Orange County MHSA Community Engagement Meetings Report

Summary and Analysis of Community Feedback

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Introduction

Orange County has conducted extensive stakeholder engagement activities associated with the Community Program Planning Process (CPPP) for its Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2020-21 through 2022-23. This input is a key component of the CPPP and helps ensure that proposed MHSA programs and services reflect the core principles of MHSA (i.e., community collaboration; cultural competence; wellness, recovery and resilience; consumer- and family-driven decision making; and integrated service experience).

The Mental Health Services Act (MHSA) was passed by California voters in 2004 to transform and expand the mental health system. MHSA funds a variety of programs that provide services to people with mental illness or those at-risk of developing mental illness, to educate and train the mental health workforce, and to ensure that counties are equipped to serve those in need.

In recent years, HCA primarily solicited stakeholder input from written and oral public comments provided during an annual Public Forum. In 2018, HCA shifted toward engaging local community members and providers through separate community engagement meetings (CEMs) hosted in each of the three Service Planning Areas (SPAs; north, central, south). Through this new process, HCA reached a total of 121 community and provider participants in 2018. The 2019-20 CPPP is being carried out on a significantly larger scale than any of the previous public forums or community planning meetings that the MHSA Office has hosted.

One portion of 2019-20 engagement effort consisted of once again engaging local community members and providers through separate community engagement meetings (CEMs) hosted in each of the three Service Planning Areas (SPAs; north, central, south). Through these meetings, HCA reached a total of 153 community and provider participants in 2019.

	Anaheim (North)	Santa Ana (Central)	Aliso Viejo (South)	Total
Organization/Sector Representatives (Providers, Advocates, Etc.)	29	28	21	78
Individual Consumer, Family, and Community Participants	22	37	16	75
Total	51	65	37	153

Overview

This year's CPPP continued the expansion of outreach to stakeholders that HCA began in 2018. In an effort to reach ever more members of the community, HCA began publicizing the planned community meetings several weeks in advance. The meeting invitation explicitly indicated that a meal and refreshments would be provided to all attendees as well as the availability of transportation assistance, interpretation services, and stipends for Consumers, Family, and Community Members. Meetings were scheduled for evening hours and held in community spaces in each of the three Orange County SPAs.

For each meeting, participants were asked to choose one of two groups, depending on whether they were contributing individually as a consumer, family member, or community member or on behalf of an

organization or sector. Each group was welcomed and provided with an overview of the process, and the discussion was framed around four underlying tenets:

- We are all here to share and listen
- We assume positive intent
- We are not here to focus on funding requests, the county procurement process, or identifying potential vendors
- We have a tight schedule so please stick to the timeframes so we can ensure we can gather as much input as possible

To help focus feedback, facilitators structured the discussion to align with the simultaneously occurring community survey. In that survey, respondents were asked to provide demographic information and to indicate the top six groups they identified as having the greatest needs or disparities across the different types of behavioral health services the County of Orange provides. The following table summarizes the service areas and populations/groups respondents were asked to consider.

Service Areas	Populations/Groups
Behavioral Health System Navigation	Children (0-15 years)
Outreach & Engagement	Youth (16-25 years)
Early Intervention	Adults (26-59 years)
Outpatient Treatment	Older Adults (60+)
Crisis Services	Foster Youth
Residential Treatment (non-emergency)	Parent/Families
Supportive Services	LGBTQ
Peer Support	Homeless
Stigma & Discrimination Reduction	Students at Risk of School Failure
Mental Health & Well-Being Promotion	Veterans
Violence & Bullying Prevention	Criminal Justice Involved
Suicide Prevention	Mental Health w/ Substance Use
	Mental Health w/ Medical Conditions
	Racial/ Ethnic Groups
	Monolingual/ Limited English
	Other

Based on the preliminary survey results available at the time the community meetings were held (comprising 865 responses), the discussions were framed around three general population clusters that had been prioritized by survey respondents:

- Children & Youth – Children (0-15 years), Youth (16-25 years), Foster Youth, Students at Risk of School Failure
- Special Populations (LGBTQ, Veterans, Homeless)
- Adults and Co-Occurring Conditions (Mental Health and Substance Use, Mental Health and Medical Conditions)

It is important to note that, while Older Adults, Racial/ Ethnic Groups, and Monolingual/Limited English-Speaking populations were not notably prioritized by survey respondents, community meeting participants consistently identified these population as priority populations. Facilitators encouraged

participants to consider these populations as appropriate within the context of the broader three categories (Children/Youth, Special Population, and Adults/Co-Occurring).

For purposes of the discussion, each group was given the opportunity to break into smaller clusters, by population category, to consider the questions below:

1. What unique barriers limit service opportunities for these populations? (5 Minutes)
   If discussing Funding, Transportation, Staffing, or Translation, please be very specific about how the barrier presents for this population.
2. What outreach and engagement strategies or activities are needed (or work best) for these populations? (10 Minutes)
3. What existing programs, activities, and/or interventions are most successful in meeting the needs of these populations? (10 Minutes)
4. What new programs, activities, and/or interventions should be considered to meet the needs of these populations? (5 Minutes)
5. What one new or existing program, activity, or intervention is the most important or most innovative for meeting the needs of these populations? (5 minutes)

The following document presents a summary and analysis of the three Community Engagement Meetings organized around responses to the five discussion questions. We have also included an appendix with the detailed range of responses, including which area of the county the responses came from and grouped by whether it was provided by someone contributing individually as a consumer, family member, or community member or on behalf of an organization or sector. Responses are further segmented based on which of the three general population clusters was being addressed.

Summary and Analysis

1. What unique barriers limit service opportunities for these populations?

Participants consistently identified a number of barriers at the Policy Level, the Organization or System Level, and the Individual/Family/Community Level. The following table summarizes these barriers.

Barrier Level	Nature of Barrier
Policy Level	• Lack of funding, Limited program capacity, geographic variation
Organization or System Level	• Fragmentation, limitations in care coordination, care transitions • Cultural, linguistic, physical • Lack of trust • Variation in consumer experience across service settings
Individual/Family/Community Level	• Lack of information about mental health and resources • Stigma, self-stigma and stigma from family and community members, fear of discrimination • Housing across the continuum (affordable, PSH, transitional, shelter) • Employment • Transportation • Social isolation

2. What outreach and engagement strategies or activities are needed (or work best) for these populations?

Participants identified an array of needed and effective types of programs. Many of these programs cut across all populations, while others were more specific to the three general population clusters being addressed. The following table summarizes these programs by their population(s) of focus.

Population(s) of Focus	Type of Program Needed
Cross-Cutting – All Populations	• Culturally and linguistically appropriate attention to population-specific needs • Meeting people where they are (not just MH and health/wellness fairs) • Faith community • Peer services • Wellness Centers • Consistent communication across providers • Customer service and empathy • Harm reduction approach • Supported transitions of care • Stable housing
Children/Youth	• Social media • Schools/teachers on early identification of MH issues • Educate youth on importance/value of therapy for stress and emotion management • Incorporate fun, engaging, age-appropriate activities such as sports, games, art in outreach and engagement efforts • Leverage schools for proximity to youth • Youth-oriented organizations like Little League, AYSO, Special Olympics • Parent education
Special Populations	• Shelter-targeted activities • Community-based efforts (not from a desk) • Include consumers in design and development of strategies. Incorporate sufficient time and space to include consumer voice -- not just over a few weeks. • LGBTQ is an umbrella term — it's not a homogeneous group. There is great diversity of experience and different services/approaches work for different groups w/in LGBTQ • Re-entry/transition support • Designated safe spaces/clubs
Adults and Co-Occurring Conditions	• Telepsychiatry • Harm reduction approach • Agency collaboration (provider) • Integrated PC and MH • Social clubs, senior centers • Wellness Centers

3. What existing programs, activities, and/or interventions are most successful in meeting the needs of these populations?

Participants identified many existing programs that successfully meet the needs of the three general population clusters being addressed. Programs with a focus on children/youth were especially numerous. These programs are summarized below by their population of focus.

Children/Youth

- 211
- After school programs & clubs
- Anti-bullying hotlines
- Art classes
- ASPIRE
- Boys and Girls Club
- CHOC mental health programs
- Didi Hirsch hotline
- Drug abuse prevention programs
- Help Me Grow
- Huntington Beach youth shelter model
- internetmatters.net
- "Know the Signs" Training for parents and teachers
- Live Stream, Instagram, Social media — can enhance connection, but can also have negative impacts if not monitored
- savethekids.us
- School based services – screening and counseling
- Seneca Adoption support services
- socialemotionalpaws.com
- South Coast Children's
- Sports/recreational activities
- VROC support services for LGBT youth. (Also includes intergenerational work, language support, social connection)
- Western Youth Services programs for 0-5

Special Populations

- LGBTQ tailored services (community centers, shelter beds/supports)
- Mental Health First Aid
- Life skill development
- Employment supports

Adults and Co-Occurring Conditions

- Wellness Centers
- Social worker/Case Manager assistance at hospital discharge
- Court Diversion programs
- “One stop shop” agencies
- Integrated primary care and mental health

4-5. What new programs, activities, and/or interventions should be considered to meet the needs of these populations? What one new or existing program, activity, or intervention is the most important or most innovative for meeting the needs of these populations?

Participants consistently identified a number of programs at the Organization or System Level and the Individual/Family/Community Level. The following table summarizes these types of programs by the level at which they operate.

Program Level	Type of Program to Consider
Organization/ System Level	• Crisis stabilization units • Transitional and long-term supportive housing

Program Level	Type of Program to Consider
	• Community education campaigns • Contracting shifts to support integration and alignment of services and communication, including cross training of service providers • Culturally and linguistically appropriate attention to population-specific needs • Social media to promote awareness of services
Individual/Family/ Community Level	• Community-based services – where people are • Parent and Family engagement • Integrated whole-person approaches to care • Care coordination • Peer-based services • Targeted outreach

Participants also identified an array of programs, activities, and/or interventions to consider or that they found to be most important or innovative. These programs, activities, and/or interventions are summarized below by their population of focus.

Population(s) of Focus	Type of Program to Consider
Children/Youth	• Residential programs • MH Spirit Week in Schools • Family retreats • School counselors • Mindfulness required curriculum
Special Populations	• Residential programs for those with developmental disabilities and mental health issues • Better access and coordination with medical treatment providers • Public hygiene centers for homeless • Safe parking lots (for services at night, for homeless living in cars) • Partnership with private funded services; MHSA cannot do it all (Community) • Unified case management • Linkage programs (e.g. Vets & Big Brothers / Big Sisters)
Adults and Co-Occurring Conditions	• Transportation assistance • Supportive Housing • Peer supports • Increased integration and communication • Consistent training • Employment supports • Residential programs • Therapists and therapy

Appendix with Anonymous Community Responses

The following appendix presents the detailed range of community responses.

Responses are organized around which of the three general population clusters was being addressed, and by those provided by someone contributing individually as a consumer, family member, or community member or on behalf of an organization or sector. Responses are further segmented by which area of the county the responses came from.

Adults and Co-Occurring Conditions -- consumer, family member, or community member

North County Participants	Central County Participants	South County Participants
Barriers		
• Affordable housing • Finding available services and providers • Lack of residential and inpatient facilities • Lack of social supports in community, isolation • Language barriers for seniors with LEP • Limited employment options • Mental health clients with health problems are falling through the cracks in the health care system • Sobriety requirements for people trying to access MH treatment • Stigma • transportation	• "In fact, they are disempowering them and making them feel ill due to their lack of ability to manage their homes for this population. Sober tenants are being triggered by those who continue to use drugs in these rental homes. Management needs education, certification, and licensure." • "These homes definitely need an overhaul. Any homeowner can rent out their home with out any understanding, education or purpose to help consumers in their well being." • Detox facilities do not address MH • For-profit drug rehab centers with poor outcomes • Inconsistent services across OC • Insurance limits on addiction treatment • Lack of affordable housing • Laws that prevent the study of effects of cannabis • Legal barriers that impede family member involvement • Limited access to medical marijuana • Limited employment • Limited rehab options that take Medi-Cal • Police called out for drug use — lack of trust • Poor quality, insufficient owner/staff training and regulation of sober living facilities • Public lack of information or Disinformation on addiction • Residential TX capacity	• 5150 procedures are not clear; poor communication to family members on the process • Access and transportation for people 60+ and those with physical disabilities • Data confidentiality • Group therapy not covered • Inconsistent access and assistance with SSI • Insufficient training on confidentiality (Veterans with PTSD fear data breach with government agencies) • Lack of knowledge on service options • Lack of providers with expertise in MH/DD • Lack of staff training in addictions • Lack of transportation • Lack of trust • No clear path to care • No inpatient psychiatric hospital beds for people with developmental/intellectual disabilities • Over medication for dual-DX populations • Room and Board options are poor quality • Services are not patient focused • SSI process is hard to navigate • Stigma of mental illness in the workplace • transportation assistance from the hospital

North County Participants	Central County Participants	South County Participants
	• Rx interactions between MH medications and other drug use • Self-medicating/chronic pain • Stigma about addiction • Transportation	
Outreach & Engagement Strategies		
• Harm Reduction Model • Peer support specialists • Provide resources and education early to engage people	• "In Our Own Voice" series from MHSA • Low/no-cost resources in the community • MHA outreach to homeless with co-occurring d/o • Motivational Interviewing techniques • OC Links/warm lines • Peer support programs and educated staff • Peers as first responders rather than police • Public events for MH awareness • Sober living/transitional living homes • Support groups (12 step) • Telecare • Telepsychiatry • Wellness Centers	• Educate school administrators and colleges • Free transportation for disabled • Golden West College course -- for police responders to mental health crises • Implement routine MH screening at early onset intervals • Inpatient activities tailored to level of care and functioning (not all people want to string beads, it's insulting) • Involve churches • OC Same Day Taxi • Peers as first responders in crisis • Police training in CIT • Quick response team with mental health training (other than law enforcement) • Training on early warning signs/symptoms for High School and College aged youth • Use of Patient Navigators • Use senior centers
Successful Programs, Activities		
• Be Well • Co-Occurring Disorder Training • Meet people where they are at and focus on positive relationship building • Peer Recovery • Peer Support Services • Wellness Centers	• AA • Churches • COD Training • College Hospital outpatient group therapy • Consumer education on addiction and MH • Coordinate with universities to expand research based interventions • Court Diversion programs • Group therapy at St. Joseph's in Santa Ana • Job training • MH Court	• AOT (Assisted Outpatient Treatment) • Irvine & Fullerton Police Departments have mental health task force • Non-govt support/therapy for veterans • Peer supports • Social worker/Case Manager assistance at hospital discharge • Supportive Housing • Telecare location in S. County • Well trained Mental Health response team using peers

North County Participants	Central County Participants	South County Participants
	• OC Links/Warm lines for peer support • Peer run programs • Peer Supports • Phoenix House • Police training on how to deal with persons with COD • PSH • Residential treatment programs • Sober living options • Supported employment • Ted Talks on MH • Telecare • Transitional housing • Transportation • Wellness Centers • Wraparound service • YMCA programs	• Wellness Centers
New Interventions if Funding		
• 24/7 Activity Centers • Employment opportunities • Housing • Peer driven and peer provided services • Staff training • transportation to Wellness Centers	• 24/7 Wellness Centers • Better wages for peer support specialists • Clubhouse models where co-ownership/stewardship can be found • Co-occurring d/o training for peer support specialists • Create a Program Development Agency with consumers to increase transparency • Expand geography of treatment programs to improve access • Expand transportation assistance to Wellness Centers, doctor/therapist appointments • HCA needs to hear from us on a regular basis • Increase coordination between PCP and psychiatry for treatment alignment • Increase education and skill level of Peer Support Specialists. • Increase funding for social/community based activities • Increase the # of licensed sober living homes	• County to work with consultants to develop a plan on how to expand residential programs for those with developmental disabilities ad mental health issues • CSU and inpatient beds for people with dual MH/DD issues • Dual Diagnosis Supportive Housing • Gene testing to determine appropriate and best fit psychiatric medications • Increase staffing capacity at Inpatient location Royale in S. county. There are amenities there that are not used due to staffing shortage • Invest in peer training • Peer on police teams • Residential Farmstead model (from TX) where people with MH/DD can live, work and socialize with supervision and supports by trained staff 24/7 • Supportive Housing

North County Participants	Central County Participants	South County Participants
	• Increase transparency • Keep Developmental Center open • More community planning opportunities • More research and education in schools about impact of marijuana use on MH conditions (e.g. paranoia, psychosis, violence) • OAC needs to give peers oversight responsibilities (by law, peers are suppose to oversee and evaluate MHSA programs) • Partner with faith-based organizations • Peer Run programs and agencies • Program evaluation • PSH • Residential treatment programs • Supportive employment	• Training for staff for dual DX MH/DD on self-injurious or aggressive behaviors • Training of law enforcement to recognize DD/ID and use appropriate de-escalation techniques • Transportation
Creative Intervention		
• Community supports that foster greater connection • Education and job training opportunities at Wellness Centers • Peer support services	• Better coordination and transition from jail to community • Integrated care (MH/Addiction treatment) • More community planning • More staff training by peers/consumers • Peer involvement in oversight of programs • Peer Support programs • PSH • Residential treatment • Telecare • Tree House / Mountain Respite Group model for OC • Wraparound programs and services that provide housing, counseling, employment	• Be Well OC needs to include the DD/ID with mental illness population in its service model. OC lacks safe emergency and inpatient psychiatric care for this population that can't be co-mingled with general psychiatric population. • Convene a strategy session with hospital leaders and Be Well OC leadership to discuss how to address psychiatric care for people with developmental or intellectual disabilities • CSU capacity • Expanded options for therapy • More therapists within CalOptima network

Children and Youth -- consumer, family member, or community member

North County Participants	Central County Participants	South County Participants
Barriers		
• Lack of providers with child expertise • Lengthy assessment process then no diagnosis and unclear next steps	• Addiction to smart phones/screens • Children not supervised after school • Cyber bullying via social media platforms • Increasing suicide rates in OC for TAY	• Cost • Cultural issues • Distance to providers • Lack of providers with child expertise

North County Participants	Central County Participants	South County Participants
• Limited options for youth that don't fit into eligibility requirements	• Intersectionality of youth (includes LGBT, homeless, foster youth) • Lack of providers with child expertise • Limited school resources • Need for parental approval to authorize therapy if under 18 • Parents are unaware of issues youth are dealing with • Poor communication/trust between youth/parents • Poor social skills among youth, lack of social connectedness with peers • Transportation • Variation is school resources across the county • Youth not at the table for planning programs and services	• Lack of standard of care • Legal barriers • Parent work schedules • Parents lack knowledge of where to go for resources • Parents not knowing psychiatric issues maybe root cause of problem behavior • Parents not understanding impact and advantage of pursuing an early diagnosis • Shame and stigma associated with mental illness
Outreach & Engagement Strategies		
• Educate schools/teachers on early identification of MH issues • Educate youth on importance/value of therapy for stress and emotion management • Incorporate fun, engaging, age-appropriate activities such as sports, games, art in outreach and engagement efforts • Leverage the schools for proximity to youth • Outreach to youth oriented organizations like Little League, AYSO, Special Olympics • Parent education • Partner with faith community	• Adjust language and communication to youth audience. Youth don't always respond to adult "lingo" • Afterschool programs and activities • Anti bullying programs (cyber bullying text line) • City/School collaboration to increase community events and activities for youth/families • Hope Squad (UT) program with positive outcomes • Leverage the schools for proximity to youth • More resources and educational materials for parents on suicide • Parent education on impact of screen time • Peer mentorship programs • Provide transportation to reach more youth • Stipends to youth to lead efforts	• Culturally sensitive outreach to diverse communities • Educate workforce on serious-emotional disturbance • Educate/train teachers for outreach and engagement • High School career days to educate about career opportunities in mental health • Leverage the schools for proximity to youth • Provide extra funding to schools for training and outreach functions • Respite for parents • Train teachers to know the signs of mental illness • Training on culturally appropriate services
Successful Programs, Activities		
• Anti-bullying programs • ASPIRE • Communications training for teens • Huntington Beach youth shelter model • Personal testimony	• "Know the Signs" Training for parents and teachers • After school programs & clubs • Anti-bullying hotlines • Art classes • Boys and Girls Club	• 211 • ASPIRE • CHOC mental health programs • Help Me Grow • Mental health counseling available in schools

North County Participants	Central County Participants	South County Participants
	• Didi Hirsch hotline • Drug abuse prevention programs • internetmatters.net • Live Stream, Instagram, Social media — can enhance connection, but can also have negative impacts if not monitored • savethekids.us • socialemotionalpaws.com • Sports/recreational activities • VROC support services for LGBT youth. Also includes intergenerational work, language support, social connection	• Mental health screening in schools • Regional Center • Seneca Adoption support services • South Coast Children's • Western Youth Services programs for 0-5
New Interventions if Funding		
• Integrate importance of MH and resource connection into existing sports program • Residential Treatment Centers • Utilize school districts	• Dedicated day across OC schools for positive MH that includes therapy dogs, yoga, stress reduction, social activities and resource sharing • Empower youth to be part of planning of new programs and strategies • Free after school programs • Hold a MH Spirit week • Increase active engagement from parents and schools • Increase community involvement • Increase financial resources for after school programs for all students • Increase opportunities or outdoor play • Limit or ban smart phone usage at school • More counselors in the schools • Peer mentors • Reading programs • Review and enforce School policies re: phone use • Study impact of screen time • Teach parents signs of bullying • Youth centered MH conference that spans all schools, includes all ages, races, sexual orientation and they develop their own workshops	• Cool down program between emergency care and inpatient care • CPS training • CSU in hospitals; inpatient beds for youth • Education/training for law enforcement • Improve access to MH evaluations for youth • Parent respite at hospital ED • Residential Treatment Centers • School District specific programs • Skill training in youth focused services for counselors, nurses, psychologists • Utilize school districts
Creative Intervention		

North County Participants	Central County Participants	South County Participants
• Adapt knowledge of successful shelter programs for youth into existing county programs	• Family retreats and parenting classes • Hope Squad with animals • MH Spirit week • Mindfulness required curriculum • Peer Mentoring programs for youth • Psychologists and counselors on all campuses • Youth driven MH day or conference	• Mindfulness required curriculum • School-based interventions • Utilize school districts for outreach and treatment

Special Populations -- consumer, family member, or community member

North County Participants	Central County Participants	South County Participants
Barriers		
• "Shelters are like prisons" with rule enforcement, lack of privacy, and freedom • Board of Directors attitudes towards these populations • Discrimination against people with criminal record, disabilities • Drug infested shelters • Employment opportunities • Housing voucher process is not transparent • Lack of accountability for government run programs • Lack of affordable housing • Lack of education • Lack of emergency shelters in OC • Lack of food, shelter and clothing for homeless • Limited funding for shelters and services • More people living on the streets than shelters can accommodate • No standard operating procedures • Programs and services not tailored to people who are in school or working • Shelter staff do not have standardized training, do not recognize/respond effectively to MH issues • Stigma, lack of dignity, respect and empathy	• "A gay man's experience is very different from a trans woman. Programs and services need to be tailored to diversity in LGBTQ community." • ***OLDER ADULTS IN CAMBODIAN *** • Appreciate invitation to provide input at meetings but this process is not designed or older adults or LEP populations • Cambodian community wants their voice heard • Detox programs treat addiction but do not dress underlying MH issues • Diagnosis prevents recognition of the needs • Distance to services for veterans (Long Beach too far) • Hard to access HCA services • Hard to self-advocate when providers do not speak our language • Homeless population — often have complex co-occurring d/o • Issues and population intersect — homeless, youth, LGBTQ • Lack of affordable housing • Lack of integrated treatment programs • Lack of interpretation at medical and MH appointments • Lack of PSH	• Homeless do not qualify as "gravely disabled" • Stigma for LGBTQ • Transitional Shelters lack a "safe space" area for LGBTQ residents

North County Participants	Central County Participants	South County Participants
	• Lack of public awareness that it is less costly to house the homeless than leave them on the streets • Lack of understanding about intersectionality of populations/issues leads to fragmented services & programs • Language and cultural competency with ethnic communities • LGBTQ stigma in community • Limited access to community forums • Low pay for peers and AOD providers • Maintaining contact with homeless population • MH condition want to stay sober — challenge to manage MH and chronic pain • MH system navigation is very difficult for monolingual communities • MH/Medical providers fear of drug use impact on Rx • Need more outreach and engagement in Cambodian language in Santa Ana • OC Links is difficult to access due to language barriers • Older adults in Cambodian community experience genocide in 1975 — have significant fear, trauma, anxiety and depression • Overlap with Co-occurring D/O population • Poor advertising of programs lack of knowledge of community services/resources • Poverty • Provider trust • Public access to showers, toilets • Shelter restrictions (e.g., pets must be registered as service animals) • Stigma re: SUD, fears of disclosing to MH or medical providers • Transportation to VA • Transportation is a barrier —many in our community don't drive • Veterans not being tech savvy	

North County Participants	Central County Participants	South County Participants
	• We can't convey our needs to our doctors — we feel frustrated, depressed. We end up hiding our feelings inside • We want to the community to know that mental illness exists at any and every age • Without translators it's hard to seek out or engage in supports — lack of knowledge of where to go for help	
Outreach & Engagement Strategies		
• Meet people in their environment • Migrate existing MHSA programs over to the homeless shelters • Partner with faith community --homeless people need love and to be told God has a plan for them • Targeted outreach at shelters	• "Point in time" count • 1:1 outreach • A person is part of a community — need to tailor O/E to the community they identify w/most • Address and build trust • Churches and shelters • Community -based outreach, not from your desk at an agency • Community driven approaches, designed and owned by the community • Hours of operation to meet community need • Include consumers in design and development of strategies. Incorporate sufficient time and space to include consumer voice -- not just over a few weeks. • LGBTQ is an umbrella term — it's not a homogeneous group. There is great diversity of experience and different services/approaches work for different groups w/in LGBTQ • Phone services with Khmer as an option • Soup kitchens & food banks • Staff training at BH service agencies to improve customer service • Translation of medical/BH services will increase access • Trust building w/LGBTQ prior to outreach and engagement	• Outreach at homeless shelters • Outreach at hospital discharge • Resource centers with information tailored to LGBTQ needs (therapists. Shelter beds, housing)
Successful Programs, Activities		

North County Participants	Central County Participants	South County Participants
• El Mejor (rehab center for homeless population) have activities and counseling • Life skill development • Mental Health First Aid • Peer support specialists • Program referrals based on assessment of level of need • Provide basic needs (food, shelter, clothing) • Psychoeducation • Social skills training • Supportive Employment; job placement • Trade schools and employment supports • Wellness Centers	• College Hospital Santa Ana • Collette's House for battered women • Employment supports • Family-inclusive approaches to treatment (e.g., Latino Health Access) • Gay Pride Celebrations • Home visits • Housing COC • HUD housing specialists/housing voucher programs • Job supports for transgender community • Knowledgeable case managers for community resources (homeless, veterans) • LGBTQ crisis hotlines • Meals on Wheels • Peer mentors • PSH • Separate programs/services that address the unique needs and nuances of the LGBTQ community • Social integration and socialization programs • Supports available to family members • Vietnamese Rainbow of OC (VROC) • Wraparound services (Telecare, Wellness Centers)	• LGBTQ Centers (like those in LA, Santa Ana) • Shelters with separate spaces for LGBTQ and those with addiction issues • Treehouse model for transitional housing
New Interventions if Funding		
• 24/7 LPN needed at facilities • Better access and coordination with medical treatment providers • Court intervention • Customer service training • Employment/job training • Expand treatment/rehab options • Homeless shelter staff training on mental illness signs/symptoms • Wellness Center expansion	• Access to therapists • Community driven and designed programs • Coordination with insurance providers to ensure access to services • Expand PSH • Job training , employment transition training for veterans • More safe and accessible shelters • Personalized treatment for LGBTQ • Public hygiene centers for homeless • Safe parking lots (for services at night, for homeless living in cars) • translation service for medical and MH	• LGBTQ Centers (like Santa Ana) • Safe housing • Transportation

North County Participants	Central County Participants	South County Participants
Creative Intervention		
• County needs to develop and share their definition of "member driven services." • Establish standard operating procedures to create consistent experience for consumers across programs • Assistance navigating the health system • Education and employment pathways • Cross sector training on empathy "we are not heard, not cared for. Everyone working in MH programs needs training." • Increase funding to Wellness Centers for 24/7 coverage	• Address intersectionality in multiple populations/issues • Community socialization programs • Job training • Medical and BH integration • Ongoing member voice and input on program design and decision making • Partnership with private funded services; MHSA cannot do it all • PSH • Shelter Plus Care -- housing vouchers • Sober living options • Transparent oversight of programs	• Employment assistance, resume building, job supports • Housing with tailored supports for LGBTQ • LGBTQ Center in S. County • Transportation

Adults and Co-Occurring Conditions -- on behalf of an organization or sector

North County Participants	Central County Participants	South County Participants
Barriers		
• 211 OC is a problem • Agencies exist in silos and don't necessarily work together • Funding – County does not score RFPs to protect local providers • Information sharing • Lack of integrated services – carve out • Older adults need special consideration • Transportation – Using Uber/Lyft vs county operated services • Transportation hours of operation • Transportation of bedridden clients • Unwillingness of people and agencies to work together • When treating MH condition, other physical needs such as diabetes or others can reduce life span	• Access to care / maintaining a medical home • Burnout • Care coordination among agencies generally, but especially for complex needs • Child care services • Cultural stigma around MH services (i.e., Chinese American parents) • Culturally and linguistically accessible • Difficulties in initiating conservatorship • Eligibility • Expensive, program specific, only for Medi-Cal • Focus on #s vs quality of care • Geographic challenges with referrals (north county vs south) – lack of referral in south • Insensitivity in care delivery • Lack of beds/facilities • Lack of integrated care / assessment of patient needs	• Expensive health insurance, limited medi-cal coverage • Lack of funding for smaller organizations (translation services are expensive, volunteers are hard to depend • Lack of time management • Life pressures • Low referrals to Mission Viejo office because of limited transportation to Good will (bus routes are early morning or late evening) • Organizing life stress • Placing others' needs over yours • Pride in asking for help • Stigma for seeking help • Transportation especially very limited in south • Under staff clinics

North County Participants	Central County Participants	South County Participants
	• Lack of knowledge of services • Language/transportation • MH and medical care integration (lack of/difficult to access) – conditions treated separately • MH and SUD treater separately • Navigation of available services and understanding of process • Need for pay parity across counties – LA and Riverside pay higher • Specialty MH referral, capacity • Stigma in MH • Translations can have problems with terminology • Transportation • Turnover in organizations AND pace of replacement	• Very limited cultural based services -- providers don't speak the language, are not aware of the religious, cultural differences
Outreach & Engagement Strategies		
• Educating PCP on MH conditions • Focus on client identified needs rather than just PCP approach – address social needs • Peer to peer network very effective • Person centered programs, treating person as a whole • Collaboration between agencies • Cost sharing among agencies • Flexible decision making at each agency • Peer to peer • RFPs demand agencies apply together • Treating whole person	• Better activities than just fairs – Art Festival, MY Colors, etc. • Board or forum to share events across the county to get outside the bubble • Just more needed • MHSA Coordinator at each hospital to support services • More cultural sensitivity training available for providers • NAMI OC Event Page • Need for hospitals to coordinate with providers • Population lack of communication • Prioritize to have culturally competent staff members to address monolingual • Using trusted sources from within the community, especially translation • "Disguised" activities • Arts • Carnival • Communication with providers and families	• Better eng from PCP • Broad background of cultures and work • Consistency in support • Develop senior leader or peer support to walk through services hand in hand • Flyers on MH issues • Mobile unit • Need S county advertising • Providers teaching coping skills • PT nav to fu on pts with MH issues • Senior leader/peer support to walk through the support services with the individual recovery services • Supported for a longer period of time and consistency • Annual exams require mental health exams put out flyers about MH teach MH coping skills • Better engagement from PCP patient navigator to follow-up on patients from MH issues • Build trust/relationships

North County Participants	Central County Participants	South County Participants
	• County transparency with decisions and funding and planning process • Cultural sensitivity training • Cultural/linguistic connection • Ducks together • Education on MH services • Having child care services onsite at providers • Hospitals/providers need to coordinate with county agencies • Incentives for diversity • MHSA funded coordinator at every hospital • More staff • Physician engagement • Support for navigation of available services and understanding of process • Trusted sources from within community (translation and outreach/engagement services) • Workforce development	• Having the individual educate us on their situation or community • Mobile unit • More outreach and awareness at primary care clinics, faith based organizations, schools, senior centers, etc. • More psychoeducation for the community • Patient navigator • Providers teaching coping skill vs. focus on masking symptoms with medication • South County advertising, more awareness about mental health programs available, targeting different demographics • Treatment specific for diagnosis – example a therapist that treats OCD
Successful Programs, Activities		
• Integrated PC and MH • OCVMFC – OC Veterans and Military Collaborative • S. Asian Network • Working with other agencies to allocate funds to support populations	• Childcare • MECCA—early intervention services for older adults • NAMI -- walks • One stop shop agencies	• Building a network, they are there forever • Cultural activities depending on audience • Engage consistently with seniors (games, activities) • Peer support • Research audience to see what works to attract and engage • Social clubs are there, senior centers • Those who identify the gaps and niche that certain groups can identify • Wellness center/consumer run support collaboration with faith based leaders to discuss mental health and more awareness • Wellness centers • Working closely with apartment manager (leader)
New Interventions if Funding		

North County Participants	Central County Participants	South County Participants
• Collaborative with agencies serving similar populations, applying for grants together • County incentives to have agencies working together • Dual diagnosis programs • Integrated mental health and primary care and SUD services • Linkage between agencies	• Allocated funds for special programs • Childcare services for working adults / Adult care • Coordination among hospitals, PCPS, agencies – social worker/case management • Immediate bed space • Localize the CA Reducing Disparities Project • More beds for older adults • Spokesperson with lived experience to raise awareness • Stigma reduction	• Aftercare for patient outcomes • Break the barriers • Bridge the care coordination between the family and client • Culturally specific programs • Have a third part mentor or case manager to help with the conditions of the clients • Networking for providers to come together hosted by Be Well • Re-entry/transition support • Supportive services (employment assistance at shelters)
Creative Intervention		
• Be Well has brought together all SUD provider to map put SOC – need to do the same for children and youth and other special populations • Providers have limited interconnection • Veterans outreach needed with peers to the older senior veteran population • Embed MH and PCP • Follow-up for referrals • Get agencies to work together -- Working collaboratively, with agencies working together for shared goal • Look at hospice model with unified payer and team approach • More strategic planning and forums for providers to discuss different populations • Need triage for dual and multi-diagnosis • Peer to peer referrals/navigation helps alleviate language barriers, red tape, transportation	• Childcare services • Importance of peer services and individuals of lived experience • Increasing staff—issue of doing this quickly, due to high burnout and turnover • Localizing CA reducing disparities project • MH Corps – incentives to encourage building the bi-lingual and bi-cultural work force • More beds for immediate response in hospitals • Need for destigmatizing awareness campaign, such as NAMI walks, but with need for OC spokesperson with big name recognition • Need for pay parity across counties – LA and Riverside pay higher • Promoting education and awareness – it's ok to talk about MH and physical health together – integration needs to be normalized • Some folks live with things for a long time that they don't reach out for help until crisis – importance of finding solutions that meet people where they are • Waiver of WET limits	• Awareness and education -- a more in depth wellness day for building willingness to engage in needed testing, assessment, services • Awareness and education -- wellness day to conduct all health tests/public awareness • Engaging trusted partners to use their collaborative efforts and specialization • ID trusted partners within culture mix and geography • Identify and engage trusted partners with a niche (culture, language, geography, etc. • More peer mentors to help • Peer mentors • Trust -- and be there when they are needed or called upon

Children and Youth -- on behalf of an organization or sector

North County Participants	Central County Participants	South County Participants

Barriers		
• Children 0-15 • Community/Agency: In home crisis service as a voluntary program, families opt out, lacking knowledge of the scope of services they need • High ratios of counselors, social workers • Immigration status • Knowledge of services • Lack of beds for children and youth • Lack of coordinated effort to reach services • Lack of coordination of care between agencies • Lack of follow-up • Lack of interconnection and intersection of services, data, and knowledge • Lack of knowledge of referral system • Lack of parent involvement • Medical perspective: lack of knowledge from family with regards to patients coming to the ER needing mental health services • No release of information – parents won't authorize consults • Outreach • Staffing at schools • Stigma • Stigma of MH parents not wanting/being educated on MH issues • Timing and availability of services • Transportation to resources • Wait list for resources	• Delays for private insurance • Follow-up on services • Kids can't get services without diagnosis • Lack of coordination between school districts and HCA • Lack of knowledge from parents and lack of resources • Lack of MH perspective from school staff • Lack of resources in integrating after school program • Need additional expertise in YOUNG children • Parents • School counseling is limited to time • Schools and HCA do not work well together • Stigma of mental health among parents in ethnic community	• 0-5 misunderstanding of ECMH • Access to MH records • Cultural concerns • Funding/staffing for SDOH services • Immigration 0-5 fear of ICE • Lack of coordination/access • Messaging per age for families/parents • Parent concern – educated • Parent connections vs peer connections • Stigma for teenagers • Stigma for underrepresented groups • Stigma/peer • Transportation for immigrant groups • Unengaged family
Outreach & Engagement Strategies		
• [4 different school districts at one table] • Ask for program specialist for mental health – go on website • Bypass parent and go straight to school IF there is a release • Community-based programs at school for parents regarding mental health • District wellness centers, or site based • Early childhood needs addressed in some way	• [Note: Two people in specific community nonprofits, CHOC, and family MHO] • Afterschool program • Aligning for a continuum where there is focus on typical vs. non-typical • Bring outreach and engagement to the people so that it meets them where they are vs expecting them to come (bring MH services to non-MH places) and weave MH into where kids are	• Designated safe spaces for homeless youth and LGBTQ (how to do safe events) need spaces in communities for these groups • Equine programs or vets • In home services – some agencies and school districts can do this, but there is a need for more ability to meet families where they are in home

• ERMHS in some districts • Getting parents linked to their own mental health services • Lack of communication between different agencies, so schools would be good place to capture children -- CHOC communicates with Anaheim elementary when kids are seen or treated and then school-based program can follow-up as appropriate • More prevention activities for parents to access • Networking with different agencies • OC Links • Outreach: more prevention for parents, more early intervention, lots of 0-5 trauma showing up in schools • Psychosocial evaluations, and connection to parents, as well as community-based groups • Psycyoeducational resources – understanding mental health and associated characteristics • Schools are the place for contact, so bringing services onsite might be critical for accessibility • Services are difficult to access, and may not be as offered • Special services / special education • Students and parents access to services that are out there • Theme of the night is coordination – need networking of organizations to communicate across agencies and individuals • Use interns as cost effective way to provide direct services to kids	• Classes not called MH, but really about that to draw in parents and kids • Collaborate with after school programs, provided through trusted CBO in communities • Community events • Don't just target the kids – parents, teachers, coaches, etc. • Families in chaos • Lack of youth rights (i.e., in Chinese community) • Leverage trusted CBOs in the community • Messages that are not MH specific • Partner with wellness centers to reach other students in districts • Peer mentorship program • Peer mentorship program • Problem solving support and education – skill building • Self-reliance / personal development classes incorporated with mental health education • Sports team, clubs, etc. (tie to kids' interest) • Workshops for youth psycho education	• Parent education and support specific to marginalized groups and advocacy • Parent peer partners group of dedicated parent peers to navigate resources or be trusted sources of support to provide guidance to school site or wellness center • Responsive funding mechanism for small organizations • Staff designated and coordinated for community services for homeless youth and LGBTQ • Target groups by geography based on language and culture with trainers and presenters that can bring our families in certain neighborhoods • TIC training and getting service providers trained • Case management • Community outreach • Early childhood services • Early years emotional wellness • Group activities • In home services • Learn early to ask for help • Mentor program for children/youth • Message to adult through lens of child – hope is message • Motivational interviewing • Parent education at schools / connect to other services • Parent/peers partners • Pediatrician outreach/ OB outreach • Peer mode • Peer program • Series of video development to understand condition • Social media • Story/relevant to age group/population and culture

		• Targeted communication for ethnic specific/ language cultural • TAY
Successful Programs, Activities		
• Child care • District resource centers • EDI data to provide services in areas needed • Extended hours • FACES • Flexible hours • Free home visits • Low cost/free programs • Placentia/Yorba Linda District Database with locations • Treatment in wellness centers • Treatment on campus	• Common themes in all programs (i.e., for screen time, sleep, etc.) • Drawing Out Stigma (MECCA) • Faculty and staff education • FRC • Multi generational program to come together through art to express themselves and their coping skills • Normalizing the situation and mental health • Parent education • Peer to peer • Preventive measures to educate children and youth – we need to also get staff, family members, parents and board to normalize situation	• Access California services • Bring things to scale • Care coordination/navigator to help parents through process • CHOC's unit • FSP keeps kids out of hospital • High School youth action team (YAT) – City of Irvine High Schools • Integrated programs with primary care services • NAMI Ending the Silent – Educational Program Teaches parents/students • NAMI on Campus High School program • Out of home care for teens • Peer Assistance Leaders (PAL) • Refugee program
New Interventions if Funding		
• Community liaisons • District wellness center • More school based interventions with flexible hours • Yoga in PE/Mindfulness	• Common messaging • Faculty and staff education • Integrating awareness and services in mental health after school program facilitated by peers • Intergenerational educational program (parents, grandparents, kids) • Nontraditional settings • Normalizing the situation by having consistent, appropriate messages • Normalizing treatment • Peer to peer • Play therapy • Whole family engagement – whole family care	• Advocacy – individual advocates • Care coordination for mental health • Culturally sensitive • More providers • Parent child mentor peer program • Parent education • Resource navigators • Silo integration • Trust based relational intervention (skills based) • Videos series storytelling – Walk in their Shoes -- Understand the condition "Hope needs to be included in the message
Creative Intervention		
• 0-5 trauma • Ability to work with different agencies • Break things down by city and not county • Campus wide peer programs in schools	• Across all providers – deliver the same messaging in each environment • Across all providers, payers – consistency of access, services, payment	• Dedicated programs and agencies to make things less reactive and more focused on T1 and T2, so less need for T3

• Centralized services • Collaboration with school districts and hospitals • Connecting with CHOC-Health Alliance to support the whole family and assist families to know what services the family needs or will need • District wellness centers • EMDR – trauma informed care • Onsite services, including therapy for students • School aged youth: holistic MH and SDOH assessments done in each year with interventions happening at school and referrals to other community agencies • Social emotional learning for all students • Use interns as cost effective way to provide direct services to kids • Wellness centers with on site therapy	• Address mental health of parents • Align child development, physical health, mental health into a continuum of care (with typical vs non typical checks) • Common services across all • Community engagement and outreach • Consistent messaging • Drawing Out Stigma as role model for expressing and addressing MH • Earlier intervention • Parenting classes and kids in non-traditional settings • Skill set building to support reducing potential for SMI • Youth advocacy to galvanize youth into talking about MH	• Find law firms that would do pro bono work to help navigate the legislation and laws that can go beyond one off calls to make changes for individuals • Having dedicated coordinator of resource navigation • MHSA responsive funding and contracting program • More resilience and coping skill training • More well trained staff for these populations • Need for support and parent education • Series of videos/stories talking about mental health challenges – to learn, teach, ex. Amazing Things Happen (re Autism)

Special Populations -- on behalf of an organization or sector

North County Participants	Central County Participants	South County Participants
Barriers		
• (Multi generational trauma) Homeless youth in crisis have parents who can't manage this due to financial stressors • (OC Accept invited to come out to speak to parents but they did not show up) • Are there other agencies out there, as the above ones are the only ones we could come up with • Homeless span county boundaries • Homeless: Many families not identifying as homeless • Homelessness • Housebound individuals • identification and self-identification • Lack of awareness of what services are available and appropriate referrals • Lack of prevention programs for homelessness • Lack of provider training/ sensitivity for populations • LGBTQ – lack of family support / parent consent due to lack of education, cultural barriers, religion	• Criminalization • Fear of retaliation / denial of public services • Getting to providers • Hard to reach • Homeless may not realize they have a need for help – and need help to get the care they need • Immigration status -- People afraid of their own immigration status will not see services • Lack of acceptance • Lack of workforce training • LGBTQ have representation challenges with providers they don't identify with • MH for bilingual • Missing documents • Navigation • Study mindset needs to move to implementation mindset for services and outcomes • Turnover in organizations	• After school supports, transportation • Homeless navigation and eligibility limited tools and understanding of services, access, technology, resources, support. Lack of centralization • Homeless need housing before MH services • ID and immediate access for 5150 hold • LGBT – funding and resources for services and staffing need well trained staff • LGBTQ and validity of information accessed. Limited to what they experience through online • NIMBYism – homelessness, missing money (CA health financing authority) • Parents denial • Restriction of funding sources • Stigma • Stigma to those accessing care

North County Participants	Central County Participants	South County Participants
• LGBTQ – only one center in OC • Need for hospice care for homeless • Needs of female veterans • Parents as barrier for specific populations/services • perceived lack of resources; • Physical and social isolation of populations • Stigma regarding these populations • Veteran: trust in system • Veterans: navigation of what's there and how to get services to them • What is out there is very limited – OC Accept, PSIDE, but minimal connection to these agencies	• Veterans don't use mental health services due to not identifying with the population	• Veterans lack of well trained PTSD knowledgeable staff – more coordination needed
Outreach & Engagement Strategies		
• Collaborations among agencies • Community navigators • Creative outreach to older veterans • District level advisor has been successful in meeting this need and communicating student needs to the district • Education on appropriate referrals • Gay straight alliance • Having onsite services – or at least very close • Homeless: systemic disconnect exists, so having one dedicated person be the case manager instead of 10-12 would be vital • LGBTQ: peers, appropriate language with employers • Meet where people are – service centers, camps • Mobile services • Older adults/veterans collaborating with schools and their children in after school programs • RFPs to encourage collaboration not competition for funding • Staying in contact (peer to peer navigation • Vets: peers	• AA • Acceptance for homelessness (not a criminal issue) • Address common threads of criminalization and higher incidence of homelessness • Better representation from individuals who are part of the population(s) • Churches, community centers • Coordination with multi-ethnic nonprofits with expertise in health and mental health • Coordination with public agencies and service providers • Culturally competent social workers who stat with client long term to navigate services • Facebook groups • Having an older adult vet talk to older adult vet • Immediate services – survival is often the top priority – food, housing, etc. • Including individual on CAT team with the clinical authority to make decisions for admittance • LGBTQ need communities of color representation • Peers and non-licensed workers – low caseload • Peers within whatever segment you're in • Recognize leaders within communities and find a way to give them a role as unlicensed work to support the mission	• Accessibility on the street for crisis response and quick response as well as dose of support • Early intervention • Extensive case management in permanent supportive housing • Extensive case management, esp. PSH for homeless • Family activities • Homeless families – designated space in the community to be able to hist McKinney Vento families – outreach ability and resources to donate clothing • Homeless youth – staff dedicated to coordinate resources • LGBTQ – Designated safe spaces/clubs • Long lasting funding into structure to support continuity of care • Mentor programs for children and youth • MHSA funding • Peer to peer SB10 (purposeful and thoughtful) qualification for those who are peer • Peer to peer support valuing connectivity with acknowledgement of need for live person to connect with • Peers

North County Participants	Central County Participants	South County Participants
	• Steve: need to be teams, not individuals, and need to cover all the needs, acting as a case manager and knowing enough about the services available across the board to be able to develop a plan • Talk with healthcare provider • Trusted messengers such as non-citizens • Unified case management system • Veterans FB groups	• Psycho education for parents and family members • Responsive community engagement • Specialize therapy support • Story telling appropriate to age and culture • Street and accessibility to crisis response – rate of response and dose of treatment • Structure of funding driving support received – need longer lasting funding model when limited during course of care • Trauma Informed Care training • Veterans – Peer programs, creative art activities, equine programs, more capacity at orgs such as Goodwill for employment services • Video messaging to adults through lens of child with story of hope • Video similar to Amazing Things Happen showing what it is like from shoes of those living
Successful Programs, Activities		
• Big Brothers / Big Sisters • Caution about competing for funding • Collaborative efforts across agencies • LGBTQ: need more centers • On campus groups in school districts • Peer advocates • Recuperative care • Supportive housing • USC Mobile Health Clinics • VA	• CHIRLA • CHOC • Community developed activities and services and interventions • LA added probation to O/E to help organize documents, elevate issues, and make ready for services • Life on the Street – transitional housing, laundry rooms, portable baths for homeless • Representatives / liaisons part of the community – better representation to help feel represented • Roles in programs/services for special populations • Use trusted messengers for populations meeting at their community locations using peers	• Counselors trained in nuances and needs of these special populations • HOUSING for homeless • Peer programs – homeless, LGBTQ, veterans • PSH onsite services (project based PSH) • Specific training to providers about specific needs populations • Wrap around services
New Interventions if Funding		
• Allow animals in housing	• Better directory – include special populations and services	• Cal Optima member care coordination – personal care coordinator

North County Participants	Central County Participants	South County Participants
• As pop ages, need to sort out how to help this population • Comprehensive exit plan • Homeless: supportive housing • Hospice care for homeless • LGBTQ: more centers • Mentoring programs • OC Accept • Peer to peer • Search teams for "shut in" veterans • Senior centers as resources for schools • Seniors as volunteers at schools • The Center OC • Veterans: cell phones for all • Veterans: more case managers • Wellness centers, with dedicated areas for homeless, veterans, LGBTQ	• Community Referral Network • Cultural competence • Unified case management for all persons experiencing mental illness coordinating with public and private	• Care coordinators to manage care while in shelters to lower evictions • Collaboration between schools and community/hospitals/providers (with legal resources paid for to figure out paperwork HIPAA/FERPA issues) • Funding for coordination of care • Funding to expand LGBTQ resources in South County • Health Homes • Homeless – more shelters, supportive services, fewer HUD restrictions for mentally ill • Innovative/Intensive case management – Community partnerships, mobile cm, day care, standard of case management, Continuity of support • System navigation groups • Transitioning mechanism and lived experience • Veterans – emotional support animals • Youth – afterschool programs and resources, tutors, school staff dedicated to follow-up and connect after 330 pm to connect with parents about education
Creative Intervention		
• (Largest group of older adults in OC) need for collaboration among agencies and communication across organizations outside of silos and into community and across agencies. Need to develop mutually beneficial relationships such as school district partnering with Jamboree housing • Collaboration among those serving – Schools, Veterans, LGBTQ • Freedom Committee in Costa Mesa • Funding should not be in siloes – increase collaboration and how we can work together • Homeless: Single or dedicated case managers and coordination • Jamboree housing and related supportive services	• Accessible catalogue of all programs • FORE family (Irvine PD) • Having acceptable catalogue provided by the County of all services around the county to support providers and community members • Housing First model • Housing first, plus a social worker/advocate • Identify one lead agency to manage all individual caring for and individual to make it easier for the individual to manage their care and not FIND care • In system services, such as jails • Lead agency or case worker for services to coordinate the system(s) • Link outreach teams with re-entry	• Centralization of services and creating of a hub • EDs and tx facilities need to refer to not just a location, but appropriate services • Identifying what it will look like for referral entities for those currently falling through gaps • Need very readily available 911 of MH services • Video story telling to walk in shoes of individuals and teach • 911 MH service line and dispatch services • Central hub for services – triage center for SPA • MHSA responsive funding mechanism to allow smaller orgs to receive funding without cumbersome RFP process

North County Participants	Central County Participants	South County Participants
• Leverage gay straight alliance at schools and connect those clubs to each other with district level advisor • LGBTQ: Paid peer mentors, or certified trained folks • School funding for social services • Veterans volunteer with Big Brothers / Big Sisters • Vets: Coordination is the key • Vets: Exit exam for MH upon leaving service • What is it we need to be able to work together? • Win win of joining veteran seniors with elementary school students	• Look at how being treated once within system, such as jail – address needs through a culturally sensitive lens • OC Community Foundation has OC ____ a collaborative representing many communities that can help with efforts for non citizens.	• Mobile crisis system tied to ER and treatment as referrals • Resilience training/coping skills training for specialized populations • Telehealth • Well trained staff for more specialized treatment