Communities Section

This section presents community-specific findings, as requested by participants to ensure a thorough representation of each of the communities involved in the engagement activities. Presenting community-level themes and ideas provides the opportunity to uplift community voices and highlight emergent concerns about mental health and substance use issues and services in their respective communities, beyond the list of global themes across all communities. It is important to iterate that **the themes in this section are not intended to be representative of an entire community**, but instead are the concerns of specific communities, community leaders, consumers, family members, community health, and social service workers gained through lived experience.

We thank each of the interview and focus group participants for their time and candid responses to our questions. This report would not have been possible without their generosity. We have done our best to report their concerns and recommendations accurately and fairly. While this report does not fully capture the richness of each community, nor the enormous multicultural nature of San Diego County, we hope it provides an important and unique contribution to community engagement.

Adult Residential Facilities

One focus group was conducted with six individuals, all working in an adult residential facility (ARF) in San Diego County. ARFs provide treatment and housing for psychiatric clients.

Participants expressed many concerns for their residents and staff at the residential facility. They reported an increase in violence within the facilities and a lack of support from the police and surrounding hospitals. One participant shared the following: *"The residents are aggressive against each other, one was bleeding from the face, the police come, they don't do anything. And a lot of things to have the police put somebody on a hold on a 5150."* If staff feel unsafe and request that a resident does not return, the facilities can potentially get penalized by the State for "refusing to take someone back." Also, ARF staff noted that fentanyl and methamphetamines were the most common substances used among residents and that this substance use *"increases the behaviors"* and *"leads to more incidents."*

Participants suggested more facilities to support both the residents and workers in this community. One participant asked, *"Is there something that [the County] could come up with, for operators to be encouraged to open more facilities? They say, there's a grant that you could use to open another board and care."*

Throughout the focus group, participants discussed the need for more staffing within their facility as a lack of staffing leads to larger issues for the residents. One participant stated, *"We can't have eyes on everyone, but it seems like we have to… so we can reduce the number of incident reports, reduce drug use… because it only takes a few seconds or a few minutes for them to overdose."* In addition to increasing staffing, one participant emphasized the importance of *"getting different trainings, different perspectives, different professionals that could help out in our day-to-day operations, even if it's repetitive, but at least, we know that they're coming to help us out."* Participants also highlighted the need for funding increases:

"I think just more funding for staffing, more benefits, like higher salary… I just feel like we're not getting any help from anybody anymore." Participants believe funding and staffing increases could *"help reduce a lot of relapses; it can reduce a lot of [residents] going to hospitals"* as the increase in staffing provides residents more supervision and support while at the ARF.

Black Community

Three interviews and one focus group with seven participants (for a total of 10 participants) were conducted with members of the Black community and people who work closely with the Black community. Participants shared prevalent behavioral health concerns while providing recommendations for how the County can best support their community.

Participants discussed many community strengths, including strong leadership and resiliency. One participant explained the community members themselves are a strength because *"You have to be resilient despite the system misusing [them]."* Another highlighted the *"organizations that are going really strong, as far as supporting mental health in the African American community"* as well as the community leadership: *"Despite the challenges that arise, [one leader] in particular, continues to pick themselves back up and continues to fight because they understand that the work that they are doing for the community is really important."*

Due to the continual harm inflicted upon the Black community, trauma is a prevalent issue community members face. One participant shared, *"Trauma is probably the most present distinguishing characteristic of the community that I represent"* and an experience where *"there was no intervention, there was nothing to help them heal from that trauma. And [the participant] doesn't think that the war on certain segments of the population has stopped. So, we are dealing with continual trauma in some spaces."*

Participants highlighted the issues of systemic and internalized racism that impact their community. One participant expressed that for their community there is a *"need to identify that we all, as products of American culture, hold racist ideas… understanding that we are working in trauma and in racism is the heart and soul of Behavioral Health Services in the communities that I come from."* Another participant touched on the issue of exclusion: *"Because I am an African American woman, my expertise is diminished. It's dismissed. That happens repeatedly in various spaces because of the systemic racism that exists, because of people's own insecurities…and that happens time and time again, not only with me but with other people of color with expertise. If we've done our work to earn our seat at the table, why don't we have a seat at the table?"*

Participants discussed the issues that stem from a lack of Black providers. One participant asserted, *"There's almost no Black therapists, there's almost no Black female therapists."* The importance of providers of color was highlighted: *"There's definitely things I wouldn't tell… to a white doctor as opposed to a Black doctor… I'm much more likely to be more like myself around someone that looks like me."*

Participants expressed the importance of including members of the Black community in County discussions and decisions: *"When those mobile units were initiated, there weren't any Black or Brown agencies that were included in that discussion. And those were deployed in the Northern part of the*

County. So, we are still kind of left to support our own. And that's the ongoing tragedy throughout the many years that I've been doing this…" One participant acknowledged the County *"has done some stuff related to cultural diversity"* but believes *"it would be awesome if [cultural diversity classes] were offered by the African Americans who are doing this work and functioning in these spaces… because then there's lived experience, there's real examples, it expands the network, and gives some real application."*

Deaf Community

We had the opportunity to host one focus group with nine staff members working in social and health services for the deaf community. Six out of the nine participants identified themselves as deaf and/or hard of hearing. Two American Sign Language (ASL) interpreters were in attendance to facilitate discussion between the English-speaking facilitator and the participants who communicate with ASL. Emergent themes follow.

According to the participants, *"the two big topics"* were *"therapy access and interpreter permission."* Participants mentioned the difficulty in finding deaf therapists or counselors: *"As far as we know, there's two deaf certified drug and alcohol counselors in the state of California, and one is someone that works here."* The participants also shared that it has been difficult hiring deaf counselors due to County contract restrictions: *"We lost the behavioral health program because they couldn't hire clinicians; the County contract requires that people live within the County boundaries. There are accessible mental health clinicians out there, but they live outside of San Diego, some that are across the country, wonderful clinicians, but they won't allow us to have that access."*

Participants asserted that therapists must understand the deaf community in order to treat deaf individuals with mental illness. One participant stated, *"Our biggest struggle is really to have a therapist who understands the struggles that a deaf person experiences in their lives, and has the cultural knowledge"* while another added, *"Most hearing therapists come from a medical perspective, and they lacked the cultural background and awareness to really understand what a deaf person goes through in their lives."* In general, the focus group participants agreed that *"the entire community has been oppressed from the hearing world throughout history."*

Participants noted the lack of interpreters as a barrier to accessing mental health and substance use services: *"The Recovery Center, mental health centers, they don't have the funding to provide interpreters, at least that's what they say."* Further, *"There should be a line item for a budget for that [interpreters], because it's set for other languages."*

According to participants, the lack of interpreters is particularly problematic in sober living spaces. As one case manager shared, *"In these hearing sober houses, if one of our Deaf clients moves there, they refuse to provide interpreters. They refuse to provide access, sometimes they have to fight to have a TV or a video phone in their room for better communication."*

While online interpreter service platforms are available, they have their own challenges: *"Some clients, for example, are Deaf-blind and struggle to actually see the interpreter on the screen."* Participants shared that they *"have explained to the County repeatedly their system of using Microsoft Teams is ineffective in a deaf space. It doesn't work because the interpreter ends up on a small box and then the closed captioning goes across their face, so they can't read the captioning or the interpreter."*

The deaf community has tried to assuage some of these issues by connecting with more organizations and institutions, but those connections have proven to be a challenge on their own. As one participant shared, *"The system is not designed to support deaf people quickly. We're not a priority, not in education, we're not a priority in employment, we're not a priority anywhere really, that's it. That's why we're doing the job because we're trying to provide culturally sensitive services. We are trying to educate and network with the police, the sheriff's department, the fire department, to become familiar, but that's not enough. That's really not enough. We need more...the question is, when we're providing deaf cultural sensitivity training, are those people really taking it in and remembering the training when they're meeting deaf clients? I don't think so. I think they're attending the training, fine in one ear, out the other."*

Participants shared a few clear recommendations for BHS to better collaborate with and support the deaf community. These recommendations include changing contract regulations so that they could refer deaf clients to deaf therapists outside of San Diego County. In addition, participants asserted that all County services should hire more ASL interpreters: *"It shouldn't be up for debate, ever."*

One participant stated the need for a specific County position to improve services for the deaf community: *"I really do believe that if we had one advocate, one, in the County system, working in the behavioral health department, advocating for these marginalized communities. One salaried position, somebody that we can connect with, somebody that we can communicate with, somebody that can intermingle with their own crowd, we can ask question after question after question."*

Individuals Experiencing Homelessness

We conducted three focus groups and two interviews with individuals who work with people experiencing homelessness. All focus groups were composed of people with lived experience of homelessness, who currently provide services to individuals experiencing homelessness. The first focus group included fifteen people, the second and third focus groups included five people each for a total of 25 participants. The following themes were evident in the discussions.

All of the participants in these focus groups and interviews identified lack of housing as a central driver of mental health and substance use issues in San Diego. One person highlighted the interconnectedness of all these factors, stating that *"Mental health and substance abuse is like hand in glove, but then you also get families who like as we return back to normalcy from COVID, somebody's new normal is they're homeless now."*

The rising rate of homelessness among elderly and disabled folks in San Diego County was a high concern for the participants, who highlighted the lack of services for these populations. As one participant shared, *"We have seen such a huge explosion of elderly. Elderly homeless. Elderly who are severely disabled, and we have no resources for them."* One participant approximated that most ("85%") housing placement issues would be solved if San Diego County would more consistently implement Americans with Disabilities Act (ADA) requirements. Relatedly, participants shared that many physically disabled people are turned away from shelters if they cannot climb up to the top bunk of remaining shelter beds. Besides offering more accessible beds, participants suggested that more of the BHS budget be allotted to disability awareness and accommodation.

Participants shared the belief that people with lived experience should play a key role in guiding homelessness and behavioral health services. One participant stated, *"A whole lot of decisions made by people who have never spent one hour working with the homeless. And there's a lot of things that sound like a really great theory, but are so impractical, and in practice, it just doesn't work."*

Lack of affordable housing in San Diego is an additional problem faced by peer support specialists working with individuals experiencing homelessness who also have a mental illness: *"It's very hard to keep people in the mental health field, in the behavioral health field, in San Diego, [because] we can hardly afford to live here."* Another participant suggested, *"One of the ways that we could potentially incentivize that is if we were to offer down payment assistance for workers in the mental health field."*

Participants were supportive of expanding housing options through a Housing First policy, a model of addressing homelessness by providing individuals experiencing homelessness with housing as quickly as possible with supportive services as needed. However, more than one participant emphasized the need for accessible behavioral health treatment along with housing. As one participant shared, *"The City of San Diego is doing, Housing First, but you put a client in without the infrastructure, the help, the support that they need, and in this case, a mental health support. They don't have the tools to maintain their housing. So we're not doing them any favors, we are actually perpetuating the cycle. And they give up."*

Justice-Involved

Through an individual interview, we gained insight into the justice-involved perspective from a participant with lived experience. This participant was formerly incarcerated in early adulthood and currently works with the County's criminal justice system in several capacities, including the District Attorney's office. This participant has a broad range of collaborations with multiple organizations, both nonprofit and for-profit, advocating for justice-involved individuals. While this participant's input was highly informative, we plan on additional interviews and focus groups with people

who have lived experience of justice involvement and their family members for next year's community engagement report.

The participant discussed the importance of including individuals with lived experience in the planning and decision-making process of the County and other organizations, as that experience can offer a unique perspective while others may be comparatively *"naïve to the justice system."* The participant elaborated on the potential benefit of collaboration between those with and without lived experience, asserting *"there's a divide right now, and that divide is growing, as the so-called peer movement is growing. There's this big clash between my 20 years of lived experience in prison, versus the 20 years it took for you to get a PhD, or 18 years it took to get your Masters…there's a clash coming. And I don't think there should be a clash; I still think there's so many lessons to learn from each other."*

Additionally, the participant highlighted the importance of acknowledging traumas and lifetime harm incarceration causes individuals: *"We don't address carceral traumas in any form or fashion. And that's easily indicated when you watch a juvenile repeat a crime that was committed against him."* The participant noted the correlated issues of substance use, mental health problems, and homelessness. It has become more evident across the country that individuals involved in the criminal justice system often have mental health problems, the participant asserted that *"whatever the problem is, you can't treat one [mental health problems or legal problems] and then go treat the other, they need to be treated simultaneously."*

The participant recommended that BHS take a closer look at the County operations to identify potential areas of improvement, such as *"...more self-investment in the [grassroots] organizations that are here, that are doing the work."* Overall, the participant asserted that *"it's [mental health] a bigger problem… unless we start again, investing in making healthy people, healthy kids at all costs."*

Latine

We conducted three interviews with individuals who identified as Latine (or Latino/Latina/Latinx) and who work in the Latine community in the County. Each participant has experience with mental health and/or substance use outreach in the community. Interview participants shared their behavioral health concerns and recommendations for effective and culturally appropriate behavioral health services for the Latine communities in the County. The following themes were evident in the discussions.

Like many other communities we reached, participants discussed fentanyl as a primary substance use concern for the Latine community. Additionally, the interview participants mentioned the impact of substance use stigma and incarceration for BIPOC (Black, Indigenous, People of Color) individuals, including Latine folks. One individual shared how substances and incarceration have affected their family: *"...I've seen this the most in my Black family and my Mexican family. The trauma keeps them completely uncomfortable with any cannabis conversation. They saw their sons get locked away for 10 years, they don't want to talk about cannabis business."*

Participants asserted the need for effective behavioral health services in the County, including more translation services and language (Spanish) accessibility, training for additional Latino therapists, and

more providers for senior Latina women with shorter wait times. For instance, one participant stated, *"There's a lot of bilingual therapists...they don't even understand where you're coming from. So I think that's one of the things you know, we need to train more Latinos in this field."* This participant also shared that *"in La Mesa, there's free therapy for senior women. But they only have one therapist, and she's the volunteer, so she doesn't get paid. And so she's booked, like the classes booked for years."*

Participants suggested that, to improve the relationship between behavioral health services and historically marginalized communities, outreach should consider the community's *"cultural perspective and history before creating more harm."* Adding that the history of the land is especially important for considering mental health issues, *"We talk about any issue, mental health, social, environment, it all goes back to that injustice here on this land."*

Finally, participants shared the need for transparency from BHS regarding the effectiveness of BHS programs and to include testimonials when reporting program effectiveness. For example, one participant stated, *"The County gives a lot of money to a lot of agencies. Millions, millions, okay, not hundreds, millions… and sometimes they are not that effective."* The participant added, *"You know, Latinos, we love testimonials...so when I talk about drugs or alcohol, I have three or four people who come and share their testimony."*

LGBTQ+

Two interviews and two focus groups, one with six participants and the other with seven participants , were conducted with LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer, etc.) community members and people working with the LGBTQ+ community. Participants shared their behavioral health concerns and challenges surrounding the LGBTQ+ community in San Diego County, while also providing recommendations for what would be most beneficial for this population.

The participants highlighted a variety of strengths within the LGBTQ+ community, especially *"taking things into their own hands," adding, "if nobody else is going to do it, we're going to do it for ourselves."* However, the County could further support this community: *"It would be amazing if we had people who aren't part of this community help us get our foot in the door, amplify our voices, help us attend these classes, get certified [to] be able to help each other."*

One participant we interviewed discussed the high prevalence of mental health issues among the LGBTQ+ community and their difficulty accessing services: *"Most often if a client is coming in who identifies as transgender, just because of the experiences that they have experienced in life, their mental health, typically is on the higher side. Yet I struggle with referring them to any other place because there is no other place that really services LGBTQ, especially transgender population. So there's a gap, there's a hole of high mental health co-occurring LGBTQ services. I can state my life on that sentence, that's a fact."* One interview participant discussed the connection between homelessness and mental health in the LGBTQ+ community: *"We have a huge homeless crisis going on, but unless the mental health is really supported and there are services…we're going to continue to have homeless people."*

Additionally, participants asserted that if LGBTQ+ community members are able to access mental health services, it is difficult to find a provider with shared experience: *"I've been in and out of therapy kind of my whole life… and seeing no one that looks like me, that I can actually talk to, and has had my experience… like there's next to no transgender therapists."* An LGBTQ+ outreach coordinator also mentioned, *"A lot of people are struggling to find therapists, specifically QT-BIPOC [Queer, Transgender, Black, Indigenous, and other People of Color] therapists that are affordable."*

When discussing services for the LGBTQ+ community, participants discussed the importance of understanding sexual health. One participant explained the positive impact of having a space for *"discovering sexual health and recovery. I don't know if any other programs have a sex group, but when we're talking about addiction and how it affects multiple areas of one's life, relationships, and sexual relationships."* Additionally, a prevention and harm-reduction approach is important. One participant explained, *"Not focusing on 'don't do these things at all,' because it's not realistic and just giving education on how bad [substances] are. It's more so the trauma-informed stuff... checking in on like, why are you doing these? Is there some underlying trauma, is there some coping going on?"*

To successfully engage with the LGBTQ+ community, participants recommended utilizing social media as it is the *"easiest and fastest way to get communication…especially younger age groups."* Additionally, when physically meeting with this community, it is important to be mindful of the venue: *"Venues [with] accessibility, good parking… good transportation, being near a bus line…venues that are BIPOC, queer owned… so you're supporting the community that you're trying to reach out to."*

Lived Experience

We conducted four "Lived Experience" focus groups, two at a clubhouse (i.e. a community-based resource for individuals suffering from mental illness), one with peer support specialists, and one other with mental health advocates.

Clubhouses

A clubhouse serves as a community-based resource for individuals suffering from mental illness. Generally speaking, a clubhouse provides a cooperative and healing atmosphere with possibilities for work, learning, skill building, housing, and better health. The clubhouse focus groups included 11 participants who experience mental illness and another group with five clubhouse staff. The following themes emerged.

Participants expressed the feeling of being surveilled and *"treated like criminals"* in mental health spaces: *"And because of all the metal detectors, it was triggering my anxiety and depression, a little bit of PTSD…all these buzzings don't always help everyone. They need to find another way to be able to help more people, but not making us feel like we're criminals coming in."* Clubhouse members also expressed concerns with mental health treatment aftercare: *"…When they go into like psych wards, and then they come back to society, they're not exactly sure how to deal with themselves and heal themselves."* Another member of the clubhouse shared his experience with stigma from a medical provider: *"I had a couple of times when*

I've been to the hospital before, and I've had doctors be rude to me because of my mental illness. And I feel that needs to be addressed as well..."

Clubhouse members also shared experiences with substance use prevalence in downtown San Diego, notably near residences of clubhouse members: *"Meth, crystal meth, fentanyl any other hard drug is as bad, it's making our communities go bad and having too many overdoses."* The high prevalence of illicit substances in the area means that clubhouse members being treated with a substance use disorder may be particularly vulnerable to relapse and overdose. Another participant added, *"Yes, alcohol can be killing everyone. But the drugs that do the most killing and we should be more concerned about the drugs that are on the street than people drinking alcohol."*

Both clubhouse members and staff recommended that BHS create additional mobile clinics for mental and physical health issues among individuals experiencing homelessness and people with mental illness: *"Get more mobile units… even if it's not the therapist, but the psychiatrists that might come to like our clubhouse. So people that don't like to travel that far to go all the way to Grossmont, or wherever to go see the psychiatrist."*

Clubhouse staff highlighted the need for better pay for people providing behavioral health services, stating, *"I think the biggest part that I would say is that behavioral health direct staff are severely underpaid. Like very severely underpaid and our contract cannot sustain it, like we are pinching pennies. To have the funds to buy enough food and to do anything like that, where it's like if somebody gets a $1 raise, it's like, okay, all of a sudden we have no recreation budgets and the inflation, and it's going to be much easier for staff in general to do well at their jobs if they are not struggling with the same problems that their members are financially. And also, just like with retention, and with attracting good staff too…"*

Lastly, clubhouse staff and members discussed the potential benefit of a universal basic income plan: *"I know they actually did the Seattle one [guaranteed income pilot program] with 12 people who were actually struggling with addictions. So nine of them, after two years, found a job and they were investing the money on education, on having a house, instead of like, they were not buying drugs or things like that."*

Mental Health Advocates & Peer Support Specialists

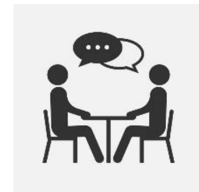
We conducted two additional "Lived Experience" focus groups, one with peer support specialists and the other with mental health advocates with self-identified lived experience of mental illness in San Diego County. A total of 8 individuals participated in these groups.

Participants shared a number of concerns around mental health that they see in their community; however, barriers to services were their most common concern. Participants discussed the lack of mental health resources for children: *"It's even hard for me to find youth tailored resources to put on that application for parents to get help for their children because a lot of the resources out for mental health and substance use disorder are just for 18 and over."*

Participants are wary about the changes to the clubhouse model in San Diego being more structured around obtaining employment and job readiness skills: *"we used to be artistic and creative and musical"* but the shift *"towards a working model, where now they're going to program us to get jobs"* includes

changes made with *“little to no input”* from people with lived experience: *“Where was our voice in taking this new clubhouse model? In shifting everything away? Like I've heard from quite a few people that they are really disheartened. And now they've left the clubhouse, and that was their little safe place.”*

Participants also shared the need to not only focus on the biomedical model of diagnosis when it comes to mental health. As one participant shared, *“I don't believe that the biomedical model completely answers what these things are…maybe let's stop medicalizing [the mind]…I don't think forced treatment is the way to go. I think it's a very temporary Band Aid fix.”*



All of the participants from each of the focus groups highlighted the importance of peer support specialists in behavioral health programs. As one participant shared, *“A strength about the peer model that doesn't get talked about as much, but it's really learning from one another how to adapt and accommodate within the system.”* Another participant shared the need for BHS administration to respect the expertise of peer support specialists, stating, *“The point is that they expect us to respect their education [BHS administration] and trust that their plan is accurate and successful. But then when we try to use our education, which is street, and drugs, and trauma, they somehow go blind and don't respect our education.”*

Participants recommended more peer-led models of care, as well as more pay for peer support specialists. For instance, one participant stated, *“I would love to see like a Soteria house sort of model where there's this peer community where peers look after each other. And it's this larger sort of ecosystem…imagine if that was funded by the County of San Diego.”* Another participant highlighted the rigorous training for peer support partners and asserted the pay should reflect the work involved: *“This is pretty simple and sounds kind of terse but pay the peer support partners more. Just pay them more. The amount of studying and testing is huge.”* Participants further suggested more active peer specialist recruitment by BHS. One participant added that there should be more recruitment of peers from different ethnicities and cultures: *“BHS should have that active peer recruiting entity that is filling spots that are speaking different languages, that are from different cultures, that are from war torn countries where we're getting the most immigrants.”*

Native American

Two interviews and one focus group participant, an outreach coordinator with a focus on Native American individuals, (for a total of three participants) were members of the Native American community or people who work with the Native American community. Participants shared behavioral health barriers and concerns unique to this community and highlighted how the County can successfully work with them.

Participants reported alcohol consumption as the most prevalent form of substance use in the Native American community. One participant stated, *“[Alcohol] would be at the top of the list because it’s socially acceptable to self-medicate with alcohol.”* The participant later discussed steps the community is taking to help reduce substance use, for instance, *“There are a lot of efforts by the tribes. Many of the tribes are ‘dry,’ where they don't allow alcohol consumption.”* Additionally, they discussed a sober living program

for Native Americans: *"It's called Well-briety, and it's a sober living program that they offer to the community. They follow native a structure that's been built over the years..."*

The Native American community faces a variety of barriers to services. One participant explained, *"A lot of the communities are very frugal and the only access to care are clinics where you get basic needs met… then therapists that work at these Indian Health Services are only there for a short period of time…people get trusted relationships with these therapists, and then they leave... so it's hard to get people to trust in anything."* Additionally, a focus group participant discussed additional barriers, like privacy and the lack of clinics: *"There's only three Native clinics in San Diego County for all Native people here. So, everybody knows everybody that goes to the clinics."* Further, there exists a hesitance to seek help due to past trauma: *"The number one concern is the results of trauma…you see a lot of pathology that is unsociable in people who have trauma, and they want to stick to themselves, or be in groups that feel safe."* Participants also discussed the war on drugs and how specific groups, including Native Americans, were targeted. One participant stated, *"How do we rectify harms caused by the war on drugs? … highlight those that are directly impacted, which according to the County assessment, is Black, Brown, and Indigenous peoples."*

For the County to best engage with the Native American community, a participant recommended the County hold *"little community events, to have a group of people to talk to them and hear them"* and involve the larger community through *"Facebook pages that [Native Americans] get all [their] information from for events that are happening, or funding, or jobs that are out there…all of us just clock on constantly to give each other information, and we trust it, because it's coming from other natives."* Participants recommended the County allows the community to lead the efforts. One participant explained, *"There's a lot of community programs that are already there, that if they were given funding, they would have the trust of the community to start things… a lot of programs that get started, they come in, they get their information, and they leave, and so the community does not want to work with outsiders anymore."*

Older Adults and Caregivers

One focus group was held with six staff with varying roles from a resource center for caregivers of older adults across San Diego County. The participants discussed behavioral health concerns of both caregivers and the older adult population and shared recommendations on how best to support these communities.

For the older adult population, a common problem is the lack of housing options and the associated cost: "*The conversation around housing is a lot around placement and how expensive it is when [clients] have dementia or significant cognitive decline and our caregivers can't take care of them...finding access to affordable or manageable memory care facilities or assisted living facilities, it's so hard.*" Additionally, when discussing barriers for these populations, the participants stated, "*Accessibility in general… some of the systems that these caregivers are working with, multiple doctors, multiple different hospitals, the VA, lots of big entities that may or may not be as helpful.*"

Family consultants highlighted isolation as a primary concern for their clients: *"[There's] still some taboo around mental health in general…a client that I worked with, not only is he experiencing isolation, but then feeling hesitant to even reach out and utilize the supports being offered to him."* Another consultant added insight: *"With the depression piece of loneliness and isolation, there is a lack of support for them with other family members or outside support."*

The participants reported alcohol as the most commonly used substance in the caregiver and older adult populations: *"I think if [substance use] presents, it's if a caregiver's using a harmful coping mechanism to deal with stress."* While an additional family consultant added, *"They report drinking in the evenings, or that type of substance, but I would just say that would be the most common [substance] that is reported to me."*

To further support the caregiver and older adult populations, a participant recommended that BHS creates a system where *"someone can call 211, or call Medi-Cal, or County, or whatever nonprofit, and describe their symptoms and their depression and things, and that person can help them connect to a program."* Further, Spanish-speaking support is needed: *"Somebody actually helping them fill out the application… whether it's applications of Medi-Cal, things like that can be very intimidating, and overwhelming, and time consuming."*

To engage with the caregiver and older adult populations, it was recommended sending *"something like a newsletter, both email and physical options are good for this community."* Family consultants mentioned that caregivers range in age and they believe *"mail would be the most effective if you're trying to reach all generations."* A participant specified, the older generation will likely engage if the information is sent to *"any type of community, whether that's senior living or a senior center, where it's a trusted space."*

Refugee Communities

Two interviews and one focus group, for a total of 11 individuals, included refugees and/or those who work in various refugee communities in San Diego. Each participant had experience with mental health and/or substance use outreach in the community. Interview participants shared their behavioral health concerns and recommendations for effective and culturally appropriate behavioral health services for the refugee communities in the County. The following themes emerged.

Participants identified a number of mental health concerns among people in the refugee community, including depression, anxiety, dual diagnosis with gambling addiction, and substance use problems. Participants described the stigma around mental health from inside and outside refugee communities as a considerable concern and barrier for care. Providers have found that the term "brain health" can help work avoid the stigma around mental health. As one participant shared, *"You can't say directly the mental issues, we have to do something like anxiety or depression or something like symptoms, we talk about the symptoms."*

Access to housing and cost of living were additional concerns: *"It always comes up. Housing is one of the main issues that we are dealing with, especially with refugees who are ending their five-year support, and they need to start finding resources for them in terms of how they're going to pay their rent. Rents are increasing, and it's always a challenge."* Another participant added, *"There is a limit on how much they can work to get cash or health insurance, or food stamps. If the County increased this amount, because when the people say, if I work like $2000, my food stamps and my cash will be cut because I have more than limited."* Participants stated that accessing basic needs is a considerable barrier to addressing behavioral health issues in refugee communities.

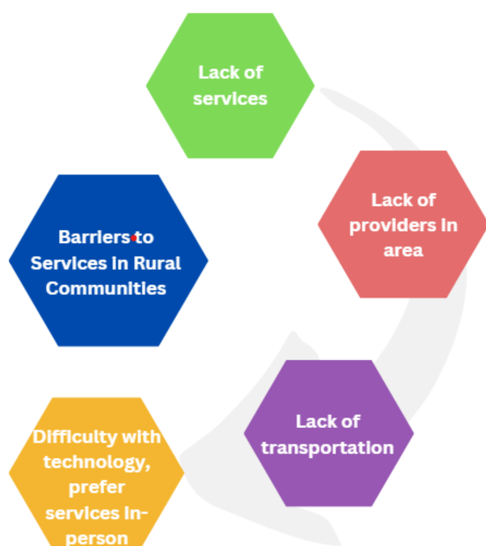
Participants highlighted the need for improved interpretation services: *"Please hire the people with the native language, not the second language."* They further added that interpreters should slow down with communicating to older adult refugee clients. As one participant shared, *"When the interpreters are interpreting, they're doing it so fast, that the older adult doesn't hear or doesn't have a chance to express."*

Finally, participants shared the need for more services for refugees with substance use disorders and for those with mild to moderate mental health issues: *"There's some restrictions on certain programs, because the criteria is still so strict that some of the older adults don't, can't even get near there, or the waiting list is too big. So perhaps some of these contractual entities can enhance or loosen up their criteria a little bit, or they can be giving more money to enhance these programs that are excellent. And what we are finding is that there's not enough services. There's a lot of services for chronically ill, mentally ill, chronic patients, but not for mild and moderate."*

Rural Communities

The following themes emerged from two interviews and one focus group (i.e., a total of four participants) with local medical and emergency service providers in a rural community in East San Diego County. All participants were staff members working in rural community health services.

It was thoroughly noted by the participants that due to the remoteness of this region, there is a general lack of behavioral health services available to community members due to a low number of providers and transportation issues. For instance, one participant stated that rural community members *"either can't drive to the store because they don't have transportation, or they don't have money for gas, to get to the store and the doctor's office and things like that."* Another participant noted the impact of isolation on mental health of the rural community: *"We know people who have suicidal ideation… we definitely have seen that. Anxiety and depression, especially in our teens. And older communities, sometimes it's hard to tell because they're very isolated…and some of the ones that we do know are dealing with dementia and Alzheimer's."*



Participants discussed the wide use of alcohol, marijuana, and methamphetamines in the region, and the perceived differences in substance use between the rural East region compared to other parts of the County. For instance, one participant stated, *"there's probably some fentanyl, but nothing. I don't think it's really kind of hit up here as much as it has down the hill."*

One participant noted the benefits of collaborating with outside organizations to provide additional behavioral health services: *"We just met with the high school, because we just helped get a contract with [another local CBO], who will come in and do therapy and do some, for the students, which will be great. But just in talking to them, the need is so big. Yeah, that I mean, that's not even going to maybe cover all of the students that actually need services."*

Participants also shared recommendations for BHS to expand services in the County such as a mobile behavioral health clinic. As one participant suggested: *"[How about] bringing the resources to them [the community] when they go to these visits because they're already there for medical care, so why not include more talk about mental health there?"*

Another participant noted the importance of pets for providing support and the need to include pets as part of behavioral health services, *"A lot of our patients have pets, and their pets are their families. For example, if there are services that could involve animals or include their pets, something like that, I think would also be beneficial for them."*

To further engage with rural communities in the County, participants recommended maintaining regular contact: *"It's just important to make those services available out there on a recurring basis. Not once a year, not bi-annually. It's got to be more often because maybe these people are at work, or they're not available that day, so they need to have other options on times to go visit and see what's available."* Additionally, an interview participant recommended *"making presentations to the Woman's Club [and] going to the chamber meetings."*

Another focus group participant shared the following details for engaging the rural community: *"Making a relationship with the community, with each individual patient too, to get your foot in the door, and then let them know that you're there for them, you're there to help them. And let them know that you're willing to come out there to see them in their homes or provide resources for them. Once you establish that kind of relationship, I think that's when you can start introducing more talks about mental health, mental health services with them."*

Transitional Aged Youth (TAY)

We conducted three focus groups to gain insight into the TAY community in San Diego. One focus group with four participants was conducted with TAY, while two focus groups, each with three participants, were held with staff who work with TAY in a TAY-oriented clubhouse and/or a non-profit organization. The participants shared the behavioral health concerns and recommendations surrounding the TAY community, based on what they have experienced and witnessed. The following themes emerged.

According to TAY, there are a variety of mental health issues affecting their population: *"I have to be blunt... a lot of suicide rates are going up, a lot of people are turning to drugs because they can't get the*

help. A lot of people are abandoning these people and the government is not giving people enough SSI [Supplemental Security Income] or giving them the proper home they need... we need to have more housing for people with disabilities, the independent living homes are just not it."

When expressing concerns surrounding the mental health of TAY, participants identified a lack of services and providers. One staff member stated, *"Over the last five, seven years, youth are not really considered [San Diego's] priority in mental health because they're not considered high-risk... it's hard to get them seen quick... [and] get services in a rapid manner... we've been told they're just not considered the highest need."* Turnover is another issue: *"Unfortunately, there's turnover of staff where these therapists will leave after six months to a year of working with this youth. And it really devastates the youth."* Income is a factor in turnover: *"People want to be in this field, but they are not having enough money to support their families and not having enough money to live right now, especially with inflation."* Additionally, one staff member discussed the lack of housing services: *"[Housing] is one of the biggest challenges, especially when [Transitional Aged Youth] come in and they want resources, and we don't have resources to give them because all the resources are exhausted."* Similarly, the participants of the TAY focus group expressed concern around Supplemental Security Income amounts while living in San Diego. One participant stated, *"I just had a call from SSI because I'm only getting $59 a month."* Another participant expressed, *"Rent is so high and if they can't lower the rent, they need to up our SSI to at least $2,000."*

Peer support has had a positive effect, according to staff: *"I'm such a big advocate for the peer support role just because both personally and professionally, I have interacted with mental health, I've seen the barriers, personally, with getting access to mental health, because of either cultural stigma, or even class backgrounds that can make it hard for someone to want to engage with services."*

An additional staff participant acknowledged the positives of working with the County and identified an area for improvement. They stated, *"Over the last 11 years, our greatest partner who understands this demographic, more than any year, has been the County. And I just wish that the County would get into helping support the long-term housing piece of youth."*

Participants recommended BHS increase services solely for the TAY to benefit their community. The participant explained, *"The big change was they're starting to become more specific young adult services, and that's helpful, but it's very few of them... if all the resources out there have one worker designed just to work with the TAY, that's helpful, because then the coordination becomes so much more easy. You get a provider who actually understands TAY, and not just a provider who's just providing resources maybe the old school way."* Another participant highlighted the need for BHS flexibility in services for this population: *"They don't adjust to the needs of what our youth are."*

Veterans

We conducted three interviews with Veterans with lived experience who also work with the Veteran community and one focus group with 20 participants from an organization composed of Veterans. These participants shared the most pressing behavioral health concerns and recommendations for the Veteran community. The following themes emerged.

The main mental health concern was the high suicide rates in the Veteran community. One interview participant explained their organization's prevention efforts, *"We're trying to just really enhance suicide prevention networks, increase engagement within Veterans, improve community climate outcomes, reducing gaps, and really improving and increasing adoption of community-based interventions for suicide prevention."* However, participants noted the need for additional suicide prevention efforts and funding for Veteran behavioral health services in the County.

Participants also expressed challenges accessing services for the Veteran community. One Veteran explained, *"I did acupuncture, and it really helped me. Well, there's a waiting list for that. Okay, I'd like to do art therapy. Well, you're not depressed enough to do it at the VA... you can't do this class because you're not in a wheelchair… I wasn't blind enough. I wasn't crippled enough."* If the Veteran is eligible for a service, they explained the additional challenge of waitlists: *"Talk therapies, normally three to six months… the colon clinic, the first time, I waited a month, for the second time anywhere between eight to twelve weeks on average to get started, but you have to do your intake. And then it'll probably be another four to eight weeks afterwards… stuff through the VA, you just kind of have to get in line."* Another Veteran expressed frustration around being in a time-restricted program: *"Everything was numbers… once they've hit 90 days, they've graduated… I get it sometimes facilities are hamstrung by budget or by constrictions…and that's really tough because you got somebody who needs more care."*

Within the focus group, the Veterans expressed continual appreciation for their art programs, and they believe it is a great way for the County to reach the Veteran community. One of the Veterans stated, *"I think [the County] supporting us financially to do more pop-up cafes in our community [is best]. Because actually seeing the average Veteran, creating artwork, and showing it to the community is huge for us. And that's someone actually getting eyes on that's therapy."*

The Veteran community recommended BHS involve more people with lived experience. One focus group participant stated, *"... our staff in the County… I feel that they're committed to help solving problems, but yet, there's not that experience base of living in your car for a while, or hitting bottom as a substance abuser, or losing a child, or getting beat up on the streets, or having domestic violence issues… you get a lot less metrics from those people."* Another interview participant discussed the issue with the County utilizing metrics when trying to reach and educate the general population: *"I see a lot of metrics at the County. And in my opinion, [there is] too much metrics…[it's better to use] anecdotal data. I don't think the vast majority of people are really interested."*

Youth

Two interviews and two focus groups, for a total of 10 participants, with adults who work closely with youth provided insight into the behavioral health challenges, concerns, and recommendations for the youth. Participants ranged in specialty, expertise, and education: from working within different departments in San Diego County school districts, to a behavioral health program, to working with youth in more specialized care.

When discussing the strengths of the youth population, one participant expressed, *"They're amazing, they're so strong. I always would joke that the adults wouldn't be able to come to work with the things that they're going through."* Additionally, a focus group touched on how the youth themselves have difficulty identifying their own strengths, so their program works with the youth for them to recognize their strengths.

The participants discussed various mental health concerns for the youth. Participants listed factors impacting the youth's mental health including income, lack of basic needs, poverty, immigration, refugee status, and the price of gas. One participant expressed, *"Trauma is the number one thing... and it's hard to learn [in school] when you're in it."* The participant also discussed what is reported in their school district: *"Primarily it is a lot of anxiety, depression... students are reporting a higher array of eating disorders... we are seeing a lot of suicidality."* One participant touched on the importance of educating parents as *"kids will identify that they have anxiety, or depression and things like that, but their parents... need further education on mental health for it to help their kids."*

Participants touched on the difficulties and restrictions that come from the County's available mental health services. One focus group participant explained, *"A lot of the County programs outpatient level are short term, six months. So what happens, they can get approved for an additional six months? But with a high turnover rate, where's the continuity?"* Another focus group participant discussed an additional dilemma: *"Thinking in terms of County outpatient programs, because it's Medi-Cal and to meet criteria eligibility for those programs, typically you need to have a severe mental illness diagnosis. What if you have some sort of milder diagnosis? What if you have a personality disorder and would need more than a short-term service?"*

Regarding substance use, vaping was frequently mentioned as a problem with the youth. One participant explained, *"They bring it to school, they're smoking it in the bathrooms... I think they have that misconception that it's healthier than smoking a cigarette."* Another participant discussed the impact of substances on the youth, explaining, *"I also have the opportunity to see, this student was tested three years ago prior to substance use, and now being evaluated three years later, seeing what that decline really looks like in their cognitive functioning, in their memory, and then ultimately, in their academic functioning."*

One focus group discussed cultural barriers the parents and students experience. A participant stated, *"The school district's incredible because they have social workers... however, they're not necessarily Hispanic, or speak the language..."* Another participant discussed the cultural challenge around mental health stigma: *"When I do help, some parents know that their children may need more support. But it takes a process for them to culturally accept."*

A participant who works in a school district explained the benefit of collaborating with the County. They explained, *"Probably the biggest support we receive from County Behavioral Health is their school-link program, where they provide us with an agency that provides counseling support, and that's for Medi-Cal eligible families. And that is through a Youth Enhancement Services Program, and that is extremely helpful..."* Another participant recommended the County continue certain services for the youth, as they have shown to be impactful: *"I would really continue having a school-based mental health provider at*

every single one of our schools. It makes such a difference to the students, it changes their lives... connection, with a safe adult, is a huge indicator of resiliency."