



# Behavioral Health Integrated Plan Community Forum

January 2026

**Behavioral Health Services Act (BHSA) Program Planning & Administration**

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# Today's Agenda



- Welcome & Opening Remarks
- Community Meeting Purpose & Goals
- New Behavioral Health Integrated Plan
- Statewide Behavioral Health Goals
- Behavioral Health Fiscal Overview
- Community Program Planning Overview
- Discussion
- Timeline & Next Steps

# Welcome & Opening Remarks



# Community Regional Meeting Purpose & Goals

## Purpose

Provide overview of the draft Behavioral Health Integrated Plan (BHIP) including programmatic changes for Behavioral Health Services Act (BHSA) funding

Present an overview of statewide priorities and local data

Share findings from the Community Program Planning (CPP) Process

Review system capacity, fiscal overview, and community input

Create space for discussion, feedback, and collaboration

## Goals

Strengthen understanding of community strengths, needs, and priorities

Advance cross-systems coordination among Behavioral Health, Public Health, and Managed-Care Plan (MCP) partners

Demonstrate alignment between community feedback, requirements, and the Behavioral Health Integrated Plan (BHIP)

Support transparency, accountability, and shared ownership in planning

Finalize community-informed input toward the new Behavioral Health Integrated Plan (BHIP)

*We seek to promote transparency, understanding, collaboration, and equity in behavioral health planning.*



**NEW**  
**Behavioral Health  
Integrated Plan  
(BHIP)**

# About the County Behavioral Health System of Care



The County has a contract with the state Department of Health Care Services (DHCS) to deliver services through the County Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS).

## **Our Services:**

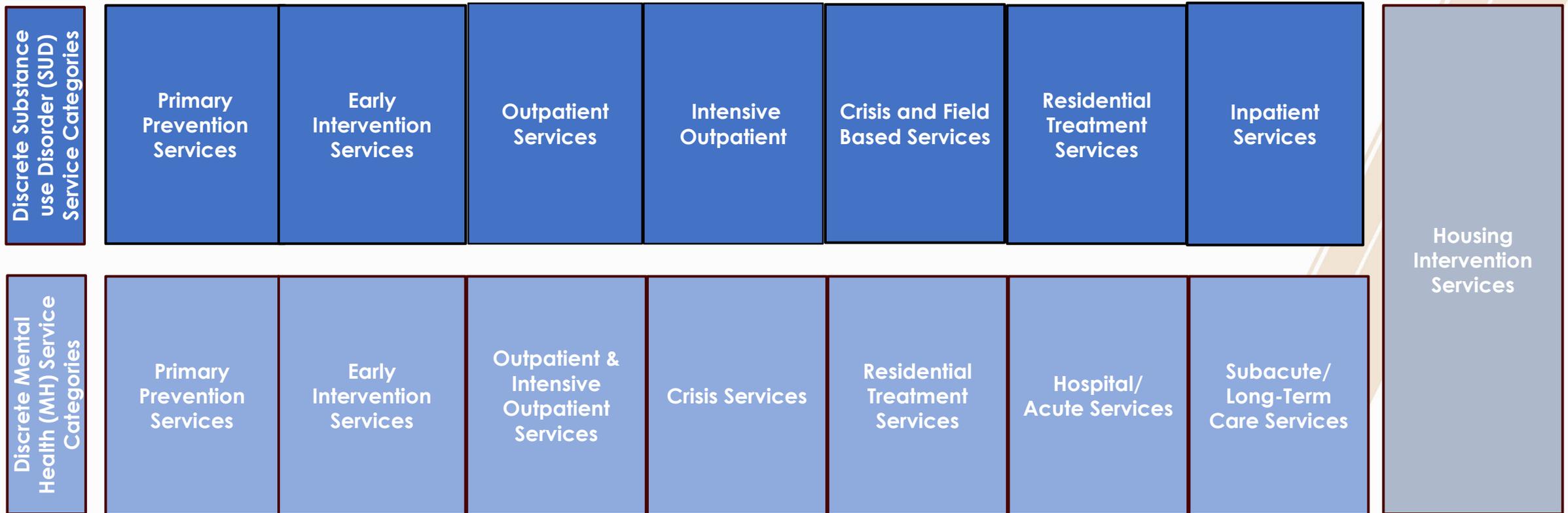
- Mental health (MH) services
- Substance use disorder (SUD) services
- Housing and residential support services
- Crisis and post hospital services

## **Who We Serve:**

- Children/youth ages 0-17 years old
- Adults 18 years and older
- Individuals who reside in Orange County and have Medi-Cal or Medicare insurance
- Uninsured individuals
- Individuals who are at risk of or have more serious mental health and substance use challenges

# 3-Year Behavioral Health Integrated Plan

**3-Year Behavioral Health Integrated Plan (BHIP)** structure for ALL county behavioral health funding sources, not just the Behavioral Health Services Act (BHSA), will be reported via the state-defined Behavioral Health Care Continuum.



# Fiscal Restructuring of the Behavioral Health Services Act (BHSA) “Millionaire's Tax” Funding

## County Allocation vs. State Allocation

4% allocation is made to the No Place Like Home (NPLH) Housing Bond before any monies are allocated to state entities or counties.

86% County Allocation down from 91%

10% State Allocation up from 5%

<p><b>35%</b> Full Service Partnership (FSP)</p>	<p><b>35%</b> Behavioral Health Services &amp; Supports (BHSS)</p>	<p><b>30%</b> Housing Interventions</p>	<p>Minimum of 4% Population Based Prevention</p>
			<p>3% State Behavioral Health Workforce</p>
			<p>3% State Administration</p>

Counties *may* request to transfer a maximum of 7% from any one BHSA funding category to another BHSA funding category with a cumulative transfer maximum of up to 14%. Orange County does **NOT** plan to request to transfer funds between the BHSA funding categories for the first BHIP.

# Behavioral Health Services Act (BHSA) Priority Populations

\*Individuals living with serious mental illness and individuals living with substance use disorders who qualify for specialty mental health services:

## Eligible Children and Youth who:

Are chronically homeless or experiencing homelessness or at risk of homelessness

Are in, or at risk of being in, the juvenile justice system

Are reentering the community from a youth correctional facility

Are in the child welfare system

Are at risk of institutionalization

## Eligible Adults and Older Adults who:

Are chronically homeless or experiencing homelessness or at risk of homelessness

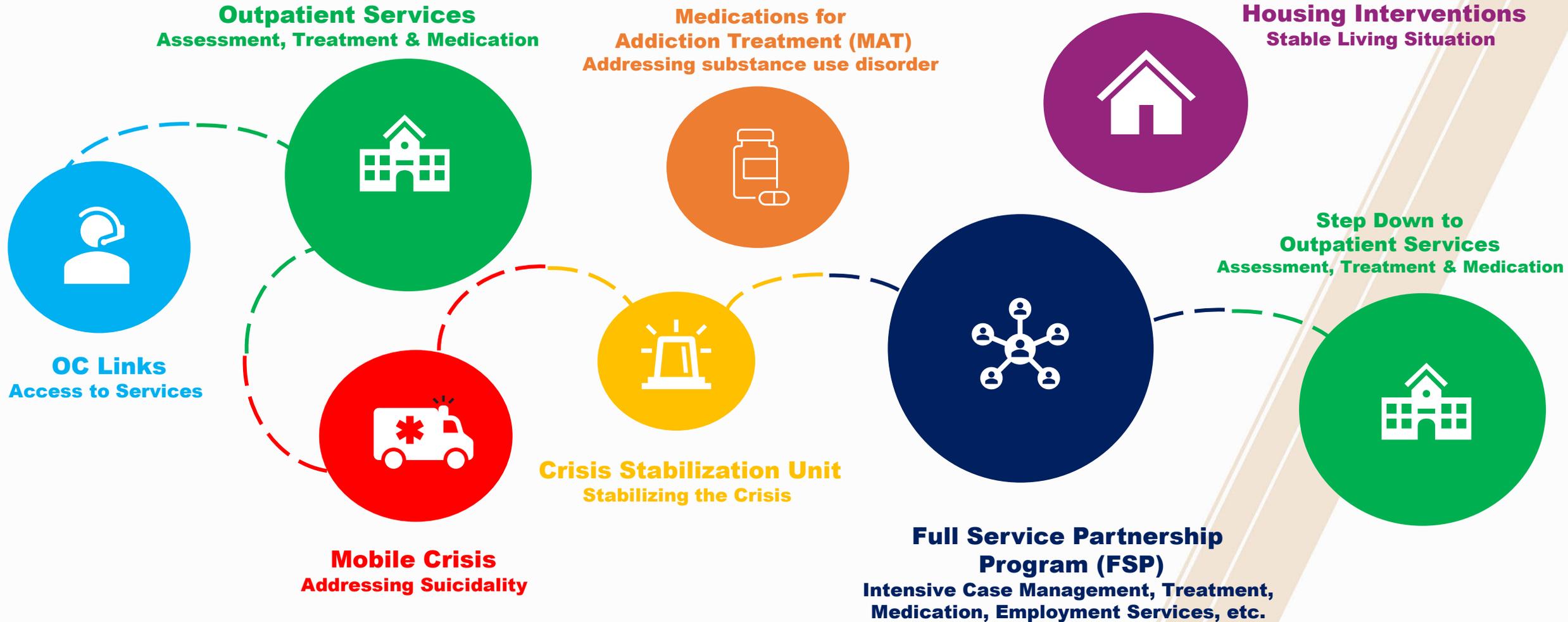
Are in, or at risk of being in, the justice system

Are reentering the community from state prison or county jail

Are at risk of conservatorship

Are at risk of institutionalization

# The Path to Wellness



# Behavioral Health Services Act (BHSA) Planning Workgroups

- This collaborative process combined consumers, system partners, professionals and other stakeholders to work together to create a more equitable system of care.
- These workgroups assisted with our community program planning by ensuring services, treatment and support programs were strategically aligned with community priorities, resources are used effectively, and desired outcomes are attained.

YOU helped to **improve** the health and well-being of the community.

YOU helped **identify** community-defined needs.

YOU helped **develop** strategies to address those needs.

# Behavioral Health Services Act (BHSA) Full Service Partnership (FSP) Identified Gaps & Next Steps

## Identified Gaps

- Use of required Full Service Partnership (FSP) evidence-based practices (EBPs) to fidelity including meeting **required** staff to consumer ratios
- Full Service Partnership (FSP) Level of Care (LOC) criteria
- Referral pathways between the 2 Full Service Partnership (FSP) levels of care and outpatient and other supports including employment and housing
- Need to strengthen local implementation of required assertive field-based for Substance Use Disorder (SUD) and rapid access to Medications for Addiction Treatment (MAT)
- Use of the required American Society of Addiction Medicine (ASAM) Substance Use Disorder (SUD) screening tool at intake for all Full Service Partnership (FSP) consumers
- Substance Use Disorder (SUD) treatment integration into Full Service Partnership (FSP) program

## Next Steps

- Engage in trainings on evidence-based practices (EBPs)
  - High Fidelity Wraparound (HFW)
  - Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT)
  - Individual Placement and Support (IPS) employment model
  - Intensive Case Management (ICM)
- Develop Levels of Care (LOC) criteria
  - FSP Level 2: (ACT/FACT)
  - FSP Level 1: (FSP ICM)
  - Outpatient Level
- Develop referral pathways and workflows for Full Service Partnership (FSP) levels of care (LOC), outpatient, Individual Placement and Support (IPS), housing supports and higher level Substance Use Disorder (SUD) treatment
- Develop process for delivery assertive field-based strategies for the initiation of Substance Use Disorder (SUD) treatment and rapid access to Medications for Addiction Treatment (MAT)

See Appendices for overarching requirements for Full Service Partnerships (FSP)

# Behavioral Health Services Act (BHSA) Full Service Partnership (FSP) Impact on the Behavioral Health Integrated Plan (BHIP)

Estimated Annual Budget for Full Service Partnerships (FSP) for Fiscal Year (FY) 2026/27 \$85,750,000

## Planned Program Implementation or Expansions for Full Service Partnership (FSP) for Children, Transitional Aged Youth (TAY), Adults and Older Adults

- ✓ Utilization of Evidence Based Practices (EBPs)
- ✓ Differing Levels of Care (LOC)
- ✓ Expansion of assertive field-based strategies for the initiation of Substance Use Disorder (SUD) treatment and rapid access to Medications for Addiction Treatment (MAT)
- ✓ Expansion of the Individual Placement and Support (IPS) employment model

# Behavioral Health Services Act (BHSA) Behavioral Health Services & Supports (BHSS) Identified Gaps & Next Steps

## Identified Gaps

- Early Intervention (EI) services for the 0-5 population
- Programs addressing Substance Use Disorders (SUD) specifically
- Capacity for Early Psychosis Early Intervention (EI) services utilizing the **required** Coordinated Specialty Care (CSC) evidence-based practice (EBP) – not enough providers
- Early Intervention (EI) services for older adults
- Desire for Walk-In “Urgent Care” in Crisis Stabilization Units

## Next Steps & Impact on the Behavioral Health Integrated Plan (BHIP)

- Design programming for 0-5 and older adult populations
- Secure Coordinated Specialty Care (CSC) training for the current First Episode Psychosis (FEP) Identification and Treatment program
  - Expand CSC-FEP to build additional capacity
- While not identified as a gap, include Veterans as an important population to be served across programs
- Release Requests for Proposals (RFPs) as needed

# Behavioral Health Services Act (BHSA) Behavioral Health Services & Supports (BHSS) Planned Use - \$112.8M (Estimated)



\$12.6M

## Outreach and Engagement

### Peers

- Hospital In-Reach
- Connection to Recovery Supports and Services

### Community Health Workers

- Access to Physical Healthcare
- SUD connections

### System Navigators

- Field-Based
- Clinics
- Justice In-Reach
- Hospitals
- Schools



\$57.6M

## Early Intervention

### Children and youth

- Family, Infant, and Early Childhood Programs (includes MH Consultation)
- Early Psychosis Identification and Treatment
- Crisis Programs
- Specialized Services, SUD, and Justice-Involved

### Adult/older adults

- Older Adult Early Intervention
- Crisis Programs, including suicide intervention
- Justice Involved Programs (re-Entry)
- Perinatal SUD for uninsured



\$42.7M

## System Supports

### Crisis

- Crisis Residential Program

### Recovery

- Wellness Centers
- Supportive Employment

### Core Services

- Pays for uninsured Children, Youth, Adults, Older Adults with SUD and/or Mental Illness who meet criteria for Specialty Services
- OC LINKS
- Centralized Intake (formerly Open Access)
- Short Term Residential Therapeutic Program (STRTP)

# Behavioral Health Services Act (BHSA) Housing Interventions Identified Gaps & Next Steps

## Identified Gaps

- Specific types of housing needed
- Use of Housing First Model across all housing programs
- Referral pathways
- Use of the Homeless Management Information System (HMIS) system for all housing programs
- Policies needed for all allowable settings and housing interventions

## Next Steps

- Develop referral pathways for Housing Intervention services specific to coordination with Managed Care Plans (MCPs) for use of Community Supports benefits
- Training in Housing First Model for staff and housing providers
- Policy development including partnering with Managed Care Plans (MCPs) and Continuum of Care (CoC)
- Release Request for Proposals (RFPs) as needed

# Behavioral Health Services Act (BHSA) Housing Interventions Impact on the Behavioral Health Integrated Plan (BHIP)

Estimated Annual Budget for Housing Interventions for Fiscal Year (FY) 2026/27 \$73,500,000

## Planned Program Implementation or Expansions for Housing Interventions

*Dollar amount listed is for Year 1 of the Behavioral Health Integrated Plan (BHIP)*

- ✓ Transitional Rent/Subsidies (Permanent or Limited) - \$23.2M (1,820)
- ✓ Capital Development Projects (Permanent) - \$18M (Units TBD)
- ✓ Interim Housing (Limited) - \$11.5M (500)
- ✓ Year-Round Shelters (Limited) - \$1.7M (93)
- ✓ Housing Supports for Full Service Partnership Consumers (Limited and Permanent) - \$4.1M (440)
- ✓ Homeless Outreach & Engagement - \$3.6M
- ✓ Other Housing Supports; Participant Funds, Landlord Mitigation, etc. (Permanent) – \$3.5M
- ✓ Administration - \$7.4M

See Appendices for overarching requirements for Housing Interventions



# Behavioral Health Services Act (BHSA) Statewide Behavioral Health Goals

# Statewide Population Behavioral Health Goals

Health equity will be incorporated into each of the Goals

7<sup>th</sup> Goal Orange County Behavioral Health Services (BHS) will focus on



Goals for Improvement 	Goals for Reduction 
Care experience	Suicides
<b>Access to Care</b>	Overdoses
<b>Prevention and Treatment of Co-Occurring Physical Health Conditions</b>	<b>Untreated Behavioral Health Conditions</b>
Quality of Life	<b>Institutionalization</b>
Social Connection	<b>Homelessness</b>
Engagement in School	<b>Justice-Involvement</b>
Engagement in Work	<b>Removal of Children from Home</b>

**Bold Blue** = The six priority goals counties are *required* to address in the Integrated Plan including actions being taken to improve outcomes related to these goals. Counties **MUST** also identify at least one additional goal in which the county's data is higher/lower than statewide rate or average, e.g., the county is underperforming on the primary measure compared to the state.

*Information related to the County's performance on all of the statewide goals is in the Appendices.*

# Prevention and Treatment of Co-Occurring Physical Health Conditions (Orange County Compared to the State)

Measure	Type of Measure	State Rate	State Median	Orange County Rate
(1) Adults' Access to Preventive/Ambulatory Health Service, 2022	Primary	65%	68%	63%
(2) Child and Adolescent Well-Care Visits, 2022	Primary	50%	48%	53%
(3) Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications, 2022	Supplemental	82%	82%	75%
(4) Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing, 2022	Supplemental	40%	38%	37%



# Behavioral Health Fiscal Overview

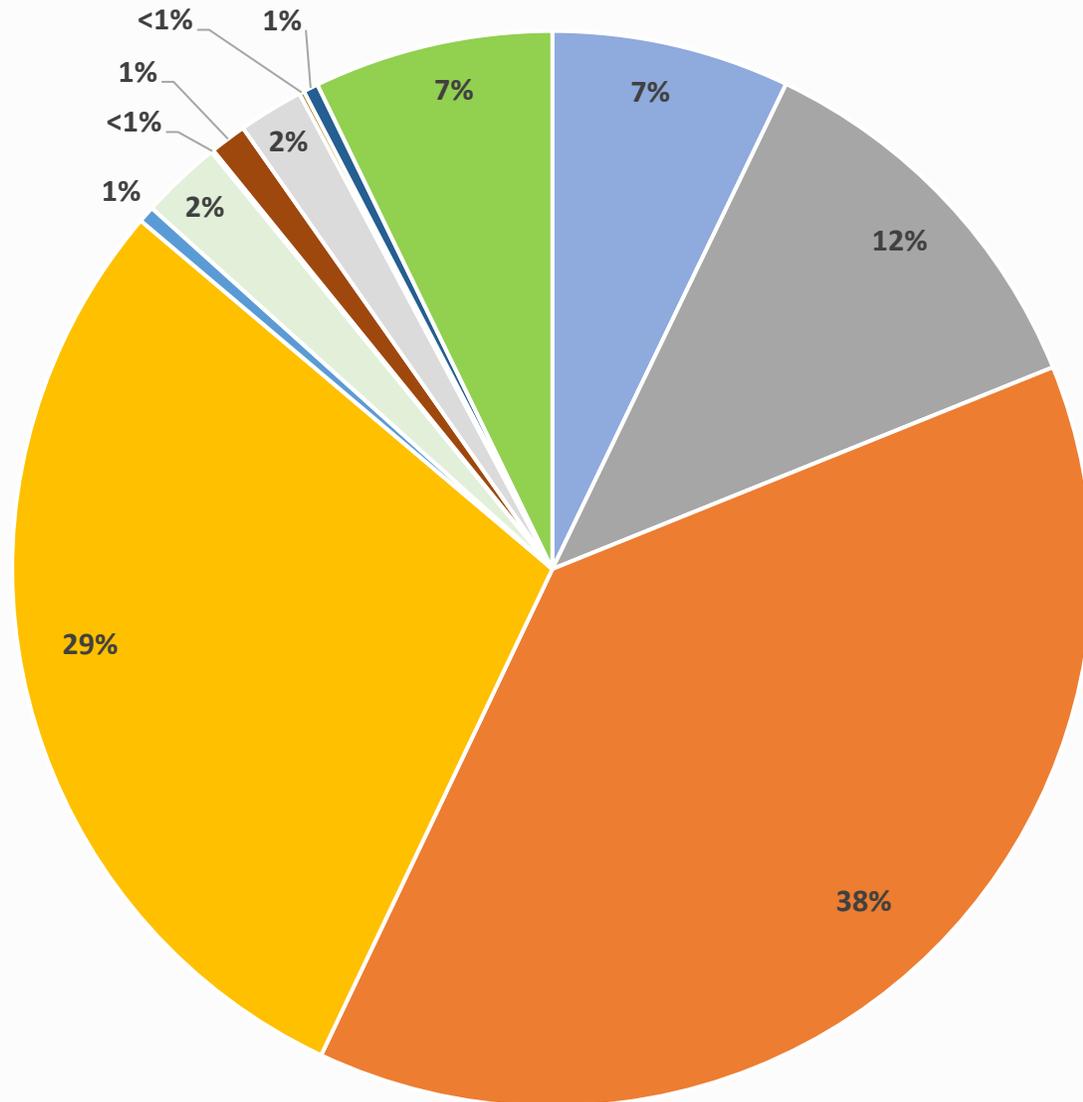
# Estimated Budget for Three-Year Behavioral Health Integrated Plan (BHIP) Fiscal Years 2026/2029

Fiscal Year (FY)	Projected Annual Budget
FY 2026/27	\$797,060,694
FY 2027/28	\$797,060,694
FY 2028/29	\$797,060,694

# Overall Estimated Behavioral Health Budget for Fiscal Year (FY) 2026/27

Funding Source	Projected Fiscal Year (FY) 2026/27
<b>Total Annual Budget</b>	<b>\$797,060,694</b>
1991 Realignment (Bronzan-McCorquodale Act)	\$56,787,449
2011 Realignment (Public Safety Realignment)	\$93,714,672
State General Fund	\$8,753,500
Medi-Cal Revenue (Specialty Mental Health Services [SMHS], Drug Medi-Cal Organized Delivery System [DMC-ODS], Non-Specialty Mental Health Services [NSMHS])	\$232,450,722
Behavioral Health Services Act (BHSA) Planned Use	\$304,164,673
Community Mental Health Block Grant (MHBG)	\$3,942,031
Substance Use Block Grant (SUBG)	\$19,306,499
Projects for Assistance in Transition from Homelessness (PATH)	\$564,842
Opioid Settlement Funds	\$15,538,699
Commercial Insurance	\$1,178,859
County General Fund	\$3,550,301
Other Federal Grants, Other State Funding, Other County Mental Health (MH)/Substance Use Disorder (SUD) funding	\$57,108,447

# Overall Estimated County Behavioral Health Budget for Fiscal Year (FY) 2026/27 (con't.)



**Total Budget for FY 2026/27**  
**\$797,060,694**

- 1991 Realignment
- 2011 Realignment
- Behavioral Health Services Act (BHSA)
- Medi-Cal Revenue
- Mental Health Block Grant
- Substance Use Block Grant
- Projects for Assistance in Transition from Homelessness Grant
- State General Fund
- Opioid Settlement Funds
- Commercial Insurance
- County General Fund
- Federal and State Grants/Other Funding

# BHSA Estimated Budget for Three-Year Behavioral Health Integrated Plan (BHIP) Fiscal Years 2026/2029

Fiscal Year (FY)	Estimated Annual Budget
FY 2026/27	\$304,164,673
FY 2027/28	\$304,164,673
FY 2028/29	\$304,164,673

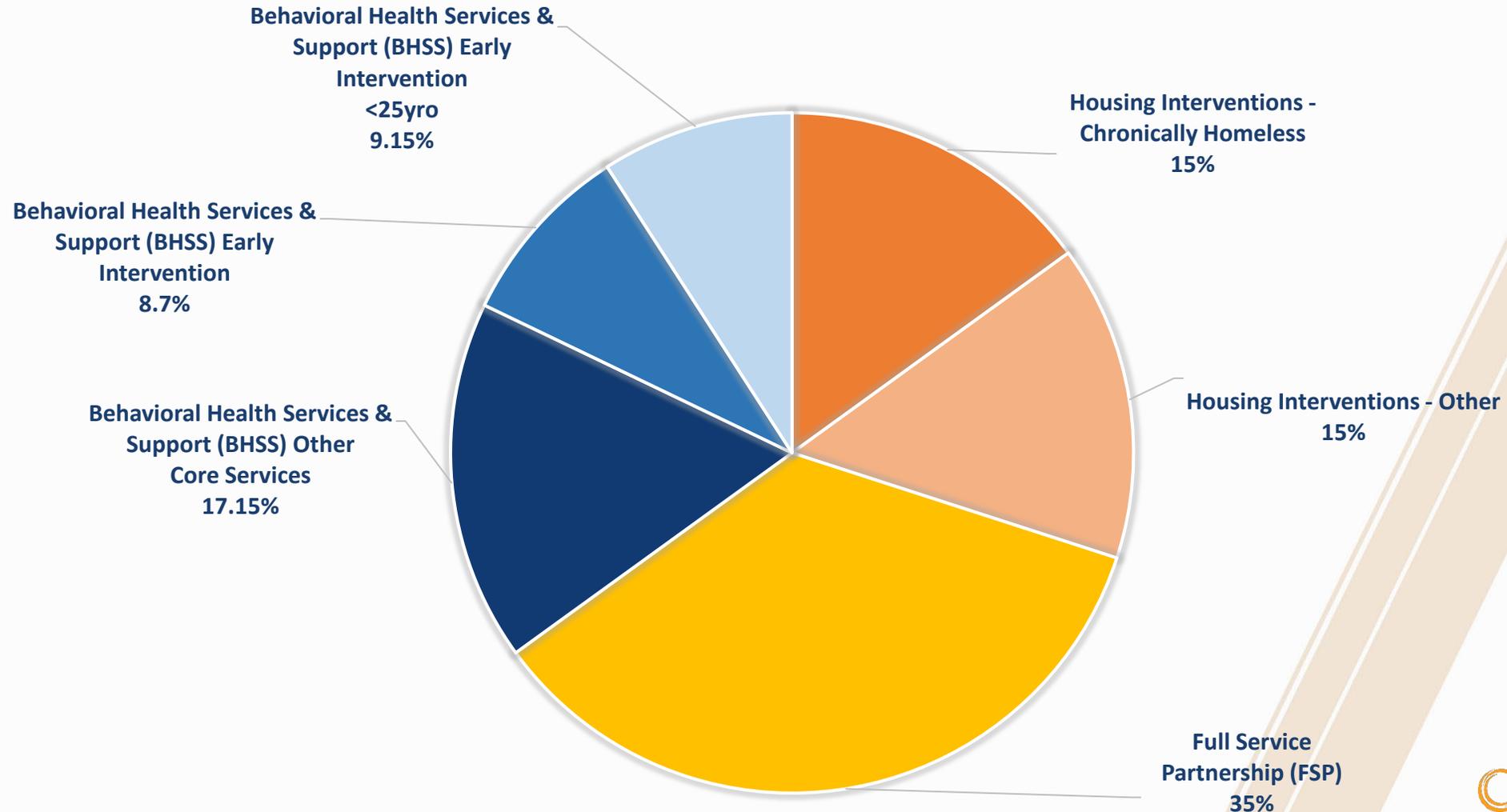
- During the transition from Mental Health Services Act (MHSA) to BHSA, counties are allowed to maintain any allocated encumbered MHSA Innovation, Capital Facilities & Technological Needs (CF/TN) and Workforce Education & Training (WET) funds and continue to spend them down as planned without transferring to the new BHSA funding categories.
 

**Estimated** totals include:

  - \$36,684,983** for current MHSA Innovation projects which are scheduled to end June of 2029
  - \$48,101,792** for CF/TN to support data and analytic systems, the existing electronic health record (EHR) and implementation of a new EHR.
  - \$11,410,385** for WET to support existing and updated delivery of workforce strategies.
- Counties will have flexibility to determine how to utilize their unspent Community Services & Supports (CSS) and Prevention & Early Intervention (PEI) MHSA funds to the BHSA components (BHSS, Housing Interventions, FSP) per local discretion.
  - Estimated** total of unspent CSS and PEI MHSA funding is **\$81,296,859** and will be spent down in the new 3-Year Plan and directed to the Behavioral Health Services and Supports (BHSS) funding category to address anticipated shortfalls and maintain required and current programming.
- The ending balance of Prudent Reserve is **\$33,285,769** and will be maintained at the current levels.

# Behavioral Health Services Act (BHSA) Funding Categories

Local Allocations at County Level (% of total County allocation per \$1M)



# A Closer Look: BHSA Budget for FY 2026/27

Behavioral Health Services Act (BHSA) Funding Category	Projected Fiscal Year (FY) 2026/27 BHSA Incoming Revenue and Budget
<b>Total Annual <i>Estimated Incoming</i> BHSA Funding (millionaire's tax)</b>	<b>\$245,000,000</b>
<b>Housing Interventions - 30% of total incoming BHSA</b>	<b>\$73,500,000</b>
Chronically Homeless (50% of Housing funds)	\$36,750,000
Other (50% of Housing funds)	\$36,750,000
<b>Behavioral Health Services &amp; Supports (BHSS) - 35% of total incoming BHSA</b>	<b>\$85,750,000</b>
<b><i>Allocation of Unspent MHSA CSS and PEI to BHSS</i></b>	<b>+\$27,098,953</b>
<b>New Annual Total for BHSS</b>	<b>=\$112,848,953</b>
BHSS Other (49% of BHSS funds)	\$55,295,987
Early Intervention (EI) (51% of BHSS funds)	\$57,552,966
*EI for <25yro (51% of BHSS EI funds)	*\$29,352,013 of EI funds <i>must</i> be directed to <25yro
<b>Full Service Partnership (FSP) - 35% of total incoming BHSA</b>	<b>\$85,750,000</b>
<b>Innovation Projects</b>	<b>\$12,228,328</b>
<b>Capital Facilities &amp; Technological Needs (CF/TN)</b>	<b>\$16,033,930</b>
<b>Workforce Education &amp; Training (WET)</b>	<b>\$3,803,462</b>
<b>Total Annual BHSA Budget Includes <i>Incoming and Unspent MHSA CSS/PEI funds</i></b>	<b>\$304,164,673</b>



# Community Program Planning Overview

# Transformation/Evolution of the Community Program Planning (CPP) Framework in Orange County

## Fiscal Year 2010/2020 Met Minimum Requirements



Mental Health Services Act (MHSA) Steering Committee – 40-60 Standing Members



Consumer Action Advisory Committee – 12 Standing Members (Ended 2020)



Behavioral Health Advisory Board (BHAB)

## Fiscal Year 2021/2022 Mental Health Services Act (MHSA) Compliant & Met Basic Standards



Mental Health Services Act (MHSA) Steering Committee Ends



Community Informational Meetings – 200 Participants



Behavioral Health Advisory Board (BHAB)

## Fiscal Year 2023/2024 Built Additional Capacity and Inclusion



Mental Health Services Act (MHSA) Planning Advisory Committee (PAC) Begins - 500+ (may be duplicated)



Consumer Voice Included as Equal Part of PAC/Focus Groups



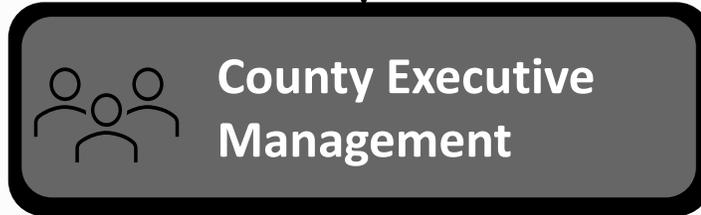
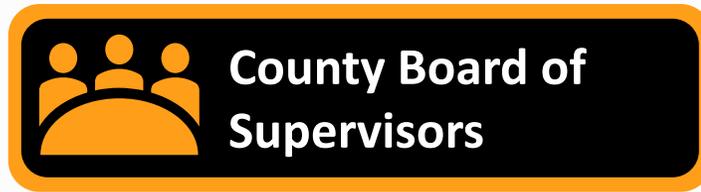
Expansion/Inclusion of Behavioral Health Equity Committee (BHEC)



Behavioral Health Advisory Board (BHAB)

# Current Community Program Planning (CPP) Framework – Started January 2025

Behavioral Health Services Act (BHSA) Compliant and Above Minimum Standards



Reached **1,282** individuals in 2025 to date\* which is a **179%** increase from 2020  
\*as of 12/31/25



# Community Program Planning (CPP) Partners 2025



**Community  
Program  
Planning (CPP)  
Partner  
Organizations**



Community Engagement



Community Engagement



Project Management &  
Community Engagement

Data & Evaluation

**Orange County  
Community  
Consumers, Family  
Members, Community  
Stakeholders,  
Community Based  
Organizations**



# How We Reached Diverse Communities & Priority Populations

## Strategies included:

1. Reached out to cultural ambassadors and existing partners
2. Went to places that communities already gather
3. Focus groups were held in the community's preferred language
4. Incentives provided for consumers, family members, and community members

*See Appendices for a list of coalition and community partners who supported the Community Program Planning (CPP) process*



# Community Engagement Events

**2** Behavioral Health Equity Committee (BHEC) Public Meetings

**3** Community Forums

**3** Behavioral Health Services Act (BHSA) Workgroups launched (Housing Interventions, Full Service Partnership and Behavioral Health Services & Supports)

**5** Behavioral Health Services Act (BHSA) Educational Sessions

**6** Key Informant Interviews

**12** Informational Meetings with systems partners

**20** Breakout focus groups across 3 Community Listening Sessions

**57** Focus Groups with priority population and stakeholder groups across 35 meetings

**22** focus groups were conducted in a language other than English.

These included:

- American Sign Language
- Arabic
- Farsi
- Khmer
- Korean
- Mandarin
- Spanish
- Vietnamese

# A Closer Look at Who We Reached

We reached ALL required BHTA stakeholders (see Appendices) including consumers and family members representing different age groups including youth, adults and older adults across all the Community Program Planning (CPP) events and of the 57 focus groups held we reached diverse communities as outlined below:

41 focus groups were held with diverse ethnic/racial or cultural communities and/or groups that are at greater risk for experiencing health disparities including:

- African American Community
- Asian American/Pacific Islander (AA/PI) Communities
- Cambodian Community
- Chinese Community
- Hispanic/Latino Community
- Korean Community
- LGBTQIA+ Community
- Middle Eastern/North African Community
- Native American/Indigenous Community
- Vietnamese Community
- Person with Disabilities

7 focus groups were held with Behavioral Health Services Act (BHTA) state-defined priority populations and/or other groups including:

- Child Welfare Involved
- Justice Involved
- Lived Experience of Homelessness
- Veterans

# Who Participated in the Community Program Planning (CPP) Process

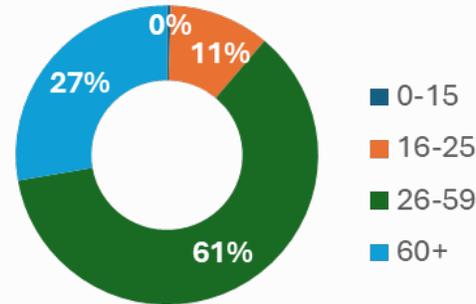
January 2025-December 2025 – Data is subject to change

## County Region Live or Work



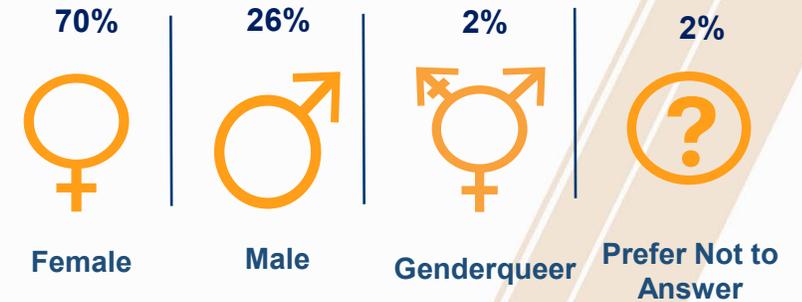
- 34% Central
- 29% North
- 19% South
- 11% All Regions of County
- 4% Other County
- 3% Prefer Not to Answer

## Ages (Years)



- 0-15
- 16-25
- 26-59
- 60+

## Gender Identity



## Race/Ethnicity

- 31% Asian
- 25% Hispanic/Latino
- 24% Caucasian/White
- 8% Middle Eastern/North African
- 8% African American/Black
- 6% American Indian or Alaskan Native
- 2% Native Hawaiian/Pacific Islander
- 3% Other Race/Ethnicity
- 2% Prefer Not to Answer

## Primary Language

- |     |            |    |                      |
|-----|------------|----|----------------------|
| 57% | English    | 3% | Other                |
| 10% | Vietnamese | 2% | Arabic               |
| 9%  | Spanish    | 2% | ASL                  |
| 6%  | Farsi      | 2% | Mandarin/Cantonese   |
| 4%  | Khmer      | 1% | Tagalog              |
| 3%  | Korean     | 2% | Prefer Not to Answer |

## Sexual Orientation

- 79% Heterosexual
- 4% Bisexual
- 2% Asexual
- 2% Pansexual
- 2% Other
- 1% Gay
- 1% Queer
- 1% Lesbian
- 8% Prefer Not to Answer

\*Each participant can select more than one race category.

# Who Participated in the Community Program Planning (CPP) Process

January 2025-December 2025 – Data is subject to change

## Lived Experience Consumers & Family Members

**20%** Consumer of Mental Health Services



**15%** Family Member of Mental Health Consumer

**5%** Consumer of Substance Use Disorder Services

**7%** Family Member of Substance Use Disorder Consumer



**5%**

Military Service



**30%**

Military Family Member



**6%**

Lived Experience with Homelessness

**3%**

Domestic Violence/Sexual Abuse Representatives



\*Each participant can select more than one stakeholder category.

# Categories of Community Feedback

What we asked our Community Program Planning (CPP) participants about

- System Strengths & Resources
- Gaps & Needs
- Barriers & Risk Factors
- Priority Populations as Identified by the Community
- Recommendations

Please see the October Planning Advisory Committee (PAC) meeting slides posted on the website at <https://www.ochealthinfo.com/bhsa-community> for the full Community Program Planning data set.



# High Level Overview of the Community Program Planning (CPP) Findings

## System Strengths & Resources

### Ranked by Top 5

1. Specific Programs/Services
2. Peer Support Providers
3. Access to Care & OC Links
4. County Efforts to Engage Community
5. Wellness Centers

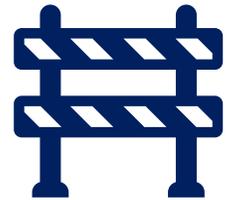


*“[There has been] a growth of services. Citizens throughout the county are getting the care they need. Not just certain cities or regions.”*

## Barriers

### Ranked by Top 5

1. Language & Culture
2. Accessing Care
3. System Navigation
4. Poor Care Coordination
5. Siloed Systems



*“Need culturally appropriate services.”*

## Risk Factors

### Ranked by Top 5

1. Stigma
2. Trauma
3. Lack of Support System
4. Inadequate Housing
5. Isolation



# High Level Overview of the Community Program Planning (CPP) Findings

## System Gaps & Needs

### Ranked by Top 5

1. More Providers
2. Services for Specific Communities
3. More Substance Use Disorder Residential Programs/Beds
4. More Mental Health Long-term Care Facilities/Services
5. More Residential Programs for Individuals with Co-Occurring Mental Health and Substance Use Disorders



*“[There is a] lack of connection to a mental health provider and inconsistency with services while hospitalized.”*

## Groups Identified as Impacted by Gaps in the System of Care

### Not Listed by Ranking

- Black and Indigenous People of Color (BIPOC)
- People with Substance Use Disorders (SUD)
- LGBTQIA+
- Deaf and Hard of Hearing
- Older adults
- Unhoused individuals or individuals at risk of homelessness
- Immigrants and individuals with English as a second language
- Children/Youth

*“There are no treatment centers for Natives at all.”*

# High Level Overview of the Priority Populations Identified by the Community

## Overall Priority Populations

Ranked by Top 5

1. Specific Groups (Adults with Eating Disorders, College Students, People with Disabilities, Vietnamese Community)
2. Older Adults
3. Consumers of Substance Use Disorder (SUD) Services
4. Immigrants & Refugees
5. Children & Youth



## Youth Priority Populations

Ranked by Top 3

1. LGBTQIA+
2. Youth At Risk of Homelessness
3. Youth At Risk of Justice Involvement



## Adult/Older Adult Priority Populations

Ranked by Top 3

1. Adults At Risk of Homelessness
2. Older Adults At Risk of Homelessness
3. Re-entering Community after Justice Involved placement



# High Level Overview of the Community Recommendations

## Suggestions to Improve the System of Care

### Ranked by Top 5

1. Increase outreach and engagement, awareness and education, and build community trust
2. Increase representation and cultural competence
3. Provide specific programs, services, and trainings
4. Increased spending on behavioral health, community-based organizations, transportation, etc.
5. Organizational growth (improved coordination, transparency, continuity, referrals, and capacity)

# Discussion



**What surprised you?**

**What resonated with you?**

**What do you still have questions about?**



# Timeline & Next Steps

# Behavioral Health Integrated Plan Community Planning Timeline

## Community Program Planning Reporting

Jan – March 2025

Plan & Assess

Community planning PAC Kick-Off, listening and data sessions throughout county, co-chair(s) recruitment and selection process

Listening and Data Overview Sessions

April – May 2025

Committees & Focus Group

PAC (April) data summary, committee co-chair selected and announced, committee work begins; BHAB CPP report out (April)

Workgroups Start

June – Sept 2025

Program Planning

PAC (July) - Committee Report Outs, review for program/system intersectionality, finalize draft programs, align evaluation plans/metrics with state requirements; BHAB CPP report out (July), and Community Forums

Community Forums

Oct – Dec 2025

Draft Plan Review

Draft Integrated Plan worked on, internal review, CPP report out at BHAB and PAC (October)

Jan – March 2026

Approve & Post

Finalize Integrated Plan, BHAB report out, DHCS approval, 30 day posting, continue Plan overview meetings during posting, implementation planning, setting up administrative infrastructure

April – May 2026

Public Hearing

Host Public Hearing, implementation planning, establishing admin infrastructure (RFPs, contract modification development, set up of financial tracking mechanisms, evaluation systems, policies and procedures, etc.)

June 2026

Board Approval

Approval, implementation continues Upon approval





# Thank You for Your Participation



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**Or check out our website**

[www.ochealthinfo.com/bhsa-community](http://www.ochealthinfo.com/bhsa-community)



**For questions, please contact**

BHSA at (714) 834-3104 or  
email [bhsa@ochca.com](mailto:bhsa@ochca.com)

# Thank You for Your Participation



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for survey

## Demographic Survey

[https://ochca.sjc1.qualtrics.com/jfe/form/SV\\_6VEIbsgUCnpL1wq](https://ochca.sjc1.qualtrics.com/jfe/form/SV_6VEIbsgUCnpL1wq)



Access QR code  
for survey

## Satisfaction Survey

[https://ochca.sjc1.qualtrics.com/jfe/form/SV\\_ef96OKxSvDnqCiy](https://ochca.sjc1.qualtrics.com/jfe/form/SV_ef96OKxSvDnqCiy)

# Thank you for your participation. Please stay connected!



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# Appendices

# Appendices: Full Service Partnership (FSP) Overarching Requirements

## 35% of the total BHSa funding:

- FSP programs provide **individualized, recovery-focused, age-appropriate care** for individuals with significant behavioral health needs.
- Services are delivered by multidisciplinary teams in partnership with families or the individual's natural supports and are anchored in a **“whatever it takes”** philosophy.
- Under BHSa FSPs will have 2 levels of care (LOC) one utilizing identified intensive Evidence-Based Practices (EBPs) and a step-down level utilizing Intensive Case Management (ICM)

## FSP are required to:

<b>Utilize</b>	Utilize Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEPs)
<b>Conduct</b>	Conduct the American Society of Addiction Medicine (ASAM) screening during the assessment
<b>Offer</b>	Offer medications for addiction treatment (MAT) or have an effective referral process in place
<b>Coordinate</b>	Coordinate with a Full Service Partnership (FSP) participant's primary care provider as appropriate
<b>Provide</b>	Provide ongoing engagement services to include peer support services, transportation and services to support maintaining housing

# Appendices: Behavioral Health Services and Supports (BHSS) Overarching Requirements

## 35% of the total BHSA Funding:

- Stigma and discrimination activities **cannot** be funded with BHSS Early Intervention (EI) these would be funded by the state via the population-based prevention
- There are 9 EI priorities the county **must** address\*
- Early Psychosis programming utilizing the Coordinated Specialty Care (CSC) model is **required**

## BHSS Other funds **can** be used for:

- Children's, Adult and Older Adult Systems of Care
- Outreach & Engagement (O&E)
- Workforce Education & Training (WET)
- Capital Facilities & Technological Needs (CF/TN)
- Innovation Pilots & Projects (expected across all BHSA funding categories)

## BHSS EI **must** include:

Outreach

Access and linkage to care

Mental Health and Substance Use Disorder early treatment services and supports

Include culturally responsive and linguistically appropriate interventions

Emphasize the reduction of the likelihood of specifically listed adverse outcomes

# Appendices: Behavioral Health Services and Supports (BHSS) Early Intervention (EI) Mandated Priorities

## BHSA Mandated EI Priorities per BHSA

Childhood Trauma Early Intervention to Deal with Early Origins of Mental Health & Substance Use D/O Needs

Early Psychosis & Mood Disorder Detection and Intervention & Mood Disorder Programming Across the Lifespan

Outreach & Engagement Targeting Early Childhood 0-5, inclusive of Out-of-School Youth and Secondary Youth

Culturally Responsive & Linguistically Appropriate Interventions

Strategies Targeting Mental Health & Substance Use D/O Needs of Older Adults

Strategies Targeting MH Needs of Children 0-5 Including Infant & Early Childhood MH Consultation

Strategies to Advance Equity and Reduce Disparities

Programs that Include CDEPs and EBPs, and MH and SUD Treatment Services

Strategies Addressing Needs of Individuals at High Risk of Crisis

# Appendices: Housing Intervention Overarching Requirements

## 30% of the total BHSA Funding:

- 50% of the Housing funds **must** be used for individuals who are chronically homeless with a focus on encampments
- 25% of the Housing Intervention funds may be used for housing capital development projects
- Core components of Housing First Model **required** across Housing Interventions
- BHSA funds **cannot** be used to pay for benefits covered by MCPs
  - ***BHSA subsidies cannot be paid until an individuals' transitional rent benefit is fully exhausted***
- Counties **cannot** use these funds for Mental Health (MH) or Substance Use Disorder (SUD) treatment or case management programs

## Allowable Housing Interventions include:

Rental Subsidies

Operating Subsidies

Allowable Settings

Other Housing Supports

Capital Development

# Appendices: Allowable Housing Settings

## Non-Time Limited Permanent Settings

Supportive housing

Apartments, including master-lease apartments

Single and multi-family homes

Housing in mobile home communities

Single room occupancy units

Accessory dwelling units, including Junior Accessory Dwelling Units

Tiny Homes

Shared housing

Recovery/Sober Living housing, including recovery-oriented housing

Assisted living (adult residential facilities, residential facilities for the elderly, and licensed board and care)

License-exempt room and board

Other settings identified under the Transitional Rent benefit

## Time Limited Interim Settings

Hotel and motel stays

Non-congregate interim housing models

Congregate settings that have only a small number of individuals per room and sufficient common space (not larger dormitory sleeping halls; does not include behavioral health treatment settings)

Recuperative Care

Short-Term Post-Hospitalization housing

Tiny homes, emergency sleeping cabins, emergency stabilization units

Peer respite

Other settings identified under the Transitional Rent benefit

# Appendices: Orange County's Performance on the *6 Required* Statewide Population Behavioral Health Goals

Goal	Better <i>(than state)</i>	Same <i>(as state)</i>	Worse <i>(than state)</i>
Improve Access to Care	<p>NSMHS Penetration Rates for Children &amp; Youth</p> <p>NSMHS Penetration Rates for Adults</p>		<p>SMHS Penetration Rates for Adults</p> <p>SMHS Penetration Rates for Children &amp; Youth</p> <p>DMC-ODS Penetration Rates, Adults</p> <p>DMC-ODS Penetration Rates, Children and Youth</p>
Reduce Homelessness	<p>PIT Count Rate of People Experiencing Homelessness</p>		<p>Percent of K-12 Public School Students Experiencing Homelessness</p>
Reduce Institutionalization	Data Not Available		
Reduce Justice-Involvement	<p>Arrests: Juveniles</p>		<p>Arrests: Adults</p>
Reduce Removal of Children from Home (foster care)	<p>Children in Foster Care</p>		
Reduce Untreated Behavioral Health Conditions			<p>Follow-Up After Emergency Department Visit for Mental Illness</p> <p>Follow-Up After Emergency Department Visit for Substance Use</p>

Performance is based on state-defined primary measures/metrics as listed in the table.

# Appendices: Orange County's Performance on the *Remaining* Statewide Population Behavioral Health Goals

Goal	Better <i>(than state)</i>	Same <i>(as state)</i>	Worse <i>(than state)</i>
Improve Care Experience	<p>Quality Domain Score: Perception of Cultural Appropriateness – Adults</p> <p>Quality Domain Score: Perception of Respect - Adults</p>	Quality Domain Score: Perception of Respect - Youth	Quality Domain Score: Perception of Cultural Appropriateness - Youth, Families, and Older Adults
Improve Engagement in School	12th Graders Graduating High School on Time		
Improve Engagement in Work	Unemployment Rate		
Reduce Overdoses	All Drug-Related Overdose Deaths (Rate)		
Improve Prevention & Treatment of Co-occurring Physical Health Conditions	Child/Adolescent Well-Care Visit		Adult Access to Preventive/Amb Care Service
Improve Quality of Life	Perception of Functioning Domain Score - Adults		Perception of Functioning Domain Score - Youth, Families and Older Adults
Improve Social Connection	Perception of Social Connectedness Domain Score - Adults		Perception of Social Connectedness Domain Score - Youth, Families and Older Adults
Reduce Suicides	Suicide Deaths		

Performance is based on state-defined primary measures/metrics as listed in the table.

# Appendices: Community Program Planning (CPP) Required BHSA Stakeholders

The County engaged ALL required stakeholders during Community Program Planning to develop the new Behavioral Health Integrated Plan.

- Eligible youth, adults, older adults and families as defined in Section 5892
- **Youths or youth mental health/substance use disorder organizations**
- Providers of mental health/substance use disorder treatment services
- Public safety partners including **county juvenile justice agencies**
- Local education agencies
- **Higher education partners**
- **Early childhood organizations**
- **Local public health jurisdictions**
- County social services and child welfare agencies
- **Labor representative organizations**
- Veterans and representatives from veteran organizations
- Health care organizations, **including hospitals**
- Health care services plans including Medi-Cal managed care plans
- **Disability insurers**
- **Tribal and Indian Health Program designees**
- **Representatives from the five most populous cities in counties with populations greater than 200,000**
- **Area Agencies on Aging**
- **Independent living centers**
- **Continuum of care including representatives from the homeless services provider community**
- **Regional Centers**
- **Emergency medical services**
- **Community-based organizations serving culturally and linguistically diverse constituents**

**Bold are newly required stakeholders**

Partner representation **must** include individuals representing diverse viewpoints to include but not limited to **youth representatives from historically marginalized communities; representatives from organizations specializing in working with underserved racially and ethnically diverse communities; representatives from LGBTQ+ communities; victims of domestic violence and sexual abuse; people with lived experience of homelessness.**

# Appendices: Community Program Planning (CPP) Coalitions & Partners Engaged in CPP Process

## Existing Coalitions & Committees

- ✓ Behavioral Health Equity Committee (BHEC) and Subcommittees
- ✓ Orange County Housing Continuum of Care (CoC)
- ✓ Orange County Asian and Pacific Islander Taskforce (OC API Taskforce)
- ✓ Orange County Crisis Intervention Team (CIT) Committee
- ✓ BHSA Workgroups (Housing, FSP & BHSS)
- ✓ Planning Advisory Committee (PAC)
- ✓ Homeless Response System County
- ✓ Community Reinvestment Workgroup
- ✓ Orange County Family, Infant, and Early Childhood Mental Health Initiative Roadmap Working Group
- ✓ Child Welfare System Improvement Plan
- ✓ OC Juvenile Justice Committee

## Community-Based Organizations & Partners

- ✓ Council on Aging
- ✓ Rescue Mission
- ✓ Project Kinship
- ✓ OC Veterans
- ✓ Latino Access Health
- ✓ Access California Services
- ✓ Korean Community Services
- ✓ Sacred Path
- ✓ AHRI Center
- ✓ BPSOS Center for Community Advancement
- ✓ Thrive Together OC
- ✓ Southland Integrated Services
- ✓ Pacific Islander Health Partnership
- ✓ Afghan American Muslim Outreach
- ✓ Tiyya Foundation
- ✓ OMID Multicultural Institute for Development
- ✓ Second Baptist Church
- ✓ Orange County Herald Center
- ✓ Orange County Asian and Pacific Islander Community Alliance
- ✓ Vital Access Care Foundation
- ✓ Viet Rainbow of Orange County
- ✓ UCI
- ✓ Adult Wellness Centers
- ✓ Wellness & Prevention Center at Capistrano Union High School
- ✓ First 5 Orange County
- ✓ CalOptima Managed Care Plan
- ✓ Kaiser Managed Care Plan