2019 DESERT HEALTHCARE DISTRICT MENTAL & BEHAVIORAL HEALTH NEEDS ASSESSMENT

SUMMATIVE REPORT

Prepared for:

DESERT HEALTHCARE DISTRICT & FOUNDATION

Prepared by:

EVALCORP Research & Consulting

Acknowledgements

EVALCORP would like to acknowledge a number of individuals for sharing their time and perspectives in support of the mental and behavioral health needs assessment. We would like to thank the Desert Healthcare District Board, Staff, and ad hoc committee for their partnership and support throughout the needs assessment. We also extend our thanks to the Desert Healthcare District Board of Directors for their valued input during the process. Immense thanks are also extended to the key stakeholders, direct service providers, and community members who participation in the data collection activities and for sharing their experiences, stories, and recommendations. This report would not be possible without their efforts.

Table of Contents

Project Overview

During 2019, the Desert Healthcare District & Foundation conducted a needs assessment (NA) to inform strategies to enhance mental and behavioral health service provision across the Coachella Valley. The primary goals were to provide information to identify needs of current residents, understand gaps in available service provision, and to develop recommendations to ensure that future efforts are targeted to best meet community needs. To conduct this NA, the Desert Healthcare District & Foundation partnered with EVALCORP Research & Consulting to engage with key stakeholders and community members, collect and analyze qualitative and quantitative data, and develop recommendations resulting from the NA.

Informed by a range of data collection initiatives designed to capture a diverse set of perspectives, this report includes a summary of key findings about priority mental and behavioral health needs, causes and contributing factors, and access to care. In addition, this report captures recommendations and actionable next steps to enhance mental and behavioral health service provision valley-wide, based on feedback from community members and stakeholders.

Methods

EVALCORP utilized a mixed-methods approach to conduct the needs assessment. The following data sources informed this report:

- **Secondary Data.** Multiple secondary data sources specific to the geographic areas served by the Desert Healthcare District & Foundation in the Coachella Valley were reviewed to provide background information about the region's demographic profile, available resources, and service utilization.
- **Key Stakeholder Interviews (KSIs).** Semi-structured interviews were conducted with 23 individuals. Key stakeholder interviews were conducted with DHCD board members to inform the NA process. Additional KSIs were conducted to gather information about the mental and behavioral health needs of Coachella Valley residents from a systems-level perspective. Participating interviewees represented the following:
    - Educators (e.g., K-12 administrators and teachers)
    - Providers (county agencies, community-based nonprofits, clinics, or community centers)
    - Medical Doctors
    - Workforce Development Specialists (e.g., recruitment professionals who address unfilled positions or staffing shortages, or grow a workforce from high school into specific college or career pathways based on regional needs)
- **Provider Survey.** The Provider Survey was developed and administered online to individuals who directly assist community members with their mental and behavioral health needs, including providers from a wide range of county, private, and non-profit agencies who serve residents of the Coachella Valley. During the two-week survey administration timeframe, a total of 73 responses were collected and used for analysis. The purpose of the survey was to obtain providers' perspectives and experiences regarding priority mental and behavioral health needs, and the availability and provision of mental and behavioral health services throughout the Coachella Valley.
- **Focus Groups.** Five focus groups were conducted to assess the current need for mental and behavioral health services, and how these needs can be better addressed within the Coachella Valley. Groups were purposively sampled to represent a variety of ages from youth to older

adults, race/ethnicities, and regions of the Coachella Valley. All focus groups used a semi-structured protocol and were facilitated in Spanish or English. A total of 48 participants were in attendance among the five sessions.

Limitations

Community engagement efforts were sampled in a purposeful way to invite diverse input; however, feedback from the key stakeholder interviews, the provider survey, and from focus groups are not intended to be representative of all stakeholders. As is the nature of qualitative data collection, participation varied across initiatives resulting in small sample sizes among specific subpopulations. The data gathered through these engagements represent the lived experiences of those who participated. Responses were coded and summarized according to themes identified by the evaluator and using best practices for analyzing qualitative data. This type of qualitative data analysis yields important findings that complement quantitative data analysis.

For quantitative data in the report, wherever possible, secondary data were drawn from the zip codes specific to the Desert Healthcare District's service area. However, in circumstances where these data were not attainable by zip code, data from Riverside County were included instead. In addition, while the demographic information presented describes residents who live within the Desert Healthcare District's service area, residents outside the Desert Healthcare District service area seek access to mental and behavioral health care within the Coachella Valley and are not represented in the secondary data. Further, when secondary data collection occurs and how recent the data sources are available varies across sources; for example, within the CHKS data sets, school districts have alternating years of data collection and within one school district, the district stopped collecting data altogether, with the most recent update completed in 2015/16. Nonetheless, best efforts were made to ensure data collection was representative of the community to inform future collaborative efforts to address mental and behavioral health needs across the Coachella Valley.

Report Organization

The following report is divided into 3 sections: (1) The Community: an overview of the Coachella Valley, demographic data, and available services, access to care, and gaps in service provision; (2) Key Findings: priority health concerns, causes and contributing factors, and barriers; and (3) Recommendations.

Of note, the current summative report is a compilation of multiple prior reports completed as part of the NA. For additional details and findings, please refer to prior reports in Appendices A-D. Additionally, all primary data collection tools developed for use in the NA are included in Appendices E-G.

Individual Reports

Appendix A: Key Stakeholder Summary of Findings
Appendix B: Provider Survey Summary of Findings
Appendix C: Focus Group Summary of Findings
Appendix D: Secondary Data Report

Primary Data Collection Tools

Appendix E: Key Stakeholder Interview Protocol
Appendix F: Provider Survey
Appendix G: Focus Group Protocol

The Community

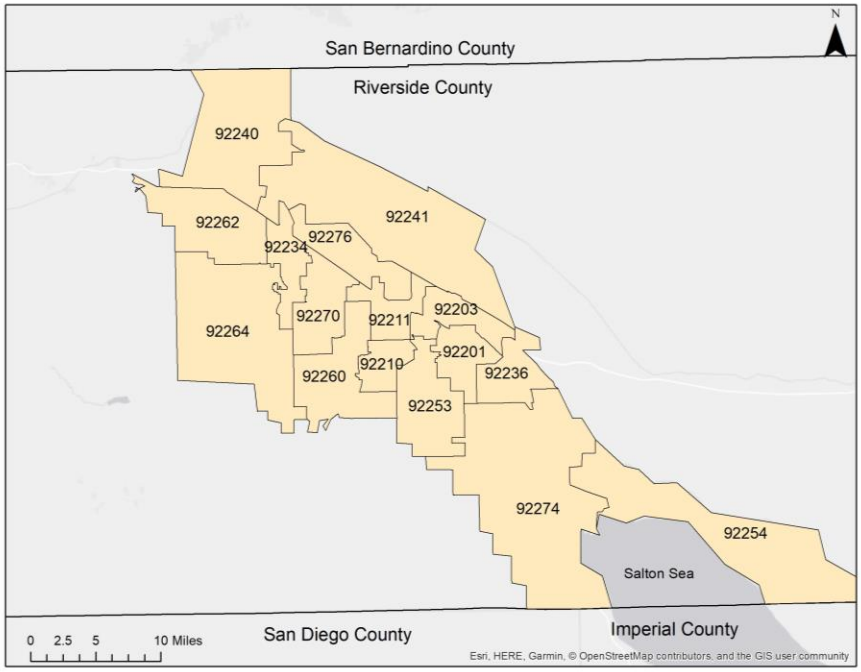
Desert Healthcare District & Foundation Service Area

The zip codes and cities currently served by the Desert Healthcare District & Foundation are listed in **Table 1**, below. As the service area continues to expand, nearly the entire Coachella Valley is covered with the exception of a few zip codes (e.g. Blythe). All references to the Coachella Valley within this report are interchangeable with the Desert Healthcare District & Foundation service area.

Table 1. Zip Codes and Cities Served by the Desert Healthcare District & Foundation

Zip Codes	City
92201	Indio
92203	Indio, Bermuda Dunes
92210	Indian Wells
92211	Palm Desert
92234	Cathedral City
92236	Coachella
92240	Desert Hot Springs
92241	Desert Hot Springs, Desert Edge, Sky Valley
92253	La Quinta
92254	Mecca, North Shore
92260	Palm Desert
92262	Palm Springs
92264	Palm Springs
92270	Rancho Mirage
92274	Thermal, Oasis, Vista Santa Rosa
92276	Thousand Palms

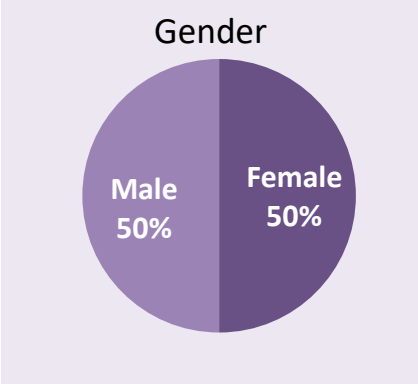
Map 1. Desert Healthcare District & Foundation Service Area by Zip Code



Coachella Valley Demographic Data[1]

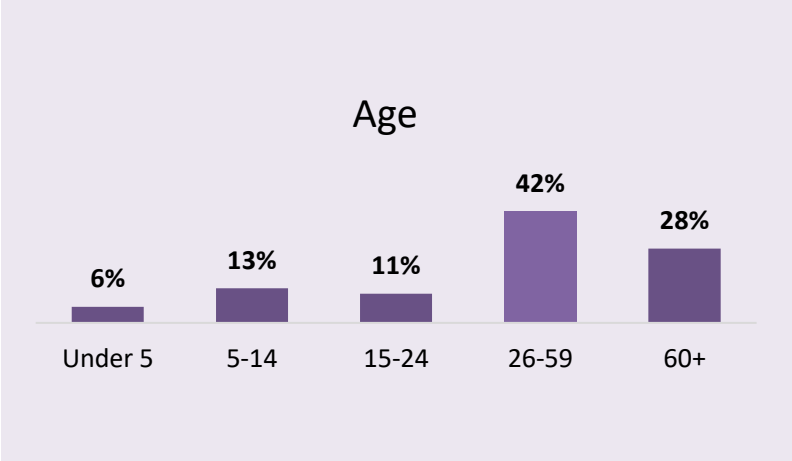
443,101

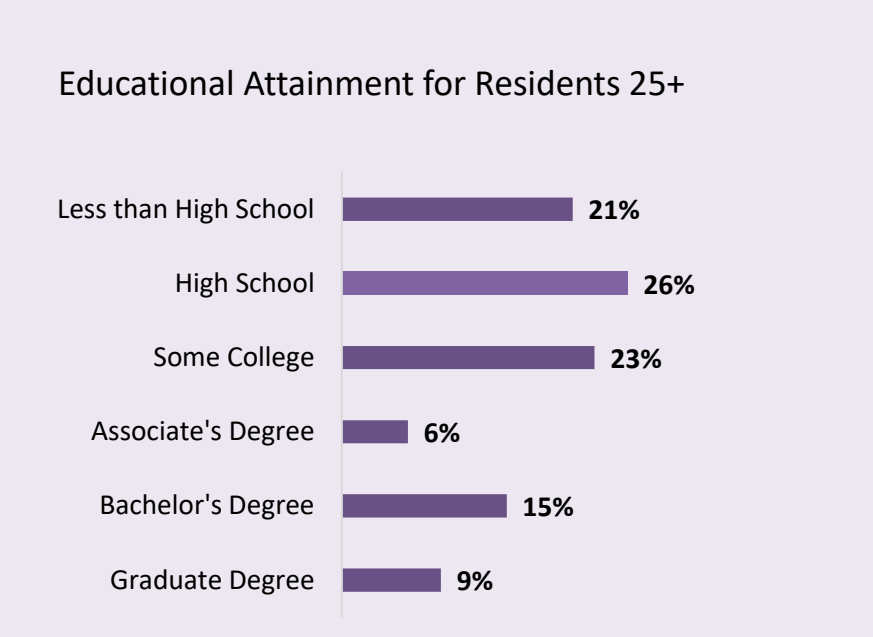
Estimated population served by Desert Healthcare District & Foundation



14% are Veterans

19% of households do not have internet access





$50,515

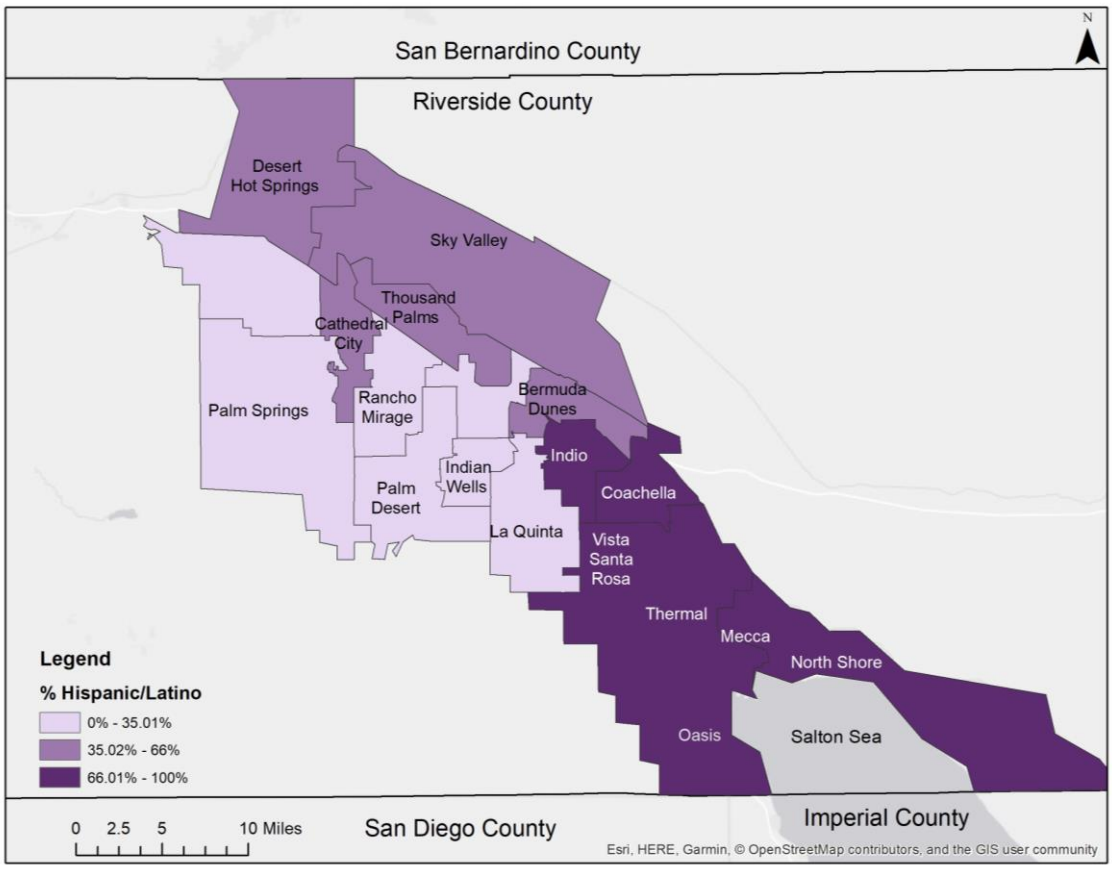
Median Household Income

Compared to the statewide median household income of $82,009

10% of the labor force (16 years and older) is unemployed.

[1] Demographic data is sourced from the American Community Survey (ACS) 5-Year Estimates 2013-2017 using the zip codes listed in **Table 1**.

Map 2. Hispanic/Latino Population by Zip Code

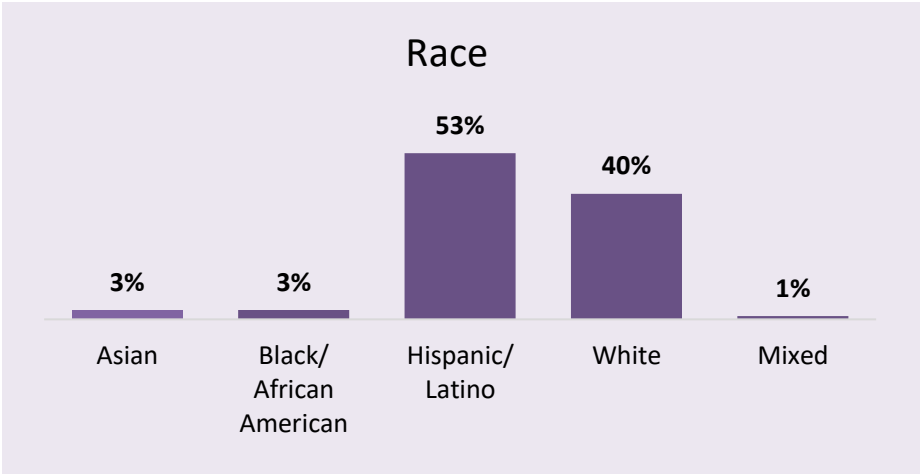


51% of community members speak English only.

40% of community members speak Spanish.

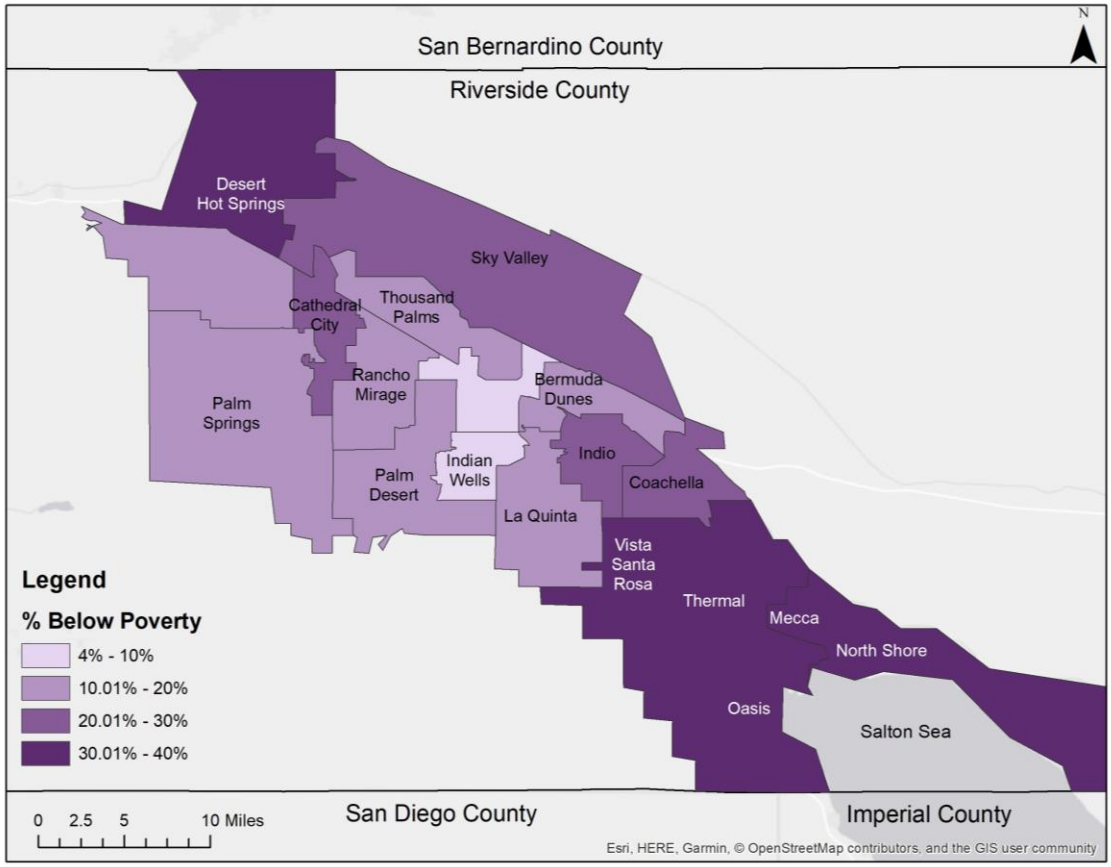
53%

of residents identify as Hispanic/Latino.



According to census data estimates there are only 1,185 Alaska Native/ Native Americans (>.01% of the total population) in the zip codes of the Coachella Valley

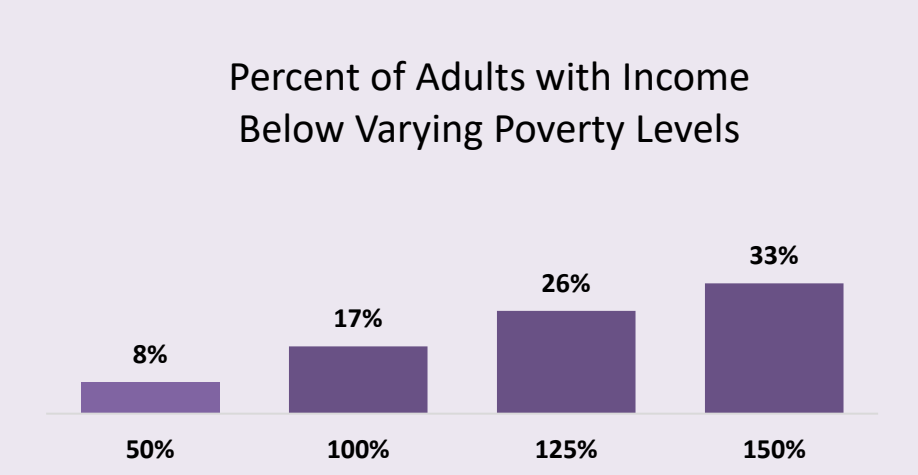
Map 3. Population Below Poverty by Zip Code



32% of individuals under 18 live 100% below the Federal Poverty Level.

17% of adults 18 and older live 100% below the Federal Poverty Level.

Total population for whom poverty status is determined is 440,865. The federal poverty level for individuals is $12,060. Statewide, 21% of children (under 18 years of age) and 13% of adults (18 and older) live below 100% of the Federal Poverty Level.



9% of households receive food stamp/SNAP benefits.

Available Mental and Behavioral Health Services

The organizations that currently provide mental and/or behavioral health services within the Coachella Valley are listed below:

Clinical Substance Abuse Services

- Oasis Behavioral Health
- ABC Recovery Center (low Cost)
- Windstone Behavioral Health
- Betty Ford Center
- Desert Comprehensive Treatment Center
- Michael's House
- Bella Monte Recovery Center
- 417 Recovery
- Ranch Recovery
- Addiction Therapeutic Services

Health Systems, Medical Centers, and Outpatient Clinics

- Riverside University Health System (RUHS)
- Telecare Riverside County Psychiatric Health Facility
- Eisenhower Medical Center
- Desert Regional Medical Center
- Crisis Stabilization Unit – Mental Health Urgent Care
- Clinicas de Salud del Pueblo
- Borrego Health
- All Desert Wellness Center
- Volunteers in Medicine
- John F. Kennedy Memorial Hospital

Other Community Organizations

- National Alliance for Mental Illness (NAMI)
- Jewish Family Services (JFS) of the Desert
- Riverside Latino Commission

Services for Children and Youth

- Safehouse of the Desert
- Barbara Sinatra Children's Center
- Desert FLOW TAY Center
- Desert/Mountain Children's Center
- Loma Linda University Children's Health - Indio
- Student Assistance Programs (School Districts)
- Olive Crest
- 360 Behavioral Health
- First 5 Riverside

Services for Seniors

- Mizell Senior Center
- Joslyn Senior Center
- Desert Hot Springs Senior Center
- Neurovitality Center

Services for Underserved Populations

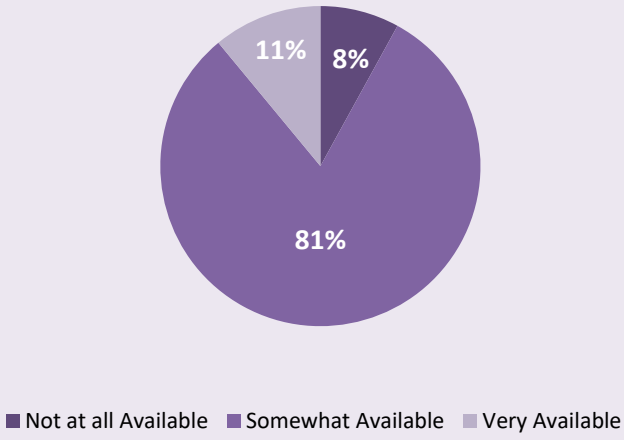
- Shelter from the Storm (Family Violence)
- Riverside-San Bernardino County Indian Health, Inc.
- Mobile Vet Center
- The Braille Institute
- Desert Arc
- Catholic Charities
- Coachella Valley Rescue Mission
- Martha's Village and Kitchen
- Well in the Desert
- Desert AIDs Project
- LGBT Community Center of the Desert – Scott Hines Mental Health Clinic

These resources can be found through a quick internet search of local mental and behavioral health services. This list may not be inclusive of all resources available to Coachella Valley residents.

Many of the services above have eligibility requirements or are cost restrictive. In addition, the Coachella Valley has seen a recent fluctuation in available mental and behavioral health services. The Valley recently lost a service provider known as Health to Hope, but has also continued to grow its

service provision; a children's clinic operated by Loma Linda University opened in Spring 2018 and a Crisis Stabilization Unit (open 23 hours a day) opened in late 2016.

Figure 1. Provider Survey: Availability of Service Providers (n=73)



Through the provider survey, community member focus groups, and key stakeholder interviews participants were asked to describe how accessible they felt mental and behavioral healthcare was in their communities. Many indicated that there are resources available to address mental and behavioral health in the Coachella Valley, but that the infrastructure to properly connect individuals to care is inadequate.

The majority of survey respondents felt that mental and behavioral health service providers were only somewhat available in the communities they serve (**Figure 1**).

Gaps in Mental and Behavioral Health Service Provision

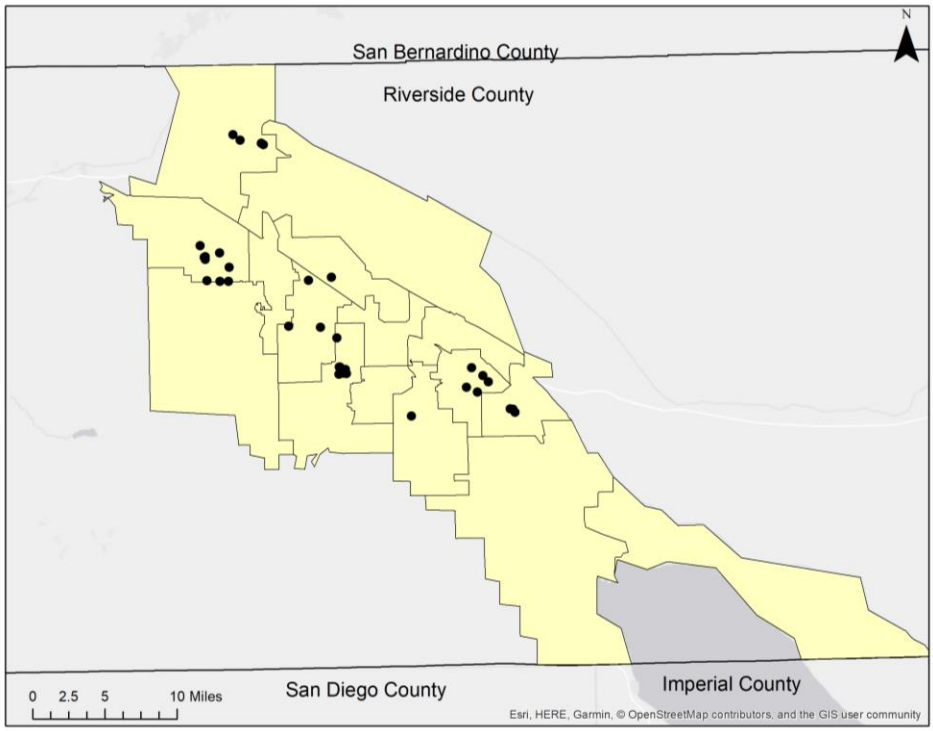
Community engagement efforts revealed that there were major gaps in the provision of mental and behavioral health services in the Coachella Valley that created barriers to accessing services that do currently exist. Gaps relating to service provision/accessing available services are listed below; key areas of concern by respondents bolded (**Table 2**).

Table 2. Gaps in Mental and Behavioral Health Service Provision

Gaps	Select Quotes
Services along the continuum of care are lacking, such as triage, outpatient, preventative, crisis, inpatient, and youth and LGBTQ+ specific care	"We have recently opened a mental health urgent care in Palm Springs that also offers services for youth as low as 13 years of age, but **there is still a gap for youth 12 and under**…"
There is a shortage of mental and behavioral health providers including those that are bilingual or culturally competent	"Even within the schools, the **referrals outnumber the mental health professionals**." "1000% need for more psychiatrists. The **only organization on the east end of the Valley** is the Latino Commission and we only have one psychiatrist." "We need more therapists, bilingual therapists." "We have a **huge psychiatric shortage** in our valley. Lack of doctors leads to long wait times."

There are long wait times and limited walk-in availability for services	"I think we have been pretty fortunate in our clinic. We can get patients in…when I speak to other professionals and patients, I hear about **long wait times**." "I have heard that **wait times can be long**. If you have private insurance it can be a very long wait to get into a provider."
Services are often unaffordable or not covered by insurance	"…especially for middle income families with insurance, it is more difficult to get services because it is **prohibitively expensive**."
There are limited transportation options	"… to get to a county clinic it's like a **2-hour bus ride**…" "The nearest clinic is in Indio and we are glad it's there, but **transportation continues to be a factor** in our area…there are some buses, but the routes are very spaced out." "There is **no public transportation**, even if they have vehicles, they may not be reliable or they may only have one."
Few services available during nontraditional hours and in nontraditional settings	"There is a lot of work centered around **telecare**, but the Southeast end of the Valley **lacks the infrastructure**."
Locations are not geographically convenient	"I think definitely the **geographic gap** (Mecca, Thermal) is very underserved." "The thing with the **desert is it is so spread out**; really hard for young people to access any services…" "We need them [services] **located in more accessible areas** to our families, closer to home. Even now there is an RUHS in Desert Hot Springs and one in Cathedral City, but if you live in Sky Valley…there aren't even buses from there…".

Map 4. Available Mental and Behavioral Health Service Locations



In **Map 4**, service locations are shown concentrated near the north end of the Coachella Valley, but many of these services have a reach that is much broader than their physical location. Additionally, there are a number of services available to residents (listed on Page 7) that are not shown here.[2]

Participants also indicated that there is an immense need for increased knowledge about mental and behavioral health and awareness of available services among both community members and service providers. Many of the gaps identified by participants were also called out as significant barriers to accessing care as will be discussed in the following section.

Respondents of the Provider Survey were asked to rate the amount of additional support or resources that are needed to address a variety of mental and behavioral health issues (**Table 3**).

Table 3. Need for Additional Support/Resources (n=73)

	None	Some	A Lot	Not Sure
ADD/ADHD	4%	51%	33%	12%
Alcoholism/Substance Use	3%	14%	83%	0%
Anxiety	0%	25%	75%	0%
Bullying	4%	39%	49%	8%
Chronic Stress	1%	37%	62%	0%
Depression	1%	15%	84%	0%
Homelessness	0%	15%	79%	6%
Thoughts of Suicide	0%	23%	71%	6%
Trauma	0%	29%	70%	1%

The majority of respondents felt that at least some additional resources or support ought to be directed to each of the above mental and behavioral health needs. Four respondents also identified additional issues including anger management, PTSD/survivor syndrome, family violence, and LGBTQ+. For these four issues, each respondent indicated "A Lot" of additional support/resources are required to address the current need.

[2] Of the 47 services listed on page seven, only 34 of them were able to be geocoded. The remaining 13 services were unable to be geocoded either because addresses were not listed, they are P.O. boxes, or the services are located outside of the Valley.

Secondary data also revealed gaps in the availability of mental and behavioral health services. The Office of Statewide Health Planning and Development (OSHPD) reports data on mental healthcare provider shortages across California's Medical Service Study Areas (MSSAs). MSSAs were originally developed as of the 1976 Garamendi Rural Health Services Act which required the development of a geographic framework to determine which parts of the state were rural and which were urban, and for determining which parts of counties and cities had inadequate health care resources and were therefore "medically underserved". MSSAs are sub-city and sub-county geographic units and each one is composed of one or more complete census tracts. Each MSSA is deemed to be a "rational service areas [RSA]" for purposes of designating health professional shortage areas [HPSAs], medically underserved areas [MUAs] or medically underserved populations [MUPs].

Medical Service Study Areas (MSSAs)[3] Within the Coachella Valley:

1 - Cathedral City Southeast, Palm Desert North, Palm Springs South, Rancho Mirage North

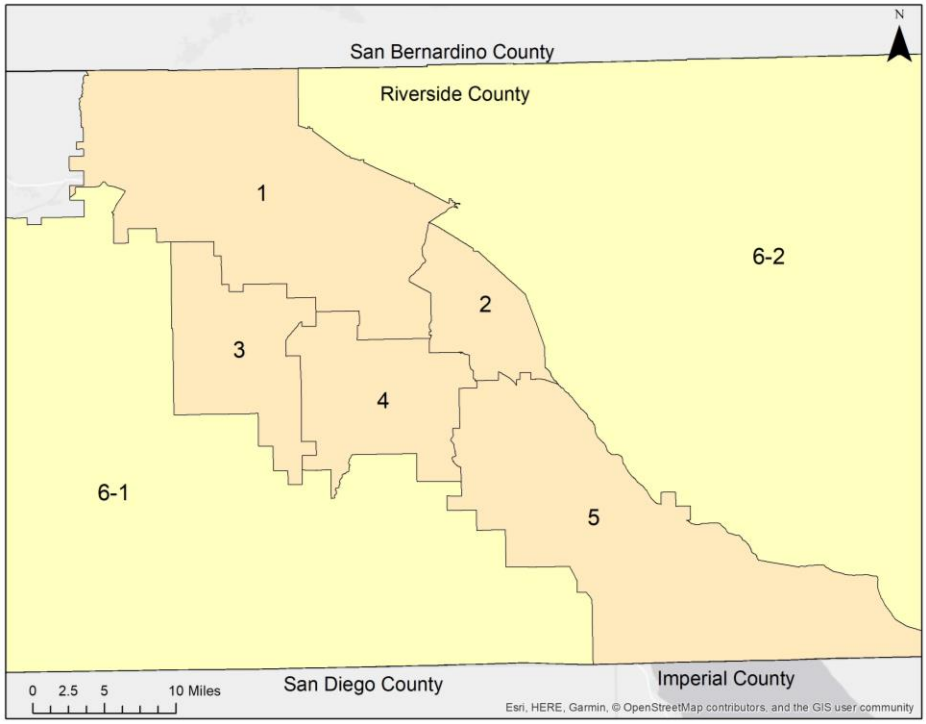
2- North Bermuda Dunes & North Indio

3 - Agua Caliente & Palm Springs

4 - Bermuda Dunes, Indian Wells, La Quinta, Palm Desert, Rancho Mirage Central & South

5 – Arabia, Coachella, Desert Beach, Flowing Wells, Indio South, La Quinta East, Mecca, Oasis, Thermal

Map 5. Medical Study Service Areas (MSSAs)



Medical Service Study Areas (MSSAs) Outside of the Coachella Valley:
6-1 - Idyllwild & Pine Cove

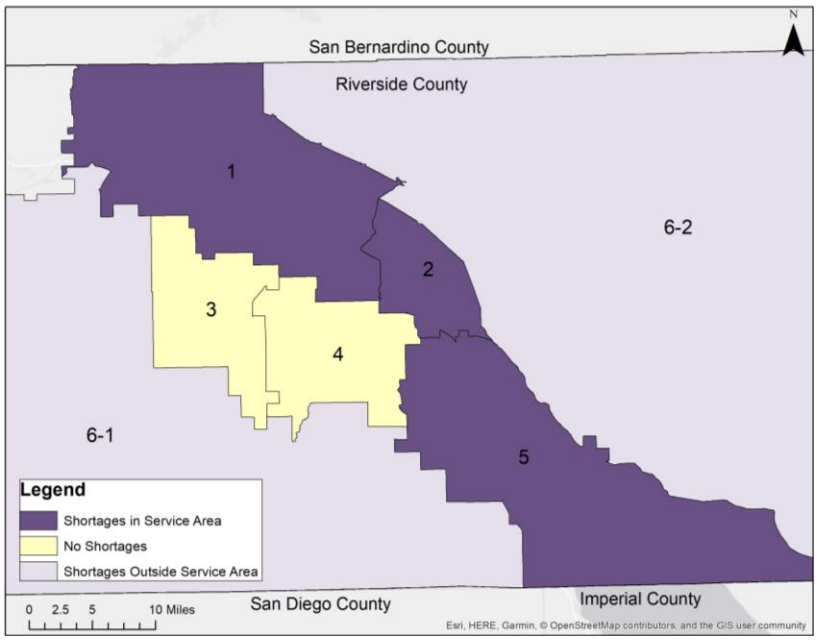
6-2 - Chiriaco Summit**,** Desert Center**,** Eagle Mountain

Health Professional Shortage Areas (HPSAs) are designations that indicate health care provider shortages in primary care, dental health; or mental health providers. These may be geographic, population, or facility-based. Benefits of designation as a HPSA include: student loan repayment, personnel placement through the National Health Service Corps (NHSC), improved Medicare

[3] Healthdata.gov; 2014

reimbursement, and enhanced federal grant eligibility. Mental Health Professional Shortage Areas[4] are identified on the basis of availability of psychiatrist and mental health professionals in addition to using these seven criteria: population-to-provider ratio, percent of population below 100% federal poverty level, elderly ratio, youth ratio, alcohol abuse prevalence, substance abuse prevalence, and travel time to the nearest source of care.

Map 6. Mental Health Provider Shortage Areas



MSSAs 1 and 2 are classified as having a population-based shortage, meaning there is a shortage of providers for a specific group(s) within the MSSAs.

MSSAs 5, 6-1, and 6-2 are classified as having a geographic-based shortage, meaning there is a shortage of providers for the entire population within the geographic area.

MSSAs 3 and 4 are not classified as mental health provider shortage areas.

In addition to provider shortages in the Coachella Valley, there are also psychiatric bed shortages. This information is provided by the California Hospital Association's (CHA) Annual Report on the Behavioral Health Delivery System. The CHA sets a goal of 50 psychiatric beds per 100,000 residents. As of 2017, Riverside County had 199 total psychiatric beds available, which equates to 8.21 beds per 100,000 residents. Among the 199 beds, 12 were designated as child/adolescent beds. The psychiatric bed shortages in the county are heightened in the Coachella Valley. Given the Valley's current population estimates, there should be at least 200 psychiatric beds. According to the most recently available data, Coachella Valley has 16 psychiatric beds available through a facility operated by Telecare. In addition, the new Crisis Stabilization Unit, operated by Resource International Inc., has 12 beds available, but they do not accept involuntary holds and do not treat children under 13 years old.

Interviewees were asked about whether they were currently engaged in any efforts to address the mental and behavioral gaps identified across the Coachella Valley. Many of the interviewees are part of agencies that are working toward addressing a severe shortage of mental and behavioral health services in the region. Their efforts are largely focused on workforce development. Workforce development efforts focus on creating career pathways in high schools and on physician recruitment. In an effort to expand direct service provision, provider agencies are placing therapists in schools and other community sites, and offering services outside of traditional hours and settings.

[4] California Health and Human Services; 2014

Key Findings

Through multiple community engagement efforts, 12 mental/behavioral health concerns, listed below, were identified as priorities. These priorities were derived from the 23 interviewees and 48 focus group participant's responses[5].

Priority Mental and Behavioral Health Concerns

- Substance use (n=28)
- Depression (n=19)
- Anxiety/Stress (n=17)
- Homelessness (n=14)
- Suicidal Ideation/Self-harm behaviors (n=13)
- Isolation/grief/loss (n=7)
- Trauma/abuse/neglect (n=6)
- Stigma (n=6)
- Anger management (n=5)
- General behavioral health (i.e., ADHD) (n=2)
- Bullying (n=1)
- Eating disorders (n=1)

Causes & Contributing Factors of Poor Mental & Behavioral Health

Interview and focus group participants[6] were asked to share factors that they perceived to contribute to or exacerbate mental and behavioral health issues. In addition to indicating that poor access to care (n=21) can contribute to or exacerbate mental and behavioral health conditions, the following factors were discussed:

Socioeconomic Status	**Poor Health**	**Violence**
• Poverty (n=9) • Homelessness (n=1)	• Stress (n=6) • Inadequate nutrition, sleep, and exercise (n=1) • Declining health and chronic pain among older adults (n=1)	• Bullying (n=12) • Unstable homelife/neglect (n=5) • Trauma (n=2) • Domestic Violence (n=1)

Other causes/contributing factors included stigma/culture (n=4), substance use (n=2), poor coping skills (n=1), biology (n=1), and loneliness (n=1).

> "If we could address poverty issues, a lot of mental health issues would also be resolved."
>
> *-Interview Participant*

[5] Survey respondents are not included here as they were asked different questions. Please see **Table 2** for a ranking of health concerns by survey respondents.

[6] Survey respondents were not asked this question

Bullying

A major concern raised by participants was bullying (often in schools, but also on social media). Though the educators that were interviewed felt bullying was well addressed in schools, many participants in the focus groups indicated that it is a problem across the three school districts in the Coachella Valley. They also expressed frustration at the lack of effective intervention on the part of the school, and that school staff often contributed to bullying in the schools. Comments revealed that participants feel many of the schools do too little to address the root causes of bullying, despite having zero tolerance policies, and can even exacerbate bullying issues by leaving students to address issues (sometimes of safety) on their own.

This topic was explored more deeply in the Transitional Age Youth (TAY) focus group, where of the 11 participants, 6 had experienced a threat of violence at school and 9 had been bullied while in school. This group in particular expressed concern about their overall safety and lack of security at their schools.

"Especially at schools, there are a lot of problems with bullying and when something happens they don't do anything about it."
-Focus Group Participant

"Growing up with the DSUSD school district what they tried to do… was to separate the problem students as much as they can and the reality was that there needs to be a process to stop the bullying …not like a slap on the wrist or a warning."
-Focus Group Participant

"I've gotten bullied multiple times…and a freshman threatened me with a knife. The actual principal didn't do anything and it wasn't until my grandmother came in here and threatened to call the police that they actually acted on it and suspended the kid."
-Focus Group Participant

Participants in the Community Health Worker focus group also expressed frustration over the lack of school security and intervention by school staff as well as the cultural barriers some students face. They shared that even though schools promote themselves/their policies as "zero tolerance" they still do not address concerns or problems raised by students and their parents.

Community Health Workers also discussed a term used among Black/African American youth, "shooting the dozens," which they explained is considered in that community to be a verbal contest of wit and words. They explained that this culturally normative behavior is being treated as bullying by public institutions like schools. Additionally, black youth may be unfairly targeted with anti-bullying policies because, as focus group participants shared, parents may encourage their children to stand up for themselves, but at school this is considered fighting and they are told to report any bullying to a teacher.

Secondary data, such as the California Healthy Kids Survey (CHKS) also demonstrates the prevalence of bullying in local schools. Self-reported indicators related to mental and behavioral health, substance use, and harassment or bullying are provided in **Table 4**, below, for the Coachella, Desert Sands, and Palm Springs Unified School Districts (USD). Chronic sadness/hopelessness and harassment or bullying are top issues in all three districts.

Table 4. Mental/Behavioral Health, Substance Use, and Bullying/Harassment Indicators for Grades 7, 9, and 11 (CHKS)*

Indicator	Coachella USD (FY 17-18)	Desert Sands USD (FY 17-18)	Palm Springs USD (FY 15-16)±
Total Enrollment for all students†	18,372	28,708	23,348
Experienced Chronic Sadness/Hopelessness, Past 12 Months	31%	33%	33%
Considered Suicide, Past 12 Months	14%	18%	19%
Any Current Alcohol or Drug Use, Past 30 Days	14%	14%	18%
Harassment or Bullying on School Property, for Any Reason, Past 12 Months	26%	34%	32%

* Percentages represent total average of self-reported data for grades 7, 9, and 11 in fiscal year shown.

† Enrollment data are for all students in the district for fiscal year shown and sourced from *Education Data Partnership*.

± The most recent data available for this school district was for fiscal year 2015-2016.

Barriers to Accessing Mental and Behavioral Health Care

Many of the barriers to care for residents are also considerable gaps in the provision of those same services. These include accessibility such as location, transportation, hours of operation (n=19); high costs and low insurance coverage (n=12); low awareness of available services and how to utilize them (n=9); and provider shortages (n=8). Barriers identified by interview and focus group participants are closely aligned with the top four barriers identified by respondents to the provider survey (n=72) as being either 'somewhat of a barrier' or a 'major barrier' were client knowledge of available services (90%), service availability (89%), insurance coverage/cost (83%), and transportation (81%). Additional barriers identified through interviews and focus groups are listed below:

- Stigma, attitudes, and beliefs about minority populations and seeking care (n=22)
- Eligibility requirements (n=3)
- Language barriers (Spanish, Indigenous, ASL) (n=2)

"There are a lot of barriers and roadblocks to getting services because of the many layers of requirements."
-Interview Participant

Stigma

Across engagements culture and stigma were discussed as a major barrier to addressing mental and behavioral health needs. Participants felt that cultural beliefs had a negative impact on mental and behavioral health. For example, participants reported that cultural beliefs held in the Hispanic/Latino community prevent people from addressing mental and behavioral health needs due to the stigma associated with mental illness, or because it is not considered a valid component of overall well-being.

"[People in the Latino community] tend to not seek [mental health services] because it means you are 'crazy'."
-Focus Group Participant

Participants also commented that in the Black/African American community, there is a macho mentality where needing mental health care is considered a sign of weakness. There were also perceptions among Black/African American participants that churches in their community dismiss mental and behavioral health concerns.

LGBTQ+ participants shared that the stigma they experience as a result of their sexual orientation and gender identity negatively impacts their mental and behavioral health (e.g., being disowned by their families and perceived bias from service providers).

Additionally, participants discussed the self-stigma they and others experience and how it prevents people from acknowledging they have may have a mental health problem and taking action to obtain needed services.

Eligibility Requirements

Many free or low-cost services have extensive eligibility requirements that keep qualified individuals from accessing services. They also keep out many families that though they do not meet all of the requirements are unable to access any services because there are no affordable alternatives.

Language Barriers

There are very few providers in the Coachella Valley that speak multiple languages fluently including Spanish; and according to participants there are none that speak local indigenous languages. Additionally, it is challenging to find medically trained translators for any language, but particularly those that are deaf or hard of hearing.

Recommendations

The recommendations provided below were informed by all participants contributing to the needs assessment to address identified needs and gaps. The recommendations below are meant to inform valley-wide collaborative efforts across multiple agencies. Furthermore, it should be understood that some of the suggested strategies may already be implemented by one or more individuals/ organizations, but that additional resources may be required to adequately address the issue.

Though there are numerous services available throughout the Coachella Valley, they do not adequately meet the high demand and many necessary services are not available locally. Additionally, services that are available are often difficult to access due to cost, hours of operation, and location.

Recommendation 1: Improving Access to Mental & Behavioral Health Resources	• Expand low cost service provision, provide financial assistance, or reduce eligibility requirements for free/reduced cost services. • Offer services in nontraditional setting and during nontraditional service hours. • Increase availability of same day/walk-in services • Increase services providers across the continuum of care including prevention, inpatient, and crisis care for all ages and income levels. • Improve access to services through vouchers for ride sharing, offering van services, or working with local transportation agencies to expand public transit. • Support interagency collaboration and integration between service providers to pool resources and increase organizational capacity.

Increasing awareness of available resources and educating about mental and behavioral health to reduce stigma are important factors for increasing access to services. The education strategies listed below target different levels of the community (individual, organizational, and system) and should be executed in conjunction to be most impactful.

Recommendation 2: Education & Stigma Reduction	• Launch a social media campaign to increase community member knowledge of mental and behavioral health, available resources, and to reduce stigma. • Provide education through local schools to increase knowledge, awareness, and reduce stigma among youth and parents. • Utilize community sites such as libraries and churches to distribute information about mental and behavioral health in communities with little to no internet access.

Providing training and education to anyone who may encounter someone in need of mental and behavioral health (including educators, first responders, and other community members) is important to ensuring that appropriate care can be delivered in a culturally appropriate and timely manner.

Recommendation 3: Professional Development	• Ensure educators and other school staff are equipped with the necessary knowledge, tools, and interventions to refer students to appropriate services. • Provide training for cultural competency and trauma informed care to all service providers. • Partner with local law enforcement agencies to provide Crisis Intervention Training (CIT) to all first responders. • Work with primary care providers to increase their confidence to discuss mental and behavioral health with their patients, in addition to informing them about available services and how to refer to them. • Increase access to intervention training such as Mental Health First Aid (MHFA) for community members.

One of the main areas of need is growing the number of mental and behavioral health practitioners (MFT, LCSW, Psychiatrists, etc.) in the Coachella Valley that are licensed and familiar with the community.

Recommendation 4: Workforce Expansion	• Expand mental and behavioral health pathways and academies in high schools, and work with local universities to create educational pipelines for these students. • Incentivize practitioners to move to or stay in the Coachella Valley (e.g., paid internships, loan repayment) • Hire practitioners that are linguistically competent (e.g., Spanish, indigenous). • Maximize Health Professional Shortage Area (HPSA) designation for underserved areas.

Finally, some of the concerns illustrated through the needs assessment, especially the prevalence and impact of bullying in the school districts, indicates a need for additional research to better inform how the issue can be effectively addressed with strategies that meet the specific needs of the diverse communities who live in the Coachella Valley.

"If we want to tackle something as big and important as mental health, we have to look at it from every angle."
-Interview Participant

"It is going to take a concerted effort on all of our parts to meet the needs of the community. The more we work together, the better off our families are going to be."
-Interview Participant

Appendix

Appendix A: Key Stakeholder Interview Summary of Findings

2019 DESERT HEALTHCARE DISTRICT MENTAL & BEHAVIORAL HEALTH NEEDS ASSESSMENT

KEY STAKEHOLDER INTERVIEWS SUMMARY OF FINDINGS

Prepared for:

Desert Healthcare District and Foundation

DESERT HEALTHCARE DISTRICT & FOUNDATION

Prepared by:

EVALCORP Research & Consulting

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Table of Contents

Introduction

The Desert Healthcare District & Foundation is conducting a needs assessment (NA) to inform strategies to enhance mental and behavioral health service provision across the Coachella Valley. The Desert Healthcare District & Foundation partnered with EVALCORP Research & Consulting to collect and analyze qualitative and quantitative data, and share information gathered for the NA. This report summarizes findings from interviews conducted with a diverse group of key stakeholders.

Methods

Key stakeholder interviews (KSIs) were conducted to gather information about the mental and behavioral health needs of Coachella Valley residents from a systems-level perspective. Interviewees were selected in collaboration with the Desert Healthcare District & Foundation Board of Directors and Staff. In total, 15 interviews were conducted. Participating interviewees represented the following:

1. Educators (e.g., K-12 administrators and teachers)
2. Providers (county agencies, community-based nonprofits, clinics, or community centers)
3. Medical Doctors
4. Workforce Development Specialists (e.g., recruitment for unfilled positions or staffing shortages, or to grow a workforce from high school into specific college or career pathways based on regional needs)

Interviewees provided information on: (1) mental and behavioral health priorities; (2) unmet mental and behavioral health needs; (3) gaps in access to and availability of service provision; (4) current efforts to address these priorities and challenges; and (5) recommendations and strategies for improving the mental and behavioral health of Coachella Valley residents.

Key stakeholders largely spoke from two perspectives: a systems-level focus on workforce and resource development or a focus on the individual, direct service needs of the communities and clients they serve. Interviewees often reflected on both of these perspectives and were not exclusive to their agency's purpose. Many of the interviewees had multiple roles. For example, teachers were not only educators, but often first responders in their schools when students experience mental/behavioral health crises. These two themes are highlighted throughout the report.

Report Organization

Following an overview of key stakeholders interviewed and who they serve, this report summarizes key findings and recommendations from the KSIs, with results from analyses of the interviews organized into four broad categories:

- **Mental and Behavioral Health Priorities and Contributing Factors**
- **Access to Care**
- **Current Efforts and Strengths**
- **Recommendations**

Selected quotes from interviewees that are relevant to key themes are included throughout the report.

Overview

Stakeholders were purposively sampled to represent a variety of sectors; populations served; and regions within the Coachella Valley. Stakeholders collectively provide coverage to all the regions of the Coachella Valley. Interviewees were asked to think about the current state of current mental and behavioral health service provision and 1) share their understanding of mental and behavioral health priorities in the Coachella Valley; 2) identify any unmet needs and gaps in service provision; and 3) provide feedback about how to best improve mental and behavioral healthcare in their communities.

Services Provided

When asked which mental and behavioral services are provided by their affiliated agency, stakeholders described their services primarily as direct service provision or as workforce development. Examples of direct service provision include:

- Mental health clinics
- Outpatient therapy (individual, couples, family)
- Mental and behavioral health assessments
- Case management
- Telepsychiatry
- Bereavement support groups
- Senior Socialization Programs
- Outreach to homeless and human trafficking survivors
- Crisis texting line
- Mental health counselors in K-12 schools
- Substance abuse counselors at high schools in the Coachella Valley Unified School District
- School-based trauma groups
- Student Assistance Program (SAP)

Examples of workforce development include capacity building and professional development for existing providers, mental and behavioral health academies/pathways in high schools and residency programs at local clinics/hospitals.

As part of their service delivery, many stakeholders and their agencies work toward reducing stigma among clients, teachers, students, parents, and in the community overall.

Communities Served

Stakeholders interviewed serve a wide array of community members from children (0-5) to older adults (65+). Some stakeholders also work with vulnerable populations including people experiencing homelessness, asylum seekers/undocumented immigrants, LGBTQ+, substance users, and survivors of abuse.

Those serving students work in largely Hispanic/Latino districts with large English Language Learner (ELL) populations where the majority of students are receiving free/reduced lunch and may be living in poverty or economic insecurity. Many educators are experienced working with vulnerable populations such as students who identify as LGBTQ+, live in the foster system, or are experiencing homelessness.

> "…next year 90% of our students will be English Language Learners (ELL), living in poverty, foster [care], or homeless."
>
> *– K-12 Educator*

Mental and Behavioral Health Priorities

The mental and behavioral health priorities described by key stakeholders are listed below in the following two categories: Mental and Behavioral Health Conditions and System-Level Needs.

Mental and Behavioral Health Conditions

- Depression (n=6)
- Anxiety (n=6)
- Suicide/self-harm behaviors (n=5)
- Isolation (n=3)
- Stress/stress management (n=3)
- Substance Abuse (n=2)
- General behavioral health (n=2) (i.e., ADHD)
- Trauma/abuse/neglect (n=2)

"…local students in college…the vast majority are describing that they are significantly stressed and experiencing anxiety and depression."
– Workforce Development

"…there is a tremendous issue with isolation and depression…this is particularly true of LGBT who are aging, they are aging without a generation behind them to care for them as they get older because many didn't have children, they have families of choice."
– Medical Doctor

Interviewees also identified factors that contribute to poor mental and behavioral health including poverty, a lack of coping skills, poor nutrition, inadequate sleep and exercise, and the effects of chronic pain and declining health.

"Of course, nutrition plays a major role in our mood... If we want to tackle something as big and important as mental health, we have to look at it from every angle."
K-12 Educator

System-Level Needs

- Access to care (n= 8) (i.e., psychiatry, follow-up, in-patient)
- Mental/behavioral health education in schools (n=2)
- LGBT and transitional age youth (TAY) specific services/resources (n=2)
- Mental/behavioral health education to primary care providers (n=1)
- Medication Assisted Treatment for substance abuse (n=1)

"We have to have conversations about mental health, stigma reduction, and suicide prevention..."
– Provider

"We have recently opened a mental health urgent care in Palm Springs that also offers services for youth as low as 13 years of age, but there is still a gap for youth 12 and under…"
– Provider

Contributing Factors

Stakeholders shared factors that they perceived to contribute to or exacerbate mental and behavioral health conditions or needs. More than half of all interviewees (9 out of 15) expressed concern about the economic situations of their students, clients, and their families, because it affects their mental and behavioral health and their ability to access care. They also indicated that access to care including awareness of available resources and how to access them, transportation, and insurance coverage is a factor (n=9).

One-third (5 out of 15) of all interviewees contributed mental and behavioral health conditions in part to poor overall health -- including high levels of stress, chronic health conditions, and/or poor nutrition habits.

"…the vast majority qualify for free/reduced lunch… food, housing, and financial insecurity… family instability, all of those things contribute…"
– Workforce Development

Two interviewees shared that Hispanic/Latino cultural beliefs regarding mental health can create significant barriers to addressing concerns early. These cultural beliefs include a hesitance to share what are considered private concerns from a cultural perspective, a resistance or refusal to ask for help for these concerns, and potentially being labeled as 'crazy' as a result of seeking treatment. Bullying (n=2), social media (n=1), homelessness (n=1), and substance use (n=1) were also indicated as factors.

"…the parents are doing their best, but they're at the bottom of Maslow's hierarchy."
– Educator

"If we could address poverty issues, a lot of mental health issues would also be resolved."
– Provider

Access to Care

Interviewees were asked to describe how accessible they felt mental and behavioral health care was in their communities. There are resources to address mental and behavioral health in the Coachella Valley, however, stakeholders illustrated that infrastructure to properly connect individuals to care is inadequate.

The top barriers to accessing care identified by interviewees are listed below.

- Transportation (n=7)
- Cost/Insurance Coverage (n=7)
- Accessibility (n=6)
    - Wait times, hours of operation, geographic location of services
- Stigma/Cultural beliefs about seeking care (n=5)
- Limited Numbers of Providers (n=5)
- Lack of Knowledge (n=3)
    - Where to go and how to access services
- Fear (n=1)

> "They [services] are accessible, but you have to go searching for them."
> *– Provider*

> "...we have populations out here, asylum seekers and populations that are undocumented...they need the services, but they don't want to access them out of fear."
> *– Provider*

Transportation was mentioned as a top barrier to care. Without access to a vehicle, the size of the Coachella Valley, a limited number of providers, and poor public transit makes for long journeys to healthcare sites. The transportation barrier is fueled in part by two other barriers; namely, the limited number of providers and where services are located.

Cost of services or poor insurance coverage is also a barrier affecting families from the poorest households to middle income homes. Additional barriers include stigma or cultural beliefs regarding mental and behavioral health, especially from Hispanic/Latino parents or those in the Hispanic/Latino community.

Lack of knowledge of available services and how to access them is also a barrier for residents when seeking care for their mental and behavioral health. Additionally, interviewees stated that if access to resources and services were improved, then providers' capacity to serve community members would be further overwhelmed.

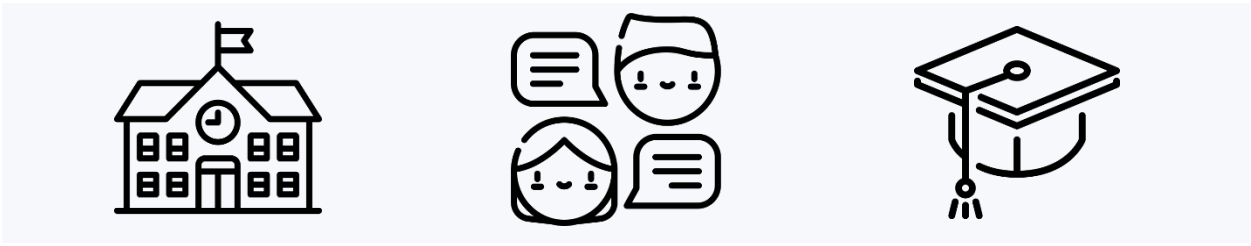
> "There are services available, but the awareness that they're available is not high enough...if the awareness were higher, the shortage of mental health staff that we already have would be exacerbated."
> *– Educator*

Current Efforts and Strengths

Interviewees were asked about the efforts they are currently engaged in to address the mental and behavioral health concerns they identified across the Coachella Valley. Many of the interviewees are part of agencies that are working toward addressing a severe shortage of mental and behavioral health services in the region. Their efforts address two facets of the issue: workforce development and direct service provision, including fostering individual resiliency in youth.

Workforce development efforts focus on creating career pathways in high schools and on physician recruitment. In an effort to expand direct service provision, provider agencies are placing therapists in schools and other community sites, and offering services outside of traditional hours and settings.

Educators are working on building resiliency in their students, recognizing their immense need for support and services, by teaching them about emotional self-regulation, providing them with the necessary tools to cope with adverse experiences, and connecting them to available resources.



Strengths as Providers of Mental and Behavioral Health Services

Stakeholders described what they perceive as their agencies' greatest strengths and assets in addressing mental and behavioral health needs. Many of the services provided are either free or offered on a sliding scale; they are also available during nontraditional hours such as during nights and weekends.

They have also worked diligently to create connections and to build trust in the communities they serve by providing culturally competent services, engaging in outreach to vulnerable populations such as LGBTQ+ and undocumented populations, and by being affiliated with trusted institutions like local school districts.

Additionally, service providers are continually working to evolve and meet emerging needs through a number of mechanisms including providing clients with pragmatic and evidence-based coping tools, offering alternative behavioral health interventions such as utilizing restorative justice, or Positive Behavioral Intervention Services (PBIS) at school sites, or through providing professional development to staff.

Finally, many agencies have support from local elected officials and governing boards that are knowledgeable about the need for services, and are dedicated and engaged in efforts to ensure access for all residents.

Recommendations

Four primary recommendations were identified by key stakeholders for strengthening mental and behavioral health service provision. Suggested strategies for addressing each recommendation were also provided by stakeholders, along with illustrative quotes highlighting interviewees' perspectives.

Recommendation 1: Maximize & Expand Resources

Interviewees emphasized the importance of maximizing and/or enhancing access to services through a number of strategies including increasing locations, hours of operation, and transportation options.

- Increase funding for mental and behavioral health services.
- Utilize technology, such as texting, to better reach youth and young adult populations.
- Improve interagency collaboration and integration between county services and local nonprofit providers.
- Expand the number of county mental health clinics to improve access to low cost services.
- Scale successful programs and services such as Positive Behavioral Intervention Services (PBIS) and Mental Health First Aid (MHFA).
- Offer local inpatient treatment particularly for adolescents, dual diagnosis, and those experiencing homelessness.
- Provide clinical service offerings for children and youth.
- Provide accessible LGBTQ+ youth services and safe spaces.

> "There are limitations with telepsych because they only see adults and the one in-house psychiatrist only sees children over 12."
>
> *– Community Provider*

Recommendation 2: Education & Outreach

Stakeholders agreed that educating the community and primary care providers about mental and behavioral health, available resources, and how to access them is an essential piece to addressing mental and behavioral health concerns across the Coachella Valley.

- Train primary care providers to increase their knowledge about available services and how to refer to them.
- Educate parents about mental and behavioral health to increase their awareness about available resources, and to break down cultural barriers and stigma.
- Provide education to youth and young adults so that they are aware of what mental and behavioral health is, how to maintain it, and how and where to seek care when needed.
- Meet families where they are by sending mental health workers into the community to conduct outreach, and to provide services in nontraditional settings such as schools and community centers.

> "I don't think there is stigma talking to people, they [youth] want to understand their feelings."
>
> *– Educator*

Recommendation 3: Professional Development

Interviewees expressed a need for professional development for a broad range of community members and service providers.

- Create a training and intervention curriculum, such as MHFA, for youth under 18. Stakeholders states that peer to peer networks are proven to be extremely successful, and may be a preferred point of entry to seeking assistance.
- Train providers such as psychiatrists, psychologists, and therapists in evidence-based treatment modalities that may be more effective during a shorter intervention period.
- Ensure all educators are equipped with the necessary knowledge, tools, and interventions to refer students to appropriate services or address a mental health crisis if need be.
- Provide cultural competency training to service providers.

"I am trying to get a program that I can teach to my kids so that maybe these kids can identify these needs before it becomes a crisis."

– Educator

Recommendation 4: Workforce Development

Stakeholders feel that there is a lack of providers in their communities. While this could be addressed by incentivizing practitioners to move into the area, it is also critical that the future workforce is "homegrown" and familiar with the communities they work in.

- Continue to expand mental and behavioral health pathways and academies in high schools.
- Increase paid internship opportunities in the Coachella Valley for students working toward their credential (i.e., MSW, LMFT).
- Offer loan repayment to incentivize practitioners to move to or stay in the Coachella Valley.
- Hire practitioners that are linguistically competent (e.g., Spanish, indigenous)

"It is important to maintain qualified home-grown folks because it helps with trust as well in the community."

– Provider

Conclusion

Interview findings revealed that there are multiple agencies across sectors working to address the mental and behavioral health needs of Coachella Valley residents. Although limited in number, these agencies and their employees are working hard to fulfill the many and diverse needs of persons with mental and behavioral health concerns.

These highly motivated key stakeholders have immense support across the valley from community members to policymakers. Still, current efforts are insufficient and recommendations with related strategies that were provided by key stakeholders are meant to fill gaps in current service provision through an informed and collaborative approach.

> "It is going to take a concerted effort on all of our parts to meet the needs of the community. The more we work together the better off our families are going to be."
> *– Community Provider*

2019 DESERT HEALTHCARE DISTRICT MENTAL & BEHAVIORAL HEALTH NEEDS ASSESSMENT

PROVIDER SURVEY
SUMMARY OF FINDINGS

Prepared for:

Desert Healthcare District and Foundation

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Prepared by:

EVALCORP Research & Consulting

EVALCORP
Research & Consulting

Table of Contents

Introduction

As part of a comprehensive valley-wide assessment initiative, EVALCORP Research and Consulting worked in collaboration with Desert Healthcare District & Foundation to develop and conduct a Provider Survey. The survey was designed for agencies and their staff who work with populations in need of mental and behavioral health services. The purpose of the survey was to obtain providers' perspectives and experiences regarding priority mental and behavioral health needs, and the availability and provision of mental and behavioral health services throughout the Coachella Valley. Recommendations for improving mental and behavioral health service delivery were also collected from providers. Key findings are summarized in this report.

Methods

The Provider Survey was developed and administered online by EVALCORP during May 2019 to multiple agencies that assist community members with their mental and behavioral health needs. The survey was distributed to a wide range of county, private, and non-profit agencies who serve residents of the Coachella Valley. During the two-week survey administration timeframe, a total of 73 responses were collected and used for analysis.

Respondent characteristics and key survey findings are outlined in the summary below.

Respondent Characteristics

Survey respondents were asked to share information regarding their title, agency, region(s) served, and the primary populations they work with.

Table 1 details the number of respondents from each agency/organization type; note that respondents were asked to indicate more than one agency type if applicable.

Table 1. Number of Respondents by Agency/Organization (n=73)

Agency Type	n
Ambulatory Care	8
Community College/College/University	3
Federally Qualified Health Center (FQHC)	9
Hospital/Medical Offices/RUHS	16
Human Services Agency	8
K-12 Education	15
Law Enforcement/Probation	3
Public Health	5
Private Providers	4
Substance Use Treatment	7
Other*	14

*Other agencies (n=14) include nonprofit agencies, retired elected officials, care providers for patients with HIV, and county contracted providers.

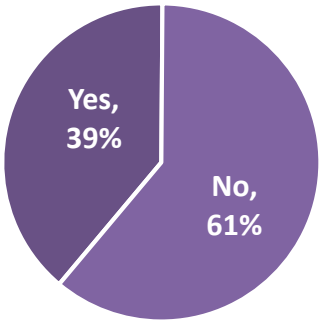
Survey respondents were asked to share information regarding their role/title and were asked to select more than role if applicable (**Table 2**). They were also asked which region(s) their agencies serve within the community and whether services were provided beyond the traditional setting/hours (e.g., Monday-Friday, 9:00am-5:00pm) (**Figure 1** and **Table 3**).

Table 2. Survey Respondent Role (n=73)

	Count
Role	n
Administrator	7
Case Worker	6
Clinical Director/Assistant Director	5
Community Health Worker	2
Counselor/Therapist (MFT, LPCC)	14
Educator	7
Law Enforcement	2
Management/CEO	7
Nurse (RN, LPN, LVN)	2
Paramedic	0
Physician (MD, NP)	5
Psychologist	2
School Counselor	5
Social Worker	6
Other*	9

*Other roles interviewees hold included housing navigator, lawyer, and peer support specialist.

Figure 1. Services Outside of the Traditional Setting (n=71)



Similar to the questions about their agency and role, respondents were asked to select more than one region served if applicable.

Table 3. Regions Served (n=73)

	Count	Percentage
City Served	**n**	**%**
Bermuda Dunes	32	44%
Blythe	4	6%
Cathedral City	51	70%
Coachella	37	51%
Desert Edge	16	22%
Desert Hot Springs	49	67%
Indian Wells	36	49%
Indio	41	56%
La Quinta	39	53%
Mecca	28	38%
North Shore	21	29%
Oasis	21	29%
Palm Desert	44	60%
Palm Springs	56	77%
Rancho Mirage	46	63%
Sky Valley	23	32%
Thermal	28	38%
Thousand Palms	43	59%
Vista Santa Rosa	13	18%
Other	10	14%

Respondents that selected other indicated that they served regions outside of the Coachella Valley including Imperial County, San Bernardino County, Orange County, and Riverside County at large.

Survey respondents were asked to indicate which populations (age groups and vulnerable populations) they work with most frequently (**Figure 2** and **Figure 3**). Respondents could indicate more than one population. More than half of all respondents work with adults (69%) and/or LGBTQ+ (62%).

Figure 2. Frequently Worked with Age Groups (n=73)

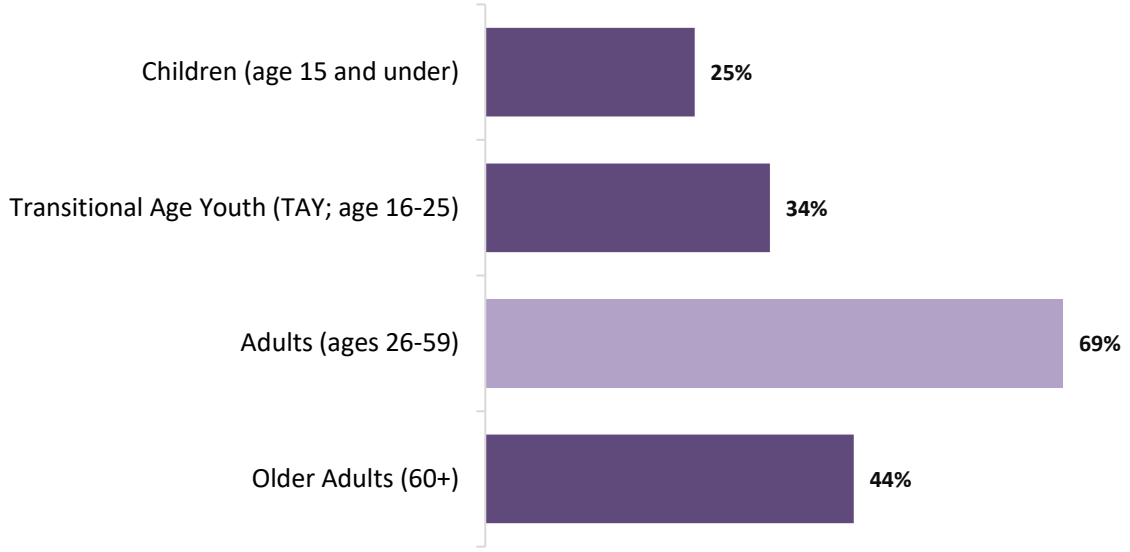
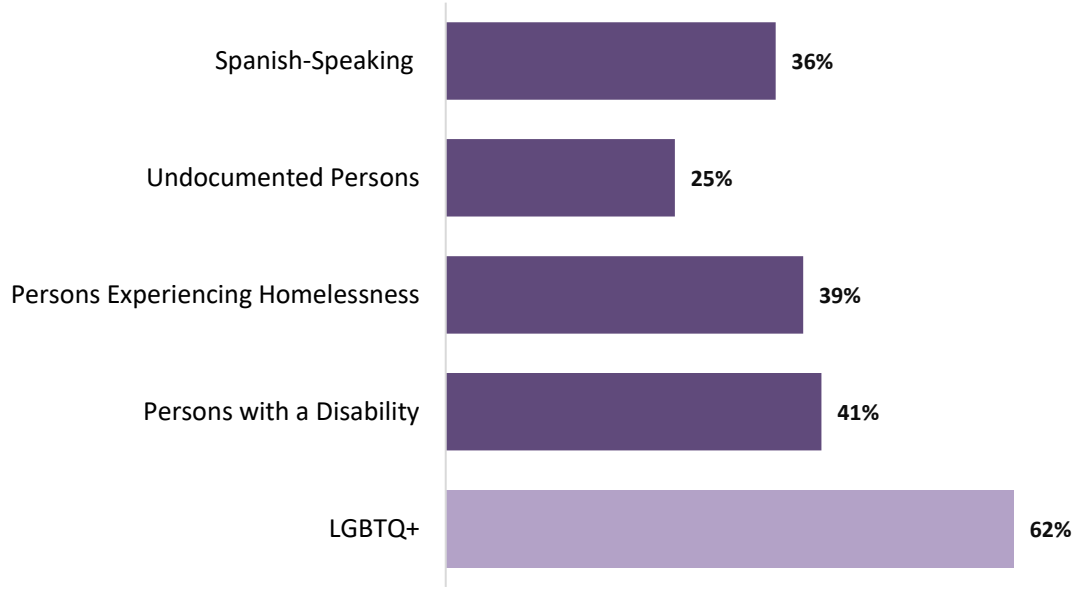


Figure 3. Frequently Worked With Vulnerable Populations (n=73)



Only one respondent indicated that they served “none of the above” vulnerable populations. An additional four identified other populations including those living with HIV (n=2) and Veterans (n=1).

Key Findings

The following pages summarize responses relative to: 1) unmet mental and behavioral health needs; 2) whether those in need of mental or behavioral health services can access them; and 3) which populations were in greatest need of mental and behavioral health services.

Unmet Mental and Behavioral Health Needs

Respondents were asked to rate the amount of additional support or resources that are needed to address a variety of mental and behavioral health issues (**Table 4**).

Table 4. Need for Additional Support/Resources (n=73)

	None	Some	A Lot	Not Sure
ADD/ADHD	4%	51%	33%	12%
Alcoholism/Substance Use	3%	14%	83%	0%
Anxiety	0%	25%	75%	0%
Bullying	4%	39%	49%	8%
Chronic Stress	1%	37%	62%	0%
Depression	1%	15%	84%	0%
Homelessness	0%	15%	79%	6%
Thoughts of Suicide	0%	23%	71%	6%
Trauma	0%	29%	70%	1%

The majority of respondents felt that there needs to be at least some additional resources or support directed to each of the above mental and behavioral health needs. Four respondents also identified additional issues including anger management, PTSD/survivor syndrome, family violence, and LGBTQ+. For these four issues stated above, each respondent indicated “A Lot” of additional support/resources are required to address the current need.

Respondents were asked to indicate what they felt were the top unmet needs in the Coachella Valley. Of those surveyed, 62 provided a response and indicated up to three unmet needs. Responses were split into two categories: individual well-being and service provision.

Individual Well-being

- Substance use disorders (n=22)
    - Dual diagnosis (dual diagnosis of substance use and mental illness), sober living, affordable treatment
- Homelessness (n=13)
    - Housing, mental health, substance abuse treatment for persons experiencing homelessness
- Depression (n=10)
- Suicidal Ideation/Self-harm behaviors (n=8)
- Anxiety/Stress (n=6)
- Trauma (n=4)

" The lack of understanding of African-Americans and the distrust between mental health providers and their trauma [is an unmet need]."

- Stigma (n=3)
- Isolation/grief/loss (n=3)
- Anger management (n=3)

Other needs included bullying (n=1).

Service Provision

- Accessibility (n=24)
    - Transportation (n=7)
    - Services available during nontraditional hours/in nontraditional settings (n=5)
    - Geographically convenient locations (n=4)
    - Low cost/affordable services (including for Medi-Cal, un/underinsured) (n=8)
- Service provision (n=22)
    - Triage, increasing county mental health locations, outpatient, preventative care, crisis services, inpatient treatment, youth specific care
- Education/awareness (n=14)
    - Community members: reduce stigma, educate about mental and behavioral health conditions and available resources (n=9)
    - Providers: educate about available resources (n=5)
- Timely access (n=12)
    - Reduce wait times, increase walk-in availability
- Culturally competent providers (n=8)
    - HIV, bilingual, LGBTQ+
- Lack of providers (n=6)

"Availability of culturally competent mental health care for long-term HIV survivors (mostly LGBT) [is an unmet need]."

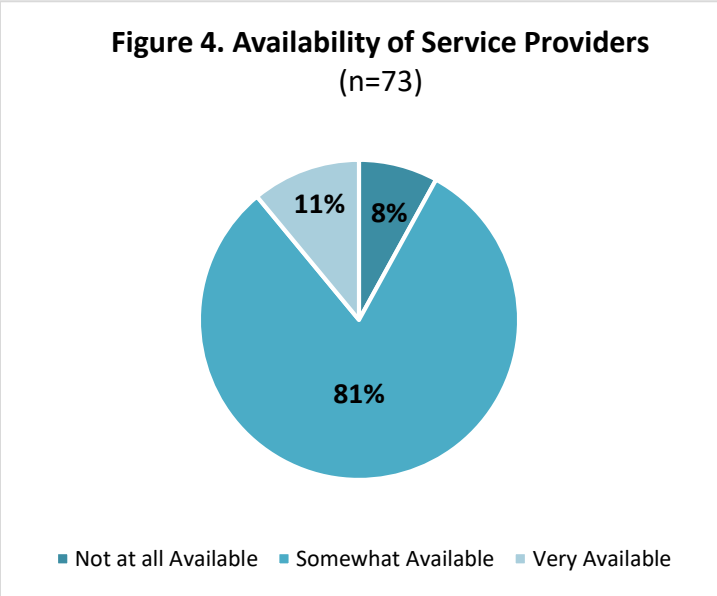
"… primary care providers are the first line of defense. The average person is more likely to go to their primary rather than seek psychotherapy or psychiatry services directly. If primary care providers don't understand the benefits of these services, the specialties, or the local providers and allies, then we miss out on getting the patient the support they need."

"Access [to] mental health services/professionals during nontraditional hours and in nontraditional locations [is a top need]."

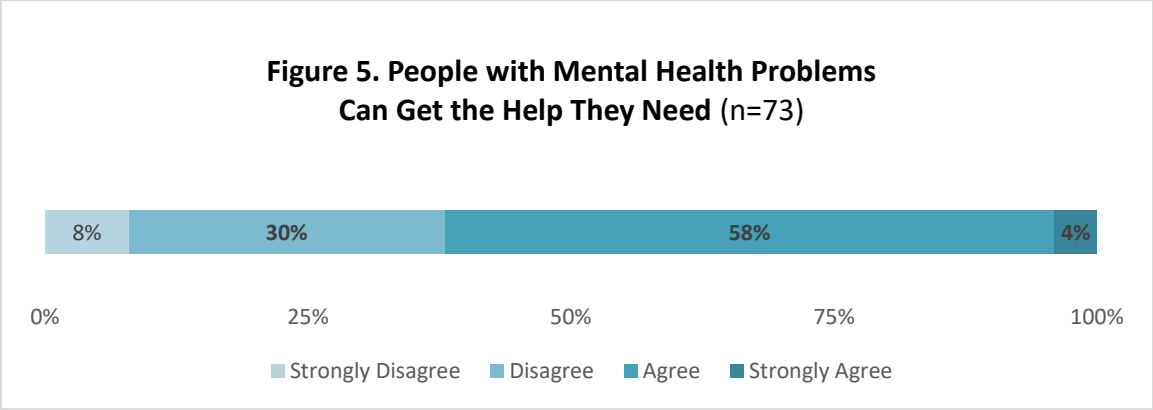
"Our organization cannot wait 30 days for an appointment if participants are presenting with manic symptoms or have a reaction to a previously prescribed medication."

Access to Care

The majority of respondents felt that mental and behavioral health service providers were somewhat available in the communities they serve (**Figure 4**).



More than half of respondents agreed or strongly agreed that people with mental health problems in their communities can receive the help they need (**Figure 5**).



Survey respondents were asked to rate available mental and behavioral health services relative to eight components (**Table 5**).

Table 5. Assessment of Available Mental and Behavioral Health Services (n=73)					
	Poor	**Fair**	**Good**	**Excellent**	**Not Sure**
Availability of appointments	33%	37%	23%	3%	4%
Capacity (sufficient beds/staff)	52%	33%	7%	1%	7%
Cultural competency of staff	12%	26%	40%	12%	10%
Hours of operation	12%	36%	40%	5%	7%
Materials are available in appropriate languages	7%	27%	34%	11%	21%
Services are available in appropriate languages	12%	30%	26%	11%	21%
Wait times in lobby to see provider	12%	30%	28%	4%	26%
Walk-in availability	51%	20%	11%	3%	15%

The two most poorly rated aspects of service provision were capacity (52%) and walk-in availability (51%). Approximately half of respondents selected either good or excellent for cultural competency of staff, hours of operation, and availability of materials in appropriate languages (52%, 45%, and 45% respectively).

Table 6. Barriers to Accessing Care/Resources (n=72)					
	Not a Barrier	**Minor Barrier**	**Somewhat of a Barrier**	**Major Barrier**	**Not Sure**
Availability of services	4%	7%	42%	47%	0%
Client knowledge of available services	4%	6%	37%	53%	0%
Insurance coverage/cost	1%	16%	29%	54%	0%
Lack of Childcare	1%	7%	36%	28%	28%
Lack of culturally appropriate services	8%	20%	31%	30%	11%
Language assistance	7%	26%	34%	19%	14%
Location of services	4%	17%	40%	35%	4%
Staff qualifications/skills	20%	29%	22%	14%	15%
Transportation	3%	9%	26%	55%	7%

The top three major barriers to accessing mental and behavioral health care and resources identified were transportation (55%), insurance coverage/cost (54%), and client knowledge of available services (53%). Only two barriers had less than 25% of respondents indicating they were a major barrier: language assistance (19%) and staff qualifications/skills (14%).

Only one respondent indicated an additional barrier related to how services are delivered, and stated, “The way services are provided…15 minutes to talk to someone to gauge meds doesn’t help anyone. There’s more than medication that can help a person dealing with these challenges.” The respondent identified this as a ‘major barrier.’

Populations in Need

Those surveyed were asked specifically which populations were in greatest need of mental and behavioral health services by 1) vulnerable population, 2) race/ethnicity, and 3) age group.

Table 7. Need for Mental and Behavioral Health Services by Vulnerable Population (n=73)				
	Low	**Moderate**	**High**	**Not Sure**
LGBTQ+	7%	21%	64%	8%
Persons with Disabilities	8%	33%	51%	8%
Persons Experiencing Homelessness	6%	16%	75%	3%
Persons that are Undocumented	12%	22%	47%	19%
Spanish-Speaking	7%	35%	46%	12%

Some respondents selected an additional vulnerable population; responses included veterans (n=2), previously incarcerated individuals (n=1), HIV survivors (n=1), uninsured populations (n=1), and those with substance use issues (n=1). Of these seven coded responses, all but one rated the need for mental and behavioral health services as 'High'.

In order to inform Desert Healthcare District & Foundation's approach to address existing health disparities among racial minorities, respondents were asked to identify the level of need for each of the racial/ethnic groups below. Mental and behavioral health needs are often adversely impacted by lived experiences and external factors such as immigration status, systematic racism, and generational trauma.

Table 8. Need for Mental and Behavioral Health Services by Racial/Ethnic Group (n=73)				
	Low	**Moderate**	**High**	**Not Sure**
African American/Black	3%	33%	47%	17%
Asian American/Pacific Islander	22%	36%	17%	25%
Hispanic/Latino	3%	28%	61%	8%
Native American/Alaskan Native	14%	33%	28%	25%
White	7%	35%	47%	11%

Additionally, three respondents included mixed-race and rated their need for mental and behavioral health services as 'High'.

Table 9. Need for Mental and Behavioral Health Services by Age Group (n=73)				
	Low	**Moderate**	**High**	**Not Sure**
Children (age 15 and younger)	12%	32%	38%	18%
TAY (age 16-25)	11%	18%	60%	11%
Adults (age 26-59)	3%	31%	56%	10%
Older Adults (60+)	6%	26%	52%	16%

Transitional age youth, otherwise known as TAY, had the highest percentage of respondents indicating their need for mental and behavioral health services as 'high' (60%).

Recommendations

Respondents were asked to provide suggestions as to how they would improve the provision of mental and behavioral health services in the Coachella Valley. Of those surveyed, 56 provided a response. Many responses were about expanding current services and increasing interagency collaboration to improve coverage across the Valley.

- Additional Services (n=44)
  - Increase providers and staff (psychiatrists and bilingual) (n=9)
  - Provide homeless services (n=7)
  - Provide same day/walk-in services (n=7)
  - Increase overall accessibility
  - (e.g. additional service locations) (n=5)
  - Increase funding; more equitable funding (n=4)
  - Provide crisis services (youth, inpatient, field teams) (n=4)
  - Open mental health hospitals/inpatient care facilities (n=4)
  - Expand school-based services (n=4)
- Services in nontraditional settings during nontraditional times such as field work, home visits, community outreach/case management (n=10)
- Provide affordable care/coverage including financial assistance, improved coverage for those with health insurance, and low cost or free services for those without health insurance (n=8)
- Transportation (n=5)
- Offer detox/substance abuse treatment that is low cost, dual diagnosis, non-faith based (n=5)
- Incentives to bring or keep providers in the area (n=4)

"County needs to reallocate funds from West Riverside County to Coachella Valley. Their 5-year plan is heavily weighted on programs that do not meet the needs of the Coachella Valley community. They get funding for us, but don't invest in us."

"Provide incentives for behavioral health professionals to practice in the Inland Empire."

Additional responses included stigma reduction (n=4), streamlining current processes for intake and referrals (n=3), cultural competency training for providers (n=2), a greater focus on prevention (n=2), peer navigation (n=1), refocusing on other care modalities (n=1), and an informational hotline (n=1).

"[I recommend] programs pitched as personal wellness programs rather than mental health service because it will minimize the stigma and encourage self-awareness and self-care as ways of combatting barriers."

"Develop a peer component to help consumers navigate systems of care."

"Talk therapy would go a long way in making improvements with the community. A lot of people just need someone to talk to and not just given meds and brush aside."

"[Offer] cultural sensitivity classes pertaining to ALL ethnic groups. This will aid in the elimination of health disparities, bridge the gap, and help to rebuild the trust in healthcare providers."

Conclusion

Provider Survey findings revealed that the Coachella Valley is in need of additional resources to address current mental and behavioral health needs. The majority of respondents indicated that services are somewhat available (81%), but access to services is limited by barriers such as poor client knowledge of available services, cost of care, and transportation to services. Capacity issues, such as the inability to meet the demand for services and limited appointment availability, further compound access issues. Additionally, vulnerable populations, such as undocumented individuals, minorities, and youth, are in particularly high need of services. Providers indicated that improved inter-agency collaboration to expand upon current services would enhance service provision and increase access to services by residents of the Coachella Valley.

Appendix C: Focus Group Summary of Findings

2019 DESERT HEALTHCARE DISTRICT MENTAL & BEHAVIORAL HEALTH NEEDS ASSESSMENT

FOCUS GROUP SUMMARY OF FINDINGS

Prepared for:

Desert Healthcare District and Foundation

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Prepared by:

EVALCORP Research & Consulting

EVALCORP
Research & Consulting

Table of Contents

Introduction

As part of an ongoing needs assessment (NA) to inform strategies to enhance mental and behavioral health service provision across the Coachella Valley, the Desert Healthcare District & Foundation partnered with EVALCORP Research & Consulting to conduct and analyze a series of focus groups. This report summarizes findings from focus groups conducted with a diverse group of community members.

Methods

Focus groups were conducted to assess the current need for mental and behavioral health services by community members and how the Desert Healthcare District & Foundation can better address needs within the Coachella Valley. All focus groups used a semi-structured protocol (see **Appendix**) and were facilitated in Spanish or English. Focus groups were purposively sampled to represent a variety of ages from youth to older adults, race/ethnicities, and regions of the Coachella Valley. Five focus groups were successfully conducted with a total of 48 participants in attendance among the five sessions. **Table 1** provides further details about each of the focus groups.

Table 1. Focus Groups Completed

Focus Group Type	# Participants	Location	Language
Community Health Worker Focus Group	9	Desert AIDs Project	English
Older Adult Focus Group	15	Jewish Family Services (JFS)	English
Parent Focus Group	9	PSUSD Family Center	Spanish
Transitional Age Youth (TAY) Focus Group	11	Desert FLOW	English
Youth Focus Group	4	Indio Mental Health Clinic	English

The following sections summarize participant demographics and key focus group findings, including participants' perspectives around mental and behavioral health needs and contributing factors, access to care, and recommendations for improving mental health service delivery.

Participant Demographics

Attendees were asked to share information regarding their age, gender, and race/ethnicity by completing a short evaluation form after each focus group. **Table 2** details participant demographics.

Table 2. Focus Group Participant Demographics

	Percentage
Gender	**n=48**
Female	75%
Male	21%
Transgender	2%
Gender non-conforming	2%
Age	**n=48**
12-14	2%
15-17	6%
18-25	23%
26-34	4%
35-49	21%
50-64	13%
65+	31%
Race/Ethnicity	**n=48**
Hispanic/Latino	48%
White/Caucasian	33%
Black/African American	11%
Multi-racial	4%
Asian or Pacific Islander	4%
American Indian or Alaska Native	0%

Mental and Behavioral Health Needs & Contributing Factors

The following section summarizes mental and behavioral health needs and contributing factors that emerged during focus group sessions.

Pressing Needs

Participants were asked about the most pressing mental and behavioral health concerns of residents in the Coachella Valley. Across groups, participants mentioned the following needs:

Mental and Behavioral Health Needs

- Depression
- Anxiety
- Eating disorders
- Anger
- Self-medicating/Substance abuse/overmedication
- Loneliness
- Homelessness
- Bullying

"Distributing medications when they are not needed or there are other coping mechanisms. It's very dangerous…[people] can get addicted to these when they might not even need them."

Focus group participants shared that some groups were more likely to be affected by mental and behavioral health including people who are undocumented, Transition Age Youth (TAY), Veterans, and people experiencing homelessness.

Participants in all 5 groups expressed that stigma, and the lack of awareness and understanding about mental and behavioral health was also a concern. They also discussed how some sub-groups are more affected than others; in particular, how stigma has greater adverse effects for those in the Latino, African American/Black, and LGBTQ+ communities.

Older adults indicated that age discrimination was a concern as it kept them out of jobs and volunteer positions that could keep them engaged.

Pressing Mental and Behavioral Health Needs as Identified by Focus Group

Youth (n=4)	TAY (n=11)	Parents (n=9)	Older Adults (n=15)	Community Health Workers (n=9)
• Depression • Anxiety • Anger • Eating Disorders • Self-denial	• Lack of awareness • Self-medicating	• Lack of awareness • Substance abuse	• Homelessness • Substance abuse • Loneliness	• Bullying • Over-medication • Stigma

Causes of Poor Mental & Behavioral Health

Participants shared factors that they felt contributed to poor mental and behavioral health in the Coachella Valley. Causes included the stress of daily life such as work-life balance and increasing financial pressure; childhood trauma, neglect, and other negative experiences early in life and in the home; domestic violence; and substance abuse. Older adults expressed that loneliness was a major contributing factor to their poor mental health. Stigma and bullying came up frequently as important causes of poor mental and behavioral health and are discussed in more detail below

Stigma

> "[People in the Latino community] tend to not seek that kind of service because it means you are 'crazy'."

Issues related to culture and stigma came up. Focus group participants felt that cultural beliefs had a negative impact on mental and behavioral health. For example, cultural beliefs held in the Hispanic/Latino community prevent people from addressing mental and behavioral health due to the stigma associated with it (i.e. that you are 'crazy') or because it is not considered a valid component of overall well-being. In the Black/African American community, there is a macho mentality where needing mental health care is considered a sign of weakness. There were also perceptions among Black/African American participants that churches in their community dismiss mental and behavioral health concerns. Additionally, LGBTQ+ participants shared that the stigma they experience as a result of their sexual orientation and gender identity negatively impacts their mental and behavioral health (e.g. being disowned by their families, perceived bias from providers to receive services).

Bullying

Many participants indicated that bullying is a major problem across school districts and that it had an impact on the mental and behavioral health of students. They also expressed frustration at the lack of effective intervention on the part of the school, and that school staff often even contributed to bullying in the schools. Comments revealed that participants feel many of the schools do too little to address the root causes of bullying, despite having zero tolerance policies, and can even exacerbate bullying issues by leaving students to address issues (sometimes of safety) on their own.

In addition, focus group participants reported that some students are more likely to be punished by school bullying policies, such as the African American/Black community. Participants commented that in this community, there is a cultural expectation to fight back, which can get students in trouble when the zero tolerance bullying policies are enforced against them. In the TAY focus group, of the 11 participants, 9 stated that they had been bullied while in school and expressed concern about their overall safety and lack of security at their schools.

Causes of Poor Mental and Behavioral Health as Identified by Focus Group

Youth (n=4)	TAY (n=11)	Parents (n=9)	Older Adults (n=15)	Community Health Workers (n=9)
• Bullying • Culture • Childhood trauma • Pressure/Stress • Unstable family environment	• Bullying • Neglect at home • Trauma • Biological factors	• Bullying • Neglect at home • Domestic Violence • Poor school environment	• Stress • Loneliness	• Substance abuse • Stigma • No culturally competent providers • Poor access • Economic pressure on families

Access to Care

Each focus group was also asked to discuss their sources for mental and behavioral health information and their experiences with the availability of mental and behavioral health resources in the Coachella Valley.

Education about Mental and Behavioral Health Information

When asked how they and others in their community learned about mental and behavioral health, many focus group participants felt that most people were not very knowledgeable about the topics. Of participants who had been educated about mental and behavioral health, the majority indicated that they only became educated once they began receiving services at facilities like Jewish Family Services of the Desert (JFS), Riverside University Health System's Children's Mental Health Clinic in Indio, and the Desert FLOW Tay Center.

Other sources of education for participants were their schools (though many students said they did not pay attention during the presentations provided); the internet, including Google searches and the Riverside County website; and through their personal experience of having to navigate the mental and behavioral health system for themselves or their family. Additionally, one youth participant in the foster care system shared that she learned about mental and behavioral health through interactions with her social worker.

Awareness of Available Resources

Though there are a variety of resources available in the Coachella Valley to address mental and behavioral health, focus group participants were relatively unaware of them. Services that they were familiar with included:

Services Listed by Focus Group Participants

- Safehouse of the Desert
- Palm Springs Unified School District Family Center
- Barbara Sinatra Children's Center
- Desert AIDs Project
- Riverside University Health System (RUHS) Children's Clinic
- Jewish Family Services (JFS)
- Braille Institute
- Borrego Health
- Clinicas de Salud del Pueblo

Participants also mentioned that there are private practices, but that many services were costly.

Access to Available Resources

Focus group participants were asked to describe how accessible they feel mental and behavioral health care is in their communities. The majority of participants said they feel it is relatively hard to access services.

Older adults shared that JFS provides them with assistance and programming. They also stated that they could go to a primary care provider for a referral, but then mentioned that referrals were often costly because they are not covered by their insurance. Mental health appointments can also be hard to get to, given mobility issues and extreme heat in the summer months.

Mothers in the parent focus group stated that it was very hard for them to access services for their children and that they had to be insistent. They felt that this was in part because they were Latino and Spanish monolingual. They also felt that they faced immense bias and racism from providers. Additionally, they felt that they were unsupported by school administrators and their children's teachers.

"Parents have to be willing to be advocates but sometimes school personnel aren't doing their job either."

Participants further elaborated upon barriers that affected access to mental and behavioral health services. The barriers to accessing care identified by participants are listed below.

Barriers to Accessing Mental and Behavioral Health Services

- Transportation
- Stigma
- Insurance coverage/Cost
- Poor quality of care
- Overmedication
- Weather
- Geographic isolation
- Safety (LGBTQ+)
- Provider shortages; Lack of culturally competent providers
- Waitlists for appointments
- Language barriers/Lack of qualified culturally competent translators
- Eligibility for services
- Provider bias/Racism
- Fear

"My family does not really understand mental health…I guess we see it as a weakness to talk about it…"

"It is a disservice to give patients translators that aren't certified."

"There is fear, just asking for the services is a problem."

"There are a lot of barriers and road blocks to getting services because of the many layers of requirements."

Fear of accessing services was raised by a few different subgroups. Youth indicated they hesitated accessing services because they were fearful of being placed on a psychiatric hold. Older adults were fearful that if they asked for help, they would be given care at a higher level than they needed, or that

their independence would be taken from them. Finally, there is fear among people who are undocumented about deportation and becoming ineligible for citizenship if they utilize services.

Barriers to Accessing Mental and Behavioral Health Services as Identified by Focus Group

Youth (n=4)	TAY (n=11)	Parents (n=9)	Older Adults (n=15)	Community Health Workers (n=9)
• Stigma • Transportation • Insurance coverage • Cost of services	• Stigma • Poor quality of care • Language • Cost of services • Eligibility requirements • Lacking familial support • Self-denial • Fear • Overmedication	• Provider bias/Racism • Poor quality of care • Eligibility requirements	• Stigma • Transportation • Poor quality of care • Cost of services • Adverse weather • Fear • Limited providers	• Adverse weather • Transportation • Language • Eligibility requirements • No culturally competent providers/ interpreters • Provider shortages • Insurance coverage • Fear • Safety for LGBTQ+ • Geographic isolation

Recommendations

Four primary recommendations were identified by focus group participants for strengthening mental and behavioral health service provision in the Coachella Valley. Participants felt that efforts to address mental and behavioral health should be part of a community wide-effort and should be bolstered along the continuum of care for prevention, early intervention, and crisis services. Additional information and suggested strategies for addressing each recommendation are also provided below, along with illustrative quotes highlighting participant perspectives.

Recommendation 1: Increase Awareness

Participants emphasized the importance of educating the community about mental and behavioral health and the available resources in the community.

- Provide education and programming to parents about mental and behavioral health
- Engage lawmakers to ensure there is attention and funding dedicated to the issue
- Launch a social media campaign to raise awareness about mental and behavioral health in the community
- Advertise services in community spaces like local churches and libraries using a variety of mediums (e.g., billboards, flyers, radio, TV advertisements)
- Host a mental health fair at schools with local resources

> "The Department of Health needs to improve how they disseminate information about available resources and educational information about mental health topics."

Recommendation 2: Enhance School-based Resources

Participants expressed that enhancing school-based services and the training of school staff would be an important step in better addressing the mental and behavioral health needs of Coachella Valley Youth.

- Increase security at schools to ensure violence- and weapon-free campuses
- Provide education to school staff (teachers, administrator, and counselors) to better recognize mental and behavioral health signs and symptoms and to appropriately respond to student needs and concerns
- Offer peer training and advocacy
- Educate students on healthy coping behaviors
- Introduce effective mechanisms to reduce and better address bullying in schools
- Host specialists at school sites to provide services after school hours

> "The peer program that we have here [Desert FLOW] is a really great support system and I feel like that should be advocated around the schools."

Recommendation 3: Provider Training

Participants discussed the need to develop the competency of service providers in responding to and addressing mental and behavioral health needs.

- Provide training to first responders (e.g., police and other law enforcement) to better respond to individuals experiencing mental and behavioral health crises (e.g., Crisis Intervention Training)
- Improve the cultural competency of providers of sub-population needs including older adults and the LGBTQ+ community
- Provide trauma informed care education to all direct service providers, including first responders, to better meet the needs of veterans and the human trafficking population

"Trans issues need to be respected and providers need to receive training on them."

Recommendation 4: Improve Access

Participants provided numerous suggestions to improve access to mental and behavioral health services by residents.

- Offer low cost or free services
- Provide financial assistance to those who cannot afford services
- Increase transportation options by offering bus or Lyft vouchers, van services, or improving current services like the Sun Bus or IEHP medical transport
- Encourage services to do additional outreach and to offer services at community sites like senior centers and schools
- Open additional service locations for existing clinics and county provided services
- Increase providers in the Coachella Valley
- Provide scholarships to pay for education, training, and certification of providers

"Drivers should be more accommodating of people with mobility challenges, such as walkers."

Conclusion

Overall, focus group participants are concerned about the communities they live in and feel that there is more that can be done to address the mental and behavioral health needs of residents in the Coachella Valley. This is due, in part, to the many barriers they, and others, face when trying to receive services including eligibility requirements, transportation to services, and awareness of what services already exist in their communities.

There was relatively low awareness of available services among focus group participants, and their recommendations include educating the community about mental and behavioral health and the available resources, in addition to bolstering the knowledge of providers, educators, and first responders. They also suggest addressing two primary barriers that they face: cost and transportation.

Focus group participants were also positive about the changes they hope to see (and foster) as part of a community-wide effort in the Coachella Valley.

> "But I'm not scared. I don't care if I have to go outside and pass flyers or walk and talk with homeless people… we can form a group and help each other. It's not just about helping people in our PTA groups or committees; it's about helping everyone and sharing information that we have. We can make the difference."

Appendix D: Secondary Data Report

2019 DESERT HEALTHCARE DISTRICT MENTAL & BEHAVIORAL HEALTH NEEDS ASSESSMENT

SECONDARY DATA REPORT

Prepared for:

Desert Healthcare District and Foundation

DESERT HEALTHCARE
DISTRICT & FOUNDATION

Prepared by:

EVALCORP
Research & Consulting

Table of Contents

List of Tables and Figures

Tables

Figures

Introduction

EVALCORP Research and Consulting conducted a review and compilation of secondary data sources in order to inform the mental and behavioral health needs assessment of the Coachella Valley, initiated by the Desert Healthcare District & Foundation. A summary of the compiled secondary data is included in this report.

Methods

This report draws from multiple secondary data sources specific to the geographic areas served by the Desert Healthcare District & Foundation. When data specific to these zip codes and cities were not available, data sources that provide information at the County-level are reported. Sources used in this report reference data collected between 2013 to 2017 and are cited throughout the report, when appropriate. A full list of sources used in the report is provided below.

List of Secondary Data Sources

American Community Survey, 5-year estimates
California Department of Health Care Services (CDHCS) – Mental Health and Substance Use Disorder Services, California Involuntary Detentions Data Report
California Health Interview Survey (CHIS)
California Healthy Kids Survey (CHKS)
California Hospital Association
Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, CDC WONDER online database
Centers for Medicare and Medicaid Services (CMS)
Education Data Partnership
Office of Statewide Health Planning and Development (OSHPD)
Riverside County, Open Data Portal
Riverside University Health System – Behavioral Health (RUHS-BH)
Strategic Health Alliance Pursuing Equity (SHAPE) Riverside County, an initiative of the Riverside County Health Coalition

Demographic Overview

Demographic information from the U.S. Census Department's 2017 American Community Survey (5-year estimates) was extracted and compiled for the zip codes and cities served by the Desert Healthcare District & Foundation. The relevant zip codes and cities are listed in **Table 1**, below.

Table 1. Zip Codes and Cities Served by the Desert Healthcare District & Foundation

Zip Codes	City
92201	Indio
92203	Indio, Bermuda Dunes
92210	Indian Wells
92211	Palm Desert
92234	Cathedral City
92236	Coachella
92240	Desert Hot Springs
92241	Desert Hot Springs, Desert Edge, Sky Valley
92253	La Quinta
92254	Mecca, North Shore
92260	Palm Desert
92262	Palm Springs
92264	Palm Springs
92270	Rancho Mirage
92274	Thermal, Oasis, Vista Santa Rosa
92276	Thousand Palms

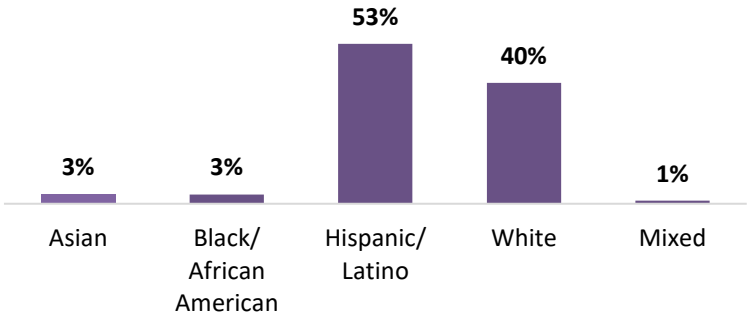
Demographic Data for Coachella Valley

443,101
Estimated population served by Desert Healthcare District

53%
of residents identify as Hispanic/Latino.

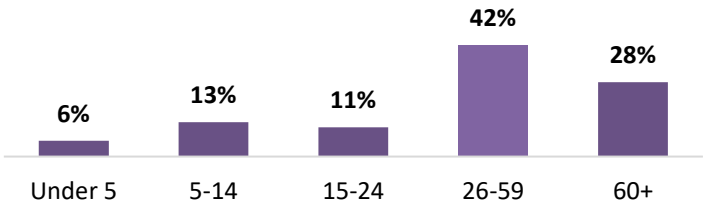
14% are Veterans

Race

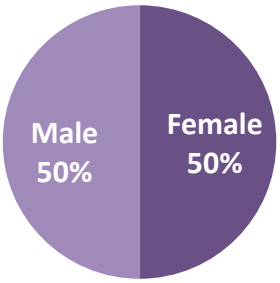


51% of community members speak English only.
40% of community members speak Spanish.

Age



Gender

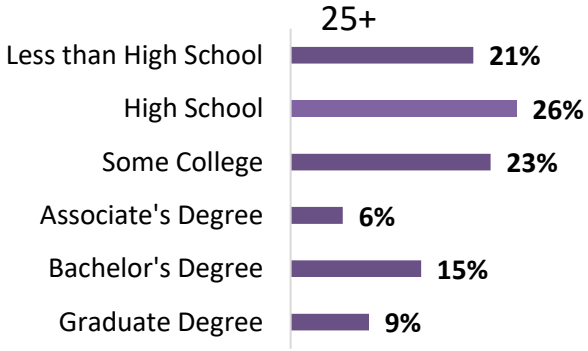


32% of individuals under 18 live below federal poverty level.
17% of individuals over 18 live below federal poverty level.

Total population for whom poverty status is determined: 440,865

19%
of households do not have internet access

Educational Attainment for Residents 25+



10% of the labor force (16 years and older) are unemployed.

9% of households receive food stamp/SNAP benefits.

Mental and Behavioral Health Needs

The following summarizes secondary data relevant to the mental and behavioral health needs in the Coachella Valley, for children and youth, as well as for adults. When secondary data specific to Coachella Valley zip codes were not available, Riverside County data are provided.

Children and Youth (Under 18)

Self-reported indicators from the California Healthy Kids Survey (CHKS) related to mental and behavioral health, substance use, and bullying and harassment are reported below for the Coachella, Desert Sands, and Palm Springs Unified School Districts (USD). Chronic sadness/hopelessness and harassment or bullying are top issues in all three districts.

Table 2. Mental/Behavioral Health, Substance Use, and Bullying/Harassment Indicators for Grades 7, 9, and 11 (CHKS)*

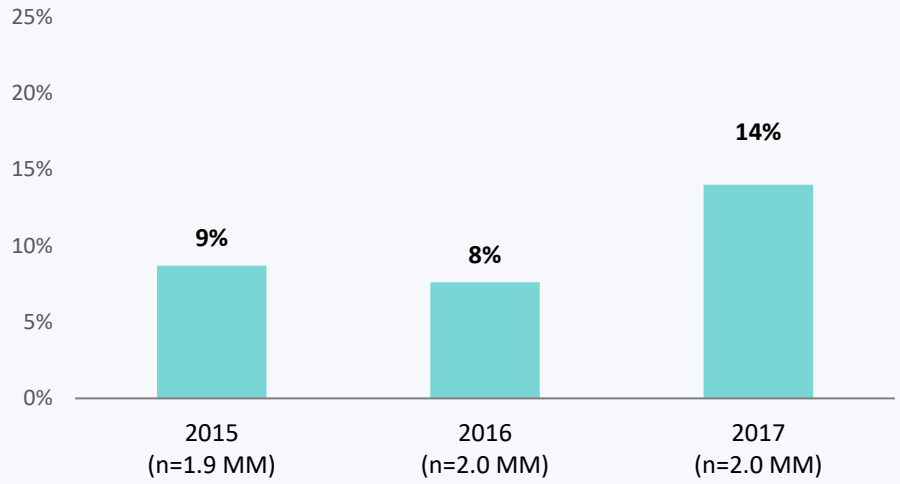
Indicator	Coachella USD (FY 17-18)	Desert Sands USD (FY 17-18)	Palm Springs USD (FY 15-16)
Total Enrollment for all students†	18,372	28,708	23,348
Experienced Chronic Sadness/Hopelessness, Past 12 Months	31%	33%	33%
Considered Suicide, Past 12 Months	14%	18%	19%
Any Current Alcohol or Drug Use, Past 30 Days	14%	14%	18%
Harassment or Bullying on School Property, for Any Reason, Past 12 Months	26%	34%	32%

* Percentages represent total average of self-reported data for grades 7, 9, and 11 in fiscal year shown.

† Enrollment data are for all students in the district for fiscal year shown and sourced from *Education Data Partnership*.

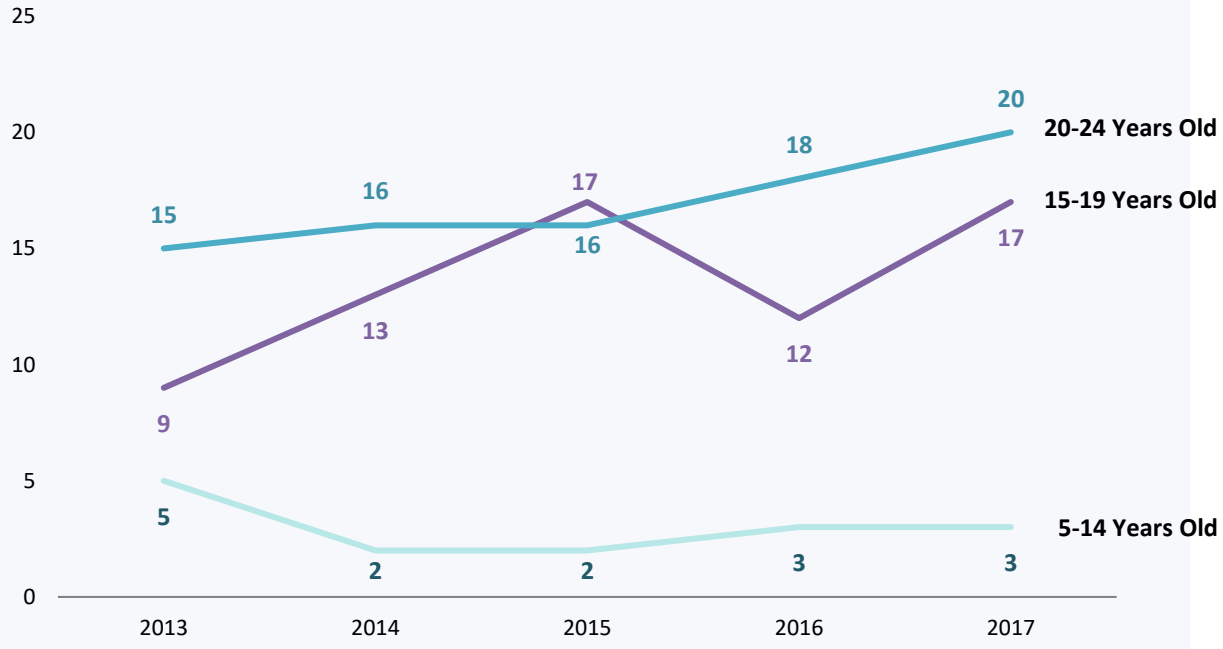
The California Health Interview Survey (CHIS) gathers self-reported data from youth ages 12-17 on mental and behavioral health characteristics at the county level. Stable estimates are available from 2015-2017 for teens in Riverside County who reported experiencing serious psychological distress within the past 12 months. A higher percentage of youth in 2017 reported experiencing psychological distress in the past 12 months compared to the previous two years (**Figure 1**).

Figure 1. Teens 12-17 years old in Riverside County that Have Experienced Serious Psychological Distress in the Past 12 Months (CHIS, 2015-2017)



County level data are also available on youth suicide rates from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics through the online CDC WONDER database. Trend data for Riverside County youth suicide deaths are shown in **Figure 2** below by age group.

Figure 2. Number of Deaths by Suicide Among Youth in Riverside County (CDC, 2013-2017)



Since 2013, there have been gradual increases in the number of deaths by suicide per year among youth 15-19 years old and youth ages 20-24 years old.

Adults (Ages 18+)

CHIS also collects self-reported data from adults 18 and older on mental and behavioral health characteristics. Four key mental and behavioral health indicators are described by CHIS as follows:

- **Serious psychological distress:** Adults ages 18+ who reported serious psychological distress in the past 12 months.
- **Family life impairment:** Adult respondents ages 18+ whose emotions interfered with their relationship with friends and/or family in past 12 months.
- **Needed help for mental health problems:** Adult respondents ages 18+ who needed help for emotional/mental or alcohol/drug problem in past 12 months.
- **Work impairment:** Adult respondents ages 18+ whose emotions interfered with work performance in past 12 months.

The four key mental and behavioral health indicators from 2014 are presented in **Table 3** at the state- and county-level. Also provided is information on these indicators across the five most populous cities in the Desert Healthcare District (see **Appendix A** for city-level data from each of the 18 cities within the Desert Healthcare District; the most recent data available at the city-level is from 2014).

Across city, county, and state-levels, percentages were consistently the highest among two CHIS indicators, *family life impairment* and *needed help for mental health problems*.

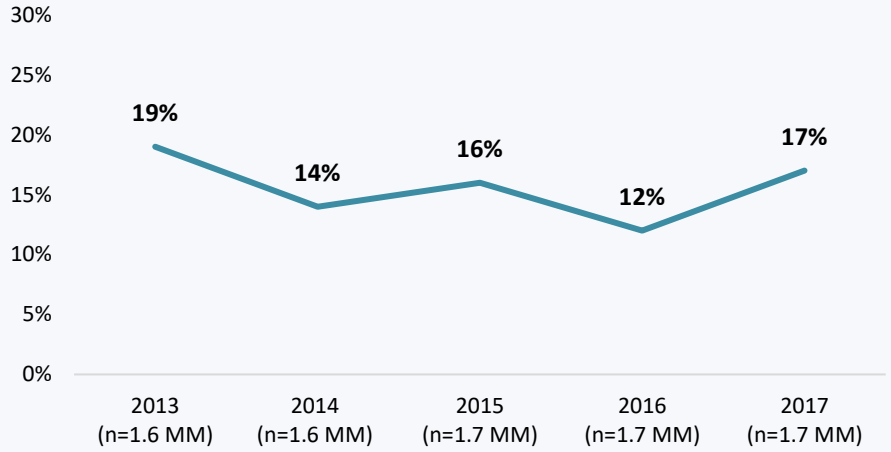
Table 3. Mental & Behavioral Health Characteristics for Adults 18+ (CHIS, 2014)

Location	Population	% Serious psychological distress	% Family life impairment	% Needed help for mental health	% Work impairment
California	28,539,200	8%	14%	16%	9%
Riverside County	1,653,400	8%	14%	17%	9%
5 most populous cities in the Desert Healthcare District combined*	202,700	7%	13%	17%	8%

* The most populous cities in the Coachella Valley are: Cathedral City, Coachella, Indio, Palm Desert, and Palm Springs.

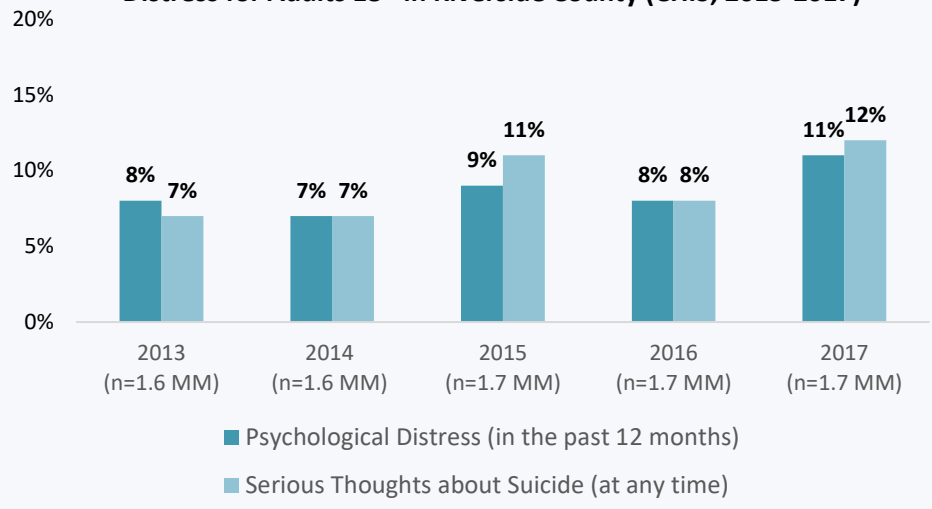
CHIS data for adults 18 and older in Riverside County over the past five years show that the percentage of adults who needed help for emotional/mental health problems or substance use has recently increased (**Figure 3**).

Figure 3. Needed Help for Mental Health/Substance Use Problems for Adults 18+ in Riverside County (CHIS, 2013-2017)



In 2017, adults 18 and older in Riverside County reported higher percentages of having serious thoughts about suicide (12%) or having experienced serious psychological distress (11%) than in any of the previous four years.

Figure 4. Thoughts about Suicide & Serious Psychological Distress for Adults 18+ in Riverside County (CHIS, 2013-2017)



Mental and Behavioral Health Services and Utilization

The following pages summarize extant data relevant to the availability of mental and behavioral health and service utilization rates. Where secondary data specific to the Desert Healthcare District were not available, secondary data for Riverside County is provided.

Mental Health Professional Shortage Areas

The Office of Statewide Health Planning and Development (OSHPD) reports data on mental healthcare provider shortages across California's Medical Service Study Areas (MSSAs).[7] Mental health professional shortage areas are determined by comparing the population in the MSSA to the number of full-time equivalent (FTE) core mental health professionals and psychiatrists.[8]

As of 2018, parts of the Desert Healthcare District are designated as mental health professional shortage areas, including: Bermuda Dunes, Cathedral City, Coachella, Indio, La Quinta, Mecca, Oasis, Palm Desert, Palm Springs, Rancho Mirage, and Thermal.

Psychiatric Bed Availability

The California Hospital Association's (CHA) Annual Report on the Behavioral Health Delivery System includes information at the county level on psychiatric bed availability. The CHA sets a goal of 50 psychiatric beds per 100,000 residents. As of 2017, Riverside County had 199 total psychiatric beds available, which equates to 8.21 beds per 100,000 residents. Among the 199 beds, 12 were designated as child/adolescent beds.

Clinic Service Availability for Mental and Behavioral Health

OSHPD houses data from 2017 for 14 licensed primary care clinics across 8 cities within the Coachella Valley. Relevant service availability and utilization data for each clinic are included in Appendix B.

Among the 14 clinics, all are classified as a Federally Qualified Health Center (FQHC) or an FQHC "look-alike."[9] One of the fourteen clinics provides community services for those experiencing homelessness and substance abuse. For the 12 clinics indicating they serve Spanish-speaking patients, all 12 also reported having one or more staff members who speak Spanish. Eight clinics have mental health providers on staff or by contract.

FQHCs are not required by the Public Health Services Act to provide mental health services and across all clinics there are fewer than 20 full-time equivalent mental health providers. These providers include

[7] MSSAs are defined by OSHPD as "sub-city and sub-county geographical units used to organize and display population, demographic, and physician data."

[8] According to the federal Health Resources and Services Administration, health professional shortage area designation for mental health providers relies on an overall score comprised of seven criteria: population-to-provider ratio, percent of population below 100% federal poverty level, elderly ratio, youth ratio, alcohol abuse prevalence, substance abuse prevalence and travel time to the nearest source of care.

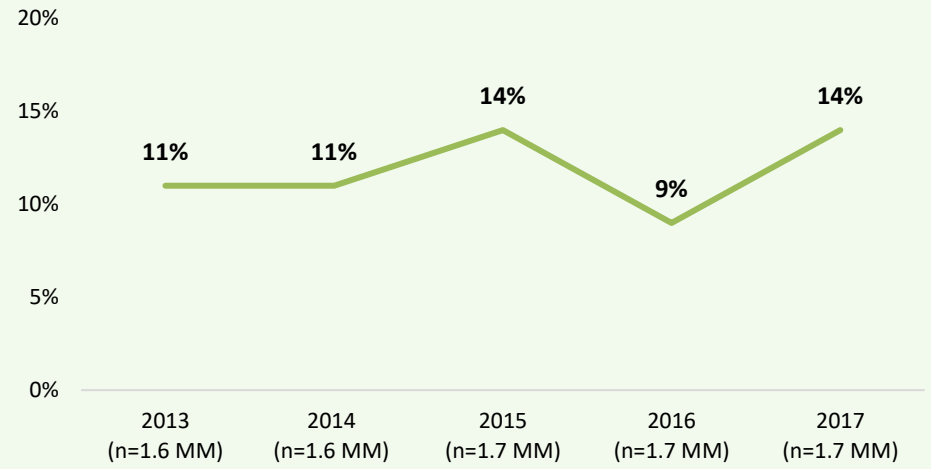
[9] FQHCs meet the federal requirements outlined in the Public Health Services Act, including that they must provide primary care services in underserved areas on a sliding fee scale and have patients on their governing boards. FQHC "look-alike" providers meet FQHC requirements in all ways, but do not receive federal Health Center Program funding.

psychiatrists, clinical psychologists, licensed clinical social workers (LCSW), marriage and family therapists (MFT), and substance abuse counselors.

Utilization of Mental and Behavioral Health Services

The figure below shows the number of adults age 18 and older in Riverside County that saw a provider for mental health or a substance abuse problem.

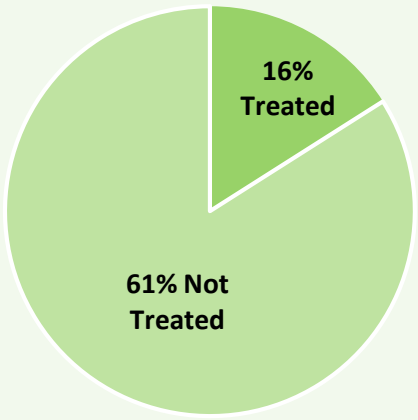
Figure 5. Adults 18+ in Riverside County that Saw a Provider for Mental Health/Substance Use Problems (CHIS, 2013-2017)



The Centers for Medicare & Medicaid Services report data on the percentage of the Medicare population[10] that has been treated for depression by county. This population represents older adults (65+) and adults under 65 with disabilities and other chronic conditions. In 2017, nearly one-sixth of adults with Medicare have been treated for depression in Riverside County. Note that this data is based on utilization; need for treatment is not indicated in this data.

[10] This data includes Medicare fee-for-service beneficiaries participating in both Part A and Part B, and excludes Medicare Advantage beneficiaries.

Figure 6. Depression Prevalence in the Medicare Population in Riverside County (CMS, 2017)*



* The total n for this data is not available from CMS; however, the American Community Survey (5-year estimates) for 2017 estimates that 342,024 people in Riverside County have some form of Medicare.

Emergency Department Utilization for Mental and Behavioral Health

OSHPD maintains emergency department utilization data for three licensed general acute care hospitals within the Desert Healthcare District: Desert Regional Medical Center, Eisenhower Medical Center, and John F. Kennedy Memorial Hospital. Data on emergency department utilization for mental and behavioral health concerns is presented in **Table 4**.

Table 4. Desert Healthcare District Emergency Department Utilization for Mental and Behavioral Health (OSHPD, 2017)

Hospital	Licensed Bed Size	# Total ED Visits	# ED Visits and Admits for Mental Health Disorders	# ED Admits for Mental Health Disorders	# Discharged/ Transferred to Psychiatric care
Desert Regional Medical Center	300-499	75,361	3,143	223	1,216
Eisenhower Medical Center	300-499	80,592	1,854	176	290
John F. Kennedy Memorial Hospital	100-149	46,840	2,571	53	897

Riverside University Health System Behavioral Health Utilization Data

Riverside County maintains an open data portal inclusive of statistics from various county agencies. Riverside University Health System – Behavioral Health (RUHS-BH) is a county-level department that provides mental health services and substance abuse prevention and treatment programming. The figures below present behavioral health data (i.e., age, race/ethnicity, and primary diagnosis) from RUHS-BH electronic health records for close to 13,000 unduplicated clients from fiscal year 2016. The data below are specific to the Desert Region, which includes 12 of the 18 cities in the Desert Healthcare District: Cathedral City, Coachella, Desert Hot Springs, La Quinta, Indian Wells, Indio, Mecca, Palm Desert, Palm Springs, Rancho Mirage, Oasis, and Thermal. Nearly a quarter of all clients served are under 18 years of age and 19% are Transition Age Youth (TAY; age 16-25).

Figure 7. Desert Region Unduplicated Client Data
Race/Ethnicity (RUHS-BH, Fiscal Year 2016)

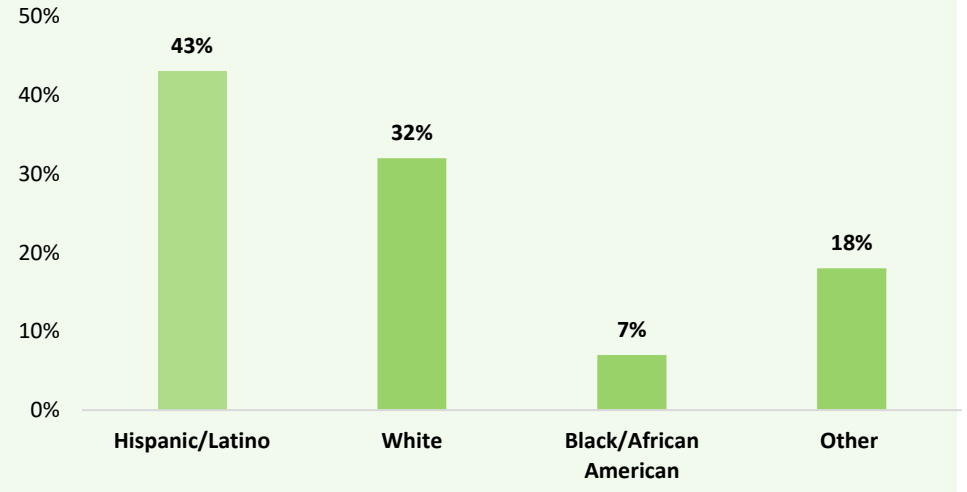
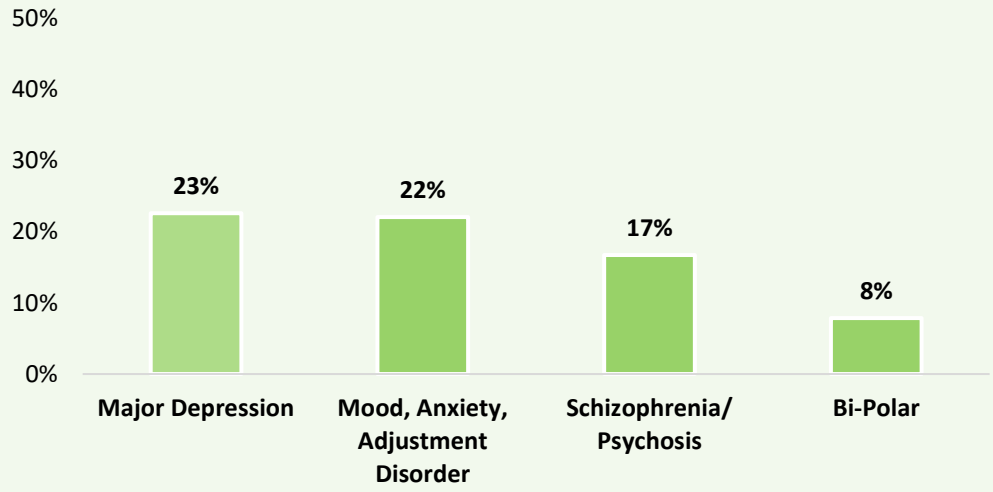


Figure 8. Desert Region Unduplicated Client Data
Top Four Most Recent Primary Diagnoses (RUHS-BH, Fiscal Year 2016)



Involuntary Detention for Psychiatric Treatment ("5150 Holds")

Data on the number of involuntary detentions for psychiatric treatment (e.g., admissions under the Welfare and Institutions Code (WIC) Section 5150) is not readily available for Riverside County and its sub-regions. The California Department of Health Care Services (DHCS) produces an annual report called *California Involuntary Detentions Data Report* that contains county-level information on involuntary detentions for both private and county psychiatric treatment. While Riverside County may be tracking this information separately, it has not reported data to DHCS for the past three years (2015-2017).

In its Mental Health Services Act (MHSA) Annual Plan Updates, RUHS reports data about Mobile Crisis Stabilization Outreach teams and their work to discontinue 5150 holds already in place for people in emergency rooms at community hospitals. In the RUHS fiscal year 2018-2019 update, it was reported that outreach teams contributed to the release of 5150 holds for 243 people.

In their 2019-2020 update, RUHS reported that the outreach team provided interventions to approximately 860 people with 5150 holds in community hospital emergency rooms. These interventions resulted in the release of 5150 holds for 206 people.[11]

[11] The data reported by RUHS are not representative of the total population of individuals being detained under 5150 holds in Riverside County.

Conclusion

Data collected and analyzed for the Secondary Data Indicators Report demonstrate that the residents of Coachella Valley are a diverse group in need of multi-cultural and multi-lingual services. Though there is a shortage of mental health providers, those that do operate in the region, tend to have services available in threshold languages (i.e. Spanish). Additionally, residents of the Coachella Valley tend to have low levels of education, this could be a contributing factor to the high level of poverty experienced by residents and indicate a need for low or no-cost services.

Furthermore, data analyzed clearly indicated a sub-group in need of further attention; youth and young adults. The most recently available data shows that a third of students (Grades 7-11) have reported experiencing chronic sadness or hopelessness in the past year. Additionally, since 2013, there has been an increase in self-reported serious psychological disorders and an upward trend in death by suicide among youth and young adults 15-24.

Though the data available is limited it is clear that the Coachella Valley is in need of additional resources to address current mental and behavioral health needs, especially among youth and young adults.

APPENDIX A

Mental & Behavioral Health Characteristics for Adults 18+ in Desert Healthcare District Cities (CHIS, 2014)

Location	Population	% Serious psychological distress	% Family life impairment	% Needed help for mental health	% Work impairment
Bermuda Dunes	8,100	8%	15%	18%	10%
Cathedral City*	34,600	8%	14%	16%	9%
Coachella*	28,500	8%	13%	13%	7%
Desert Edge	2,200	5%	9%	14%	5%
Desert Hot Springs	18,000	8%	14%	16%	8%
Indian Wells	4,700	4%	8%	16%	6%
Indio*	55,800	8%	14%	16%	9%
La Quinta	25,100	7%	14%	17%	9%
Mecca†	6,400	-	-	-	-
North Shore†	3,000	-	-	-	-
Oasis	4,300	7%	11%	11%	7%
Palm Desert*	41,000	7%	12%	18%	8%
Palm Springs*	42,800	7%	13%	18%	7%
Rancho Mirage	15,500	5%	9%	15%	6%
Sky Valley	1,900	6%	12%	14%	6%
Thermal	1,100	9%	13%	13%	9%
Thousand Palms	6,000	6%	11%	12%	7%
Vista Santa Rosa	5,900	7%	12%	14%	7%

* The most populous cities in the Desert Healthcare District are: Cathedral City, Coachella, Indio, Palm Desert, and Palm Springs.

† Mecca and North Shore data are not available because the response rate was too low for these cities.

APPENDIX B

Coachella Valley Primary Care Clinic Data (OSHPD, 2017)

Primary Clinic by City	Total # of Patients	Community Services	Mental Health Provider FTEs*	Mental Health Patient Encounters/ Contacts†	Patient Age Groups	Staff Language Capacity
Cathedral City						
Centro Medico	30,052	-	6.62	10,964	0-65+	Spanish
Coachella						
Coachella Health Clinic	4,527	-	1	857	0-65+	Spanish
Planned Parenthood – Coachella Valley	5,877	-	0	0	13-64	Spanish
Desert Hot Springs						
Desert Hot Springs Community Health Center	49,054	-	0.8	995	0-65+	American Sign Language
Desert Hot Springs Health and Wellness Center	3,098	-	0	-	0-65+	Spanish
Indio						
Central City Community Health Center, Inc.	(no data)	-	-	-	-	-
Indio Health Center	(no data)	-	-	-	-	-
Mecca						
Mecca Health Clinic (Suite 300)	1,943	-	0	-	0-65+	Spanish
Mecca Health Clinic (Suite 500)	5,457	-	0.07	282	0-65+	Spanish
Palm Springs						
Desert AIDs Project	4,584	Homeless, Substance Abuse	6.38	5,133	15-65+	Spanish
Desert Oasis Womens Health Center	2,995	-	0.1	121	5-65+	Spanish
Rancho Mirage						
Planned Parenthood – Rancho Mirage	8,713	-	0	-	5-65+	Spanish
Thermal						
Centro Medico, Coachella	5,275	-	0.94	1,206	0-65+	Spanish
Centro Medico, Oasis	4,099	-	0	1	0-65+	Spanish
Total	**125,674**	-	**15.91**	**19,559**	-	-

* Includes full-time equivalent psychiatrists, clinical psychologists, licensed clinical social workers (LCSW), marriage and family therapists (MFT), and substance abuse counselors.

† As defined by OSHPD, patient encounters are recorded when a licensed primary care practitioner examines or treats a patient. Multiple encounters on the same day are possible but they require multiple providers, a separate diagnosis, or treatment plan by each provider. A patient contact is similar, but for clinical support staff such as Marriage and Family Therapists and Substance Abuse Counselors.

Appendix E: Key Stakeholder Interview Protocol

Desert Healthcare District Mental/Behavioral Health Needs Assessment (MBHNA)
Key Stakeholder Interview Protocol
Overview and Informed Consent

[THE FOLLOWING IS TO BE READ AT THE START OF EACH INTERVIEW]

Hello, my name is _____ and I am with EVALCORP. We were contracted by Desert Healthcare District to conduct a Mental/Behavioral Health Needs Assessment for the Coachella Valley.

The purpose of today's interview with you is to identify:

- Mental/behavioral health priorities,
- Any unmet mental/behavioral health needs, and
- Any gaps in service provision.

Please know that your participation is voluntary. **All of the information collected through the interviews will be reported in aggregate form – that is, nothing you say will be quoted or attributed to you directly without your explicit permission.**

The interview is expected to take approximately 30 minutes to complete.

Thank you in advance for your participation -- your time and responses are greatly appreciated.

Do you have any questions of me before we begin?

Proceed to begin interview →

Desert Healthcare District Mental/Behavioral Health Needs Assessment (MBHNA)
Key Stakeholder Interview Guide

Date: _____ **Interviewer Initials**: _____
Respondent: _____ **Agency or School**: _____
Position or Title: _____

I. Respondent Background Information

1. What is your current role at [Agency]?
    a. How long have you been in this role?

2. Please briefly describe the work that [Agency] conducts/engages in with mental/behavioral health service provision?

3. Is your agency engaged in stigma reduction activities for those receiving services?
    a. If so, please describe.

4. Which populations do you work with most?

5. Which geographic areas does your agency serve?
6.

II. Mental Health in the Coachella Valley

7. What are the most pressing mental/behavioral health related concerns or needs you're seeing in the communities you work in? Why?
    a. Which populations/communities are most affected by these?

8. What are some factors that contribute to poor mental/behavioral health in the communities you work in?
    a. Do these factors vary by population or region?

9. How accessible is mental/behavioral health care in the communities you work in?

10. What are the biggest challenges community members face when trying to access mental/behavioral health services?

11. How can access to mental/behavioral health services be improved in the communities you work in?

12. What efforts is your agency implementing to address mental/behavioral health concerns?

13. What would you say are your greatest strengths or assets as an organization in addressing mental/behavioral health needs?

14. Is there anything else you would like to share with us that we haven't already talked about that would be helpful for understanding the mental/behavioral health needs in the communities you work in?

Appendix F: Provider Survey

Mental/Behavioral Health
Provider Needs Assessment Survey

Will be administered online

Please take a few minutes to complete all questions, selecting a response that best fits your beliefs. Your opinion is very important to us. All responses are anonymous.

Part 1: Mental/Behavioral Health Service Provision

Please take a moment to think about the communities you work in. Please answer the following questions thinking about the strengths, gaps, and greatest needs regarding mental/behavioral health in the communities you serve.

1. How available are mental/behavioral health service providers in the communities that you serve?

   ❑ Very Available
   ❑ Somewhat Available
   ❑ Not at All Available

2. How much do you agree or disagree with the following statement?
   People with mental health needs can get help in the communities that I serve.

   ❑ Strongly Agree
   ❑ Agree
   ❑ Disagree
   ❑ Strongly Disagree

3. Thinking about the available mental health services in the communities that you serve, please rate each of the following.

	Poor	**Fair**	**Good**	**Excellent**	**Not Sure**
Appointment availability					
Cultural competency of staff					
Capacity (sufficient beds/staff)					
Hours of operation					
Materials available in appropriate languages					
Services available in appropriate languages					
Wait times in lobby to see provider					
Walk-in availability					

4. Please rate the need for mental/behavioral health services for each population below:

	Low	Moderate	High	Not Sure
LGBTQ+				
Persons with disabilities				
Persons experiencing homelessness				
Persons that are undocumented				
Other				

   a. If you selected other please specify: _____

5. Please rate the need for mental/behavioral health services for each racial/ethnic group below:

	Low	Moderate	High	Not Sure
Asian American/Pacific Islander				
Black/African American				
Hispanic/Latino				
Native American/Alaska Native				
White/Caucasian				
Other				

   a. If you selected other please specify: _____

6. Please rate the need for mental/behavioral health services for each age group below:

	Low	Moderate	High	Not Sure
Children (age 15 and under)				
Transitional Age Youth (TAY) (ages 16-25)				
Adults (ages 26-59)				
Older Adults (age 60 and older)				

7. For each of the following mental/behavioral health issues how much **additional support/resources** should be devoted to address existing needs in the communities that you serve?

	None	Some	A Lot	Not Sure
Chronic Stress				
ADD/ADHD				
Bullying				
Depression				
Anxiety				
Alcoholism/Substance Use				
Homelessness				
Trauma				
Thoughts of Suicide				
Other Concern				

   a. If you selected other please specify: _____

8. Please rate how much of a barrier each of the items below is to accessing mental and behavioral health services:

	Not a Barrier at All	Minor Barrier	Somewhat of a Barrier	A Major Barrier	Not Sure
Availability of services					
Client knowledge of available services					
Insurance coverage/cost					
Lack of childcare					
Lack of culturally appropriate services					
Language Assistance					
Location of services					
Staff qualifications/skills					
Transportation					
Other					

   a. If you selected other please specify: _____

9. What are the top three unmet mental/behavioral health needs in the communities that you serve?

10. What recommendations or suggestions do you have to better meet the mental/behavioral health needs in the communities that you serve?

Part 3: Questions about You

1. Which agency/organization do you represent? (select all that apply)
   - ❑ Ambulatory Care
   - ❑ Community College/College/University
   - ❑ Hospital/Medical Office
   - ❑ Human Services Agency
   - ❑ K-12 Education
   - ❑ Municipal Police Department
   - ❑ Probation
   - ❑ Public Health
   - ❑ RUHS
   - ❑ Sheriff's Office
   - ❑ Substance Use treatment
   - ❑ Other

     Please Specify: _____

2. Does your agency provide mental/behavioral health services beyond the traditional setting/hours (e.g. Monday-Friday 9am-5pm)?
   - ❑ Yes
   - ❑ No

3. What is your role? (select all that apply)
   - ❑ Police Officer
   - ❑ Probation Officer
   - ❑ Educator
   - ❑ Community Health Worker
   - ❑ Social Worker (LCSW, MSW)
   - ❑ RN/LPN/LVN
   - ❑ Physician (MD, NP)
   - ❑ Paramedic
   - ❑ Counselor (MFT)
   - ❑ Other

     Please Specify: _____

4. What geographic area(s) do you serve? (select all that apply)
   - ❑ Bermuda Dunes
   - ❑ Coachella
   - ❑ Desert Hot Springs
   - ❑ Indio
   - ❑ Mecca
   - ❑ Oasis
   - ❑ Palm Springs
   - ❑ Sky Valley
   - ❑ Thousand Palms
   - ❑ Cathedral City
   - ❑ Desert Edge
   - ❑ Indian Wells
   - ❑ La Quinta
   - ❑ North Shore
   - ❑ Palm Desert
   - ❑ Rancho Mirage
   - ❑ Thermal
   - ❑ Vista Santa Rosa
   - ❑ Other Please Specify: _____

5. Which age groups do you work with most often? (select all that apply)
   - ❑ Children (age 15 and under)
   - ❑ Transitional Age Youth (TAY) (ages 16-25)
   - ❑ Adults (ages 26-59)
   - ❑ Older Adults (age 60 and older)

6. Which of the following populations do you work with? (select all that apply)
   - ❑ LGBTQ+
   - ❑ Persons with disabilities
   - ❑ Persons experiencing homelessness
   - ❑ Persons that are undocumented
   - ❑ None of the above
   - ❑ Other

     Please Specify: _____

Appendix G: Focus Group Protocol

Community Health Forum/Focus Group Protocol

[THE FOLLOWING IS TO BE READ TO PARTICIPANTS AT THE START OF THE FOCUS GROUP]

Introduction

Good [*morning/afternoon/evening*] and welcome. Thank you for taking the time to talk with us [*today/tonight*]. You were invited here today to participate in a discussion about the mental and behavioral health needs you see within your communities.

My name is [*Insert Name*] and I work with EVALCORP Research & Consulting. I will be the moderator/facilitator for this focus group.

As moderator/facilitator, my job is to ask all of you a series of questions, and ensure that we get through everything we have planned for today on time. Assisting me as a note taker is [*Insert Name*], who will make sure we capture the conversation and the information you provide.

Purpose of Focus Group

We would like to hear your perspectives and opinions about the needs people experiencing mental/behavioral health issues in the Coachella Valley.

The information you share with us will help shape how mental/behavioral health services and resources are provided countywide.

Our goal today is to learn more about:

1. Services and strategies that currently exist for those experiencing mental/behavioral health issues;
2. unmet needs for individuals seeking mental/behavioral health assistance; and
3. barriers that limit people from accessing and/or locating services.
4.

There are no right or wrong answers to the questions. People may have different points of view, but all responses are valid and equally important. Please feel free to share your point of view, even if it differs from what others have said. We want to hear from each of you. We ask that you let everyone have a chance to talk. I will make sure that you each have a chance to express your thoughts.

Timing

We expect this conversation to last about 60 - 90 minutes.

Participation/Confidentiality

Please know that your participation is completely voluntary. Everything you tell us is confidential. Nothing you say will be personally linked to you in any reports that result from this focus group. All of the comments today will be put together and no one's name will be tied to what they have said.

Ground Rules

In order to ensure that everyone has an equal opportunity to communicate and participate in a respectful atmosphere, I'd like to share some ground rules for us to keep in mind during the focus group.

1. All ideas are welcome – there are no right or wrong answers
2. One person speaks at a time, please don't interrupt someone who is speaking
3. Please speak only for yourself

Time for Questions

Does anyone have any questions before we begin? [*Respond to questions*]
If there are no other questions, let's go ahead and get started.

Participant Introductions

In order for us to get to know each other better, I'd like to start by going around the room and asking you to please share your first name, how long you've lived in the Coachella Valley, and why you chose to attend today's focus group.

Focus Group Items

Mental/Behavioral Health

Let's begin by discussing mental and behavioral health in your community.

1. When you hear the terms mental and behavioral health, what comes to mind?
2. In your opinion, what are the most pressing mental and behavioral health concerns in the community you live in?
    a. Are there certain groups or populations more affected than others?
3. What do you think are some causes of mental and behavioral health issues in the community you live in?
4. How do you receive information about mental and behavioral health?
5. What resources or services are available in the community you live in to help address mental and behavioral health?
    a. How did you learn about them?

Personal Experiences and Ideas for Increasing Access

Now we are going to talk about your experiences with mental and behavioral health.

6. What kinds of things do you and your family do to stay physically and mentally healthy?
7. Thinking about yourself, your family, or other people you know, how easy or hard it is to get help for mental/behavioral health issues in your community?
8. Again, thinking about yourself, your family, or other people you know, what stops people from getting mental and behavioral health help or support?
9. How can access to mental and behavioral health services be improved?
10. What are some ideas you have to make mental/behavioral health services more available to the people that need them?

Closing Question(s)

11. Is there anything else you would like to share with us about mental/behavioral health in your communities?