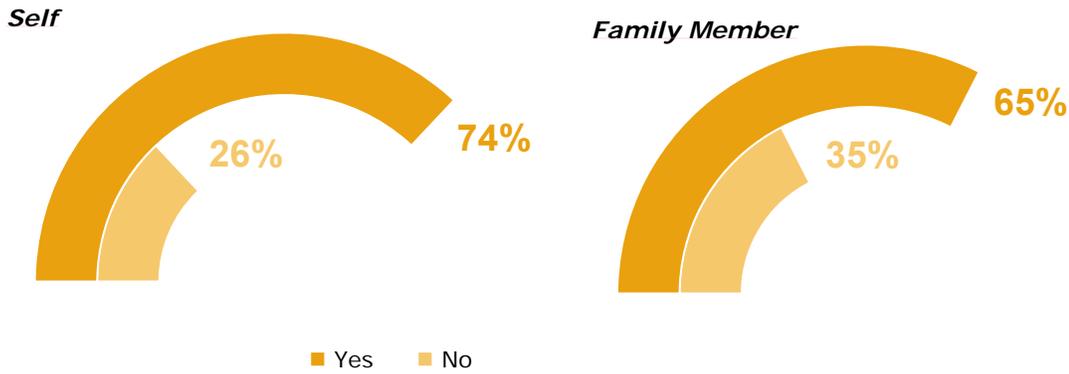
About 33% of survey respondents indicated they had needed mental health services in the past 12 months, and 42% of them indicated that a close family member of theirs had needed mental health services in that time period (Exhibit 28). *Of those respondents that indicated that they or a close family member needed services, 26% said they had not received needed services and 35% said a family member had not received them.* (Exhibit 29) These latter figures represent potential indicators for lack of access to mental health services in Ventura County.

Exhibit 28. Over half of respondents said they or a close family member had needed mental health services in the past year.



*n*_{self}=2,987, *n*_{family}=2,452

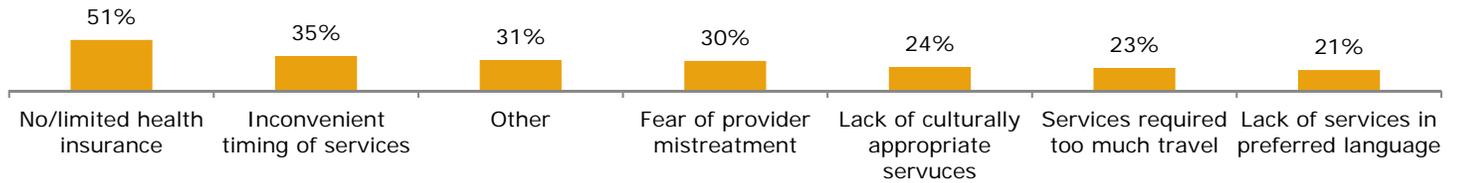
Exhibit 29. A substantial proportion of survey respondents said they (26%) or a close family member (35%) had not received needed service in the past year.



n_{self}=2,987, *n_{family}*=2,452

Of the respondents that indicated they or a close family member had not received needed mental health services, the reasons or barriers to accessing mental health services were varied. The three most frequent barriers cited included being uninsured or underinsured (51%), the timing of mental health services not being convenient (35%), and fear of being mistreated by a provider (30%). However, all listed barriers were selected by a substantial proportion of respondents (Exhibit 30). "Other" category was selected by 31% of respondents, who indicated various reasons, including cost of services or copays for services, stigma, long length of time to get an appointment or a provider not returning a call, services being denied, being unwilling to receive services, or being unaware of existing services.

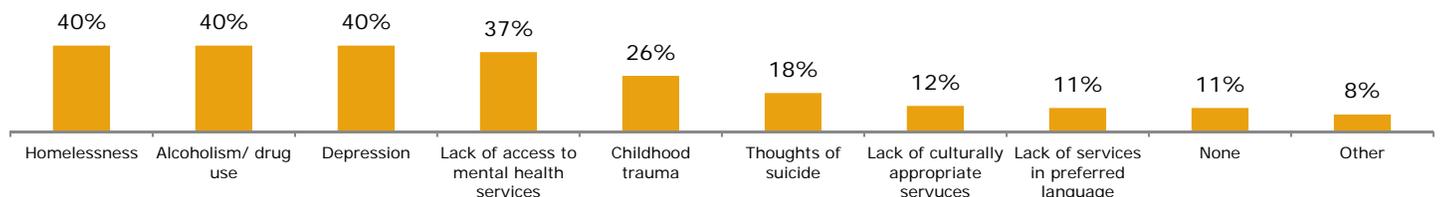
Exhibit 30. Respondents indicated numerous substantial barriers to accessing mental health services.



n=533

Responses were similarly varied as to respondents' opinions on the most urgent community mental health needs in Ventura County. The top four issues were homelessness (40%), alcoholism and/or drug use (40%), depression (40%) and lack of access to mental health services (37%). Other listed responses also gathered a substantial number of "votes," ranging from 11-26%. (Exhibit 31)

Exhibit 31. Respondents indicated homelessness, substance use, depression and access as the most urgent community mental health needs in Ventura County



n=3,715

Key Community Survey Findings by Geographic Region

To reiterate, for purposes of this CMHNA, Ventura County was divided into seven regions, as follows:

1. Camarillo
2. Conejo Valley
3. Ojai
4. Oxnard
5. Santa Clara Valley
6. Simi Valley
7. Ventura

Advisors and community stakeholders had mentioned that there were key demographic differences across these regions, which might drive key differences in mental health outcomes. As expected, there were significant differences in certain demographic indicators (such as age, race/ethnicity and income), but broad agreement across all but a few key mental health outcome indicators. This section highlights indicators for which there are clear, key differences across regions.

In terms of age, Ojai’s respondents skewed older than other regions (median age=51), while Oxnard’s residents skewed younger (median age=37; Exhibit 32). While the proportion of respondents aged 26-59 tended to remain quite stable across regions, differences in median age were determined by the balance between TAY (18-24) and older adult (60+) respondents.

Exhibit 32. Differences in median age across Ventura County regions

Region	Number	Median Age
Camarillo	308	42
Conejo Valley	275	45
Ojai	93	51
Oxnard	1,759	37
Santa Clara Valley	477	42
Simi Valley	421	43
Ventura	649	47

In terms of race/ethnicity, White respondents comprised the majority in all regions except Oxnard and Santa Clara Valley, where Hispanics/Latinxs were the majority (Exhibit 33). These two regions also had the highest proportions of Spanish-speakers or foreign-born individuals (typically from Mexico).

Exhibit 33. Differences in racial/ethnic majority (White vs. Hispanic/Latinx) across Ventura County regions

Region	Number	Hispanic/Latinx	White
Camarillo	308	39%	55%
Conejo Valley	274	31%	66%
Ojai	93	31%	67%
Oxnard	1,741	74%	16%
Santa Clara Valley	469	89%	12%

Region	Number	Hispanic/Latinx	White
Simi Valley	418	35%	62%
Ventura	647	34%	61%

Income distribution also varied greatly by region, with Camarillo (49%) and Simi Valley (55%) having the smallest proportion of low income residents, in contrast to Oxnard and Santa Clara Valley (83% for each), which has the largest proportion (Exhibit 34). Note that Oxnard and Santa Clara Valley are also the regions with the highest proportion of Hispanics/Latinx, Spanish-speakers, and Mexican-born individuals.

Exhibit 34. Differences in income distribution across Ventura County regions

Region	Number	Low 0-80% MFI	Moderate 81-150% MFI	High 151%+ MFI
Camarillo	157	49%	22%	27%
Conejo Valley	133	69%	17%	14%
Ojai	66	76%	14%	11%
Oxnard	854	83%	11%	6%
St. Clara Valley	233	83%	11%	6%
Simi Valley	247	55%	23%	22%
Ventura	385	63%	21%	16%

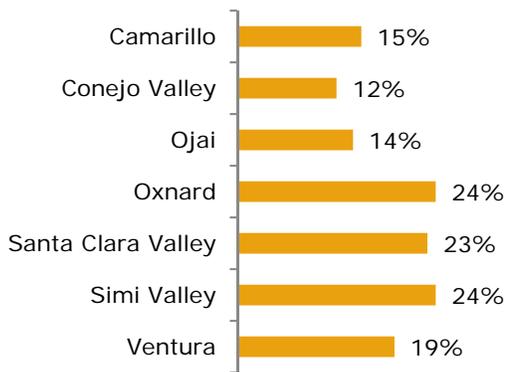
While overall mental health rating was similar across regions, Conejo Valley stands out with the lowest self-reported mental health ratings in Ventura County (45% indicated poor or fair mental health, compared to 30-34% for all other regions; Exhibit 35). Conejo Valley is unique among the CMHNA regions in that it includes areas in both Ventura County and Los Angeles County, since the proximity of Agoura Hills and Westlake Village (in Los Angeles County proper) to Ventura County's clinics means that residents of those cities have easier access to Ventura County facilities than to Los Angeles County facilities.

Exhibit 35. Differences in rating of poor/fair or good and better mental health across Ventura County regions

Region	Number	Poor or Fair	Good and better
Camarillo	293	34%	66%
Conejo Valley	249	45%	56%
Ojai	86	31%	69%
Oxnard	1,551	32%	68%
Santa Clara Valley	443	34%	66%
Simi Valley	383	30%	70%
Ventura	626	31%	69%

Access to mental health services also varied widely across the county, with respondents from Oxnard, Santa Clara Valley, and Simi Valley reporting not receiving needed care in higher proportions than other regions (23-24%, compared to 12-19% in other regions; Exhibit 36). However, the reasons for not receiving needed care varied somewhat across regions, without clear patterns or trends emerging.

Exhibit 36. Differences in percentage that “did not receive access to needed mental health services” across Ventura County regions



Interestingly, the top 4 most urgent community mental health needs in each region were the same in all regions, as compared to the overall sample, including: (1) homelessness, (2) depression, (3) alcohol and drug use, and (4) lack of access to mental health services.

Key Community Survey Findings by Priority Population

Priority groups for this CHNA included the following:

- African American
- Asian / Pacific Islander
- Hispanic/Latinx
- Homeless
- LGBTQ+
- Mixteco
- Older Adults
- TAY

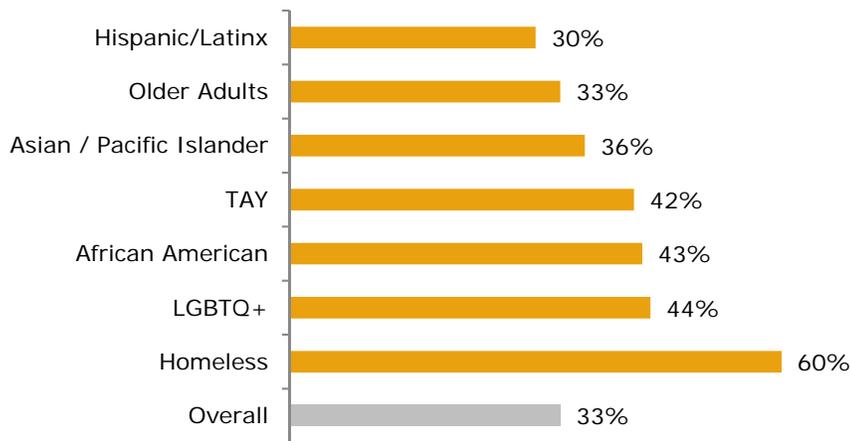
As expected, since these groups differ by identity-based demographic factors, the demographics of each group varied widely (in terms of country of origin, language, socioeconomic status, educational attainment, etc.). However, in terms of the overall components of mental health status surveyed, there was much less variation.

Nevertheless, four key areas stood out due to the wide variation in outcomes by priority groups:

1. Self-reported overall mental health rating
2. Suicidal ideation or attempts
3. Substance use
4. Cultural and linguistic appropriateness of services

In terms of overall mental health rating, homeless respondents reported overall worse mental health than other groups (60% reporting fair or poor mental health). LGBTQ+, African American and TAY groups also reported lower mental health ratings (42-44%) than other groups (ranging from 30-36%). By comparison, overall, 30% of respondents rated their mental health as fair or poor. (Exhibit 37)

Exhibit 37. Differences in overall mental health rating across priority groups



Both substance use and suicidal ideation or attempt were lower overall among older adults and Hispanic/Latinx, but were substantially higher in all other groups, as compared to overall. In both instances, homeless respondents reported substance use and suicidal ideation in greater proportion than other groups. (Exhibits 38 and 39)

Exhibit 38. Differences in substance use across priority populations (responded "yes" to substance use in the last 12 months)

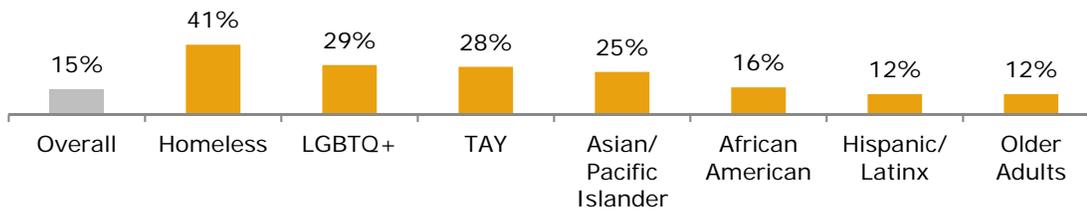
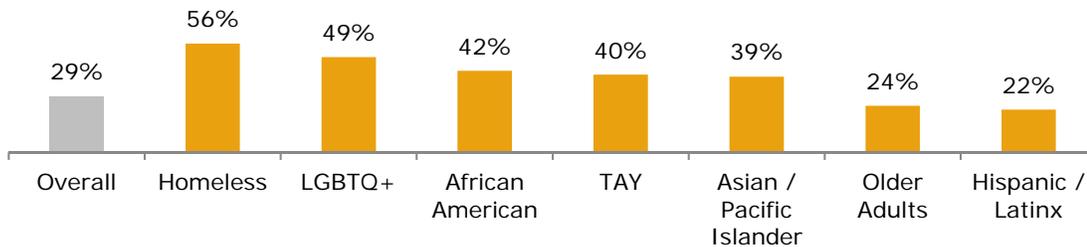
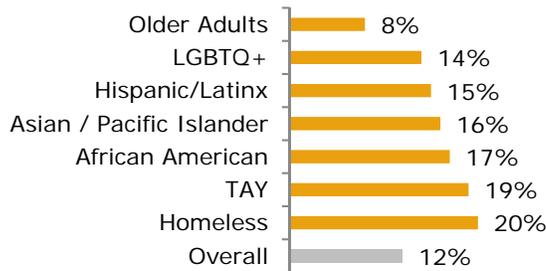


Exhibit 39. Differences in suicidal ideation or attempts across priority populations (responded "yes" to ever thinking about or attempting suicide)



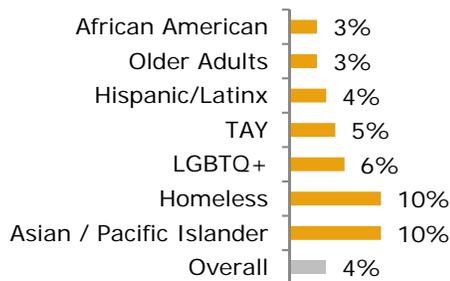
All groups except older adults reported experiencing higher-than-overall lack of cultural appropriateness when receiving mental health services. Overall report of lack of cultural appropriateness was 12%, compared to 8% for older adults and 15-20% for all other groups. (Exhibit 40)

Exhibit 40. Differences in lack of culturally appropriate services across priority populations (indicated “services provided were not sensitive to my culture”)



In terms of linguistic appropriateness, Asians and Pacific Islanders, as well as homeless people, reported experiencing a lack of linguistic appropriateness (services available in their preferred language) in higher proportions than other groups. (Exhibit 41)

Exhibit 41. Differences in lack of linguistically appropriate services across priority populations (indicated “services provided were not in my preferred language”)



Despite these differences, there was broad agreement across priority groups in terms of the top three barriers to accessing mental health services, as well as for the top four most urgent community mental health needs. Furthermore, these top responses were therefore also consistent with overall results and regional results. The sole exception was among Mixteco respondents, for whom cultural and linguistic appropriateness were simultaneously the top two barriers to accessing mental health services as well as the top two most urgent community mental health issues. This broad agreement across the overall data set, across geographic regions, and across the vast majority of priority populations signals clear community-wide priorities.

These results also highlight two unique priority groups: namely Mixtecos and homeless people. Mixtecos appear to be a group whose needs differ greatly from those of other priority populations, since their top barriers and most urgent issues differ substantially from those of other priority populations. This may be due to

cultural, linguistic and political/legal factors that many advisors and community stakeholders pointed out as unique to the Mixteco population. On the other hand, while homeless people share the same barriers and most urgent issues with other priority groups, they appear to be in need of services to a greater extent than other groups, since they consistently had the least favorable outcomes for all of the indicators considered in this section, suggesting that homeless people warrant particular attention, even if they constitute a small proportion of Ventura County's residents.

Key Provider Survey Findings

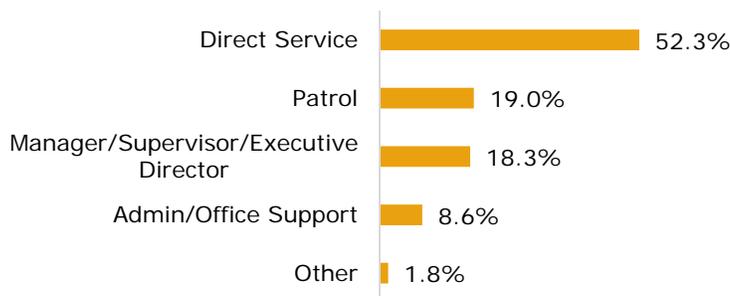
Of the 690 provider surveys collected, 676 respondents indicated which agency they worked for. The majority (61%) of respondents were from either from VCBH or law enforcement agencies, which included the Sheriff's Office, municipal police departments and probation. Other respondents' places of employment included educational institutions (such as those who work in primary, secondary, and higher educational institutions), Public Health, Human Services Agency, hospitals, ambulatory care, and community-based nonprofits (Exhibit 42). Over 70% of respondents identified as direct service providers or patrol interfacing directly with individuals. (Exhibit 43)

Exhibit 42. Provider survey respondent agency



n=676
 Note: multiple choices possible; may not add up to 100%

Exhibit 43. Provider survey respondent role



n=673
 Note: multiple choices possible; may not add up to 100%

Assessment of Available Mental Health Services in Ventura County

Respondents were asked about the availability, wait times, cultural competency, and ease of access for clients given the currently “in place” mental health services within Ventura County (Exhibit 44). Highest rated (i.e., deemed good or excellent) were: cultural competency of staff; hours of operation; and materials/services provided in multiple languages. Almost half (49%) rated “capacity” as poor.

Exhibit 44. Assessment of available mental health services

	Not Sure	Poor	Fair	Good	Excellent
Availability of appointments	25%	24%	26%	18%	7%
Hours of operation	20%	16%	26%	30%	8%
Wait times in lobby to see provider	43%	12%	16%	20%	9%
Capacity	22%	49%	17%	10%	2%
Cultural competency of staff	31%	7%	20%	32%	10%
Ease of access for clients	18%	25%	28%	22%	7%
Materials or services provided in multiple languages	35%	8%	20%	28%	9%
Childcare availability	56%	28%	11%	4%	1%
Referrals provided to clients/families	31%	11%	26%	26%	6%

n=634

After ranking the quality of the mental health services above, respondents were asked to explain their answers. Of the 634 who ranked the availability or quality of mental health services, 145 elaborated further. A sample of responses illustrating common themes is provided below:

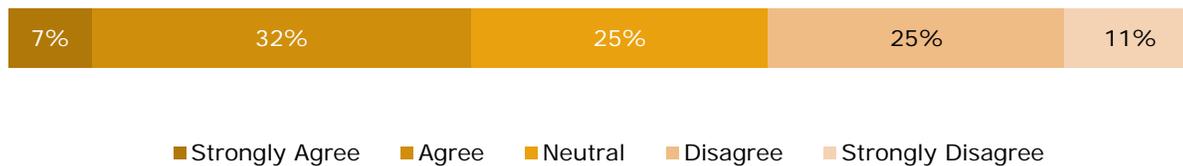
- “Excellent patient care is possible when there is enough staff. When there is minimal staff there is minimal care.”
- “Clients have transportation and language barriers. The process is too lengthy and most clients give up and decide not to follow through with therapy. The ones that do go through the process are then placed on a waiting list due to the low number of bilingual therapists available. When they finally get called to set up therapy, they are no longer interested.”
- “There is a continuous need for mental health workers to work in the field with patrol officers.”
- “Materials are in multiple languages, but are not culturally competent”
- “Public transportation for ease of access is limited”
- “We need more therapists and psychiatrists desperately. Our appointments are booked out too far. Our therapy waiting lists are too long.”
- “I believe our agency does a great job at recognizing the clients that need services and what they need. However, there isn’t enough staff to accommodate the need.”

Unmet Mental Health Needs

As part of the assessment, respondents were also asked (1) whether those in need of mental health services can access them; (2) what the most urgent issues affecting mental health are at this time; (3) which populations were in greatest need of mental health services; (4) what, if any, unmet mental health needs exist within the communities they serve; and, (5) whether their agency’s capacity is currently sufficient to meet identified needs.

As seen below (Exhibit 45), respondents were split when asked if people with mental health problems in their communities can receive the help they need.

Exhibit 45. People with mental health problems can get the help they need



n=645

Respondents were asked to consider available mental health services in the communities they serve and indicate which barriers listed below may prevent clients from accessing care (Exhibit 46). Providers identified (1) transportation, (2) awareness and (3) availability of services, and (4) location of services as the greatest barriers to receiving mental health services.

Exhibit 46. Barriers to accessing mental health care

	Number	Percent of Respondents
Transportation	469	77%
Client knowledge of available services	397	65%
Availability of services	302	49%
Location of services	261	43%
Lack of childcare	182	30%
Lack of culturally appropriate services	100	16%
Staff competency	69	11%

n=612
 Note: multiple choices possible; may not add up to 100%

When asked about the most urgent issues affecting mental health, respondents most frequently indicated (1) substance use, (2) homelessness, (3) lack of access to services, and (4) depression (Exhibit 47).

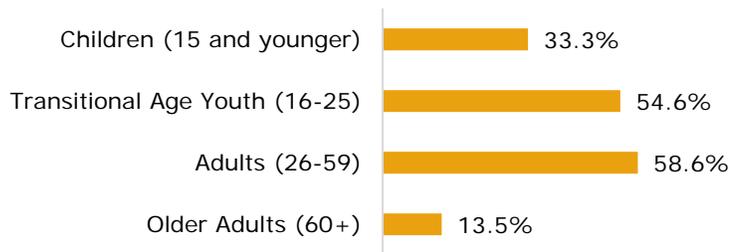
Exhibit 47. Most urgent issues affecting mental health

	Number	Percent of Respondents
Alcoholism/Drug use	399	62%
Homelessness	387	60%
Lack of access to mental health services	343	53%
Depression	323	50%
Childhood trauma	272	42%
Thoughts of suicide	247	38%
Lack of culturally appropriate services	108	17%
Lack of services in clients preferred language	95	15%

n=648
 Note: multiple choices possible; may not add up to 100%

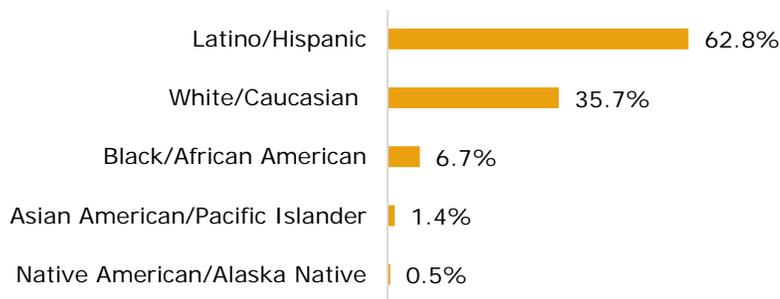
When asked specifically which age group is in greatest need of mental health services, the most frequently chosen age category was Adults (26-59), followed closely by TAY (ages 16-25; Exhibit 48). Latinos/Hispanics, followed by Whites/Caucasians were the most frequently selected racial/ethnic groups in greatest need of mental health services. (Exhibit 49)

Exhibit 48. Age groups in greatest need of mental health services



n=645
 Note: multiple choices possible, may not add up to 100%

Exhibit 49. Racial/ethnic groups in greatest need of mental health services



n=631
 Note: multiple choices possible; frequencies may overlap

Of particular note in considering the provider survey results against the findings from the community survey is the level of agreement on the most urgent mental health issues in the county. Both surveys identified the same top four issues: (1)

homelessness, (2) substance use, (3) depression, and (4) lack of access to services, reinforcing the near-universal feedback that these four issues warrant deeper consideration by VCBH and other providers in Ventura County.

Community Focus Group Findings

15 focus groups were conducted, including 116 participants overall.

The priority populations along which focus groups were divided include:

- Hispanic/Latinx (English and Spanish speakers)
- Homeless
- LGBTQ+
- Mixteco
- Families with children of SED
- TAY
- Older adults
- African-Americans

Below are the findings from the focus groups, broken down by priority population.

Hispanic/Latinx Focus Groups

Community Priorities

Hispanic/Latinx focus group participants identified depression, stress, and anxiety as the most urgent mental health issues among this population. In particular, they emphasized the way mental illness can progress from stress to more serious mental health issues, such as depression.

"I think it all starts with stress, then depression and it becomes worst. It's not just one thing but a group of things that come from stress. People don't know they're sick, they start feeling stress, they don't feel any other symptoms, and they're not informed."

Mental Health Access, Barriers & Quality

Participants felt that there are often unreasonably long wait times in order to get the mental health care they need. For those with ongoing mental health treatment, consistently getting to services could be difficult due to a lack of reliable transportation options. Additionally, despite the fact that Spanish speakers form one of the largest groups in Ventura County, some participants said Spanish-speakers may not be aware that language services exist, or may be too shy to ask for Spanish interpretation.

"The process takes too long. The process is long it could take up to 5 months to see someone for help."

"The transportation, getting rides was hard these eight months. Getting rides 'cause I had to get rides with family and they said just don't ask for rides anymore 'cause it's bothering them. But I had needs, you know. I was hitchhiking for rides and I was going to extremes. Due to my mental illness I can't drive"

"You get there, and you ask for an interpreter who can give you the information. However, many families don't have this service; they don't ask for it because they may feel scared or shy. They don't ask for help."

- Community Member

Some participants said they or their family members have had to attend several different institutions to get the care they needed, and that the services they received did not satisfy them, since they felt they did not receive the appropriate attention and they felt that they had been disrespected, abused or experienced racial discrimination.

“So usually what I see is all the Americans leave first, then the Blacks, the Mexicans are the last ones to leave the hospitals. So, I see a discrimination in race. Whenever I’m there, the persons that they help are the Americans. Then the Blacks, then the Hispanics, and then the Asians. They do that, they discriminate with race. You have racial discrimination in the hospitals, with the police officers and with everybody.”

Community Recommendations

Participants noted the need for supports for patients that were dually diagnosed with mental illness and substance use disorders. Additionally, they recommended more equitable distribution of services across the county, particularly in areas of the county where services are less present currently.

In addition, a high priority for Hispanic/Latinx participants was in improving the capacity of staff in order to reduce wait times, and including more peer-to-peer services (that would not necessarily require additional clinicians), such as support groups for adults and youth.

“I think we can be maybe more specifically Simi Valley, because they have bipolar groups in Thousand Oaks and in Ventura and Camarillo. What we need is more of those things in Simi Valley.”

“Make the process shorter or quicker to see someone or receive the help you need.”

“More support groups, more talk groups, more emotional groups, activities for the youth and the adults to learn, youth groups so they can talk about things and open up about their issues.”

Homeless Focus Groups

Community Priorities

Participants in the focus groups centered on homelessness mentioned numerous mental health issues or other adverse emotions experienced within that population, ranging from feelings of isolation and loneliness to depression, schizophrenia and suicidality. No one issue stood out, since participants noted that these were the prevalent and co-existing issues among homeless individuals.

Mental Health Access, Barriers & Quality

Participants noted that the key barriers to accessing mental health services and supports among the homeless population included stigma, shame and embarrassment with seeking services, a lack of trust with providers and law-enforcement, and self-doubt. These barriers combine to prevent homeless individuals from seeking the help they need. Constant feelings of rejection when seeking help also create a fear among homeless individuals of seeking help in the future. This stigma perpetuates and exacerbates mental health issues, since these issues go untreated.

*“There isn’t enough help for the **dual diagnosis patients**, because, you know, a lot of them suffer from the mental illness and drug addiction.”*

- Community Member

"It takes a lot to mess up that confidence to ask for help. And when you get shot down and it took everything out of you to ask for that, you don't have that willingness or that open-mindedness."

"You reach out and you get turned down a lot because you are homeless or because you don't look clean, or you have some shoes that don't look brand new. You are judged a lot. And, just because you're homeless, doesn't mean you are a bad person..."

Because of the high proportion of homeless individuals that are dually diagnosed (mental illness and substance use), some individuals may also fear seeking mental health due to perceived legal ramifications.

"But you know, a lot of these homeless people struggle. It's just the thing is they're afraid to call somebody for help because they're afraid they're going to get arrested because they're on drugs. That's the main thing. People get scared to get help."

Participants felt that when they do access mental health services, those services are helpful. Such services included therapy, general behavioral health services, access to wellness centers, and psychiatric help. They also felt that services were most helpful when they felt comfortable sharing their feelings.

Community Recommendations

Participants recommended improving transportation in order to facilitate mental health access, as well as providing education about mental health and homelessness to reduce stigma.

In addition, they pointed to the need for additional housing through shelters, and quality of life services such as showers and the provision of hygiene items and toiletries, programs about proper nutrition, art or meditation, and more advertising about available resources in the community.

"Educating everybody about being homeless. That we are not, to the public, that we are not bad people. We are humans like everybody else."

"I think the most important thing is maybe they could put in a nutrition [program]. Like some type of thing where they talk about food and how food affects you. Because, what you put in your body affects your body."

LGBTQ+ Focus Groups

Community Priorities

LGBTQ+ focus group participants identified several mental health issues they believe most affect the LGBTQ+ population, including eating disorders, social anxiety, social stigma, and substance abuse. In particular, participants stressed substance use as a coping mechanism that may lead to isolation, which further exacerbates mental health issues.

"Substance abuse is a huge problem that contributes to mental health challenges and also isolation in so many forms: isolation from family, isolation from a capacity to find friends, isolation from that sense of wellbeing in yourself and connected to your own self-worth."

Mental Health Access, Barriers & Quality

"For me CRT, behavioral health, and stuff, that was the best thing that happened to my life, thanks to my therapist. Behavioral health is the maximum, the best thing that can happen to anybody that is suffering from some mental issues."

- Community Member

Some focus group participants mentioned not being satisfied with mental health services due to their low quality. This low quality manifested itself in various ways, such as not feeling that providers were professionals committed to their work, and not being able to receive appropriate attention based on their specific needs. Getting appropriate services was identified as particularly difficult for trans youth or non-English speakers, including those who need sign language interpretation. Thus, addressing a perceived lack of cultural and linguistic appropriateness was a paramount concern among the LGBTQ+ community.

"The therapist doesn't know anything about they/them pronouns, even though supposedly she had been trained how to work with trans youth."

Participants notes that the disconnect between providers and LGBTQ+ individuals seeking mental health services had systemic roots. Because of racial and ethnic disparities in access to education, there was a lack of culturally diverse providers for the LGBTQ+ community, which created cultural and linguistic disconnects among LGBTQ+ clients and providers.

"Education is mad expensive and a lot of people who do have the money probably don't come from cultures or tribes that need it, you know? It's just like, 'Oh, we have a bunch of doctors,' but none of them speak Spanish and they all decide to work in Oxnard."

Participants from this group noted other significant barriers to accessing mental health services and supports, including social stigma, lack of support from family members (including lack of support for medical transitioning from trans youth), and geographic disparities in availability of services.

However, some participants expressed positive experiences, including being able to access the right services through various different programs, and having easy access to services, including ease of transportation and knowing where to go to receive services.

"There tend to be an East-West sort of division. And some people would just not ... like they would do things in the Thousand Oaks, Simi Valley area and would not think of coming to Ventura. And likewise, there seems to be when there are resources in one place, if they are not living in that place, that seems to be a geographical divide."

Among youth, some noted not being taken seriously by adults, or adults and other authority figures not being knowledgeable about which services and supports youth were entitled to.

"I would say that some of the barriers are also not having adults know what youth rights are. For instance, the right for minors, they are able to access mental wellness counseling appointments on their own without parental or guardian consent as long as they're at the age of 12 years above. So I think that making sure that adults or even people in position of power, whether it's educational institutions or medical facilities, they just don't know that. So it makes it harder for people just to know what people's rights are to begin with."

The lack of support from family in particular created significant barriers for youth seeking mental health services and supports, and the stigma of being LGBTQ+ was compounded by the stigma around mental illness.

"Especially trans youth whose parents may not even want them to go to a

"That stigma prevents people from seeking help with mental health because of shame. And also within families, it's been my experience that my family wouldn't let me see a therapist, for example, because they were ashamed of me."

- Community Member

support group because they don't want them to be influenced by us [other LGBTQ+ youth]. They have to lie about it, too. I've known a lot of people who had to lie about where they were in terms of being at a support group specifically for LGBTQ support."

Community Recommendations

Participants expressed a multitude of desired services, including having a support system that includes schools, services for patients and family members, drop-in centers or residential facilities, and education on effective coping mechanisms, as well as group therapy.

"We need a support system, because this is a really big thing when we're being asked to make huge decisions. Sometimes they're single parents and one parent agrees and the other parent doesn't. So that comes into play."

Participants suggested services that would be helpful for LGBTQ+ clients, including providing culturally appropriate therapy and peer support groups with providers with whom they feel comfortable, since services where LGBTQ+ clients could express their feelings in a safe environment were lacking.

"When I went to work in L.A. I found a doctor and I've been seeing my doctor for 20 years. I could talk to him about anything. And it's just really welcoming. I wouldn't switch my doctor because I feel so comfortable with him. So the most important thing is finding someone that one feels comfortable with."

Mixteco Focus Groups

Community Priorities

Mixteco focus group participants listed numerous, concrete life events that could precipitate mental illness or depression, including the death of a loved one, domestic violence, separation from parents (due to immigration), sexual abuse, bullying, concerns over legal or citizenship status, and lack of employment. Participants noted that all these issues were prevalent within the Mixteco community.

"Just by hearing on the news about 'illegals' automatically you begin to worry. When parents get separated from their children, mental health affects the children the most."

"Domestic violence also affects the children especially when alcohol is involved and they watch the violence occur in front of them."

- Community Member

Mental Health Access, Barriers & Quality

Participants mentioned numerous barriers to accessing mental health services and supports, including stigma, fear of exposure due to their documentation status, the hours of operation of mental health services, lack of transportation, lack of health insurance, and lack of awareness of location of existing services. Participants also identified language as a major barrier, since many community members only speak a Mexican indigenous language (e.g. Mixtec). Additionally, stigma around mental illness and notions of masculinity intersected to create a significant barrier for men to admit they have a mental health issue, let alone seek care for it.

"Our indigenous community is the one that seek less of these types of services or resources... The first barrier is definitely the language, and the biggest barrier is the fear of these clinics asking for your legal status. The men that are affected normally don't seek for the help they need. Most of

them are afraid that they could be seen as weak, they don't want to be seen vulnerable."

"I personally find it hard to seek for help because I work and by the time I am done with work these places are already shut by then. I work in the field in the area of Camarillo and every now and then there are people who come to us to the field and hand out information about mental health. Some of us this is how we receive information about mental health. Some people don't know that there resources, but most don't know where they are located."

Community Recommendations

Mixteco focus group participants also mentioned various needed services that are not available in the community, or improvements that can be made to expand the capacity of the mental health care system. This list included providing support groups, staffing more providers that speak Mexican indigenous languages or that have lived experience with mental illness, and conducting more advertising about available mental health services available in the county. Focus group participants also mentioned needing more services during afterhours and weekends.

"Assign someone from the community who speaks our same language. This would be ideal to build trust rather than return on a different date/time or find it difficult to find an interpreter. It's ideal to build the trust from the very beginning, that's why a lot of people prefer not to return due to these barriers, and if they don't receive the service they need instantly most of the time it's too late to get the help they need."

"Have staff who conducts support groups for people who need assistance almost immediately, not necessarily have an educated person or someone with a title always present, but have staff who have experienced the same things that everyone are else is experiencing. You want to have who understands and have gone to similar things this is another way to feel supported."

Focus Groups with Families of Children with Mental Health Diagnoses

Community Priorities

Parents of children with mental health diagnoses mentioned various concerns related to mental health, including stigma, lack of health insurance, disrupted class time to receive care, and working parents being unable to take time off from work to seek care for the children. While parents still did what they could to ensure their children received needed care, these barriers took a toll on both the children's educational outcomes and parents' employment outcomes.

"Most families are working, parents are gone most days, their kids are alone, they can't get the treatment or the help... I afford to miss work [sic] and take my kid to therapy or do I have to stay at work and make sure we have a roof over our head?"

"Seen some counselors in school but they need more... they pull 'em out of class and they miss whatever's being lectured... they pull them out for an hour every so often, then they missed what was in the class and that gets them behind and as soon as they start to slip behind a little bit it just snowballs. So getting help from the school counselor, I found to be more detrimental than positive."

Participants and their family members have had to seek services at various different institutions, and the services they received were not satisfactory to them since providers changed frequently, and some felt that the treatment provided and diagnoses made were not appropriate. Yet some parents, despite the quality issues identified, still praised the quality of services received overall. Parents mentioned that these services were especially helpful when they were in their preferred language and were sensitive to one's culture and lifestyle.

"They had a lot of people in and out in a hurry and most kids with issues have difficulty with change and so they weren't long enough even for the kids to become comfortable with the doctor before there was change, but other than that they've been responsive. I don't think he could have gotten better care anywhere."

Community Recommendations

Participants mentioned a need for expanding services helpful to children, such as therapy, peer groups and school counselors with proper training. They mentioned that new tools with which children and youth could relate, such as social media or digital material, would be helpful for them too. This insight speaks to the need for "culturally" appropriate services for children in the age of internet culture.

"Most kids that have mental illnesses feel isolated. Kids just want to fit in, they want to be normal, and if they aren't normal because they have a mental illness they always feel like they're on the outside looking in. So I think if there were some groups, small groups, where they could interact, get conformable with enough, where they could discuss their issues and maybe even do a little bit of role play like what do you do when you feel like you're being bullied, how do I respond to that bullying."

"I think because things are getting more digital, we should have more digital versions, group chats."

- Community Member

TAY Focus Groups

Community Priorities

Participants in the TAY focus groups identified stress and anxiety as the most urgent mental health conditions affecting youth and young adults. These adverse emotions appeared to be prevalent among people of this age group, who are in a state of transition into adulthood and the responsibilities that come with it.

Mental Health Access, Barriers & Quality

Some participants mentioned that they are able to access all the services they need, but must do so through various different programs. Nevertheless, TAY noted barriers to access to services, such as difficulty with transportation and knowing where services were located. Additionally, they noted a lack of clinicians as another significant barrier to accessing mental health services.

These barriers to access were often exacerbated by long wait times once they were able to connect with needed care. The intersectionality between being a TAY and being undocumented also posed barriers to finding a clinician, since some participants felt the options for mental health providers were more limited for those without documentation.

"Just finding a psychologist is very hard. There's a waiting list, and then after that waiting list you have to wait. I myself am undocumented, so I have to specifically find somebody that would take in my situation. And even then, I'm limited to a very small amount of help after being helped."

Community Recommendations

Participants recommended the implementation of a culturally competent support system that includes schools, expanded crisis intervention services, group therapy, and skill-building workshops. Because of the multiple needs of TAY with mental illness, integration of the numerous services to which a TAY may need access was seen as critical to quality of care. Some participants expressed the importance of social interaction and peer support for this age group, and that services that incorporate a social or peer component might better retain TAY clients.

"I think cultural competency and cultural connectedness has to be essential - it has to be the driving force. So you don't feel judged and you don't feel, you know, like you don't belong."

"Why can't we have free group therapy? We should. Just all you gotta do is get one facilitator and just let it flourish and get food and get drinks and people come and that could save so many lives. That is pure therapy and that's a lot cheaper than hiring a bunch of therapists. If you could just make people do it together, work it out together - people just wanna talk."

Focus Groups with Older Adults

Community Priorities

Older adults mentioned loneliness, isolation and depression as a major mental health issue among those living by themselves or in assisted living facilities. They noted that even in "senior homes," there is often limited social interaction among residents, and that the amount of time by themselves without human interaction or someone to talk to can be very detrimental to mental health.

Mental Health Access, Barriers & Quality

Participants noted that a lack of clinicians creates significant barriers to accessing mental health services. Because of this lack of capacity, participants felt that providers either rushed through their time with older adults or they had difficulty making appointments with them.

Because of their isolation, many older adults sometimes just wanted their providers to take the time to listen to them. Participants noticed a lack of interest from mental health professionals, who had dismissive attitudes toward their patients and their work. This sometimes manifested itself as verbal or physical abuse of older adults.

"You can tell when someone doesn't like their job, you can tell it when you go to a store, you can also tell it when you're dealing with healthcare providers, and hospitals, psychiatrists, nurses, you can tell when they don't like their job, and they take it out on you."

"My experience of being admitted to a medical, mental healthcare hospital is I do not want to go back, under no circumstances I'm going. The way that I was treated... I went to one and it was terrible, I wanted to get out of there. The treatment is so bad. They shame you, they were disrespectful, you were not treated like a human being."

Nevertheless, participants generally felt that there were a couple key, high quality facilities and programs in Ventura County that supported older adults. Participants cited high quality of care at these facilities, when they were able to access services.

Community Recommendations

Participants noted how critical transportation services are for older adults, many of whom have serious mobility issues, and the need to expand these services. In addition, because of the isolation many older adults experience, participants recommended focusing on social activities as a mental health service in and of itself, or the ability to interact with someone who would listen.

Also due to the isolating nature of living alone or in assisted living facilities, participants recommended providing services around the clock, since older adults might experience loneliness or a mental health crisis at any time of day.

African-American Focus Groups

Note: Audio recordings and transcripts of the African-American focus groups were not available. The summary below is based on the facilitators' notes on the focus group, and does not include a community recommendations section.

Community Priorities

Participants in the African-American focus groups indicated numerous mental health challenges among the African-American population in Ventura County. Some of the challenges listed included contextual factors that led to poor mental health outcomes, such as housing (presumably high cost and unavailability of housing) and the need for more intercultural events. Other responses indicated the role that general physical health, including preventable disease, plays in creating poor mental health outcomes. Participants listed depression, anxiety and PTSD as common mental health diagnoses that came to mind among the African-American population.

Participants noted that the groups that most struggle with mental health tended to be homeless individuals, whether they were unsheltered or in temporary living arrangements ("on couches, beach, cars") and socially isolated. In addition, participants also listed numerous other groups (either sub-populations of African-Americans, or in Ventura County as whole) that they felt bore a disproportionate burden of mental health illness, including single people, alcohol and substance users, ceterans, older adults, victims of abuse (mental or sexual), the LGBTQ+ community, unemployed individuals, victims of racism, single parents, teens and young adults, and low-income people.

Mental Health Access, Barriers & Quality

Participants generally indicated that African-Americans in their communities seek out a variety of resources for mental health issues, including family, friends, churches and other social settings, noting that these sources were trustworthy to them. However, participants generally felt that there factors in the African-American community that made it difficult to get help for mental health challenges, including the stigma and shame surrounding mental health, as well as cultural attitudes and prejudice around mental health.

As noted, most participants indicated that formal mental health services (e.g. through a licensed provider) were not a preferred source of mental health support for the African-American community. Participants indicated that when they did seek out formal mental health services, cultural relevance was a significant barrier, and that providers were "not totally culturally fluent," owing to the fact that classes on cultural sensitivity were not enough to remedy this lack of fluency. Other notable access issues included the lack of sufficient African-American clinicians, the need

for culturally appropriate case management, frequent changes in providers (it was unclear whether this was due to provider turnover or clients discontinuing service with a provider), and the need to include clients in decision-making on treatment.

Some noted geographic differences in access to mental health services. For example, they indicated a relative lack of services in East Ventura County (e.g. Santa Paula), and the difficulty of getting appointments for mental health services in Oxnard. Participants also noted that many of the services in Oxnard were geared towards Hispanic/Latinx clients, but there was a lack of services for African-Americans specifically.

Synthesis of Findings

Ventura County generally compares favorably against California as a whole in terms of social, economic, and mental health indicators. However, county-level data masks the stark disparities that exist among Ventura County's regions. For example, the median yearly household income in Ventura County is about \$82,000, compared to California's figure of \$67,000. However, the difference between Ventura County's highest income city, Thousand Oaks (\$104,000) and its lowest income city, Santa Paula (\$55,000) is about \$49,000 per year. Disparities such as this pointed to the need for original, more granular data that could be segmented by demographic and geographic factors, which was the impetus for the community survey and focus groups.

The community survey and focus groups uncovered several key differences by age, race/ethnicity, sexual orientation, and housing status, among others. Please refer to previous sections of this report and its appendices for detailed considerations of these differences.

However, there was also broad agreement on the top four most urgent mental health needs in Ventura County: (1) access to services, (2) depression, (3) homelessness, and (4) substance use. This agreement resonated within and across all three of the primary data collection methods (community focus groups, community survey and provider survey). For example, within the community survey, all regions and priority populations (with the exception of Mixteco respondents) ranked the same top four issues listed above. Likewise, consumers and providers (through the community and provider surveys, respectively) were also in agreement on these top four issues.

Despite this broad agreement, it is important to note the disparities that exist within the top four mental health needs. A synopsis of each of the top four issues identified in the community and provider surveys is provided below.

Access to Services

37% of community survey respondents and 53% of provider survey respondents felt that depression was one of the top mental health issues in their community. Of those community survey respondents who said they or a close family member had needed mental health services in the past year, 26% said they had *not received those needed services*, while 35% of them said the same of a close family member.

Most of those respondents (51%) said the reason for not receiving needed services was no or limited health insurance. A substantial proportion also noted various other reasons, including inconvenient timing of services, services required too much travel, fear of provider mistreatment, and a lack of culturally or linguistically appropriate services (ranging from 21-35% of respondents).

Cultural and linguistic appropriateness or sensitivity are important factors in access to services, and varied greatly across priority groups. All priority groups other than older adults reported culturally inappropriate services in higher-than-overall proportions (14-20%, compared to 12% overall). Homeless and Asian/Pacific Islander individuals reported a lack of linguistic appropriateness in higher proportions than other groups.

These results point to the need for reassessing cultural appropriateness of services for nearly all priority groups, and that special attention may be warranted to linguistic appropriateness for homeless individuals (who may be members of other priority populations with special linguistic needs) and Asian/Pacific Islander individuals, who comprise a small proportion of the population and who, as a group, are very diverse linguistically, which may pose a challenge for providers attempting to deliver services in multiple Asian or Pacific Islander languages.

Depression

40% of community survey respondents and 50% of provider survey respondents felt that depression was one of the top mental health issues in their community, while 52% of survey respondents indicated they had been diagnosed with depression by a healthcare provider in the past. About 29% of survey respondents also indicated that they had ever thought about or attempted suicide. Depression and suicidal ideation was thus a highly prevalent mental health condition among survey respondents.

Diagnosis of depression was fairly uniform across most priority groups. Notable exceptions included homeless (65%) and LGBTQ+ (62%) respondents, who both indicated having been diagnosed with depression in higher proportions. By contrast, Mixteco respondents indicated having been diagnosed with depression in much smaller proportions (20%), but this may indicate lack of access to mental health providers (since the survey question asked if they had been diagnosed by a healthcare professional), or cultural differences in the meaning or understanding of depression. (See Community Survey Databook in Appendices for figures on depression for each priority group.)

However, suicidal ideation did differ substantially across priority populations. Homeless (56%) and LGBTQ+ (49%) individuals indicated past suicidal ideation or attempts in higher proportion than all other groups. Asians/Pacific Islanders, Blacks/African-Americans, and TAY also reported higher-than-overall rates of suicidal ideation or attempts (39-42%).

Homelessness

40% of community survey respondents and 60% of provider survey respondents felt that homelessness was one of the top mental health issues in their community, while about 4% of survey respondents indicated they were actually homeless. This does not necessarily mean that community members and providers saw homelessness as a serious issue in and of itself, but that it was a serious issue *within the context of mental health*.

During Ventura County's most recent point-in-time homeless count, in 2018, there were about 1,299 homeless individuals, and about 28% of them had mental health problems, while 26% were substance users. (Note: 41% of homeless respondents to the community survey indicated they used a substance other than alcohol or tobacco in the past 12 months.) The high proportions of homeless individuals with mental health problems and who reported using substances suggests that homeless individuals may shoulder a disproportionate burden of serious, adverse mental health outcomes, and bear special consideration by mental health providers, regardless of whether the raw numbers of homeless individuals in Ventura County constitute a large proportion of the county's population.

Indeed, the community survey found that homeless individuals reported *worse mental health outcomes than every other priority population* across several key factors, including: (1) self-rated mental health status, (2) substance use, (3)

suicidal ideation or attempts, and receiving mental health services that were either (4) culturally or (5) linguistically inappropriate.

Homelessness is also unevenly distributed across Ventura County. The 2018 point-in-time homeless count showed that two thirds of homeless individuals were living in the cities of Oxnard and Ventura, the county's largest urban centers. Thus, homelessness and its attendant mental health and substance use issues appear to be a primarily (but not entirely) urban mental health concern.

Substance Use

40% of community survey respondents and 62% of provider survey respondents felt that substance use was one of the top mental health issues in their community, while about 15% of survey respondents indicated they had used a drug other than alcohol or tobacco in the past 12 months (see Community Survey Databook in Appendices). Note that other drugs may include cannabis/marijuana, which was decriminalized by state ballot in California for medical use in 1996 and for recreational use in 2016.

Despite the fact that only 15% of respondents indicated recent substance use, certain priority populations reported use in substantially higher proportions. For example, 41% of homeless respondents to the community survey indicated recent substance use, compared to 29% for LGBTQ+ respondents, 28% for TAY respondents, and 25% for Asian/Pacific Islander respondents. Thus, if substance use is a community concern, homeless individuals especially, as well as LGBTQ+, TAY and Asian/Pacific Islander individuals may benefit from targeted substance use services.

Other Findings

Focus group findings provided substantial, in depth detail into the specific mental health needs of the priority groups identified, and they also revealed many similarities. These similarities included transportation issues, limitations in the ability to access services due to the timing or hours of those services, and stigma. These findings were generally in line with that of the community survey, and provided additional insight into the context that may have led community survey participants to flag these issues as significant barriers.

While homeless individuals fared worse in side-by-side comparisons of mental health indicators with other priority groups, LGBTQ+ individuals also indicated the second-highest proportion of self-rated poor mental health, substance use, and suicidal ideation or attempts. As such, the LGBTQ+ community may also warrant special consideration for mental health services, since the community surveys highlighted them as shouldering a greater burden of adverse mental health outcomes than most other priority groups.

Additionally, it is worth noting that respondents to the *provider* survey felt that Hispanic/Latinxs were the racial/ethnic group in highest need of mental health services. Indeed, Hispanics/Latinx constitute 42% Ventura's County population and are considered a threshold population warranting special consideration by VCBH.

Overall, the county must balance the need to provide services to large consumer populations (like Hispanic/Latinx, who make up a large proportion of those individuals needing mental health care in the county, despite faring proportionally better on many key mental health outcomes in the provider survey than other priority populations) as well as smaller groups that are very high need (like homeless and LGBTQ+ individuals, who comprise a relatively small proportion of

the county's population, but nevertheless may be subject to more serious or urgent mental health conditions).

Discrepancies Among Data Collection Methods

As mentioned, there was wide agreement among data collection methods, and among geographic regions and priority populations in terms of mental health outcomes and perceived urgent needs. Nevertheless, some notable discrepancies exist in the data.

One issue that was not included among the top four most urgent issues in the community survey, but which was rated most poorly in the provider survey, was capacity of staff to meet the demand for mental health services. Nevertheless, this issue was corroborated in the focus group findings, where numerous participants, indicated that a lack of providers exacerbated wait times and sometimes led to providers rushing consultations.

Perhaps the most notable discrepancy in the findings was that, while providers gave themselves the most favorable ratings on issues of timing of services (hours of operation and wait times), as well as cultural and linguistic competency, the community survey and focus groups revealed nearly universal dissatisfaction with timing of services, and certain priority populations indicated substantial dissatisfaction with the availability of services in their preferred language and of services sensitive to their culture or lifestyle: all groups aside from older adults indicated greater-than-overall dissatisfaction with cultural appropriateness of the mental health services they received, and homeless and Asian/Pacific Islander individuals indicated much greater-than-overall dissatisfaction with linguistic appropriateness of the mental health services they received.

This disconnection between providers and community members may point to two implications. The first implication of this disconnection is the need to address gaps in perception between providers and consumers when it comes to the appropriateness of hours of operation, the availability of services and materials in various languages, and the availability of staff with cultural competence for racial and ethnic groups that constitute a lower proportion of the county's population, such as African Americans/Blacks, Asians and Pacific Islanders, and Mixtecos.

Additionally, stigma may lead members of some groups to seek help later in their symptom expression, and thus, there is a sense of urgency when they seek help that cannot be met by providers who themselves feel beyond capacity to serve additional clients. This implication may present an opportunity to bring in more preventive and educational services outside of traditional behavioral health providers (which may be more culturally relevant and this reduce the stigma of utilizing them), which may lead to better alignment between community members seeking care and providers' ability to deliver services in a timely manner. ✚

Community Input and Recommendations

Community Input Process

Community input was instrumental in both determining the design of data collection protocols, and in interpreting the outcomes of that data collection to develop recommendations.

During the first community input session, attendees identified priority populations that served as the basis for outreach and recruitment of focus group participants, as well as breakdowns of the community survey data. In addition, attendees requested breakdowns of the community survey data by region.

Once data collection was completed, VCBH and Harder+Company presented the results during the second community input session. As noted previously, the community survey surfaced four issues that were identified by survey respondents as being the greatest mental health needs in the county: (1) access to mental health services, (2) depression, (3) homelessness, and (4) substance use. While the exact rank of these four issues varied by region and priority population, these four issues were always the top four in every breakout of the community survey data.

Attendees were split into small groups, each considering one of the four issues listed above. Attendees were then asked to consider the results of all the data presented (the community surveys and focus groups, as well as the provider survey); to discuss their observations, reflections and interpretations of the data together; and then to formulate and present their recommendations based on the data. The results of this discussion form the primary basis for the set of recommendations presented below.

Recommendations

In the spirit of community involvement and in accordance with the Community Program Planning process, the second community input session yielded community recommendations. Based on these recommendations and on Harder+Company's synthesis of the CMHNA findings, below are presented various county-wide considerations, recommendations for Ventura County providers (including, but not limited to, VCBH, Public Health, law enforcement and non-profits), and suggestions for further research and data analysis. Note that the bulk of these recommendations are based on priorities identified in the community and provider surveys (which aligned on the top-four issues), and discussed by participants at the second Community Input Session.

County-Wide Considerations

Below, are presented specific considerations for each of the four issues mentioned above. Note that these considerations apply to a Ventura County's mental health providers at large, and not solely to VCBH. While VCBH may take the lead on implementing some of these considerations, other agencies or organizations may also be involved and/or may be better suited to leading the implementation of some of these considerations.

Access to Mental Health Services

Mental Health Navigation. Community leaders highlighted the fact that, while numerous mental health services exist throughout the county, utilization of these services remains low. This is due to two reasons: (1) consumers are not aware these services exist, (2) providers are not aware of available services outside of their agency or organization. Community leaders recommended a “one-stop-shop” – whether in the form of a resource center and/or or hotline – that could help both consumers and providers navigate the mental health services landscape across Ventura County, the requirements for accessing those services (including which services are free or do not require health insurance coverage) and provide education on mental health issues in general.

Such a resource center would need to have robust capacity to address the needs of specific priority populations, both linguistically and culturally, and keep its inventory of mental health services and educational offerings up to date. Additionally, this resource center would need to have ongoing communication with county agencies, non-profits and private health facilities in order to maintain broad coverage of services available county-wide.

In accordance with community survey findings, homeless individuals and Asians/Pacific Islanders may warrant particular attention in terms of linguistic appropriateness of services, since these groups indicated a lack of linguistic appropriateness in the services they received in higher proportion than all other groups (10% vs. 4% overall). For cultural appropriateness, there are no particular “stand-out” priority groups; rather, special attention should be paid to ensure consideration of as many cultural or racial/ethnic groups as possible.

“No Wrong Door” Integration. The type of resource center described above may be an ideal entry point into the mental health services system for many consumers. However, community leaders pointed out that there are already many existing entry points into this system. Because of this, there must be stronger integration across mental health providers in the county, including VCBH, other county agencies, law enforcement, non-profits and private health facilities so that consumers can be triaged to the appropriate services (or at the minimum, to the resource center).

This integration would be part of a “no wrong door” philosophy to prevent consumers in need of mental health services from being turned away or “going home empty handed” if they do not meet the criteria for the services provided (e.g. they do not meet the medical necessity criteria for depression) at the entry point in question, but who may benefit from other mental health resources and services available elsewhere. This approach (especially in tandem with a resource center), would help increase access (those in need of services of any sort would be more likely to receive them) and prevent consumers from “falling through the cracks.”

Provider and First Responder Education. While much of the discussion among community leaders focused on increasing consumers’ knowledge about mental health services, community leaders also highlighted a need to educate providers to provide higher quality services. Community leaders highlighted cultural and linguistic competency as one of the primary educational needs.

This need extended beyond traditional mental health providers, but also to potential “first responders” for individuals at risk of mental illness or in need of mental health services, for example: law enforcement or faith leaders. These types of stakeholders are not traditionally thought of as “mental health providers,” but they may nevertheless be in a position to recognize the early warning signs of mental illness and may be able to formally or informally refer individuals to mental health resources.

A provider education system may be possible through the aforementioned resource center. The resource center could identify community organizations that are trusted by underserved cultural and linguistic groups in the county, and these organizations could provide the actual trainings to providers. These educational opportunities would be in addition to existing trainings and certifications, and need not be limited to VCBH or county staff, but can also be available to law enforcement and non-profit and private providers.

Destigmatization. Community leaders pointed to the need for broad destigmatization efforts, and pointed to other destigmatization models for other domains as examples. For example, some pointed to groups like Alcoholics Anonymous or Al-Anon/Alateen and the work they do to destigmatize alcohol use and alcoholism. They pointed out that support groups for mental health (e.g. support group for adults with depression, support group for parents of teens with severe emotional disturbance, etc.) might be a start to more open conversations about mental health. Focus group findings indicated that all priority groups suffer from the general stigma surrounding mental health. However, specific groups, such as the homeless, LGBTQ+, and immigrants (some of whom may be undocumented), also face stigma related to their membership in these groups, and this can exacerbate the stigma of mental health. Therefore, it is especially important to have support groups geared towards these priority populations.

Additionally, several community leaders pointed out that, in the vein of early intervention, it was critical to provide mental health education in schools, either as part of a regular curriculum (similar to substance use or sexual education curricula) or with outreach to school-aged children and teens. These efforts would require not only providing general information about mental health and resources maintaining good mental health, but also with an explicit focus on removing the stigma around mental health. For example, this could include changing the root language used to talking about mental health, and instead focusing on “mental wellbeing” or other concepts that do not have a stigma attached to them.

Depression

Education and Outreach. Because depression is one of the most prevalent mental health illnesses in Ventura County (and in the nation), many of the recommendations for depression were similar to those for access to mental health services in general. Such is the case on the topic of education and outreach to destigmatize depression, within which community leaders noted that in-school discussion of the topic with school-aged children and teens could help to identify depression for early intervention, and reduce the stigma associated with depression. Priority populations that reported higher prevalence of depression in the community survey include the homeless and LGBTQ+; these are also populations that reported the highest rates of suicidal ideation or attempts, and may experience stigma from family members and providers due to their homelessness or their sexual orientation, making destigmatization education and outreach especially critical.

Harder+Company further recommends efforts to learn about how the Mixteco

community defines or understands depression, and suggest that VCBH equip Mixteco community groups that are “trusted messengers” in the community to take the lead in these efforts. Mixteco respondents indicated diagnoses of depression in much lower proportion (20% vs. 29% overall) than all other groups. This may signal one or both of the following scenarios: (1) that Mixteco residents truly to experience depression less, and there may be cultural assets present in this population that are protective against depression, or (2) that Mixteco residents have less access to mental health providers, and thus less opportunity for a diagnosis of depression, or that there are cultural or linguistic differences that may cause depression to be underreported. It is important to distinguish between these two scenarios in order to ensure that Mixteco residents are not wrongly assumed to have lower mental health needs than other priority populations.

Focus on Priority Populations. Community leaders noted that education and outreach on depression was especially critical for several key priority groups. For example, low-income communities and homeless individuals may need specialized services or particular outreach focus, since these groups may experience less access to mental health services overall, whether through the perception that they can’t afford it, or because of the stigma associated with those two statuses.

Community leaders also noted that depression is especially difficult for older adults, who often live isolated lives, either in their own homes or in assisted living facilities. They noted that older adults are a unique population since even affluent older adults often live in isolation and are therefore at higher risk of depression (i.e. higher income is not as much of a protective factor against depression among older adults).

Homelessness

Understanding Homeless Subpopulations. Community leaders noted that the term “homeless” encompasses a broad range of subpopulations, all of whom have high mental health needs, but for whom mental health services must be tailored. For example, transitionally homeless (those recently or temporarily homeless due to an adverse life event, like the loss of employment) have different needs than the chronically homeless (individuals who have been unhoused in the longer term and may find it difficult to reintegrate into a housed situation). In addition, among the chronically homeless, those with a dual diagnosis of mental illness and substance use will require additional services.

In order to address this, community leaders recommend exploring these subpopulations in depth in subsequent surveys or research, in order to understand how the needs of these populations overlap or differ. This knowledge may help determine the types of services needed, and the extent to which these services are needed throughout the county.

Regional Approach. Community leaders also noted that there may be certain cities or areas in Ventura County with greater needs for homeless services, and that subsequent data analyses should be done to determine the distribution of homelessness by location within the county. Indeed, the 2018 homeless point-in-time count for Ventura County showed that the majority of homeless individuals resided in the cities of Oxnard and Ventura. It may be productive for VCBH to partner with the 2019 homeless point-in-time count to further assess the geographic distribution of homeless individuals, and ask more in-depth questions about mental health status.

Early Intervention. Community leaders also recommended a concerted effort to address the needs of transitionally homeless individuals, in order to prevent them

from becoming chronically homeless. These services may include not only traditional mental health services, but also linkage with social services, such as housing/rental assistance or employment assistance. They pointed out that the cost of providing temporary assistance to individuals and families to stabilize them in housing outweighs the cost of social services for chronically homeless individuals. Therefore, early intervention would require not only focusing on transitionally homeless individuals, but also thinking “outside the box” about the types of services that should be provided to prevent chronic homelessness.

Triage from Law Enforcement to Social Services. Community leaders pointed out that law enforcement can often be the entry point for homeless individuals into the mental health services system. However, they recognize that a more appropriate entry point for homeless individuals may be social welfare, since the issues of homeless individuals (especially the chronically homeless) are multi-faceted and require a case worker that can assess the individual's needs holistically.

Community leaders therefore recommended explicit cross-agency protocols among law enforcement and county social welfare providers to ensure that police responding to non-violent incidents involving homeless individuals can triage them to social welfare services.

However, in addition to community leaders' recommendation, Harder+Company recommends linking law enforcement to education on culturally appropriate ways to interface with homeless individuals (perhaps through the aforementioned resource center). This recommendation is in recognition of the fact that in the triage scenario outlined above, law enforcement will still have some level of engagement with homeless individuals, and the triage process itself will require culturally-based skills in order to prevent behavioral escalation during encounters.

Substance Use

Understanding Substance Use Subpopulations. As with homelessness, community leaders noted that there are distinct needs (and sense of urgency for treatment or intervention) among substance users, depending on the particular substance used. While the data from this CMHNA's community survey found that some priority groups use substances at higher rates than others (e.g. 41% of homeless respondents vs. 15% overall), it did not distinguish among the various types of substances, and there may also be differences in the types of substances used among different priority populations, that may indicate varying degrees of severity (for example, use of marijuana vs. use of heroin).

For example, while alcohol, tobacco and cannabis are all psychoactive and potentially addictive drugs, the mental health needs of users of these substances will differ from those that use substances that may currently be illicit (opioids, cocaine, methamphetamines, etc.). Community leaders recommended further research to uncover which substances are being used, and what connections those have with mental health. In order to understand these connections, community leaders also recommended more in-depth methods, such as focus groups, with consumers and providers of substance use services in order to further understand the service needs they are experiencing.

Focus on Low Income and Homeless Populations. In terms of service recommendations, community leaders suggested a focus on low income and homeless individuals, who they felt were at greatest risk for substance abuse and addiction. They noted that the issue of access to mental health services was particularly salient for these populations, and therefore these groups are likely to

also be unserved or underinsured in terms of both mental health and substance use services.

Recommendations for VCBH

In addition to the county-wide considerations outlined above, Harder+Company also makes the recommendations below to VCBH. These recommendations relate to “next steps” after the CMHNA, and/or to specific practices that VCBH can incorporate into other initiatives in order to facilitate continuous and responsive assessment of residents’ mental health needs.

Engage in future discussions on the data generated by this CMHNA. This CMHNA and the various Advisory Group meetings and community input sessions are a starting point for a new approach to VCBH's engagement with Ventura County residents.

The Advisory Group brought together diverse providers from across the county's network of services, including mental health, public health and law enforcement. Harder+Company recommends maintaining this network actively by having ongoing conversations with the Advisory Group to further explore how individual agencies or organizations can come together to collaborate on improvement in mental health services.

Harder+Company also recommends ongoing community input sessions, including both community leaders and grassroots residents, to share the results of this CMHNA. It may be best to hold grassroots community information sessions outside of VCBH, and to segment the audiences either by region or by priority group.

Conduct additional focus groups to better understand priority populations. Focus group participants generally expressed a desire for more focus groups, due to their appreciation of VCBH's efforts to listen to community perspectives. All the focus groups included unserved or underserved populations, or populations from whom input is not routinely sought. As such, focus group participants appreciated VCBH's efforts to engage deeply with residents and to focus attention on groups that often feel “left out” of county-wide conversations. Since not all potential priority populations were reached through focus groups, there may be an opportunity for additional focus group outreach to other populations (such as other groups that may be at risk for mental illness, for example, youth, formerly incarcerated individuals, veterans, etc.).

Use qualitative data in future engagements with the community. A further recommendation is for VCBH to consider the use focus groups not only for future CMHNAs, but to also as needed for future initiatives to address service needs or gaps in knowledge. The combination of quantitative data (i.e. surveys) with qualitative data (i.e. focus groups) enables a rigorous approach to uncovering mental health needs with both breadth and depth.

Suggestions for Further Research and Data Analysis

This CMHNA created a rich data set of mental health needs and perspectives of mental health services across the county. Such a data set creates an opportunity for providers to make better-informed decisions on how to respond to community mental health needs.

In addition, this CMHNA should be seen as a starting point for this discussion;

Harder+Company concurs with the sentiment of many community leaders, who pointed out that much further work is needed, and that therefore the data gathered from the community survey can be a launching point for further study.

(Analogously, the community recommendation discussion can be seen as one of a series of ongoing conversations on mental health needs between VCBH and the broader public.)

Below are presented recommendations from both community leaders and Harder+Company, on potential further research, or on future data analysis that can be carried out with the existing community and provider surveys.

Community leaders requested further analysis on existing data, including:

1. Breakdown of mental health needs by language in the community survey, in order to understand how mental health needs differ by linguistic group, particularly with regard to perceptions of whether services received were culturally and linguistically appropriate.
2. Breakdown of self-reported ratings of the quality of existing mental health services by provider type in the provider survey, in order to determine if there are unique perceived strengths or challenges among direct service providers, law enforcement, education, etc. Such a breakdown could be provided to the responding agencies so that they can use this information to make decisions about service changes, or to determine which types of trainings may be necessary in order to improve service quality.
3. Breakdown of homelessness by region in the community survey, in order to determine where resources or attention should be focused in terms of providing homeless services.

Additionally, community leaders also recommended carrying out the following new research:

1. Future iterations of a community survey to include feedback on access and quality by provider type. This data would dovetail with the further analysis of the provider survey noted above, by showing perceptions of quality of services, as well as cultural and linguistic appropriateness, by provider type. This data would be a rich source of information for agencies in order to make informed decisions on necessary service changes or trainings.
2. Future iterations of a community survey or community focus groups to take an in depth look at homeless subpopulations (transitional vs. chronic, as well as dually diagnosed). This would provide further granularity on the blanket term "homeless," and provide the county with a more detailed profile of homeless individuals in Ventura County, in order to make decisions tailored to each subpopulation's needs.
3. Future iterations of a community survey or community focus groups to take an in depth look at substance use subpopulations (alcohol, tobacco, cannabis, and other illicit drugs). This would allow the county to differentiate among the needs of different types of substance users to develop more tailored outreach and services.

Harder+Company would also like to make the following recommendations regarding VCBH's approach to further research:

1. We concur with the additional data analysis and further research above, and believe these approaches will lead to greater insight into the mental

health needs of Ventura County's priority populations.

2. We recommend ongoing community and provider surveys, ideally annually, but even a survey up to every three years would provide an appropriate trend line for tracking outcomes. Long-term tracking of community survey outcomes will also help indirectly track the effectiveness of changes made as a result of the current and future community mental health needs assessments.
3. We recommend continuing the existing lines of survey questions in future community and provider surveys, so that responses can be tracked over time. In other words, there should be a high threshold for removing existing questions, so that longer time series of data can be made available.
4. We recommend that the design of future community surveys and focus groups be carried out by local research partners, namely universities or research non-profits based in Ventura County or that serve the county's residents. Local researchers will help balance the need for rigor, objectivity and cultural appropriateness.
5. We recommend continuing the rigorous, community-oriented approach that VCBH took in carrying out outreach for the community survey and focus groups, including on-demand technical assistance with survey communications, distribution and collection; ongoing tracking of ZIP codes reached through the survey to ensure broad, county-wide coverage; translation of protocols in relevant languages; coordinating with community organizations to host focus groups and recruit participants; and working with community-based facilitators to carry out focus groups. ✚

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