

Orange County Needs and Gaps Analysis



FINAL REPORT – October 2019

Part 1: Prevalence of Mental Health Symptoms and Service Utilization

Part 2: Geographic Access to Behavioral Health Services and Other Behavioral Health Provider Facilities

Part 3: Barriers to Behavioral Health Care from Provider/Advocate and Cultural/Linguistic Minority Community Members' Perspectives



Table of Contents

INTRODUCTION	4
PART 1: PREVALENCE OF MENTAL HEALTH SYMPTOMS AND SERVICE UTILIZATION IN ORANGE COUNTY	5
1. Mental Health Symptoms among Adults, Transitional-Aged Youth and Veterans in Orange County	5
1.1 Introduction	5
1.2 Prevalence of Serious Psychological Distress among Adults	6
1.3 Prevalence of Serious Psychological Distress among Transition Age Youth	10
1.4 Summary	11
2. Mental Health Service Utilization among Adults and Transitional-Aged Youth in Orange County	12
2.1 Introduction	12
2.2 Untreated Mental Health Symptoms among Adults	13
2.3 Untreated Mental Health Symptoms among Transitional-Aged Youth	19
2.4 Summary	19
3. Mental Health Symptoms and Mental Health Service Utilization among Adolescents (ages 12–17 years) and Children (ages 4–11 years) in Orange County	20
3.1 Introduction	20
3.2 Mental Health Symptoms and Untreated Mental Health among Adolescents	21
3.3 Mental Health Symptoms and Untreated Mental Health among Children	22
3.4 Summary	24
4. Mental Health Symptoms and Mental Health Service Utilization among Homeless Persons in Orange County	25
4.1 Introduction	25
4.2 Mental Health Outcomes among Homeless Persons	25
4.3 Untreated Mental Illness among Homeless Persons	26
PART 2: GEOGRAPHIC ACCESS TO BEHAVIORAL HEALTH SERVICES (BHS).....	27
5. Geographic Availability of BHS.....	27
5.1 Introduction	27
5.2 Geographic Distribution of Behavioral Health Services in Orange County	28
5.3 Geographic Distribution of Behavioral Health Services in Select Cities.....	29
5.4 Geographic Coverage of Behavioral Health Services by Age	30
5.5 Geographic Coverage of Behavioral Health Services by Insurance Coverage	31
5.6 Geographic Coverage of Behavioral Health Services for non-English Speakers	33
6. Geographic Distribution of Behavioral Health Services and Serious Psychological Distress.....	50
7. Geographic Disparities in Behavioral Health Services.....	51
8. Estimating Needs Related to Hospital and Emergency Department Utilization for Psychiatric Care	54
PART 3: BARRIERS TO ACCESSING BEHAVIORAL HEALTH SERVICES FROM PROVIDER/ADVOCATE AND CULTURAL/LINGUISTIC MINORITY GROUP PERSPECTIVES.....	56
9. Introduction.....	56
10. Focus Group Results	57

10.1 Barriers to Accessing Mental Health Services in Orange County Exist Throughout the Service Delivery System.....	58
10.2 Engagement and Retention of Vulnerable Populations Relies on Genuine and Trusting Relationships ...	65
10.3 Need for Expansion of Existing Successful Service Delivery Strategies in Orange County.....	69
DISCUSSION AND RECOMMENDATIONS.....	75
Discussion.....	75
Comparison to the 2018 CalOptima Member Health Needs Assessment Report	75
Recommendations	77
Part 1. Prevalence of Mental Health Issues and Service Utilization.....	77
Part 2. Geographic Distribution of Behavioral Health Services.....	77
Part 3. Barriers to Accessing Behavioral Health Services from Provider/Advocate and Cultural/Linguistic Minority Group Perspectives	79
APPENDICES	81
Appendix- Part 1	81
Appendix 1A: Estimated Population	81
Appendix 1B: Methodology	87
Appendix 1C: References	91
Appendix Part 2	92
Appendix 2A: Methods.....	92
Appendix 2B: List of Facilities.....	95
Appendix 2C: References	107
Appendix Part 3	108
Appendix 3A: References	108
Appendix 3B: Methodology	108

INTRODUCTION

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The intention was to expand and improve mental health services for Californians living with or at risk of serious mental illness. The MHSA applies a tax of 1% on incomes over \$1 million to fund public mental health services and through this new funding stream, has provided services for priority populations identified as being unserved or underserved by the public mental health system. This includes highly vulnerable groups such as veterans, transitional-aged youth, individuals who are homeless, and underserved racial/ethnic minorities.

Consistent with prior efforts focused on reforming the delivery of mental health care in California, the MHSA provides broad policy guidance but relied on local mental health agencies to design and implement new programs. The Orange County Health Care Agency used MHSA funding to expand upon a multitude of services for children, teens, and adults. The decision of which services to provide in Orange County was the result of extensive planning efforts that started over a decade ago when MHSA became state law in 2005.

This report assesses the current state of mental health need and unmet need in Orange County since implementation of the MHSA, and is divided into three parts:

- Part 1 of this report provides estimates of the *Prevalence of Mental Health Symptoms and Service Utilization* in Orange County, with additional information presented for specific subgroups of interest, using data from the California Health Interview Survey.
- Part 2 examines *Geographic Access to Behavioral Health Services* using data from the Orange County Health Care Agency Behavioral Health Services Directory and the online facility locator database maintained by the Substance Abuse and Mental Health Services Administration. Part 2 also includes a supplemental analysis on the impact of the availability of psychiatric hospital beds on overnight emergency room stays using data from the Office of Statewide Planning and Development's (OSHPD) Hospital Annual Utilization Report.
- Part 3 identifies *Barriers to Behavioral Health Care from Provider/Advocate and Cultural/Linguistic Minority Community Members' Perspectives* using data from focus groups. A final section provides recommendations based on the findings from this report.

The final section of this report includes recommendations at the county and provider-level which may help address the needs and gaps identified in these analyses.

PART 1: PREVALENCE OF MENTAL HEALTH SYMPTOMS AND SERVICE UTILIZATION IN ORANGE COUNTY

1. Mental Health Symptoms among Adults, Transitional-Aged Youth and Veterans in Orange County

1.1 Introduction

This section of the report assesses the current state of mental health need and unmet need in Orange County since implementation of the MHSA, including prevalence estimates of need for mental health services among adults (aged 18 years and older), transitional-aged youth (age 18-24 years), veterans, using data from the California Health Interview Survey (CHIS). Mental health symptoms are assessed using validated instruments to measure serious psychological distress in the past year.

Serious Psychological Distress (SPD) is measured with the Kessler 6 (K6) scale and is designed to estimate the proportion of individuals in a population who are likely to have a serious mental illness. Originally developed for use in the U.S. National Health Interview Survey, the K6 has been validated in multiple studies and has yielded national, state, and local-level prevalence estimates of serious mental illness.^{1,2} This report uses the widely accepted cut-point of $K6 \geq 13$ to identify past year serious psychological distress.³

In this section, the annual average estimates for the 2011 to 2016 data from the CHIS are presented for serious psychological distress in the past year. To estimate the prevalence of serious mental illness and use of services among individuals who are homeless, this report relies on data collected through the 2016 Orange County HCA Outreach Civic Center Homeless Survey and the 2017 Point-in-Time Count and Survey commissioned by the 2-1-1 Orange County.

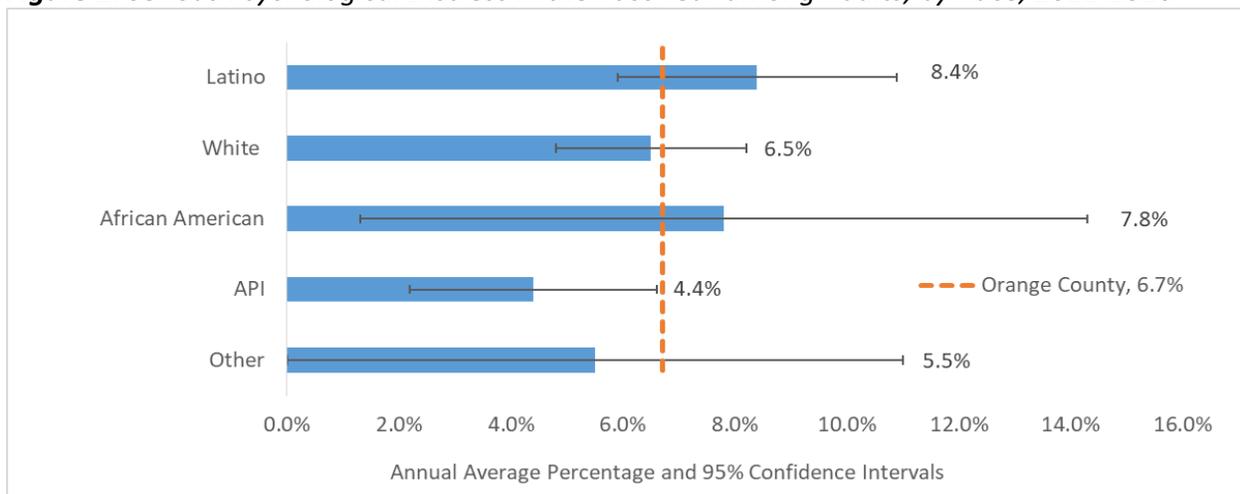
Appendix 1A includes detailed estimates of the population for the groups of interest in this analysis, Appendix 1B includes detailed information on how serious psychological distress was constructed, and Appendix 1C includes references for this section.

1.2 Prevalence of Serious Psychological Distress among Adults

In Orange County, 6.7% of the adult population was identified as having serious psychological distress in the past year (95% confidence interval [CI]: 5.7-7.8), which is lower than the California state average of 8.2% (95% CI: 7.8-8.4). Notable differences in the rate of serious psychological distress were identified across demographic groups in Orange County.

Race/Ethnicity. The prevalence of serious psychological distress did not significantly vary by race/ethnicity; meaning that the differences between racial/ethnic groups were not statistically significant. However, potentially meaningful differences were noted. Latino and non-Latino African American adults had the highest prevalence of SPD (8.4% and 7.8% respectively) whereas Asian/Pacific Islanders (API) had the lowest prevalence (4.4%, Figure 1).

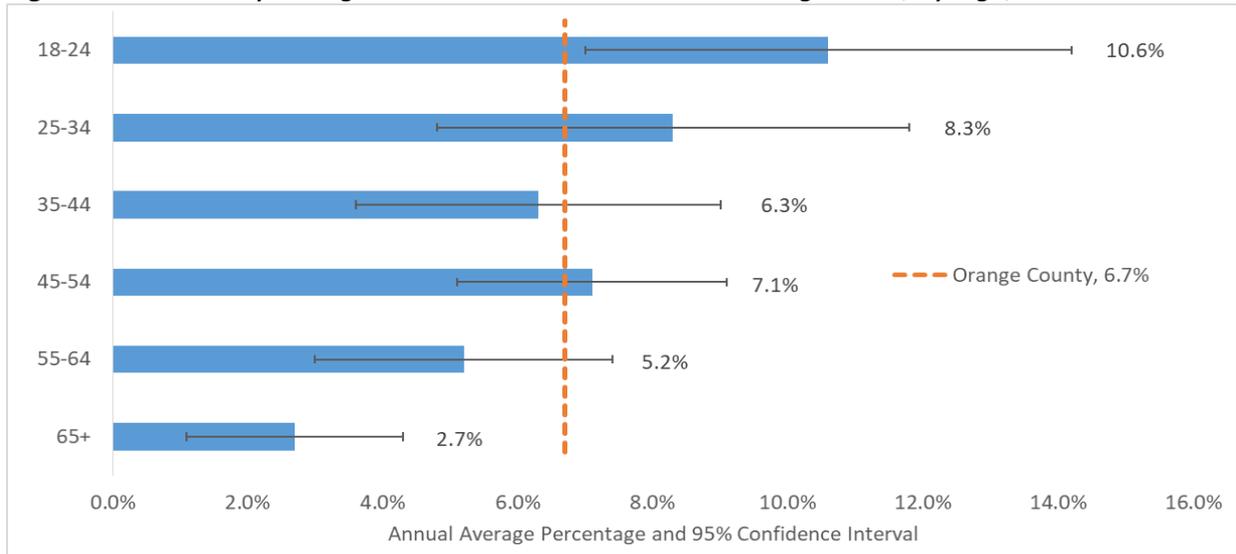
Figure 1. Serious Psychological Distress in the Past Year among Adults, by Race, 2011-2016



Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API) and other includes American Indians/Alaska Natives and individuals reporting ≥ 2 races

Age. The prevalence of serious psychological distress varied significantly by age group; meaning that the differences between age groups were statistically significant. The prevalence was highest among transitional-aged youth, aged 18-24 years (10.6%), and adults, aged 25-34 years (8.3%, Figure 2).

Figure 2. Serious Psychological Distress in the Past Year among Adults, by Age, 2011-2016



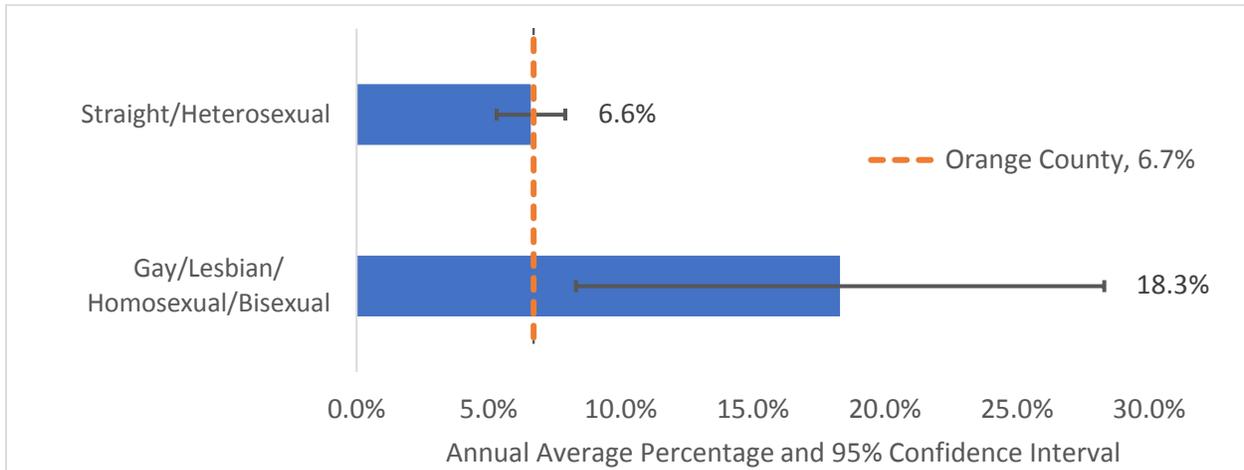
Marital Status. The prevalence of serious psychological distress varied significantly by marital status in Orange County. Unmarried adults (e.g., never been married, were widowed, separated or divorced, or living with a partner) had a significantly higher prevalence of serious psychological distress than married adults (9.7% vs. 3.8%).

Education. The percentage of adults with serious psychological distress varied significantly by educational level in Orange County. Adults with a high school education (9.4%) and some college (8.1%) had the highest prevalence of serious psychological distress, whereas the prevalence rate was lowest among adults with a Bachelors’ degree or higher (4.9%).

Employment. The percentage of adults with serious psychological distress varied significantly by employment status in Orange County. Unemployed adults had a significantly higher prevalence of serious psychological distress than employed adults (9.2% vs. 5.6%).

Sexual Orientation. The percentage of adults with serious psychological distress varied significantly by sexual orientation in Orange County. Gay/Lesbian/Homosexual/Bisexual adults had significantly higher rates of serious psychological distress than Straight/Heterosexual adults (18.3% vs. 6.6%, Figure 3).

Figure 3. *Serious Psychological Distress in the Past Year among Adults, by Sexual Orientation, 2011-2016*



API Ethnic Groups. The prevalence of serious psychological distress did not vary significantly by API ethnic groups, but differences were noted. Korean (7.1%), Filipino (6.5%) and Chinese (5.1%) adults had the highest prevalence of serious psychological distress among the API ethnic groups in Orange County and this exceeded the countywide average of 4.4 percent among API.

Veterans. The prevalence of serious psychological distress among veterans in Orange County was 4.4%, which is below the countywide average among all adults (6.7%) and is also lower than the statewide average among veterans (5.7%).

Table 1 displays the prevalence of serious psychological distress by demographic characteristics in Orange County and the State of California. The estimated population size for each of the respective demographic groups in Table 1 can be found in Appendix 1A, Table A.

Table 1: Past Year Serious Psychological Distress among Adults age 18 or older, by Demographic subgroups, CHIS 2011-2016 (Annual Averages)

Demographics (Adult)	Serious Psychological Distress				p-value
	Orange County		California		
	%	95% CI	%	95% CI	
Overall	6.7%	5.5 - 7.8	8.2%	7.8 - 8.4	
Gender					
Male	5.5%	3.7 - 7.3	6.7%	6.3 - 7.2	0.0586
Female	7.9%	6.3 - 9.5	9.3%	8.9 - 9.8	
Age (years)					
18-24	10.4%	6.9 - 13.9	11.8%	10.6 - 12.9	0.0101
25-34	8.3%	4.8 - 11.7	10.3%	9.4 - 11.3	
35-44	6.3%	3.6 - 9.0	7.7%	7.0 - 8.5	
45-54	7.1%	5.1 - 8.9	8.6%	7.8 - 9.4	
55-64	5.2%	3.0 - 7.5	6.8%	6.2 - 7.4	
65+	2.7%	1.1 - 4.3	3.5%	3.0 - 3.9	
Race/Ethnicity					
Latino	8.4%	5.9 - 10.9	8.8%	8.2 - 9.4	0.0762
White (non-Latino)	6.5%	4.8 - 8.3	7.9%	7.4 - 8.3	
African American (non-Latino)	7.8%	4.7 - 11.1	9.8%	8.3 - 11.3	
API (non-Latino)	4.4%	2.2 - 6.6	5.4%	4.6 - 6.2	
Other (non-Latino)	5.5%	0 - 11.5	13.4%	11.2 - 15.6	
Limited English Proficiency					
No	6.7%	5.5 - 8.0	8.2%	7.6 - 8.9	> 0.10
Yes	7.3%	4.6 - 11.2	7.4%	6.5 - 8.3	
Marital Status					
Married	3.8%	2.6 - 4.9	4.7%	4.3 - 5.1	<0.001
Not Married	9.7%	7.7 - 11.7	11.4%	10.9 - 11.9	
Sexual Orientation					
Straight/heterosexual	6.6%	5.3 - 7.9	8.1%	7.8 - 8.5	0.0011
Gay/Lesbian/Homosexual/Bisexual	18.3%	8.3 - 28.3	19.1%	16.6 - 21.9	
Education					
Less than High School	6.3%	3.3 - 9.2	9.9%	8.9 - 10.8	0.0027
High School	9.4%	6.4 - 12.4	8.7%	8.1 - 9.4	
Some College	8.1%	5.4 - 10.8	10.0%	9.2 - 10.8	
Bachelor's degree or higher	4.9%	3.2 - 6.5	5.5%	5.0 - 5.9	
Employment					
Unemployed	9.2%	7.1 - 11.3	10.4%	9.9 - 11.0	0.0044
Employed	5.6%	4.2 - 7.0	6.7%	6.3 - 7.1	
Health Insurance Status					
Uninsured in past year	9.4%	4.6 - 14.2	10.3%	9.4 - 11.1	> 0.10
Insured all past year	6.0%	4.6 - 7.3	7.5%	7.2 - 7.8	
Served in Armed Forces					
Served	4.4%	1.0 - 5.4	5.7%	4.9 - 6.5	> 0.10
Did not serve	7.0%	5.7 - 8.2	8.3%	7.9 - 8.6	
Asian Ethnic Groups					
Chinese	5.1%	0.3 - 10.0	4.1%	2.9 - 5.2	> 0.10
Japanese	1.5%	0 - 5.5	5.0%	1.0 - 8.9	
Korean	7.1%	1.9 - 12.7	9.0%	4.6 - 13.4	
Filipino	6.5%	1.1 - 12.0	6.6%	4.3 - 8.9	
Vietnamese	3.1%	0 - 6.3	5.4%	2.4 - 8.3	
Other Asian	2.7%	0.09 - 8.5	5.9%	4.2 - 7.7	

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and an adult sample size of n = 6,780.

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians, Alaska Natives, and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

NOTE: p-value assesses the association between serious psychological distress in Orange County and demographic characteristics.

1.3 Prevalence of Serious Psychological Distress among Transitional Age Youth

In Orange County, 10.4% of transitional-aged youth (TAY) experience serious psychological distress in the past year (95% CI: 7.0-14.1).

Sexual Orientation. The prevalence of serious psychological distress varied significantly by sexual orientation among TAY in Orange County. Gay/Lesbian/Homosexual/Bisexual TAY had a significantly higher prevalence of serious psychological distress (39.7%) than straight/heterosexual TAY (8.7%, Figure 4).

Figure 4. *Serious Psychological Distress in the Past Year among Transitional-aged Youth, by Sexual Orientation, 2011-2016*

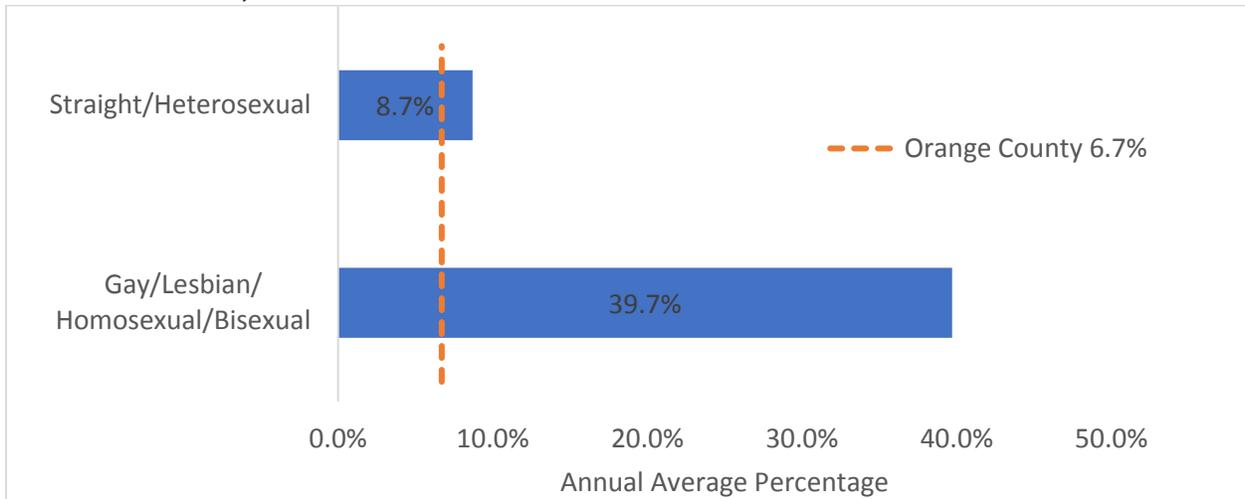


Table 2 displays the prevalence of serious psychological distress by demographic characteristics among the TAY population in Orange County and California. The estimated population size for each of the respective demographic groups in Table 2 can be found in Appendix 1A, Table B.

Table 2: Past Year Serious Psychological Distress among Transitional-aged Youth, age 18–24 years, by Demographic subgroups, CHIS 2011-2016 (Annual Averages)

Demographics (TAY)	Serious Psychological Distress in Past Year				p-value*
	Orange County		California		
	%	CI	%	CI	
Overall	10.4%	6.9 - 13.9	11.3%	10.1 - 12.4	
Gender					
Male	9.7%	4.9 - 14.6	9.9%	8.5 - 11.4	> 0.10
Female	10.8%	5.5 - 16.2	13.7%	11.9 - 15.5	
Race/Ethnicity					
Latino	16.6%	9.8 - 23.4	11.2%	9.5 - 13.0	> 0.10
White (non-Latino)	9.0%	4.6 - 13.5	13.4%	11.4 - 15.4	
African American (non-Latino)	12.8%	0 - 28.8	10.7%	5.7 - 15.8	
API (non-Latino)	9.4%	2.0 - 16.8	9.9%	7.1 - 12.6	
Other (non-Latino)	*	*	14.5%	9.3 - 19.6	
Sexual Orientation					
Straight/heterosexual	8.7%	5.2 - 12.2	10.8%	9.6 - 11.9	< 0.001
Gay/Lesbian/Homosexual/Bisexual	39.7%	18.3 - 66.0	25.5%	20.4 - 31.4	
Education					
Less than High School	13.5%	7.2 - 19.8	12.2%	10.6 - 13.8	> 0.10
High School	14.1%	7.2 - 20.9	12.0%	10.3 - 13.8	
More than HS	8.7%	4.1 - 13.3	11.4%	9.8 - 12.9	
Employment					
Unemployed	10.2%	4.6 - 15.8	11.7%	9.8 - 13.6	> 0.10
Employed	10.6%	5.9 - 15.2	11.9%	10.4 - 13.3	
Health Insurance Status					
Uninsured in past 12 months	9.5%	2.4 - 16.6	11.0%	8.6 - 13.4	> 0.10
Insured all past 12 months	10.3%	6.5 - 14.1	12.1%	10.7 - 13.4	

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and a TAY sample size, n =465.

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

NOTE: p-value assesses the association between serious psychological distress in Orange County and demographic characteristics.

* Low precision; no estimate reported.

1.4 Summary

Overall, 6.7% of adults, 10.4% of transitional-aged youth, and 4.4% of veterans in Orange County have experienced serious psychological distress in the past year. The highest rates of distress were observed by the following demographic groups:

- Unmarried adults, 9.7%
- Adults with a high school education, 9.4%
- Unemployed adults, 9.2%
- Adults and TAY who are gay, lesbian, homosexual or bisexual, 18.3% and 39.7%
- TAY with a high school education, 14.1%
- Latino TAY, 16.6%
- African American TAY, 12.8%

2. Mental Health Service Utilization among Adults and Transitional-Aged Youth in Orange County

2.1 Introduction

This section provides prevalence estimates of untreated mental health illness among adults (aged 18 years and older) and transitional-aged youth (TAY; aged 18-24 years) with serious psychological distress.

Mental health services accessed by adults and TAY were assessed in the California Health Interview Survey (CHIS) by asking individuals whether they sought care for their mental health and among those who saw a healthcare professional, the number of visits in the past year for problems with their mental health. In addition, adults and TAY were asked about their use of prescription medicine, such as an antidepressant or sedative, for an emotional or mental health issue where use of prescription medicine was defined as almost daily for two weeks or more.

Using the results from these questionnaire items, a 3-level measure of mental health service utilization was defined that reflects evidence-based guidelines for the treatment of serious mental illness among adults.⁶ “Minimally Adequate Treatment” (MAT) was identified for individuals reporting four or more visits with a health professional in the past year as well as the use of prescription medication for mental health issue in the past year. “Some Treatment” was identified for individuals reporting receiving one or more services but not meeting the requirements for MAT. “No Treatment” was identified for individuals who reported not receiving any mental health treatment in the past year.

In this section, the annual average estimates for the 2011 to 2016 data from the CHIS are presented for mental health service utilization in the past year among adults and transitional-aged youth with serious psychological distress.

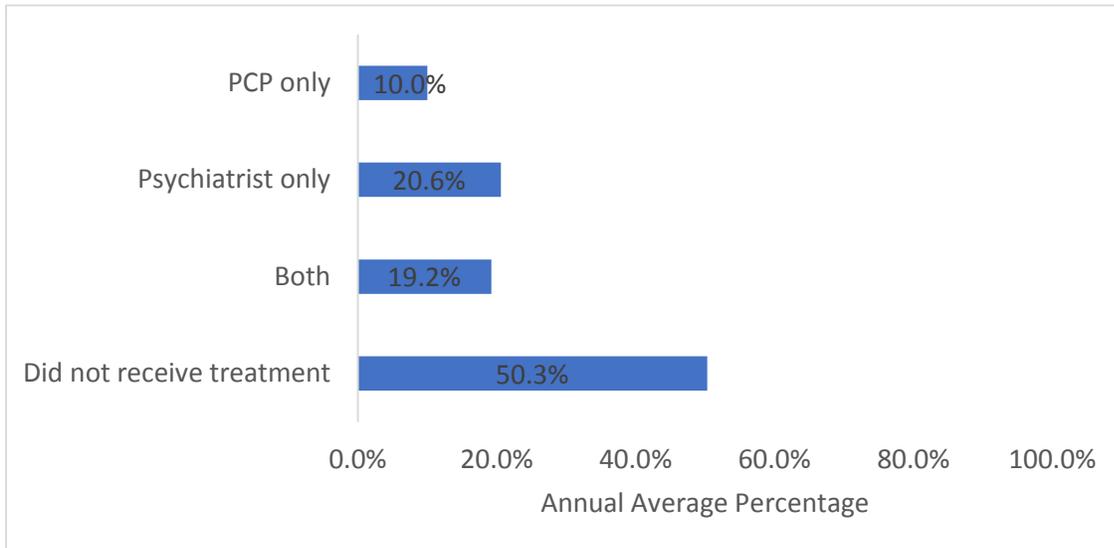
Detailed information on how the measures of mental health services and utilization were constructed can be found in Appendix 1B.

2.2 Untreated Mental Health Symptoms among Adults

Of the 6.7% of adults experiencing serious psychological distress in Orange County, about half (49.8%) received treatment from a mental health professional or primary care provider (PCP). The majority of adults receiving care had one or more visits with a mental health professional such as a psychiatrist or psychologist (39.8% of those with serious psychological distress); whereas 10% received care from their PCP only in the past year (Figure 5).

The estimated population of adults with access to mental health services can be found in Appendix 1A, Table C.

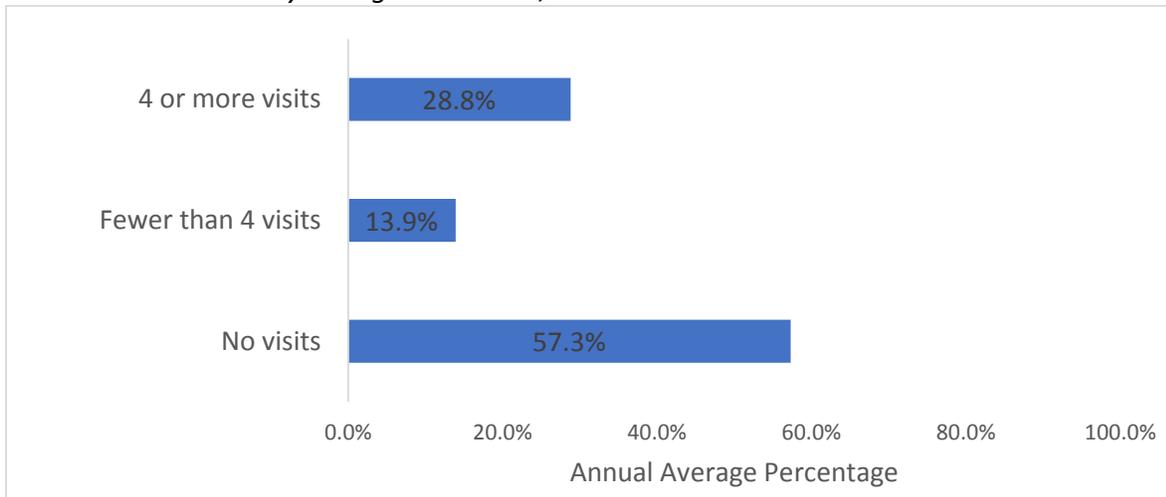
Figure 5. Access to Mental Health Services for Mental Health in the Past Year among Adults with Serious Psychological Distress, 2011-2016



NOTE: Both includes receiving care for mental health from a psychiatrist or psychologist and from a primary care physician (PCP) or general practitioner.

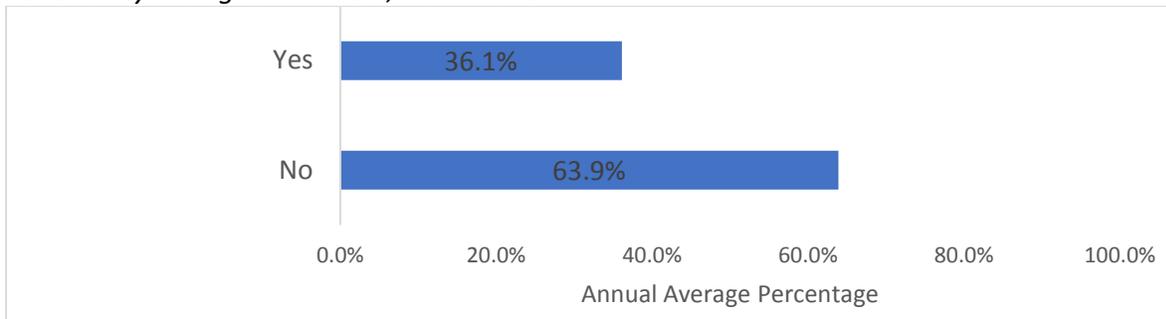
Number of Visits to see a Health Professional for Mental Health. Among adults with serious psychological distress who sought out care, 28.8% made four or more visits to a health professional; whereas 13.9% made fewer than 4 visits (Figure 6). The estimated population of adults who went to see a health professional for their mental health symptoms in the past year can be found in Appendix 1A, Table C.

Figure 6. Number of Visits to a Health Professional for Mental Health in the Past Year among Adults with Serious Psychological Distress, 2011-2016



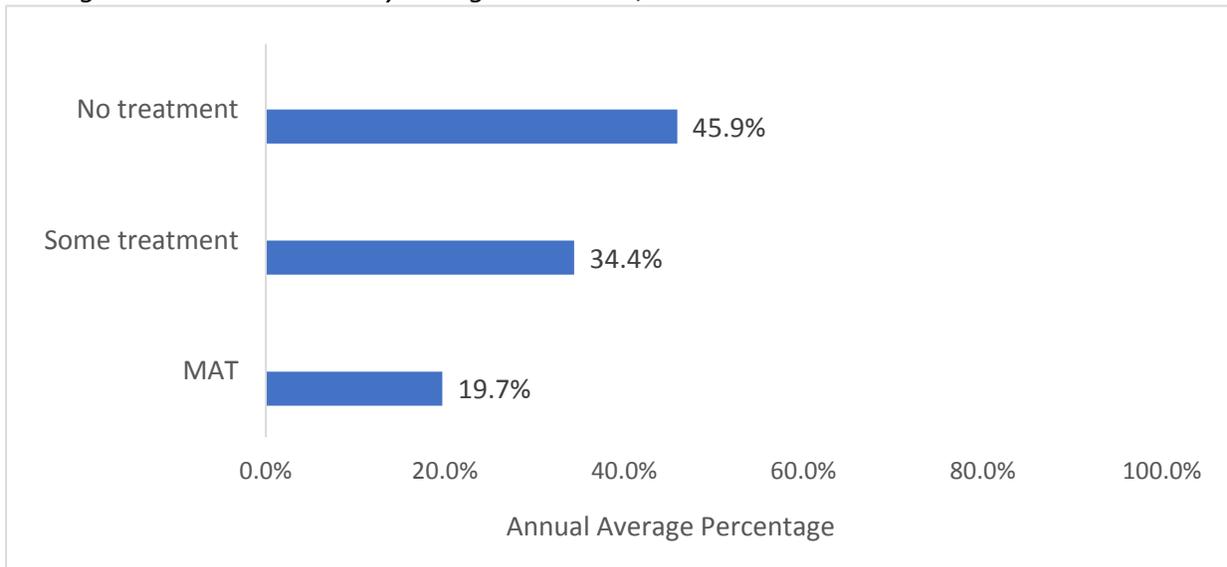
Prescription Medication Use. Among adults with serious psychological distress, 36.1% took prescription medication, almost daily for two weeks or more, for their mental health symptoms (Figure 7). The estimated population of adults who took prescription medication for their mental health symptoms can be found in Appendix 1A, Table C.

Figure 7. Took Prescription Medication for Mental Health in the Past Year among Adults with Serious Psychological Distress, 2011-2016



Minimally Adequate Treatment (MAT). Among the adults with serious psychological distress, approximately one-fifth received minimally adequate treatment (19.7%), defined as four or more visits with a mental health professional in the past year and taking prescription medication for mental health. More than one-third of adults with serious psychological distress received some treatment in the past year but this treatment did not meet the minimally adequate treatment standards (34.4%, Figure 8). The estimated population of adults accessing minimally adequate treatment can be found in Appendix 1A, Table D.

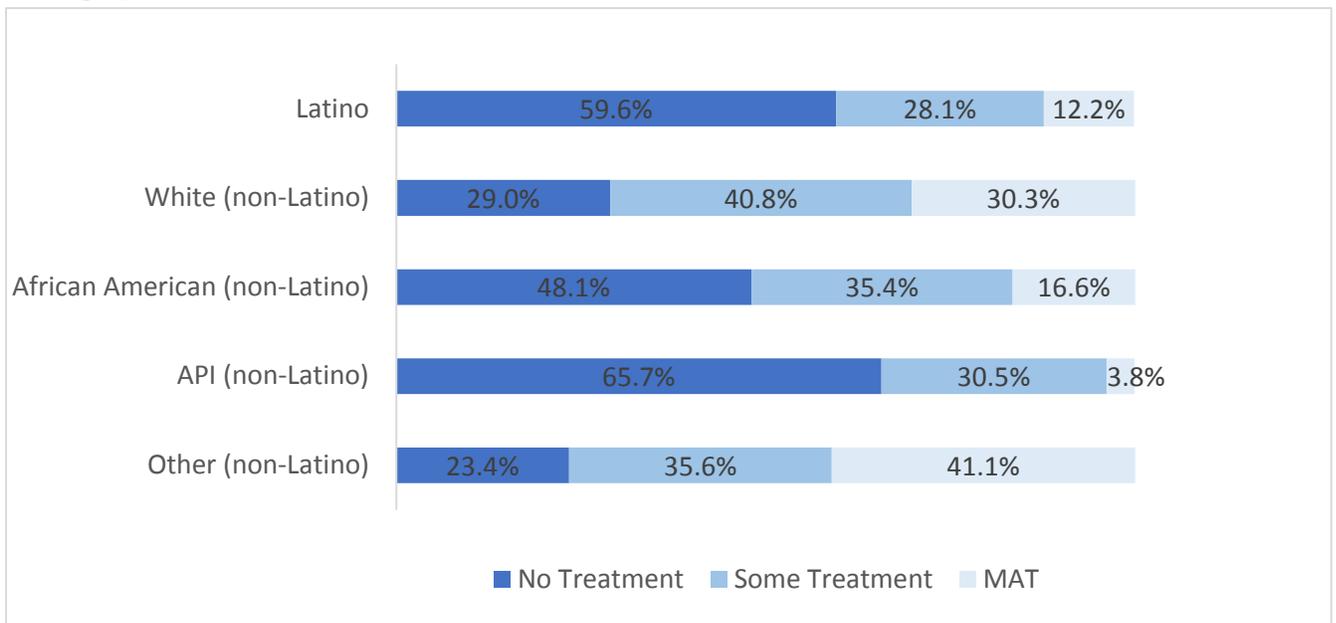
Figure 8. Access to Minimally Adequate Treatment (MAT) for Mental Health in the Past Year among Adults with Serious Psychological Distress, 2011-2016



NOTE: Minimally Adequate Treatment is defined as four or more visits with a health professional in the past year as well as prescription medication for mental health; Some treatment captures adults who received some treatment, but that treatment did not meet the minimally adequate treatment standards; No treatment reflects adults that did not receive any mental health treatment in the past year.

Minimally Adequate Treatment by Race/Ethnicity. Receipt of minimally adequate treatment among adults with serious psychological distress varied significantly by race/ethnicity. API (3.8%), Latino (12.2%) and African American (16.6%) adults had the lowest rates of minimally adequate treatment; whereas white (30.3%) and other (41.1%) adults had the highest rates of minimally adequate treatment (Figure 9). The estimated population of adults, with breakdowns by race/ethnicity, accessing minimally adequate treatment can be found in Appendix 1A, Table D.

Figure 9. Access to Minimally Adequate Treatment (MAT) for Mental Health in the Past Year among Adults with Serious Psychological Distress, by Race/Ethnicity, 2011-2016 (Annual Averages)



NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API). Similarly, due to small sample size, American Indians/Alaska Natives and individuals reporting ≥2 races were grouped in the 'Other category. Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino. Please refer to Appendix 1A, Table D, for the estimated populations of these demographic groups.

Minimally Adequate Treatment by Sexual Orientation. Receipt of minimally adequate treatment among adults with serious psychological distress also varied significantly by sexual orientation. Gay/lesbian/homosexual/bisexual adults had over two times the prevalence of minimally adequate treatment compared to straight/heterosexual adults (48.2% vs. 17.0%). The rate of not receiving mental health treatment in the past year was similar among gay/lesbian/homosexual/bisexual adults and straight/heterosexual adults (44.4% vs. 47.4%, Figure 10).

Figure 10. Access to Minimally Adequate Treatment (MAT) for Mental Health in the Past Year among Adults with Serious Psychological Distress, by Sexual Orientation, 2011-2016 (Annual Averages)

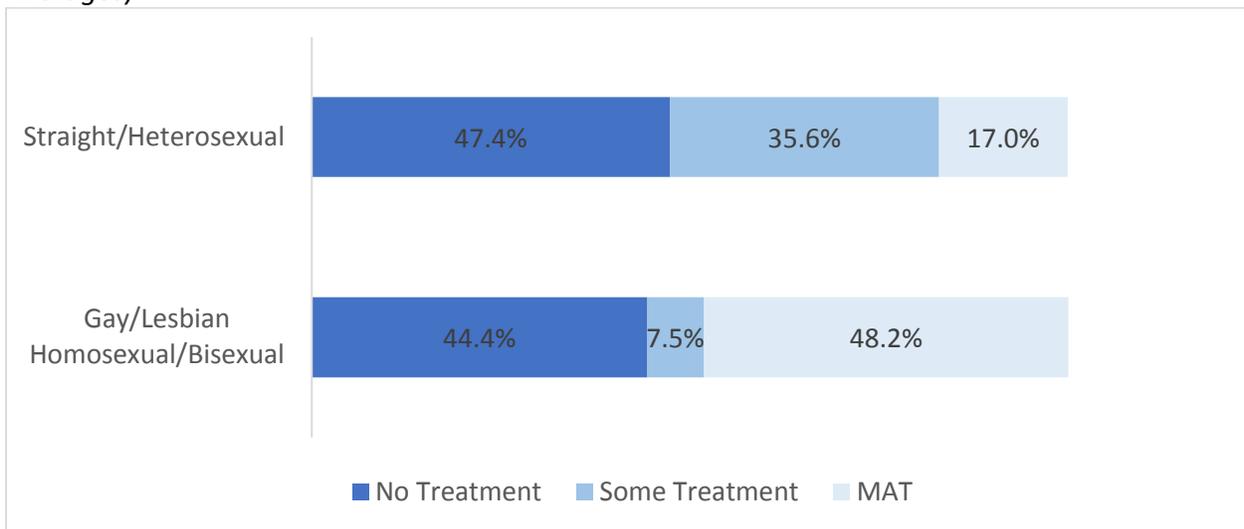


Table 3 displays the prevalence of minimally adequate treatment among adults with serious psychological distress by demographic characteristics in Orange County. The estimated population of adults receiving minimally adequate treatment overall and by demographic groups can be found in Appendix 1A, Table D.

Table 3: Access to Minimally Adequate Treatment (MAT) for Mental Health in past year among Adults with Serious Psychological Distress, by Demographic subgroups, CHIS 2011-2016 (Annual Averages)

Demographics	No Treatment	Some Treatment	MAT	p-value
	%	%	%	
Overall	45.9%	34.4%	19.7%	
Gender				
Male	57.6%	31.1%	11.4%	0.0731
Female	38.3%	36.5%	25.2%	
Age (years)				
18-24	57.7%	28.7%	13.6%	> 0.10
25-34	52.9%	31.2%	15.9%	
35-44	33.0%	40.3%	26.8%	
45-54	41.2%	31.6%	27.2%	
55-64	47.0%	35.0%	18.0%	
65+	23.9%	60.1%	16.0%	
Race/Ethnicity				
Latino	59.6%	28.1%	12.2%	0.0115
White (non-Latino)	29.0%	40.8%	30.3%	
African American (non-Latino)	48.1%	35.4%	16.6%	
API (non-Latino)	65.7%	30.5%	3.8%	
Other (non-Latino)	23.4%	35.6%	41.1%	
Limited English Proficiency				
No	42.2%	36.3%	21.5%	> 0.10
Yes	64.1%	24.7%	11.2%	
Marital Status				
Married	46.6%	31.5%	22.0%	> 0.10
Not Married	45.7%	35.5%	18.8%	
Sexual Orientation				
Straight/heterosexual	47.4%	35.6%	17.0%	0.0128
Gay/Lesbian/Bisexual/Celibate	44.4%	7.5%	48.2%	
Education				
Less than High School	47.0%	31.8%	21.3%	>0.10
High School	56.4%	29.1%	14.5%	
Some College	35.2%	37.2%	27.6%	
Bachelor's degree or higher	46.2%	37.6%	16.2%	
Employment				
Unemployed	36.0%	37.6%	26.5%	>0.10
Employed	53.7%	31.8%	14.5%	
Health Insurance Status				
Uninsured in past 12 months	50.0%	36.2%	13.9%	>0.10
Insured all past 12 months	44.6%	33.7%	21.7%	

NOTE: Orange County statistical estimates are based on a subset of the CHIS adult sample, which is limited to adults with serious psychological distress, n = 358.

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

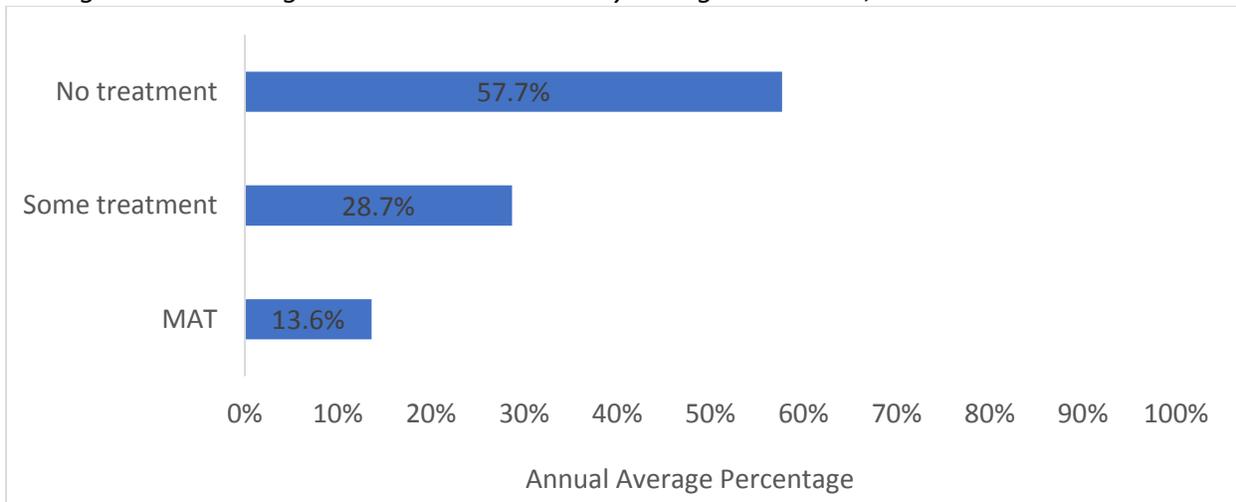
NOTE: p-value assess the association between 3-level treatment categories (no treatment, some treatment and MAT) in Orange County and demographic characteristics.

NOTE: No estimate reported on treatment by Veteran status due to the low number of Veterans identified as having serious psychological distress in the past year.

2.3 Untreated Mental Health Symptoms among Transitional-Aged Youth

Of the 10.4% of transitional-aged youth (TAY) experiencing serious psychological distress in Orange County, 13.6% received MAT while 28.7% received some treatment that did not meet the MAT standard (Figure 11). The estimated population of TAY receiving minimally adequate treatment can be found in Appendix 1A, Table D.

Figure 11. Access to Minimally Adequate Treatment (MAT) for Mental Health in the Past Year among Transitional-aged Youth with Serious Psychological Distress, 2011-2016



NOTE: MAT defined as four or more visits with a health professional in the past year as well as prescription medication for mental health; Some treatment captures adults who received some treatment, but that treatment did not meet the MAT standards; No treatment reflecting adults that did not receive any mental health treatment in the past year.

2.4 Summary

Overall, 19.7% of adults and 13.6% of TAY with serious psychological distress in Orange County received MAT. Additionally, 34.4% of adults and 28.7% of TAY with serious psychological distress received some treatment in the past year but this treatment did not meet the MAT standard. The rate of untreated mental health symptoms was higher among TAY than adults in Orange County: 57.7% vs. 45.9%.

Mental health service utilization varied significantly across race/ethnicity and sexual orientation with the following demographic groups most likely to go without treatment in the past year:

- Asian and Pacific Islanders, 65.7%
- Latinos, 59.6%
- African Americans, 48.1%
- Straight/Heterosexual adults, 47.7%

3. Mental Health Symptoms and Mental Health Service Utilization among Adolescents (ages 12–17 years) and Children (ages 4–11 years) in Orange County

3.1 Introduction

This section provides prevalence estimates of mental health symptoms and mental health service utilization among adolescents (ages 12-17 years) and children (ages 4-11 years) in Orange County. Mental health symptoms were assessed using validated screening instruments to measure serious psychological distress in the past month among adolescents and among children, and emotional and behavioral problems in the past 6 months.

Serious Psychological Distress (SPD) is measured using the **Kessler 6 (K6)** scale and is designed to estimate the proportion of individuals in a population who are likely to have a serious mental illness. Originally developed for use in the U.S. National Health Interview Survey, the K6 has been validated in multiple studies and has yielded national, state, and local-level prevalence estimates of serious mental illness.^{1,2} This report uses the widely accepted cut-point of $K6 \geq 13$ to identify adolescents with SPD in the past month.⁸

The Brief Strengths and Difficulties Questionnaire (brief SDQ) assesses the risk for development of emotional and behavioral problems in the general population of children, ages 4-11 years.⁹ The brief SDQ asks parents about emotional symptoms, conduct problems, hyperactivity-inattention, peer problems (for difficulties), and prosocial behavior (for strength). The five symptom questions are scored and categorically classified as “normal”, “borderline”, or “abnormal”.¹⁰ Children were identified as having mental health symptoms if they scored within the “abnormal” range of the brief SDQ (i.e., abnormal mental health development). The brief SDQ has been validated in multiple studies around the world.¹¹⁻¹²

Mental Health Service Utilization was assessed by asking adolescents and the parents of children whether they received any psychological or emotional counseling in the past year.

Detailed information on how the measures, SPD and brief SDQ, as well as mental health service utilization were constructed can be found in Appendix 1B.

3.2 Mental Health Symptoms and Untreated Mental Health among Adolescents

In Orange County, 4.2% of the adolescent population experienced serious psychological distress in the past month (95% CI: 0.0 – 8.4). This rate is the same as the overall statewide rate for adolescents (4.2%, CI: 3.3 – 5.2). Although the prevalence of serious psychological distress did not differ significantly by demographic groups, there were some notable differences. Younger adolescents, ages 12–14 years, had a higher rate of serious psychological distress than older adolescents, ages 15-17 years (6.7% vs. 4.3%). Additionally, Latino adolescents has nearly twice the prevalence of serious psychological distress than non-Latino adolescent (6.0% vs. 3.4%). Of the 4.2% adolescents with serious psychological distress, over half did not receive psychological or emotional counseling for their mental health in the past year (63.5%, Figure 12).

Figure 12. Access to Treatment for Mental Health in the Past Year among Adolescent with Past Month Serious Psychological Distress, CHIS 2011-2016

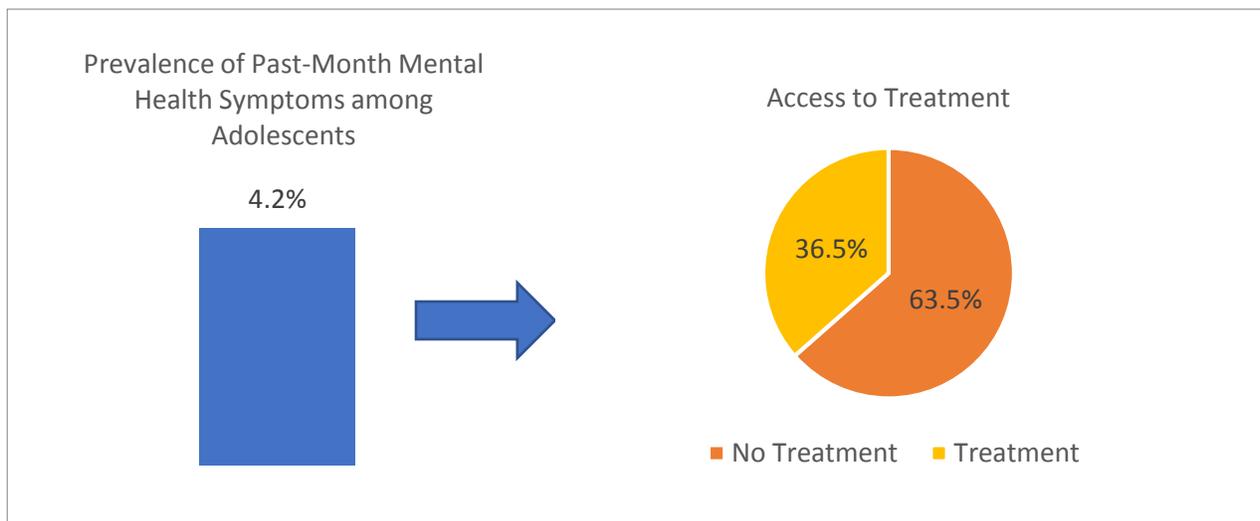


Table 4 displays the prevalence of past-month serious psychological distress among adolescents by demographic characteristics in Orange County. The estimated population of adolescents with serious psychological distress overall and by demographic groups can be found in Appendix 1A, Table E.

Table 4: Past Month Serious Psychological Distress among Adolescents, ages 12–17 years, by Demographic subgroups, CHIS 2011-2016 (Annual Averages)

Demographics	Past Month Serious Psychological Distress among Adolescents				p-value
	Orange County		California		
	%	95% CI	%	95% CI	
Overall	4.2%	0.0 - 8.4	4.1%	3.3 - 5.2	-
Gender					
Male	3.6%	0 - 8.8	2.0%	1.3 - 3.2	> 0.10
Female	5.4%	1.8 - 8.9	6.3%	4.8 - 8.1	
Age (years)					
12-14	6.7%	0 - 14.4	4.3%	3.0 - 6.1	> 0.10
15-17	4.3%	1.8 - 6.8	3.9%	3.0 - 5.1	
Latino Ethnicity					
non-Latino	3.4%	1.2 - 9.4	3.4%	2.5 - 4.6	> 0.10
Latino	6.0%	1.2 - 24.4	4.9%	3.5 - 6.7	
Received psychological or emotional counseling in the past year					
Received Treatment	36.5%	4.9 - 86.5	40.2%	29.9 - 51.3	> 0.10
Received No Treatment	63.5%	13.5 - 95.1	59.9%	48.7 - 70.1	

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and a CHIS adolescent sample size of n = 6,646.

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

NOTE: p-value assesses the association between serious psychological distress in Orange County and demographic characteristics.

3.3 Mental Health Symptoms and Untreated Mental Health among Children

In Orange County, 5.9% (95% CI: 4.1 – 8.4) of children, ages 4-11 years, had abnormal mental health development in the past six-months. Boys were significantly more likely than girls to have abnormal mental health development (6.2% vs. 5.5%). Although not significant, Latino children had a higher prevalence than non-Latino children of abnormal mental health development (8.3% vs. 3.8%). Of the 5.9% children with abnormal mental health development, 56.6% did not receive psychological or emotional counseling for their mental health in the past year, Figure 13.

Figure 13. Access to Treatment for Mental Health in the Past Year among Children with Abnormal Mental Health Development in the Past Six-Month, CHIS 2005-2009

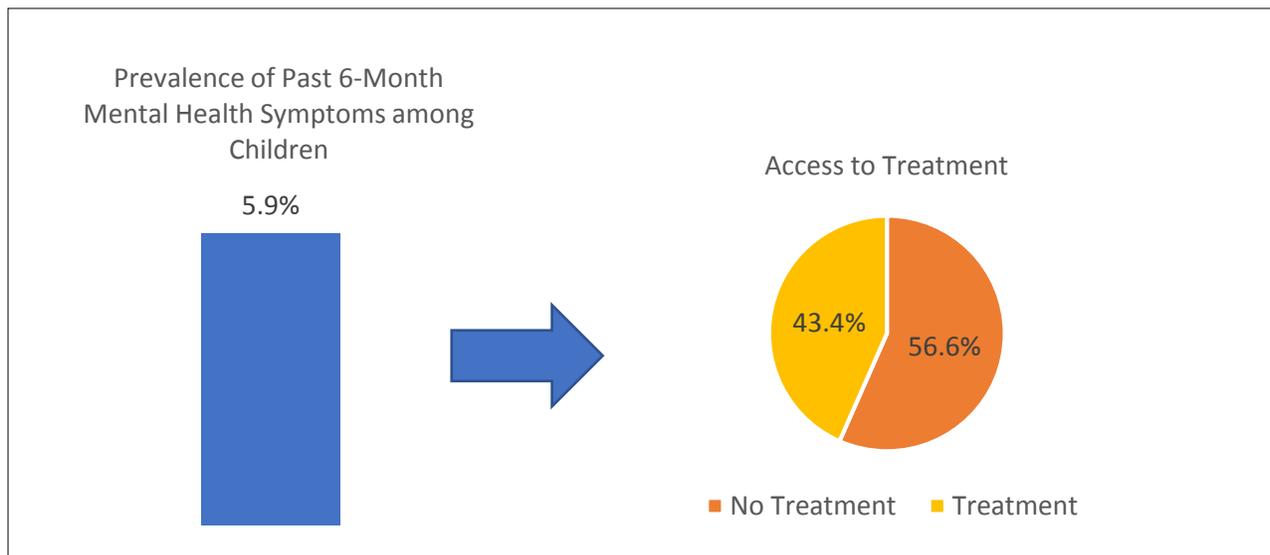


Table 5 shows the prevalence of abnormal mental health development in the past six-months among children by demographic characteristics in Orange County. The estimated population of children with abnormal mental health development overall and by demographic groups can be found in Appendix 1A, Table F.

Table 5: Abnormal Mental Health Development in the Past Six Months among Children, ages 4-11, CHIS 2005-2009 (Annual Averages)

Demographics	Abnormal Mental Health Development among Children Orange County		California		p-value
	%	95% CI	%	95% CI	
Overall	5.9%	4.1 – 8.4	5.3%	4.8 – 5.9	
Gender					
Male	6.2%	4.0 – 9.5	6.2%	5.5 – 7.0	0.0132
Female	5.5%	3.0 – 10.2	4.3%	3.6 – 5.2	
Latino Ethnicity					
non-Latino	3.8%	2.3 – 6.3	5.0%	4.4 – 5.7	> 0.10
Latino	8.3%	5.0 – 13.4	5.6%	4.7 – 6.7	
Received psychological or emotional counseling in the past year					
Received Treatment	43.4%	25.3 – 63.5	33.7%	29.3 – 38.4	<0.001
Received No Treatment	56.6%	36.5 – 74.7	66.3%	61.6 – 70.7	

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and a CHIS child sample size of n = 1,216.

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

NOTE: p-value assesses the association between serious psychological distress in Orange County and demographic characteristics.

3.4 Summary

Overall, 4.2% of adolescents, ages 12-17 years, experienced serious psychological distress in the past month in Orange County. The highest rate of serious psychological distress was among:

- Younger adolescents between the ages of 12-14 years, 6.7%
- Latino adolescents, 6.0%

Among the 4.2% of adolescents with serious psychological distress, more than half (63.5%) did not receive emotional or psychological counseling in the past year.

Overall, 5.9% of children, ages 4-11 years, had abnormal mental health development in Orange County. The highest rate of abnormal mental health development was among:

- Boys, 6.2%
- Latino children, 8.3%

Among the 5.9% of children with abnormal mental health development, more than half (56.6%) did not receive emotional or psychological counseling in the past year.

4. Mental Health Symptoms and Mental Health Service Utilization among Homeless Persons in Orange County

4.1 Introduction

This section provides the prevalence of serious mental illness and mental health service utilization among homeless persons in Orange County. Every two years, Orange County conducts the Homeless Point-In-Time (PIT) Count¹³ by enumerating all individuals experiencing homelessness in the county within a twenty-four-hour period during the last ten days of January. The PIT Count is congressionally mandated for all communities that receive federal funding for homeless programs. The count includes sheltered and unsheltered people (e.g., individuals living on the streets, in vehicles, emergency shelters or transitional housing) and excludes individuals residing with friends/family or in a motel/hotel. The PIT count identifies homeless persons experiencing serious mental illness among adults only, age 18 and older. The PIT count does not collect information on utilization of mental health services among homeless persons. Rather, data identifying the prevalence of untreated mental illness in this report was obtained from the 2016 Orange County HCA Outreach Civic Center Homeless Survey.¹⁴ This survey enumerates all people experiencing homelessness in the Civic Center area of Santa Ana within a 10.5-hour period on August 23, 2016. The count provides a snapshot of the number of homeless persons who self-reported mental health symptoms and access to mental health treatment. The PIT count captures the general population of homeless individuals with a census-style approach, whereas the HCA Civic Center Survey captures a sample including more chronically homeless individuals (i.e., over 50% of those surveyed in the Civic Center had been continuously homeless for more than 1 year compared to 19% surveyed in the PIT count).

4.2 Mental Health Outcomes among Homeless Persons

Based on the 2017 PIT count, there were an estimated 4,034 homeless adults age 18 and older in Orange County. An estimated 66% of homeless persons with serious mental illness were unsheltered while 34% were sheltered. Furthermore, an estimated 893 homeless adults (19%) were considered to be “chronically homeless individuals,” defined as “an adult with a disabling condition who has been homeless (sheltered or unsheltered) for at least twelve consecutive months OR has had at least four episodes of homelessness in the past three years with a total duration of at least one year.”¹³

Per the PIT county Of the 4,034 homeless adults age 18 and older in Orange county, 12% (or 474) experienced serious mental illness (Table 6). This prevalence of serious mental illness among all homeless adults in Orange County may seem low, but was similar to prevalence rates based on PIT counts in the adjacent counties of San Diego (14%) and Riverside (12.8%), but differed from Los Angeles (27.2%).¹⁵⁻¹⁷ However, according to the 2016 Orange County HCA

Outreach Civic Center Homeless Survey, which was implemented among a population of more chronically homeless individuals, a relatively higher proportion (44%) of homeless adults felt they had a mental health condition, and 40% reported that they had mental health issues that prevented them from doing things they wanted to do within the past year. Table 6 also shows the proportion of homeless adults who felt they had a mental health condition from the HCA Civic Center survey applied to the chronically homeless population estimate from the PIT count.

4.3 Untreated Mental Illness among Homeless Persons

According to the 2016 Orange County HCA Outreach Civic Center Homeless Survey, the majority of homeless persons (63%) have never accessed mental health treatment. Table 6 shows this treatment access estimate applied to the chronically homeless population estimates from the PIT count.

Table 6. Prevalence of Mental Health Symptoms and Access to Treatment among Homeless Adults in Orange County

	%	Estimated Population
All Homeless Adults	100%	4,034
Serious Mental Illness	12%	474
Chronically Homeless Adults	19%	893
Any Mental Health Condition*	44%	393
Never received any mental health treatment*	63%	529

* Prevalence estimates (%) were obtained from the HCA Outreach Civic Center Survey and estimated population totals are indirectly estimated using the PIT Count estimate of the total number of chronically homeless adults (i.e., n=893).

These estimates reinforce that compared to the general population of individuals facing homelessness at any point in time, chronically homeless individuals are more likely to have mental health issues. The HCA Civic Center Survey report only reports on the proportion of mostly chronically homeless respondents in their survey who had never received any mental health treatment and not specifically among those who reported having any mental health issue. Therefore, we cannot report unmet treatment need among homeless individuals who have mental health issues, only on the frequency of receiving treatment across all chronically homeless adults.

PART 2: GEOGRAPHIC ACCESS TO BEHAVIORAL HEALTH SERVICES (BHS)

5. Geographic Availability of BHS

5.1 Introduction

This section of the report assesses geographic access to Behavioral Health Services (BHS) in Orange County. The geographic location of BHS facilities was obtained from the Orange County Health Care Agency Behavioral Health Services Directory and the online facility locator database maintained by the Substance Abuse and Mental Health Services Administration. A demographic summary of the Orange County population was obtained from the U.S. Census American Community Survey, 5-year estimates (2012-2016). Please note that this section is reporting on access to physical facility locations; Orange County provides many field-base services which are designed to serve areas where there are no facilities.

A quantile classification method was applied to the maps displaying the density of BHS facilities and demographic data. Under the quantile method, the data being mapped was grouped into three categories with approximately the same number of zip codes assigned to each category. When moving from one class to the next class, the data linearly increased (or decreased) and hence the classes were defined as low, medium, or high.

Detailed information on geographic mapping methods can be found in Appendix 2A, a list of all facilities with their characteristics can be found in Appendix 2B, and references for this section can be found in Appendix 2C.

5.2 Geographic Distribution of Behavioral Health Services in Orange County

There were 201 facilities providing Behavioral Health Services (BHS) through the Orange County Health Care Agency (OC HCA; Figure 14). More than half of Orange County zip codes (52%) had at least one BHS facility and these facilities were located in the more populated regions of the county. As shown in Table 7, nearly two-thirds of the Orange County population resided in a zip code with at least one facility. Zip codes with at least one facility had a significantly higher proportion of Latino residents (39.7% vs. 23.3%) and a significantly lower proportion of white residents (37.2% vs. 50.3%) compared to zip codes without a BHS facility (Table 7). Additionally, zip codes with at least one facility were more likely to have a greater proportion of uninsured (14.1% vs. 8.4%) or publicly insured residents (31.0% vs. 26.5%), as well as a younger resident population (median age 30.9 years vs. 45.5 years).

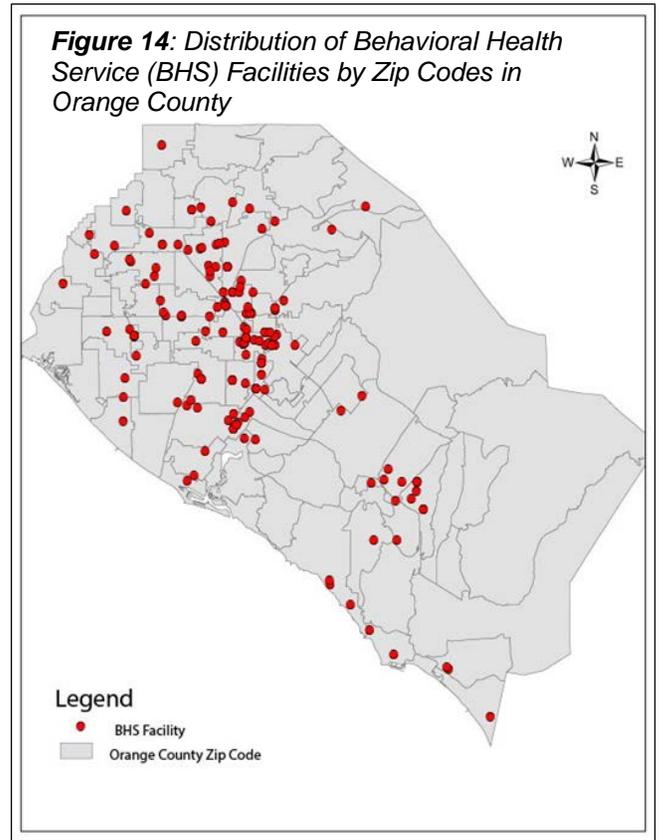


Table 7. Demographic Characteristics in Orange County and Stratified by Presence of Behavioral Health Service Facility

Demographic Characteristics	Overall	No Facility	At least one BHS Facility	p-value
Race/Ethnicity				
Latino	34.2%	23.3%	39.7%	< 0.001
White	42.0%	50.3%	37.2%	0.0016
African American	1.5%	2.1%	1.6%	0.6975
API	19.3%	20.6%	18.9%	0.9877
other	3.0%	3.7%	2.6%	0.001
Insurance Status				
Private Insurance	65.7%	74.3%	61.7%	0.001
Public Insurance	29.5%	26.5%	31.0%	0.0119
Uninsured	12.3%	8.4%	14.1%	< 0.001
Living Below Federal Poverty Level	12.5%	9.8%	12.9%	0.5586
Median Age (in years)	37.3	45.5	30.9	0.0010
Total Population Size	3,371,361	1,165,031	2,206,330	<0.001

5.3 Geographic Distribution of Behavioral Health Services in Select Cities

Most BHS facilities in Orange County are concentrated in and around the zip codes covering the cities of Anaheim, Costa Mesa, Orange, and Santa Ana (Figure 15). These four cities contained 65% of all the BHS facilities and account for 31% of the population (Table 8).

Figure 15: Distribution of Behavioral Health Service Facilities in Zip Codes within the Cities of Anaheim, Costa Mesa Orange, and Santa Ana

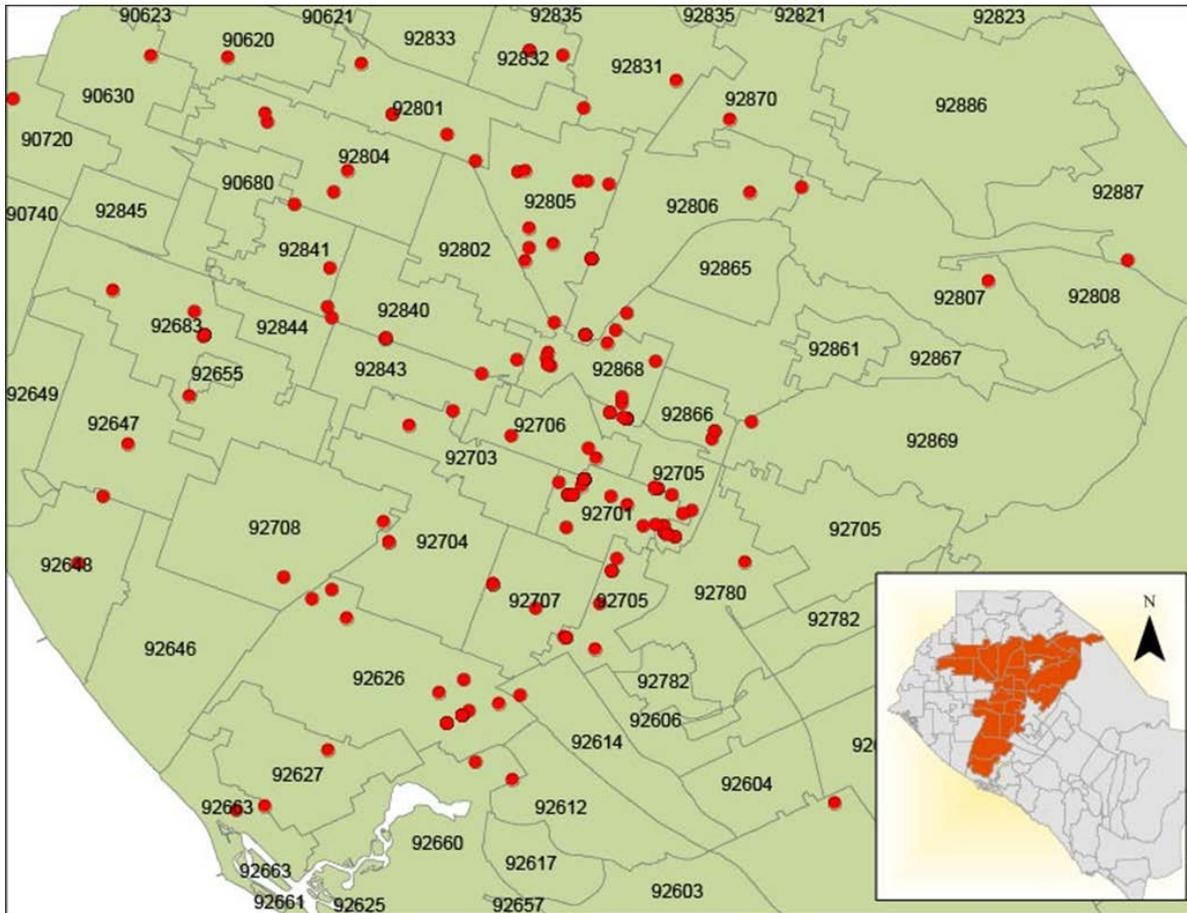


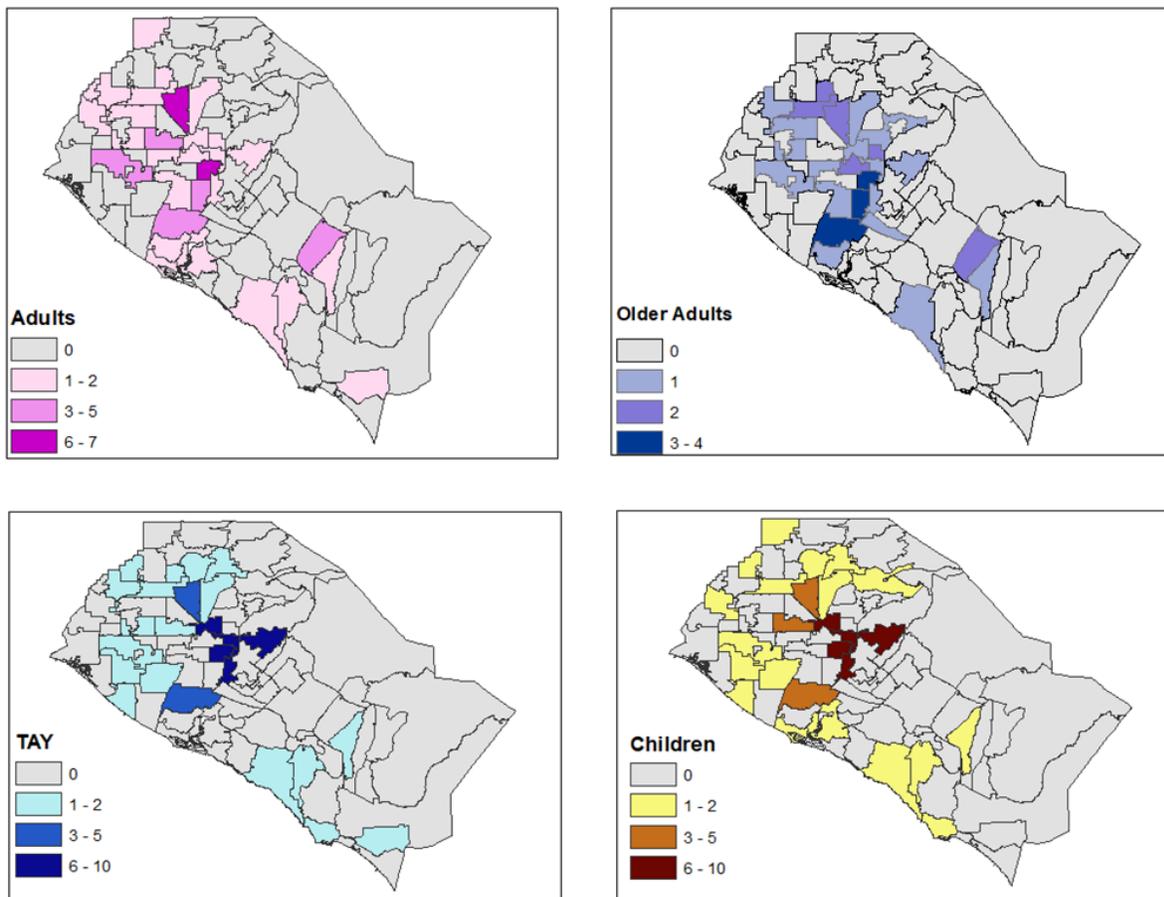
Table 8. Behavioral Health Service Facilities and Population Size in Select Orange County Cities

Cities	Number of BHS Facilities	Population size	Density of services per 10,000 residents
Anaheim	30 (14.9%)	367,602 (11.6%)	0.84
Costa Mesa	17 (4.5%)	114,250 (3.6%)	1.48
Orange	23 (11.4%)	145,240 (4.6%)	1.46
Santa Ana	61 (30.4%)	357,192 (11.3%)	1.82

5.4 Geographic Coverage of Behavioral Health Services by Age

Figure 16 displays the geographic coverage of BHS facilities stratified by the population being served. Zip code 92701, in Santa Ana, had the largest number of behavioral health programs for adults (n=7), older adults (n=4), TAY (n=10) and children (n=8). Additional zip codes with a large number of services specific to these populations included 92805, in Anaheim, for adults; 92707, in Santa Ana and 92626, in Costa Mesa, for older adults; and 92705 and 92868, in Santa Ana for children and TAY. There was some overlap in the geographic availability of facilities with services that were specific to children and TAY since several of these facilities were programs targeting both age groups.

Figure 16: Number of Behavioral Health Services (BHS) Facilities Providing Services Specific to Adults, Older Adults, Transitional Age Youth (TAY), and Children by Zip Code in Orange County

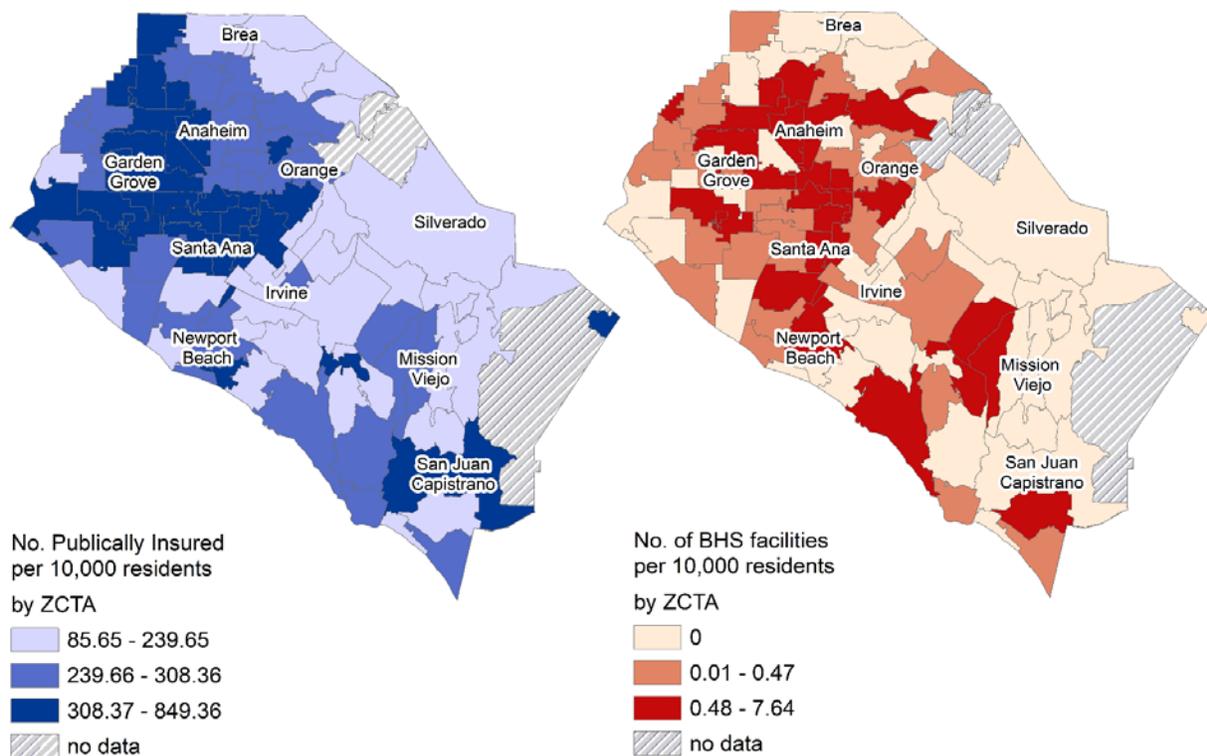


5.5 Geographic Coverage of Behavioral Health Services by Insurance Coverage

Approximately 30% of the Orange County population is publicly insured (Table 7). The majority of the publicly insured population reside in the northern region of the county, in the cities of Seal Beach, Garden Grove, Santa Ana, Anaheim, Villa Park, Fullerton, Buena Park and La Habra (Figure 17). Parts of the southern region of Orange County also have a large number of publicly insured individuals. This includes the southwest section of Newport Beach, Laguna Woods, and San Juan Capistrano (Figure 17).

Similarly, the northern region of Orange County has the highest density of BHS facilities, measured as the number of BHS facilities per 10,000 residents (Figure 17). Areas with a high density of BHS facilities spatially overlap with areas in which there is a high density of the publicly insured population. However, there may be gaps in BHS coverage in San Juan Capistrano where there is a high density of publicly insured residents but no BHS facility.

Figure 17: Distribution of Public Insurance Coverage and Behavioral Health Services (BHS) Facilities in Orange County by Zip Code Tabulation Areas (ZCTA)



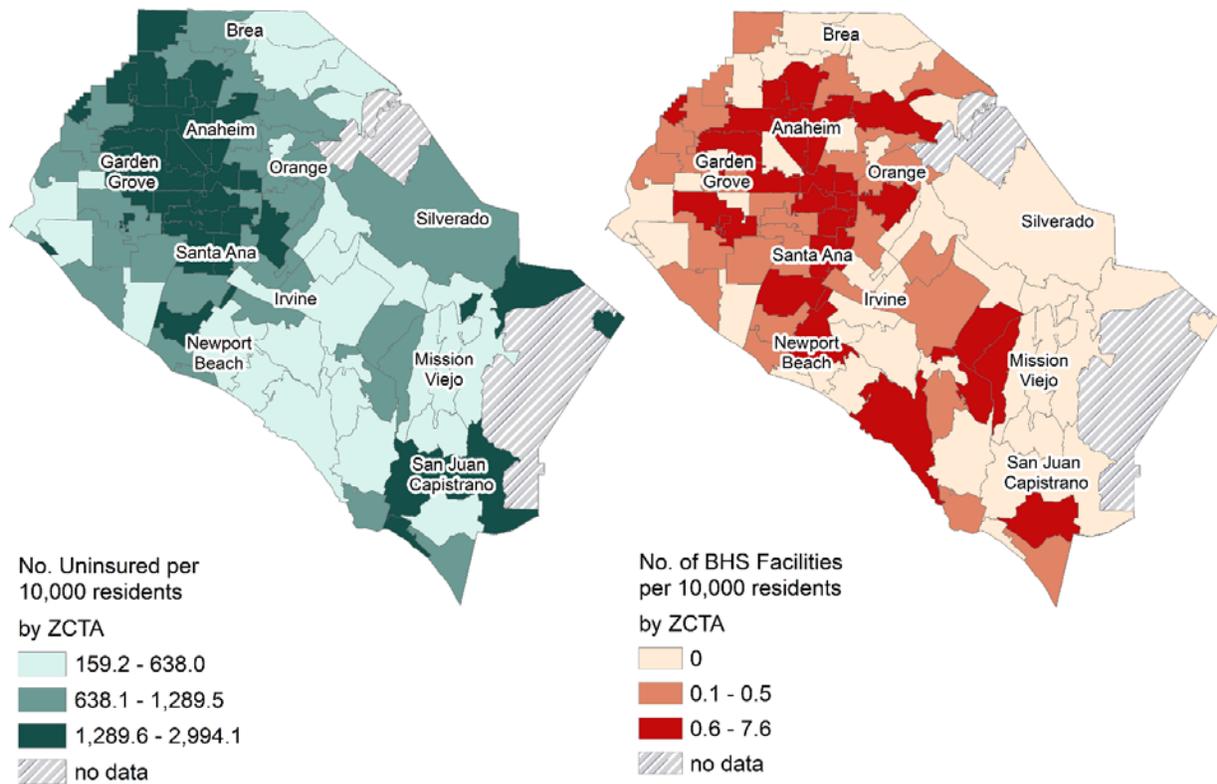
Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

Approximately 1 out of 10 residents are uninsured in Orange County (Table 7). The majority

of the uninsured population reside in the northern region of the county, in the cities of Garden Grove, Stanton, Santa Ana, Anaheim, Fullerton, Buena Park and La Habra (Figure 18). Parts of southern Orange County also have a high presence of uninsured individuals including San Juan Capistrano/Capistrano Beach (Figure 18).

Areas with a high density of BHS facilities spatially overlap with areas in which there is a high density of the uninsured population. However, there may be gaps in BHS coverage in Trabuco Canyon and San Juan Capistrano/Capistrano Beach, where there is a high density of uninsured residents but no BHS facility.

Figure 18: Distribution of Uninsured Coverage and Behavioral Health Services (BHS) Facilities in Orange County by Zip Code Tabulation Areas (ZCTA)

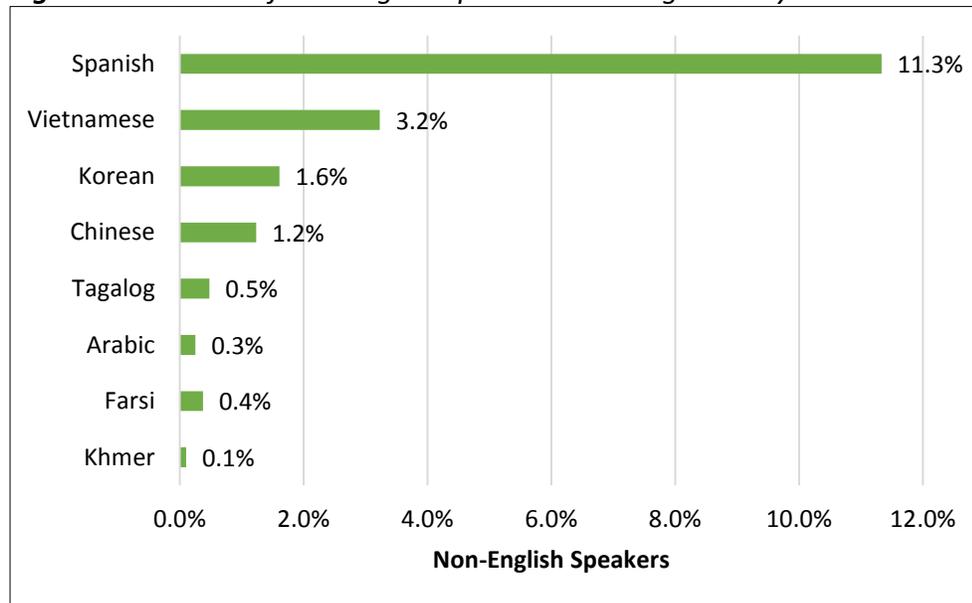


Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

5.6 Geographic Coverage of Behavioral Health Services for non-English Speakers

Approximately 19% (586,471) of Orange County residents are not fluent in English. As shown in Figure 19, the most common non-English languages, spoken among those not fluent in English, are Spanish (11.3%), Vietnamese (3.2%), Korean (1.6%), and Chinese (1.2%).

Figure 19: Percent of non-English Speakers in Orange County



Of the 201 BHS facilities in Orange County, over half (61%; n=123) provide services in Spanish (Table 9). The other most common linguistic services offered at BHS facilities include Vietnamese (38%; n=76), Farsi (23%; n=47), and Korean (17%; n=35).

Table 9. Linguistic Services Offered at BHS Facilities and Population of non-English Speakers

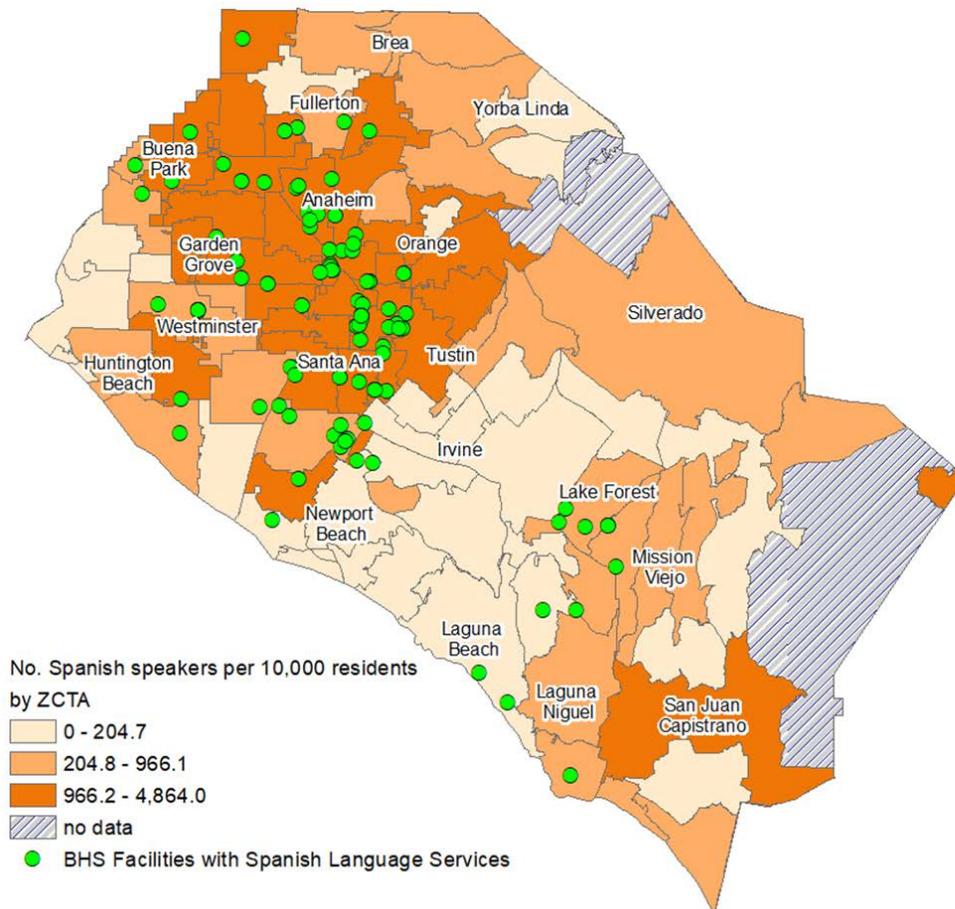
Language	BHS Facilities		Population of non-English Speakers	
	Number	Percent ^a	Number	Percent
Spanish	123	61%	357,014	11.3%
Vietnamese	76	38%	101,780	3.2%
Korean	35	17%	50,763	1.6%
Chinese (Mandarin)	8	4%	38,822	1.2%
Tagalog	10	5%	15,098	<1%
Arabic	6	3%	7,943	<1%
Farsi	47	23%	11,813	<1%
Khmer	3	1%	3,238	<1%

^a Percentages are calculated with a denominator of 201 which is the total number of BHS facilities in Orange County

Figures 20-27 display maps of the locations of BHS facilities offering specific linguistic services by the resident population speaking those respective languages. The maps are color coded to capture a low, medium and high density of non-English speakers where density is measured as the number of non-English speakers per 10,000 residents.

Spanish-Speaking Population: The highest density of Spanish speaking residents, measured as the number of Spanish speakers per 10,000 residents, is in the cities of Huntington Beach, Costa Mesa, Anaheim, Orange, Santa Ana, and San Juan Capistrano. As shown in Figure 20, there are a total of 123 BHS facilities with Spanish-speaking staff, accounting for 61% of all BHS facilities in the County. The Spanish-speaking facilities are located throughout Orange County and the majority (69%; n=85) are situated in cities with a high density of Spanish speaking residents (La Habra, Fullerton, Anaheim, Orange, Santa Ana, and Garden Grove; Table 10).

Figure 20: Distribution of Spanish speakers per 10,000 residents and BHS Facilities with Spanish Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

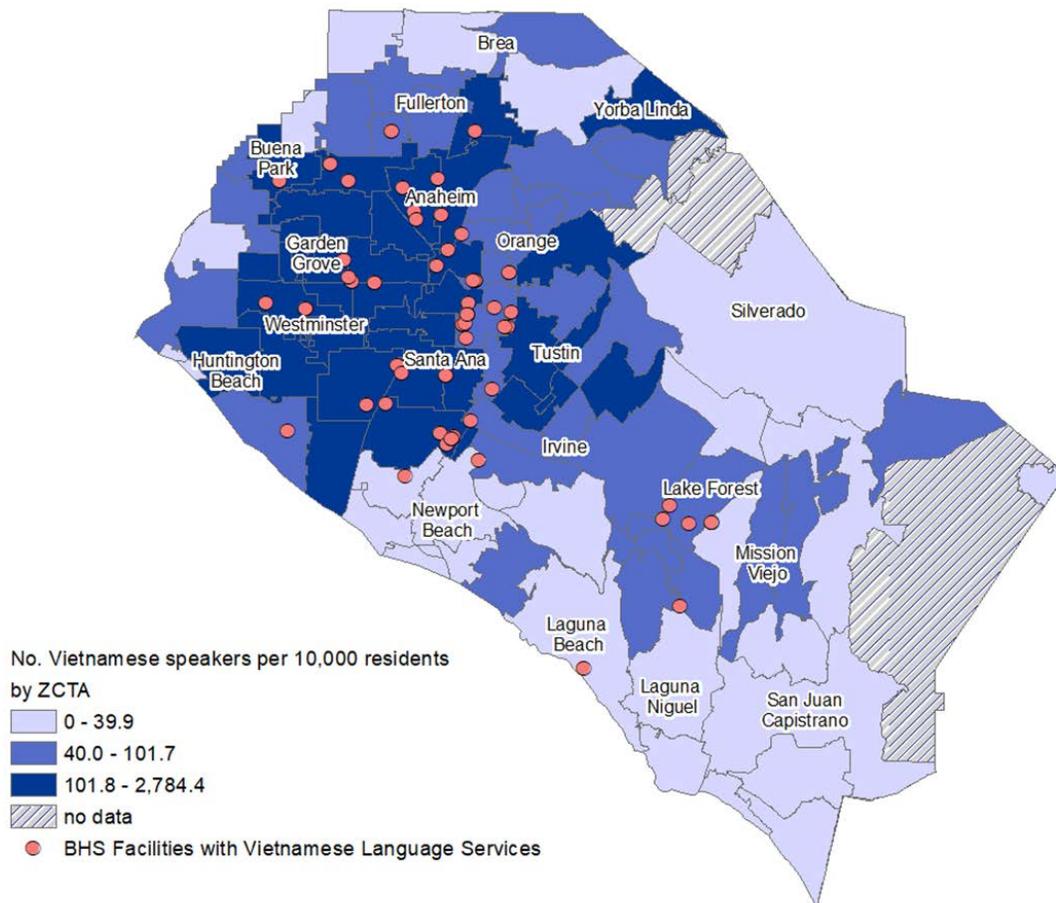
Table 10. Number of BHS facilities with Spanish-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Spanish-Speaking Residents

ZCTA*	City	No. of Spanish speakers per 10,000 residents	No. of BHS facilities with Spanish-speaking Staff
90620	Buena Park	1,091.6	1
90621	Buena Park	2,374.7	1
90631	La Habra	1,692.3	1
90680	Stanton	2,018.8	0
92530	Trabuco Canyon	1,640.5	0
92627	Costa Mesa	1,605.1	1
92647	Huntington Beach	966.6	1
92655	Midway City	1,056.3	0
92675	San Juan Capistrano	1,761.4	0
92701	Santa Ana	4,864.0	18
92703	Santa Ana	4,148.3	0
92704	Santa Ana	3,000.3	1
92705	Santa Ana	1,402.3	13
92706	Santa Ana	3,504.5	2
92707	Santa Ana	3,682.0	4
92780	Tustin	1,611.3	0
92801	Anaheim	2,017.5	4
92802	Anaheim	2,521.4	0
92804	Anaheim	1,585.5	1
92805	Anaheim	3,270.3	7
92806	Anaheim	1,874.8	5
92832	Fullerton	1,935.3	3
92833	Fullerton	1,167.5	0
92840	Garden Grove	1,370.6	4
92841	Garden Grove	1,098.4	1
92843	Garden Grove	1,645.3	1
92866	Orange	2,125.5	2
92867	Orange	1,155.8	1
92868	Orange	1,582.1	12
92869	Orange	1,354.7	0
92870	Placentia	1,034.3	1
TOTAL			85

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 92530 is not part of the US postal zip code system but 92530 geographically overlaps with the postal zip code 92679 in Trabuco Canyon.

Vietnamese-Speaking Population: The majority of Vietnamese-speaking residents are located in the northwest region of Orange County covering the cities of Huntington Beach, Westminster, Garden Grove, Santa Ana and Anaheim (Figure 21). There are a total of 76 BHS facilities with Vietnamese-speaking staff, accounting for 38% of all BHS facilities. Several of the Vietnamese-speaking BHS facilities are located in the northwest region of the county where there is a high density of Vietnamese speaking residents. Of the 76 Vietnamese-speaking BHS facilities, 54% (n=41) are located in areas with a high density of Vietnamese speaking residents (Table 11). However, there is a lack of Vietnamese language services in Yorba Linda, Tustin, and Irvine where a high density of Vietnamese-speaking individuals reside.

Figure 21: Distribution of Vietnamese speakers per 10,000 residents and BHS Facilities with Vietnamese Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

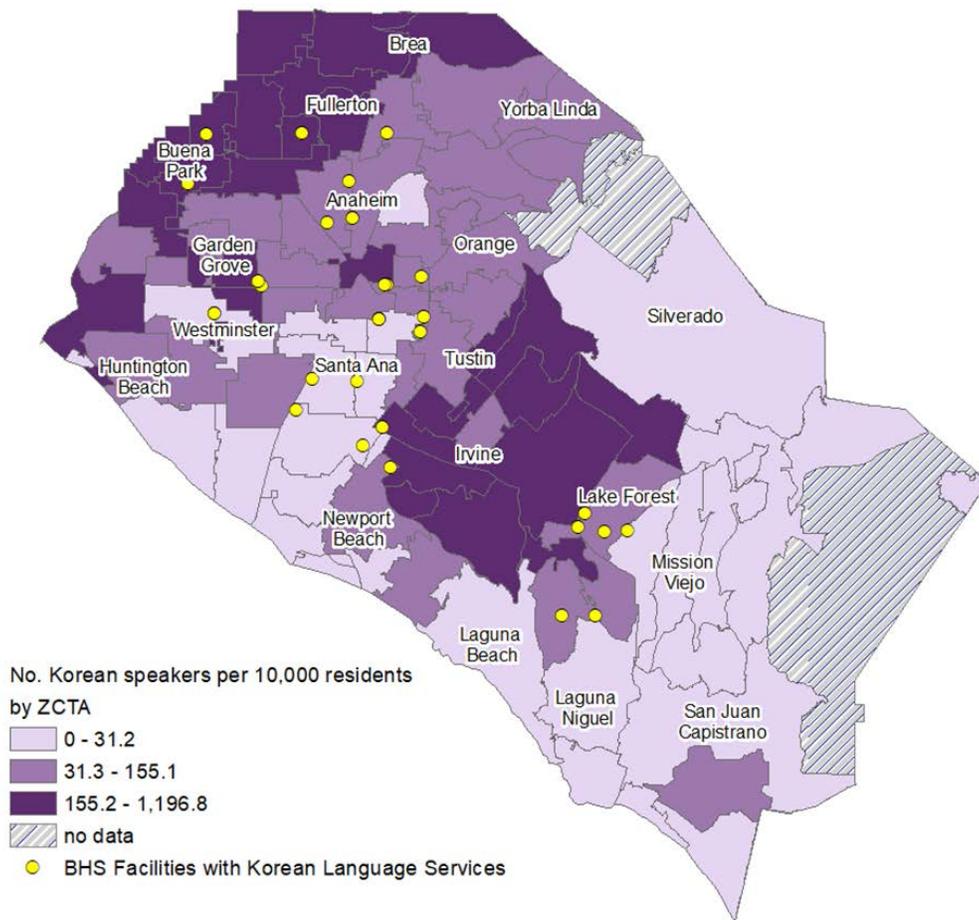
Table 11. Number of BHS facilities with Vietnamese-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Vietnamese-Speaking Residents

ZCTA*	City	No. of Vietnamese speakers per 10,000 residents	No. of BHS facilities with Vietnamese-speaking Staff
90620	Buena Park	132.3	1
90680	Stanton	1,010.3	0
92606	Irvine	134.4	0
92620	Irvine	134.8	0
92626	Costa Mesa	114.5	7
92646	Huntington Beach	110.5	0
92647	Huntington Beach	252.1	0
92649	Huntington Beach	147.2	0
92655	Midway City	2,576.3	0
92683	Westminster	2,501.6	6
92703	Santa Ana	853.5	0
92704	Santa Ana	777.9	1
92706	Santa Ana	247.7	1
92707	Santa Ana	164.6	3
92708	Fountain Valley	988.8	2
92780	Tustin	165.0	0
92782	Tustin	228.9	0
92801	Anaheim	228.8	2
92802	Anaheim	366.3	0
92804	Anaheim	623.6	0
92805	Anaheim	102.5	4
92806	Anaheim	187.4	3
92840	Garden Grove	1,428.1	4
92841	Garden Grove	1,839.2	1
92843	Garden Grove	2,400.4	0
92844	Garden Grove	2,784.4	0
92845	Garden Grove	334.4	0
92868	Orange	232.8	5
92869	Orange	124.9	0
92870	Placentia	113.5	1
92887	Yorba Linda	175.0	0
TOTAL			41

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the Zip Code areas used by the United State Postal System for mailing address. The U.S. Census Bureau publishes statistical census data by ZCTA.

Korean-Speaking Population: A high density of Korean-speaking residents are located in the northern region of the county, in cities bordering Los Angeles County (Seal Beach, Cypress, Garden Grove Buena Park, Fullerton, La Habra), as well as in the city of Irvine (Figure 22). There are a total of 35 BHS facilities with Korean-speaking staff, which accounts for 17% of all BHS facilities in the county (Table 12). Only seven facilities are situated in areas with a high presence of Korean-speaking residents. There are few of facilities with Korean-speaking staff in the cities bordering Los Angeles County and the city of Irvine.

Figure 22: Distribution of Korean speakers per 10,000 residents and BHS Facilities with Korean Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

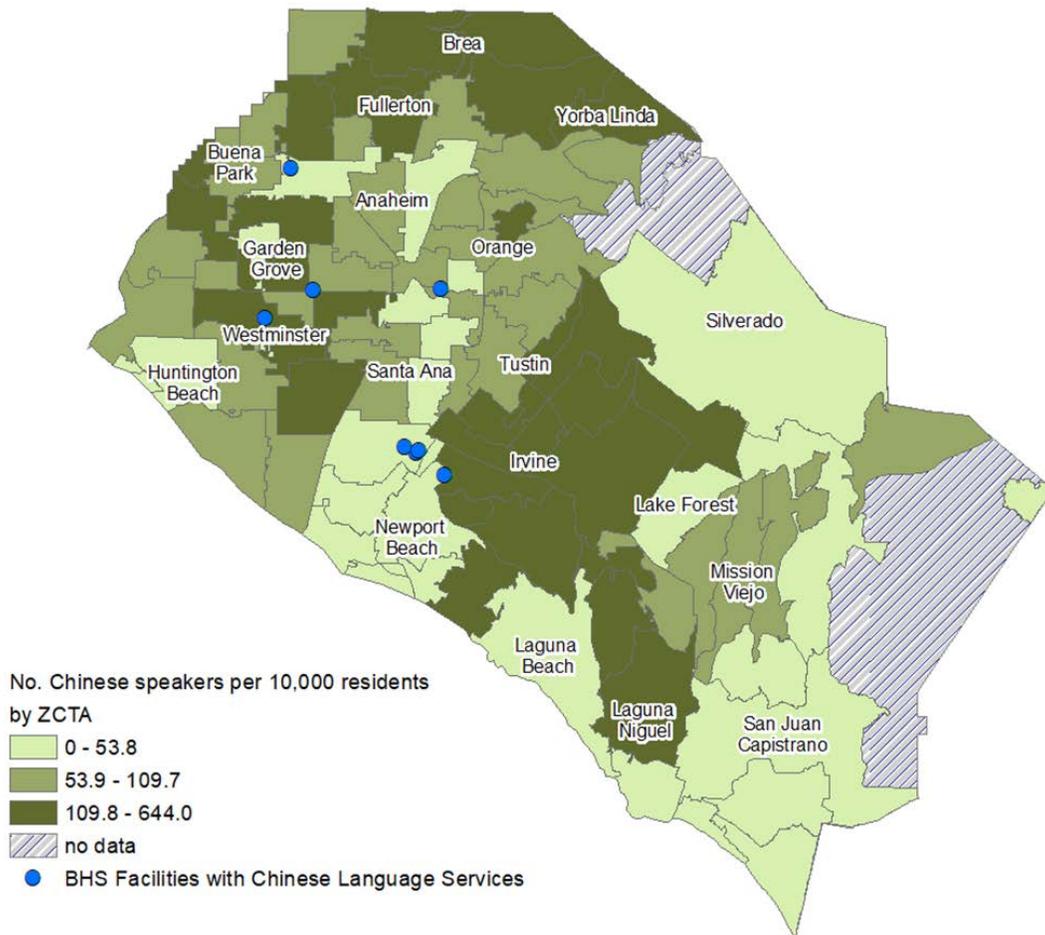
Table 12. Number of BHS facilities with Korean-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Korean-Speaking Residents

ZCTA*	City	No. of Korean speakers per 10,000 residents	No. of BHS facilities with Korean-speaking Staff
90620	Buena Park	537.9	1
90621	Buena Park	1,196.8	1
90623	La Palma	742.0	0
90630	Cypress	876.5	0
90631	La Habra	205.1	0
90638	La Mirada	487.8	0
90703	Santa Ana	744.9	0
90720	Los Alamitos	155.2	0
90740	Seal Beach	207.3	0
90742	Huntington Beach	174.2	0
92602	Irvine	382.0	0
92603	Irvine	167.9	0
92606	Irvine	161.8	0
92610	Foothill Ranch	179.8	0
92612	Irvine	228.9	0
92614	Irvine	162.0	1
92617	Irvine	197.4	0
92618	Irvine	225.6	0
92620	Irvine	592.2	0
92637	Laguna Woods	402.6	0
92655	Midway City	198.7	0
92782	Tustin	280.7	0
92801	Anaheim	193.2	0
92821	Brea	250.4	0
92823	Brea	322.4	0
92831	Fullerton	170.1	0
92832	Fullerton	206.5	1
92833	Fullerton	1,132.5	0
92835	Fullerton	556.5	0
92841	Garden Grove	327.4	0
92844	Garden Grove	327.8	0
92868	Orange	182.1	3
TOTAL			7

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the Zip Code areas used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 90742 is not part of the US postal zip code system but 90742 geographically overlaps with the postal zip code 92649 in Huntington Beach.

Chinese-Speaking Population: The majority of Chinese-speaking residents are located in the northeast (Fullerton, Brea, and Yorba Linda) and southern regions (Irvine and Laguna Niguel) with additional Chinese-speaking residents in the cities of Cypress, Garden Grove and Westminster (Figure 23). There are a total of 8 BHS facilities with Chinese-speaking staff, which accounts for 4% of all BHS facilities (Table 13). Nearly all of the Chinese-speaking facilities are located in areas that do not have a high presence of Chinese-speaking residents. Rather there is only 1 Chinese-speaking BHS facility in an area with a high density of Chinese-speaking residents and this is in the city of Westminster.

Figure 23: Distribution of Chinese speakers per 10,000 residents and BHS Facilities with Chinese Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

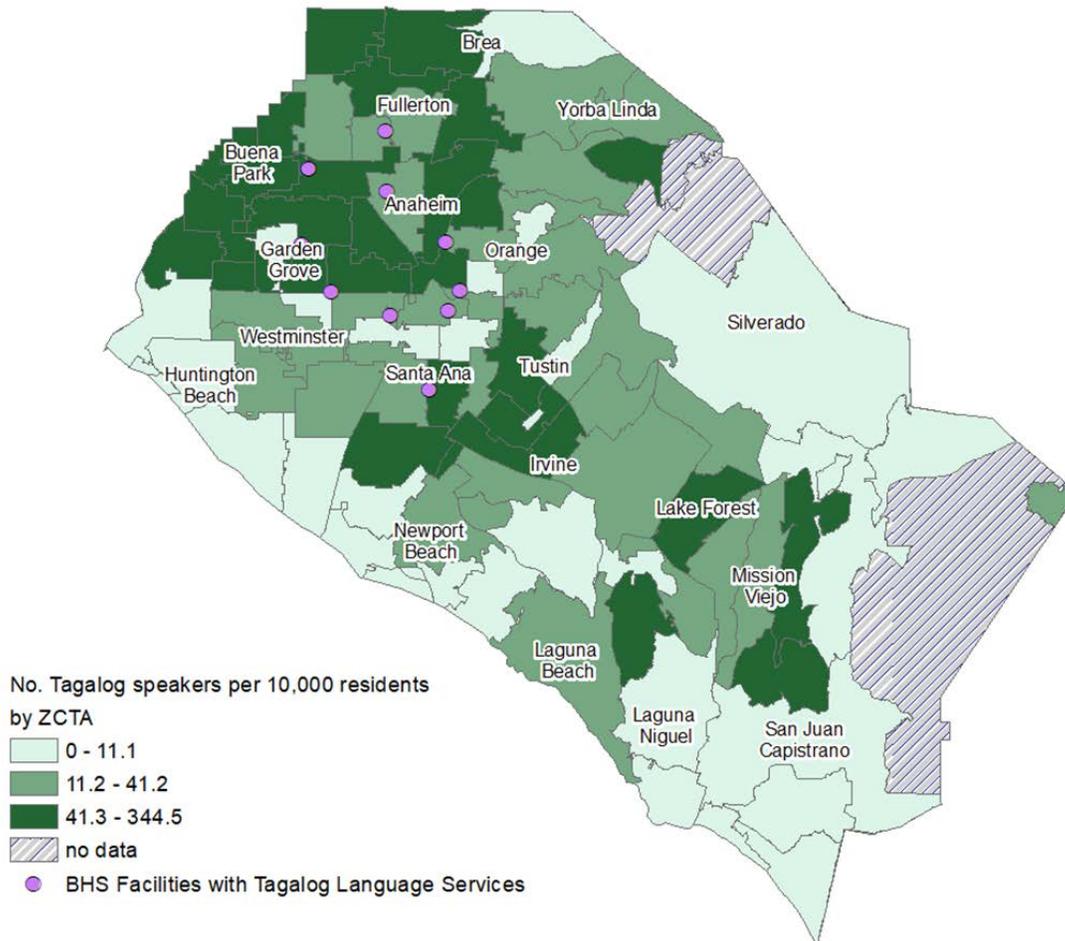
Table 13. Number of BHS facilities with Chinese-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Chinese-Speaking Residents

ZCTA*	City	No. of Chinese speakers per 10,000 residents	No. of BHS facilities with Chinese-speaking Staff
90621	Buena Park	109.7	0
90623	La Palma	343.4	0
90630	Cypress	291.7	0
90703	Santa Ana	638.1	0
92602	Irvine	200.4	0
92603	Irvine	471.0	0
92604	Irvine	399.9	0
92606	Irvine	644.0	0
92610	Foothill Ranch	173.4	0
92612	Irvine	451.2	0
92614	Irvine	511.3	0
92617	Irvine	464.0	0
92618	Irvine	499.3	0
92620	Irvine	598.4	0
92637	Laguna Woods	240.5	0
92656	Aliso Viejo	115.7	0
92657	Newport Coast	133.2	0
92677	Laguna Niguel	110.6	0
92683	Westminster	122.9	1
92708	Fountain Valley	208.9	0
92782	Tustin	328.0	0
92804	Anaheim	110.0	0
92821	Brea	131.1	0
92823	Brea	344.5	0
92831	Fullerton	285.2	0
92833	Fullerton	191.7	0
92835	Fullerton	287.4	0
92841	Garden Grove	173.1	0
92843	Garden Grove	119.3	0
92861	Villa Park	166.6	0
92886	Yorba Linda	165.5	0
92887	Yorba Linda	198.6	0
TOTAL			1

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing zip codes used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

Tagalog-Speaking Population: Tagalog-speaking residents are located throughout Orange County. As indicated in Figure 24, the highest density of Tagalog-speaking residents are in the northern (Buena Park, Garden Grove, Santa Ana, Fullerton, Anaheim, and Brea) and southern (Tustin, Irvine, Lake Forest, Mission Viejo) regions. There are a total of 10 BHS facilities with Tagalog-speaking staff, accounting for 5% of all BHS facilities (Table 14). All of these facilities are located in the northern region of the county with 5 of the Tagalog-speaking BHS facilities situated in areas with a high density of Tagalog-speaking residents. There is an absence of Tagalog-speaking staff in the southern region of the county where there is a high presence of Tagalog-speaking residents.

Figure 24: Distribution of Tagalog speakers per 10,000 residents and BHS Facilities with Tagalog Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

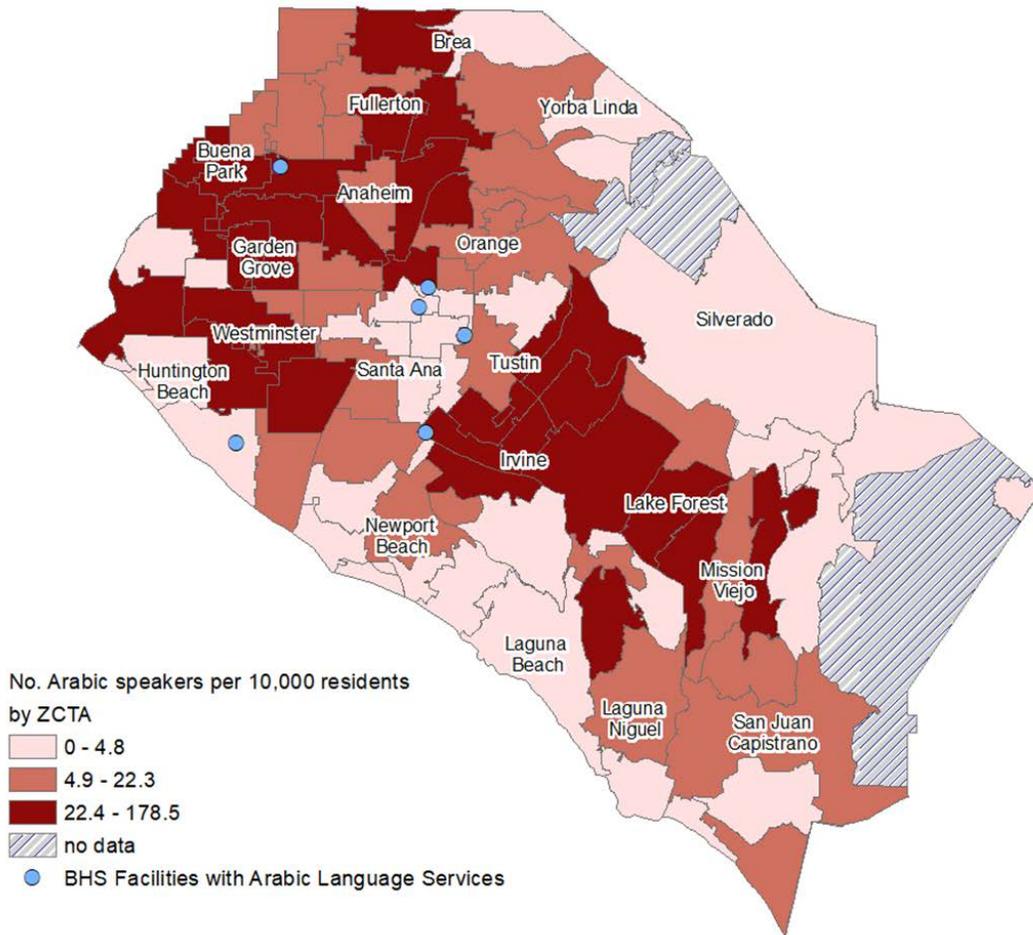
Table 14. Number of BHS facilities with Tagalog-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Tagalog-Speaking Residents

ZCTA*	City	No. of Tagalog speakers per 10,000 residents	No. of BHS facilities with Tagalog-speaking Staff
90620	Buena Park	344.5	0
90621	Buena Park	226.8	0
90623	La Palma	107.1	0
90630	Cypress	102.3	0
90631	La Habra	47.3	0
90638	La Mirada	137.9	0
90703	La Palma	265.1	0
90720	Los Alamitos	77.6	0
92604	Irvine	57.4	0
92606	Irvine	57.5	0
92614	Irvine	43.7	0
92626	Costa Mesa	56.0	0
92630	Lake Forest	104.6	0
92655	Midway City	41.3	0
92656	Aliso Viejo	43.6	0
92688	Rancho Santa Margarita	48.4	0
92694	Ladera Ranch	55.0	0
92707	Santa Ana	43.2	1
92780	Tustin	67.1	0
92801	Anaheim	102.9	1
92802	Anaheim	42.1	0
92804	Anaheim	156.4	1
92806	Anaheim	74.3	0
92808	Anaheim	55.4	0
92821	Brea	50.3	0
92835	Fullerton	67.3	0
92840	Garden Grove	50.3	1
92841	Garden Grove	64.4	0
92845	Garden Grove	47.6	0
92865	Orange	102.1	0
92868	Orange	47.9	1
92870	Placentia	73.7	0
TOTAL			5

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing zip codes used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 90703 is not part of the US postal zip code system but 90703 geographically overlaps with the postal zip code 90623 in La Palma.

Arabic-Speaking Population: The highest density of the Arabic-speaking population is located in the cities of Seal Beach, Westminster, Buena Park, Fullerton, and Anaheim (northern region) and the cities of Tustin, Irvine, Lake Forest, and Mission Viejo (southern region). A total of 6 BHS facilities have Arabic-speaking staff, which accounts for 3% of all BHS facilities. Most of these Arabic-speaking facilities are in the city of Santa Ana (Figure 25); an area with the lowest density of Arabic-speaking residents. The remaining Arabic-speaking BHS facilities are located in areas with a high density of Arabic-speaking residents (Table 15).

Figure 25: Distribution of Arabic speakers per 10,000 residents and BHS Facilities with Arabic Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

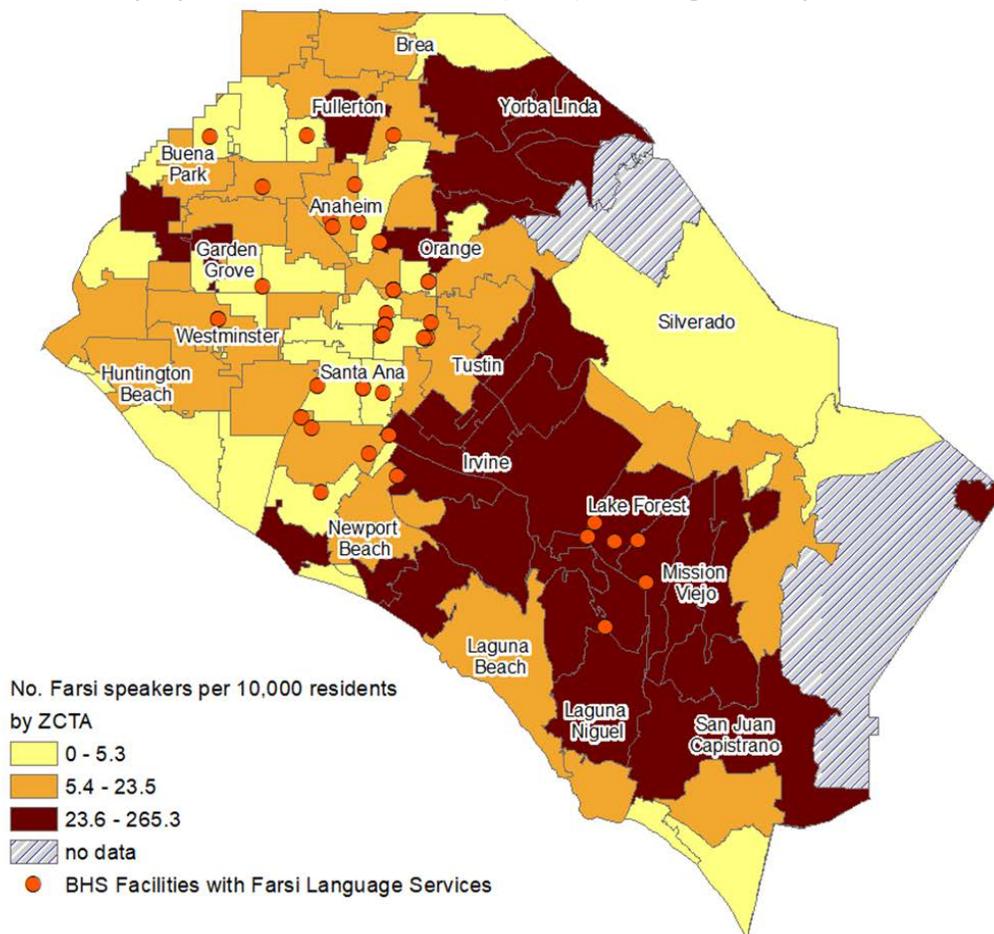
Table 15. Number of BHS facilities with Arabic-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Arabic-Speaking Residents

ZCTA*	City	No. of Arabic speakers per 10,000 residents	No. of BHS facilities with Arabic-speaking Staff
90620	Buena Park	35.5	0
90623	La Palma	49.2	0
90630	Cypress	32.0	0
90680	Stanton	30.9	0
90703	La Palma	55.6	0
90740	Seal Beach	25.6	0
92602	Irvine	178.5	0
92604	Irvine	55.6	0
92606	Irvine	137.1	0
92612	Irvine	65.0	0
92614	Irvine	100.0	1
92618	Irvine	161.8	0
92620	Irvine	26.7	0
92630	Lake Forest	37.8	0
92647	Huntington Beach	91.6	0
92656	Aliso Viejo	26.3	0
92683	Westminster	33.3	0
92688	Rancho Santa Margarita	42.4	0
92691	Mission Viejo	29.6	0
92708	Fountain Valley	45.7	0
92782	Tustin	28.7	0
92801	Anaheim	54.3	1
92802	Anaheim	61.1	0
92804	Anaheim	100.9	0
92806	Anaheim	31.1	0
92821	Brea	30.0	0
92831	Fullerton	44.5	0
92841	Garden Grove	59.1	0
92865	Orange	24.9	0
92868	Orange	22.6	1
92870	Placentia	23.1	0
TOTAL			3

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing zip codes used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 90703 is not part of the US postal zip code system but 90703 geographically overlaps with the postal zip code 90623 in La Palma.

Farsi-Speaking Population: A high density of Farsi-speaking residents are located in northeastern region of the county in the cities of Anaheim, Orange and Yorba Linda and in the southern region covering the cities of Newport Beach, Irvine, Tustin, Lake Forest, Mission Viejo, Laguna Niguel, Trabuco Canyon, and San Juan Capistrano. A total of 47 BHS facilities have Farsi-speaking staff, accounting for 23% of all BHS facilities. The majority of Farsi-speaking facilities are in the cities of Santa Ana, Orange, and Anaheim (Figure 26). Only 19% (n=9) of the Farsi-speaking facilities are located in regions of the county with a high density of Farsi-speaking residents (Table 16).

Figure 26: Distribution of Farsi speakers per 10,000 residents and BHS Facilities with Farsi Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

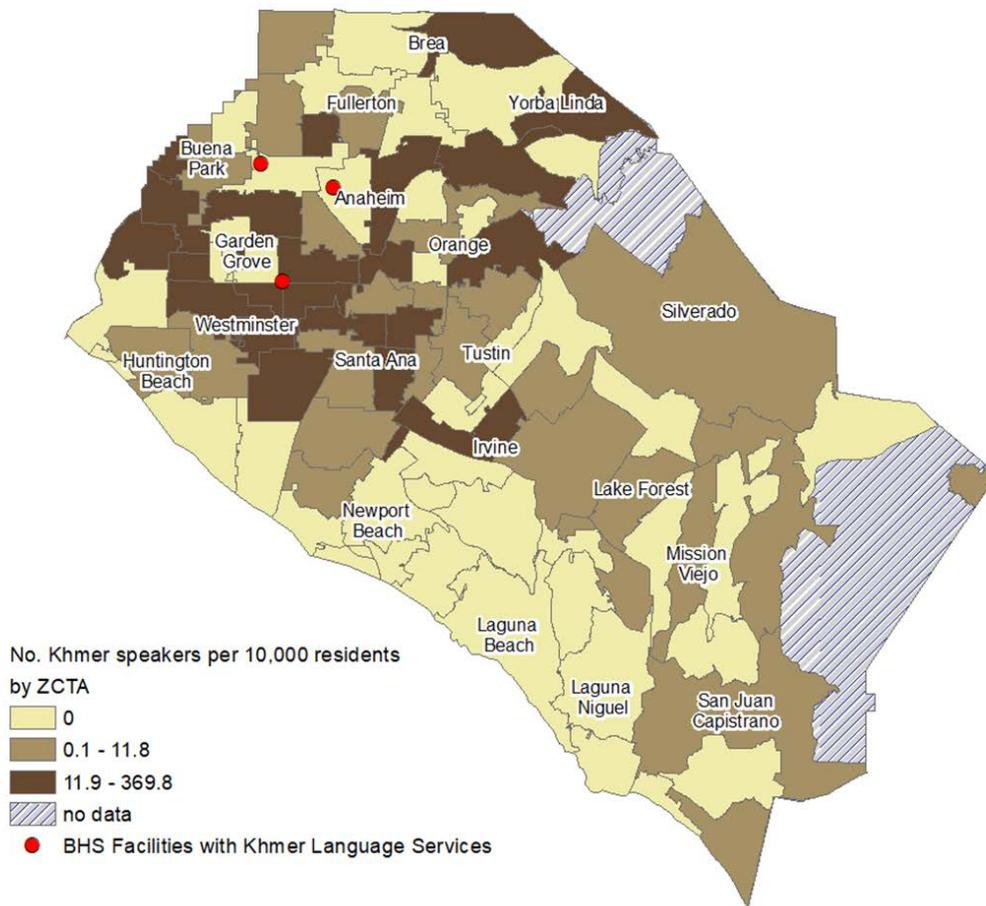
Table 16. Number of BHS facilities with Farsi-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Farsi-Speaking Residents

ZCTA*	City	No. of Farsi speakers per 10,000 residents	No. of BHS facilities with Farsi-speaking Staff
90630	Cypress	42.0	0
90680	Stanton	24.6	0
92530	Trabuco Canyon	24.0	0
92602	Irvine	166.5	0
92603	Irvine	133.1	0
92604	Irvine	125.7	0
92606	Irvine	217.5	0
92612	Irvine	265.3	0
92614	Irvine	238.7	1
92618	Irvine	126.8	0
92620	Irvine	196.8	0
92625	Corona del Mar	34.9	0
92630	Lake Forest	55.7	3
92637	Laguna Woods	125.4	0
92653	Laguna Hills	107.1	0
92656	Aliso Viejo	115.7	1
92657	Newport Coast	93.6	0
92663	Newport Beach	45.0	0
92675	San Juan Capistrano	42.4	0
92677	Laguna Niguel	142.8	0
92688	Rancho Santa Margarita	55.3	0
92691	Mission Viejo	121.4	3
92692	Mission Viejo	175.8	0
92694	Ladera Ranch	64.2	0
92782	Tustin	57.0	0
92807	Anaheim	81.3	0
92808	Anaheim	134.4	0
92831	Fullerton	60.2	0
92867	Orange	30.2	1
92886	Yorba Linda	34.0	0
92887	Yorba Linda	65.5	0
TOTAL			9

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing zip codes used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 92530 is not part of the US postal zip code system but 92530 geographically overlaps with the postal zip code 92679 in Trabuco Canyon.

Khmer-Speaking Population: The majority of the Khmer-speaking population of Orange County is located in the northern region, primarily in the cities of Westminster, Santa Ana, Buena Park, Fullerton, Anaheim, Brea and Yorba Linda (Figure 27). There are 3 BHS facilities with Khmer-speaking staff, and all of these are located in the northwestern region covering the cities of Garden Grove and Anaheim. However, of the 3 BHS facilities, only one facility, located in Garden Grove, is within close proximity to areas that have a high presence of Khmer-speaking residents (Table 17).

Figure 27: Distribution of Khmer speakers per 10,000 residents and BHS Facilities with Khmer Language Services by Zip Code Tabulation Areas (ZCTA) in Orange County



Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of mailing address zip codes used by the United States Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA.

Table 17. Number of BHS facilities with Khmer-Speaking Staff in Zip Code Tabulation Areas (ZCTA*) with the Highest Density of Khmer-Speaking Residents

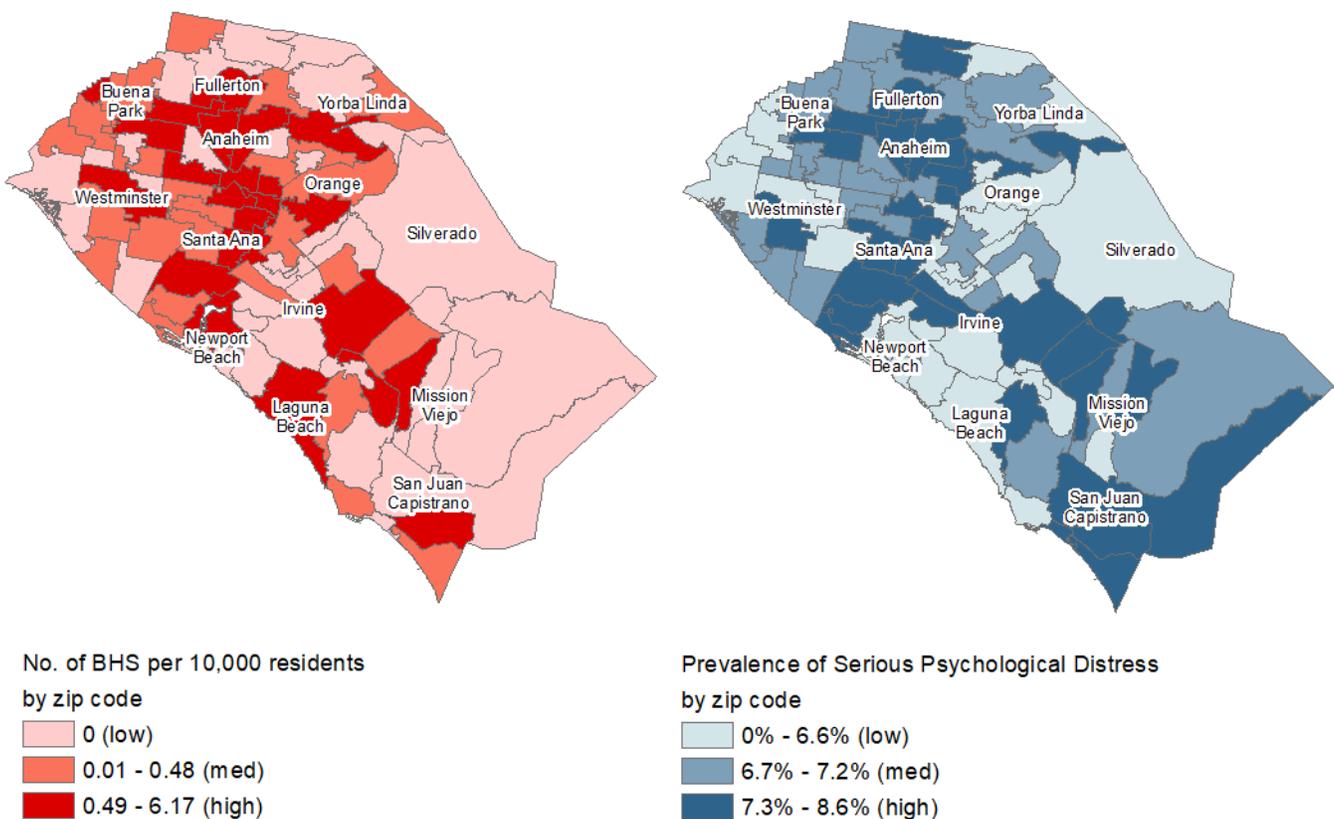
ZCTA*	City	No. of Khmer speakers per 10,000 residents	No. of BHS facilities with Khmer-speaking Staff
90623	La Palma	20.0	0
90630	Cypress	13.0	0
90703	La Palma	35.5	0
90720	Los Alamitos	21.1	0
90815	Los Alamitos	13.4	0
92604	Irvine	17.9	0
92614	Irvine	27.8	0
92655	Midway City	21.7	0
92683	Westminster	26.0	0
92701	Santa Ana	64.6	0
92703	Santa Ana	28.6	0
92707	Santa Ana	21.3	0
92708	Fountain Valley	15.8	0
92804	Anaheim	16.2	0
92806	Anaheim	43.4	0
92807	Anaheim	13.1	0
92823	Brea	369.8	0
92832	Fullerton	19.5	0
92840	Garden Grove	31.7	1
92843	Garden Grove	21.4	0
92844	Garden Grove	45.4	0
92845	Garden Grove	12.8	0
92868	Orange	25.0	0
92869	Orange	15.1	0
92887	Yorba Linda	29.3	0
TOTAL			1

*Note: Zip Code Tabulation Areas (ZCTA) are generalized areal representations of the mailing zip codes used by the United State Postal System. The U.S. Census Bureau publishes statistical census data by ZCTA. ZCTA 90703 is not part of the US postal zip code system but it geographically overlaps with the postal zip code 90623 in La Palma. ZCTA 900815 is not part of the US postal zip code system but it geographically overlaps with the postal zip code 90720 in Los Alamitos.

6. Geographic Distribution of Behavioral Health Services and Serious Psychological Distress

As previously described, the highest density of behavioral health services per 10,000 residents is in the northern region of the county. Additionally, there are a few zip codes in the southern region with a high density of BHS facilities (Figure 28). The overall prevalence of serious psychological distress among adults age 18 and older is 6.7%. Areas with a high density of BHS facilities spatially overlap with areas in which there is a high prevalence of serious psychological distress. However, there may be gaps in BHS coverage in San Juan Capistrano where there is a high density of prevalence of serious psychological distress but no BHS facility.

Figure 28: Distribution of Behavioral Health Services (BHS) per 10,000 Residents and Prevalence of Serious Psychological Distress across Orange County Zip Codes

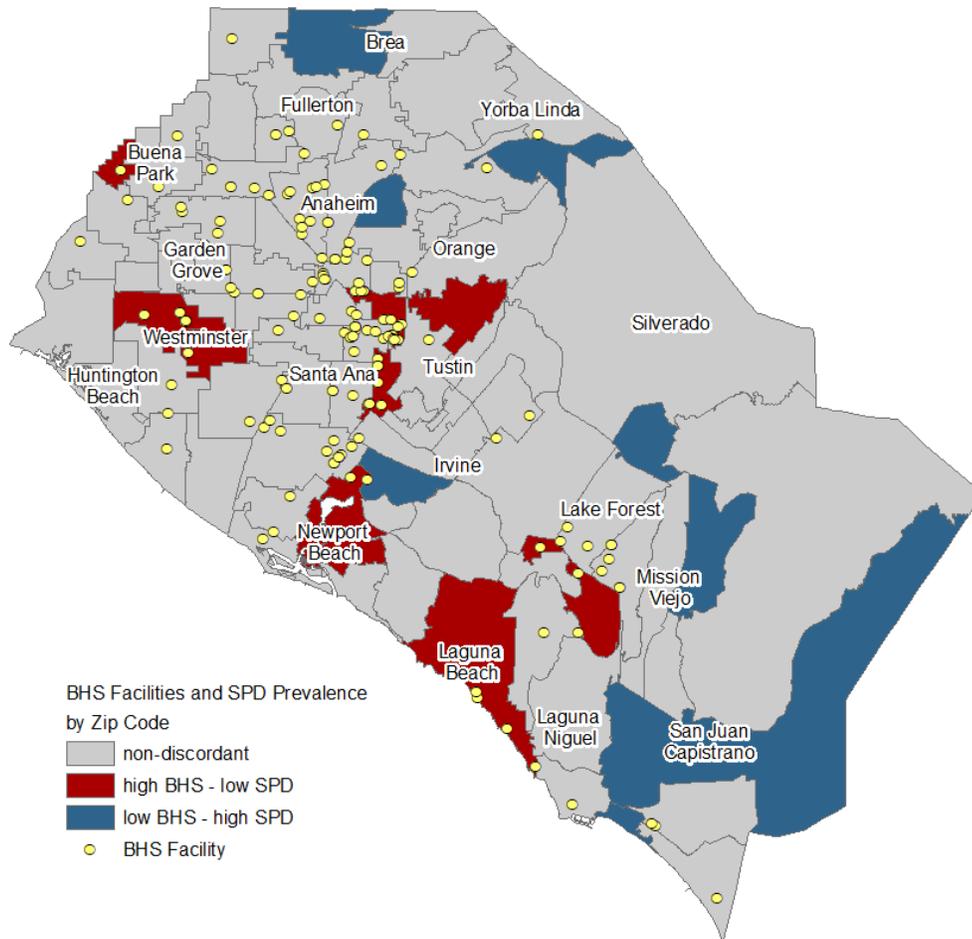


7. Geographic Disparities in Behavioral Health Services

Figure 29 displays zip codes with geographic discordance between the location of BHS facilities and the prevalence of serious psychological distress including:

1. Zip codes with a *high* density of BHS facilities (measured as the number of BHS facilities per 10,000 residents) and a *low* prevalence of serious psychological distress (high BHS – low SPD, shown in red in Figure 29), and;
2. Zip codes with a *low* density of BHS facilities and a *high* prevalence of serious psychological distress (low BHS – high SPD, shown in blue in Figure 29).
3. Non-discordant areas, shaded in grey in Figure 29, indicate zip codes in which there was less discrepancy between the availability of behavioral health services and the need for such services.

Figure 29: Geographic Discordance between the Density of Behavioral Health Services (BHS) Facilities and Prevalence of Serious Psychological Distress (SPD)



Note: Classification of high-low defined as follows: $0.49 \leq \text{High BHS density} \leq 6.17$; low BHS density = 0; $7.3\% \leq \text{high SPD} \leq 8.6\%$; low SPD $\leq 6.6\%$

Table 18 identifies the specific zip codes from Figure 30 in which the density of BHS facilities at the zip code-level was low relative to the prevalence of serious psychological distress (i.e., low-high) or conversely, where the density of BHS facilities was high relative to the prevalence of serious psychological distress (i.e., high-low).

Demographically, residents of the zip codes listed in Table 18 are more likely to be privately insured (71% vs. 65%) and less likely to be uninsured (9.3% vs. 12.6%) compared to residents of the remaining zip codes in Orange County. We therefore sought to determine whether the zip codes listed in Table 18, truly had low geographic coverage or no geographic coverage of mental health services.

Table 18. Disparities in Geographic Coverage of HCA Behavioral Health Services

City	Zip Code	Density of BHS facilities per 10,000 residents	Prevalence of Serious Psychological Distress (SPD)	BHS Services relative to SPD	Density of office-based Psychiatrists per 10,000 residents ^a	Density of office-based Therapists per 10,000 residents ^a
Orange	92865	0	7.3%	Low-High	0 (0)	0.98 (2)
San Juan Capistrano	92675	0	7.3%	Low-High	0.27 (1)	1.07 (4)
Anaheim	92808	0	7.6%	Low-High	0.94 (2)	0 (0)
Brea	92821	0	7.4%	Low-High	0.55 (2)	1.36 (5)
Irvine	92612	0	8.0%	Low-High	1.35 (9)	3.03 (9)
Rancho Santa Margarita	92688	0	7.6%	Low-High	0.22 (1)	0.45 (2)
Foothill Ranch	92610	0	7.6%	Low-High	0 (0)	0 (0)
Capistrano Beach	92624	0	7.4%	Low-High	0 (0)	1.42 (1)
La Palma	90623	0.61	6.2%	High-Low	0.61 (1)	0 (0)
Newport Beach	92660	0.58	6.0%	High-Low	7.28 (25)	11.36 (39)
Laguna Beach	92651	1.63	4.7%	High-Low	1.23 (3)	1.63 (4)
Laguna Hills	92653	0.68	6.5%	High-Low	3.06 (9)	7.49 (22)
Santa Ana	92705	5.0	6.6%	High-Low	1.09 (5)	2.39 (11)
Westminster	92683	0.98	5.9%	High-Low	0.22 (2)	0.11 (1)
Midway City	92683	1.16	5.7%	High-Low	0 (0)	0 (0)

^a Note: the value enclosed in parenthesis is the number of office-based establishments

Using data from the U.S. Census County Business Patterns Survey, we examined the geographic availability of mental health specialists (e.g., psychiatrists) or practitioners (e.g., therapists) at the zip code level. In Orange County, there were a total of 165 office-based establishments with a psychiatrist(s) of which the majority of these establishments (80% or n=132 establishments) had between 1-4 employees. Further, there were a total of 303 office-based establishments with a mental health therapist in Orange County of which 83% of these

establishments (n=253) had between 1-4 employees. Based on this database, we calculated the density of office-based establishments per 10,000 residents.

As shown in Table 18, the density of office-based establishments varied across zip codes. Importantly, zip codes with no geographic coverage of BHS facilities did in fact have at least one establishment with a mental health psychiatrist(s) and/or therapist(s) (with the exception of Foothill Ranch). Irvine (zip code 92612), which had the highest prevalence of serious psychological distress, had a total of 18 office-based establishments with either a psychiatrist(s) or therapist(s). Note, we defined 'no geographic coverage of BHS facilities' as zip codes that were absent of any behavioral health services as reflected in the databases obtained through OC HCA or the Substance Abuse and Mental Health Services Administration (SAMHSA).

8. Estimating Needs Related to Hospital and Emergency Department Utilization for Psychiatric Care

To supplement these geographic analyses, we examined psychiatric care-related inpatient and emergency department services use to determine whether there are gaps in the availability of psychiatric inpatient beds in Orange County. There was an expressed concern that limited availability of psychiatric beds was leading to overnight stays in the emergency room. Data on inpatient admissions and emergency department encounters were obtained from the Office of Statewide Planning and Development (OSHPD). Data on the number of psychiatric beds in a hospital were obtained from OSHPD’s Hospital Annual Utilization Report.

Inpatient admissions data were used to calculate the number of individuals who were staying overnight at each the hospital for psychiatric care in Orange County in 2015. Psychiatric-related inpatient admissions were identified using the Medicare Severity Diagnosis Related Group (MS-DRG). The MS-DRG classification system uses diagnosis and procedure codes to identify the primary reason for the inpatient stay. We included all admissions with MS-DRGs related to psychiatric care. We then used the admission and discharge dates to identify the number of individuals who were staying overnight at each hospital for psychiatric care for each day in 2015. The mean number of individuals with inpatient psychiatric care was 23.6 (SD=16.5) individuals per hospital per day (Table 19). The majority of admissions (82%) were related to psychosis. The average length of inpatient stay was 11.8 days (SD=22.3). A large percentage of inpatient admissions were among repeat users: 38% of admissions were among individuals who had an admission previously during the year.

Emergency department encounter data were used to calculate the number of individuals who had a visit for psychiatric care in Orange County in 2015. Psychiatric-related emergency department visits were identified using the principal diagnosis code for the encounter. We included all emergency department visits with diagnoses related to psychiatric care. We then used the encounter dates to identify the number of individuals who were receiving psychiatric care at each hospital emergency department for psychiatric care for each day in 2015. The mean number of individuals with emergency department psychiatric care was 2.4 (SD=2.3) individuals per hospital per day (Table 19). The most common diagnoses were related to anxiety (47%), mood disorders (26%) and schizophrenia or psychosis (19%). A large percentage of emergency department visits were among repeat users: 37% of visits were among individuals who had an admission previously during the year.

Table 19: Select Characteristics of Psychiatric-Related Inpatient and Emergency Department Admissions in Orange County, 2015

	Psychiatric-Related Inpatient Admissions	Emergency Department Psychiatric Visits
Mean number of individuals receiving care per hospital per day	23.6 (SD=16.5)	2.4 (SD=2.3)
Proportion of admissions related to psychosis	82%	19%
Proportion of patients who were repeat users	38%	37%

We combined inpatient and emergency department data at the hospital level. This provided data on the number of individuals with overnight stays and with emergency department visits for psychiatric care for each hospital and each day during 2015. Using data from Hospital Annual Utilization Report, we created an indicator variable for when the hospital met or exceeded their capacity for overnight stays for psychiatric care.

We identified 12 hospitals with psychiatric beds in Orange County in 2015. We excluded two hospitals that did not have an associated emergency department: College Hospital Costa Mesa and Newport Bay Hospital. The remaining 10 hospitals are shown in Table 20 including their number of licensed psychiatric beds and the number of days in 2015 when the number of individuals with overnight stays for psychiatric care exceeded the number of licensed psychiatric beds. In total there were 56 hospital day combinations during 2015 when hospitals exceeded their capacity for inpatient psychiatric care.

Table 20: Hospitals with Licensed Psychiatric Beds in Orange County and the Number of Days Meeting or Exceeding their Capacity for Inpatient Psychiatric Care in 2015

Hospital Name	Number of Psychiatric Beds	Days Meeting or Exceeding Capacity in 2015
Chapman Global Medical Center	12	5
Anaheim Global Medical Center	90	0
Huntington Beach Hospital	25	0
La Palma Intercommunity Hospital	17	3
Los Alamitos Medical Center	25	15
South Coast Global Medical Center	23	0
University of California Irvine Medical Center	48	3
Mission Hospital Laguna Beach	36	0
St. Joseph Hospital - Orange	37	0
West Anaheim Medical Center	30	30

We used regression analysis to determine whether emergency department admissions were related to a hospital meeting or exceeding its capacity for inpatient psychiatric care. We used a random-effects regression with each hospital serving as a panel. The number of emergency department visits on a given day was the dependent or outcome variable, and the indicator variable for hospital capacity was the independent or predictor variable. We found no relationship between emergency department visits and meeting or exceeding capacity for inpatient psychiatric care ($P=.474$). We also found no relationship when limiting the analysis to children or adults.

In summary, this section assessed the geographic availability of behavioral health services in Orange County to identify potential geographic disparities in access to care. In general, BHS facilities were significantly more likely to be located in the more populated regions of the county. Additionally, areas with a high density of BHS facilities spatially overlap with areas in which there is a high density of the publicly insured population as well as areas with a high prevalence of high psychological distress.

PART 3: BARRIERS TO ACCESSING BEHAVIORAL HEALTH SERVICES FROM PROVIDER/ADVOCATE AND CULTURAL/LINGUISTIC MINORITY GROUP PERSPECTIVES

9. Introduction

Our team conducted 19 focus groups throughout Orange County to understand the strengths of the mental health service delivery system within the county and to identify gaps and opportunities for improvement. We conducted focus groups with 10 stakeholder organizations and 9 cultural/linguistic minority focus groups. We specifically recruited focus groups from community organizations who were not funded by Orange County BHS and focus group participants who were not receiving services from Orange County BHS. Focus group members were queried about barriers to behavioral health services in general, not specifically BHS funded programs.

Between January and October 2018, focus group interviews were conducted with 10 stakeholder organizations. These focus groups included mental health practitioners, advocates, family members, administrative and support staff from a diverse sampling of mental health advocacy organizations, service providers and community stakeholders. In this report, these focus groups are referred to as “provider/advocate focus groups.” Table 21 summarizes the participating stakeholder organizations and populations that they represented.

Table 21. Provider/Advocate Organizations Participating in Focus Groups

Organization	Population Represented
Orange County Mental Health Board	Persons with mental illness
National Alliance for Mental Illness (NAMI)	Persons with mental illness and families
Orange County Older Adults Mental Health Board	Older Adults
Orange County Children and Families	Children and Families
Dayle McIntosh Center	Persons with disabilities with or at risk for mental illness
The LGBT Center OC	Persons who are lesbian, gay, bisexual, or transgender (LGBT) with or at risk for mental illness
OC Women’s Health Project	Women who have experienced intimate partner violence
California Department of Corrections Day Reporting Center	Justice-involved adults
Orange County Re-entry Partnership & Phoenix House	Justice-involved adults
Child Guidance Center, Inc.	Children and Youth with or at-risk for mental illness

Between September and November of 2018, nine focus groups were conducted with individuals representing six cultural/linguistic minority groups. Languages represented in these groups included Vietnamese, Spanish, Mandarin and Cantonese, Korean, Khmer, and Farsi. These

focus groups included practitioners, family members, and mental health consumers. In this report, these focus groups are referred to as “cultural/linguistic minority focus groups.” Table 22 summarizes the communities represented by each focus group and number of participants.

Table 22. Cultural/Linguistic Minority Populations Participating in Focus Groups

Population and language represented	Number of participants
Vietnamese	8
Spanish 1	10
Spanish 2	12
Spanish 3	7
Chinese	7
Korean 1	7
Korean 2	9
Khmer	9
Farsi	9
Total Groups = 9	Total Participants = 78

Detailed focus group data collection and analysis methods can be found in Appendix Part 3, Appendix 3B.

10. Focus Group Results

Focus group participants identified barriers to mental health service access at various levels of service delivery, including: 1) policy, 2) agency, and 3) individual/family/community levels. Table 23 summarizes the barriers identified by focus group participants at these service delivery levels, which will be explained in further detail below.

Table 23. Barriers to Accessing Mental Health Services Identified in Focus Groups

Service Delivery Level	Barriers to Access
Policy Level	<ul style="list-style-type: none"> • Lack of funding for community mental health services • Limited program capacity • Lack of transportation to access services
Agency Level	<ul style="list-style-type: none"> • Fragmentation of the system and accompanying limitations in care coordination • Limited availability of linguistically appropriate services • Limited access for persons with disabilities and mobility impairment • Lack of trust towards mental health providers
Individual/Family/Community Level	<ul style="list-style-type: none"> • Lack of information about mental health and resources • Stigma, including self-stigma and stigma from family and community members • Fear of discrimination • Social isolation

10.1 Barriers to Accessing Mental Health Services in Orange County Exist Throughout the Service Delivery System

Policy level barriers to accessing mental health care in Orange County

Insufficient funding for community mental health services. Participants from several provider/advocate focus groups described how lack of funding for community mental health services adversely impacts a program’s capacity to serve individuals in need of mental health care. According to one mental health advocate:

“The nonprofit, or profit agencies don’t have the funding to be able to provide these services to the individuals that need served. Then they’re unable to have that need met. A lot of the programs have limits on how many clients they can have in the program 400, 300 is the limit on max. And they can’t go over that. When you have an underserved population of 1,000, 2,000, 3,000, what do you do with that?”

Limited program capacity. Participants from all provider/advocate focus groups described how such limitations on program capacity can snowball and create additional barriers to receiving care as a result. For example, lack of funding leads to limited appointment availability, shortage in staff with necessary expertise, and limited physical space for service provision. According to one provider:

“Here we don’t have a ton of space. So, we are limited in how many people we can serve. So we don’t—it’s not enough space to really do what it is that we could potentially be doing.”

Some provider/advocate focus group participants described how appointment shortages can impact justice involved individuals with co-occurring substance abuse disorders. When a motivated individual is put on a waitlist for mental health care, participants report that an individual’s drive to engage in services can be diminished and the critical window of opportunity to engage this person in services can be missed. One individual described the “downward spiral” resulting from waitlists and shortage of inpatient beds:

“So being put on a wait list, you’re going to lose motivation, you’re going to continue to use and end up in the hospital. You’re going to no longer meet the criteria because you’re going to need a higher level of care, we’re going to lose contact with them altogether.” (Phoenix House)

Transportation barriers. Focus group participants described limited public transportation throughout Orange County as an additional barrier that should be addressed at a policy level.

“It’s a really important point for our county in particular. if you go to LA, other areas, they have pretty decent transportation, right? We have terrible public transportation there. Our best systems have actually been reduced to the point where there are entire lines that were eliminated. So, the impact to families, low-income families in particular, is really an issue in terms of accessing services.” (OC Children and Families)

According to several participants, limited public transportation presented an especially profound barrier to receiving care, due to the geographic organization and limited availability of mental health services in some parts of Orange County. Specifically, participants from all focus groups reported that there is a significant dearth of services in South Orange County, with one participant claiming that it is a “*service desert.*” According to one focus group participant:

Most of the services are really concentrated in central and north Orange County, commensurate with the need, don’t get me wrong. That’s where they need to be, but at the same time, most people assume that South County is largely affluent, and you have little pockets down there...

Participants from cultural/linguistic minority focus groups also cited infrequent and poorly planned public transportation as barriers to receiving mental health services when needed. According to one Khmer participant:

“For me, one of the other key challenges is transportation. And some of the places that I want access are far. For example, my house is very far from this [mental health program] so I have to ask my family members to pick me up and drop me off at this place so it’s hard for me. I want to come to access this program as much as I want but transportation has limited my ability to come and access the service.”

Agency level barriers to accessing mental health care in Orange County

Limited care coordination. At the agency level, provider/advocate focus group participants described the challenges of working in a fragmented system of care. Consequently, the sub-theme of limited care coordination figured prominently during discussions about barriers to accessing mental health care. Some providers reported that they do not have dedicated case/care managers on their mental health teams:

“I mean we don’t have any case managers here at the center... We all do our own case management.” (LGBT)

According to some advocates, the fragmentation of services can be especially problematic for individuals who are in transition from one program to another:

“So, the County has some 250 programs. But, the problem is, I often say it's like a patchwork quilt. Every piece is beautiful and designed for a specific purpose and attractive by any measure. But, it's never been quilted together. So, people get into a program. And many of the programs, I think, do a reasonably good job. But then, at a certain point, they transition to another program. And that's always a spot where the chances of re-hospitalization become very great because the stress that that transfer provokes.... “

Limited availability of linguistically appropriate services. Focus group participants also reported several population-specific barriers to care, including limited availability of linguistically appropriate services. For example, the low number of psychiatrists who can offer in-language services to linguistic minority populations presents a crucial barrier to care for some racial and ethnic minority groups in Orange County. Specific groups that were mentioned by providers and advocates included Vietnamese, Chinese, Cambodian, and Spanish speaking populations. According to one advocate:

“We still have difficulty recruiting therapists who are able to speak the language and understand the cultural needs. I've just been at (X service delivery entity) a couple months, and we already had needs for Mandarin, Chinese... and we do have a Cambodian population here, right now that's our biggest struggle, is learning how to engage that population. ...And bilingual psychiatrists. I think from what I understand, there's only one in Orange County.”

Participants across all cultural/linguistic minority focus groups also expressed a need for increased availability of linguistically appropriate services. According to one Korean service provider who participated in a Korean language focus group:

“How great is the adult FSP program? But there isn't one you can send Korean patients to. If the patient speaks only Korean, there is no place we can send them. FSP is the best program available in MHSA but there isn't anything for Koreans.”

Other participants noted that while some members of their communities are able to speak English, they still prefer to receive their mental health services in the language they are most comfortable speaking:

“I feel like we’re lacking like the Chinese speaking mental health services and we don’t know where to turn because I know there’s a lot of new immigrants or international students. English is not their first language. Even if they can speak fluent English, they still want to get help in Chinese.”

Barriers for persons with disabilities and mobility impairment. Advocates and service providers also described “literal access” barriers for persons with disabilities and mobility impairment as a concern. Participants described how persons who rely on assistive devices such as canes, walkers, or wheel chairs are often not physically able to enter a mental health clinic. Access to care for persons with disabilities or impaired mobility can also be hindered by lack of training of persons working in health care settings. According to one advocate:

“You know, there’s a proper way to guide, to be a sighted guide to a blind person. And that’s very basic stuff. But, I’ve rarely gone into a medical-related situation where the staff knew how to guide me properly or how to get my signature or anything like that. So, there’s just such a real need (to address) those kinds of barriers.”

Lack of trust towards mental health providers. Finally, some cultural/linguistic minority focus group participants noted that they simply did not “*know who to trust*” with respect to sharing their experiences with mental health and their histories of trauma. According to one member of the Farsi-speaking focus group:

“Many providers have the experience, but they don’t care, they just look at it from business perspective. They see someone is coming, and tell himself/herself “OK, I will make a 150\$ for this client...”

Individual, family, and community level barriers to accessing mental health care

Community members need information related to mental health. Individuals across cultural and linguistic minority focus groups reported having several questions related to mental health. For example, one person from the Khmer focus group reported a desire to learn strategies for reducing stress.

“I would like to know how to reduce stress, what are the strategies to do that. I need to get out of the stress.”

While some focus group participants vocalized a desire for more information related to improving their mental health, others participants (unknowingly) reported misinformation about mental illness. Some individuals espoused beliefs that persons with mental illness cause problems, that mental illness leads to violence, or are prone to hurting others, and that mental illness is something that can be overcome on one's own. According to one Korean participant:

“You have to overcome (mental illness) by yourself, cheering yourself...all this would be overcome only if I cheer myself.”

Many community members are unsure how to discuss mental health. Across focus groups, participants agreed that there was a need for increased access to mental health information and dialogue in their communities, but several individuals admitted their communities are, in general, unsure of how to discuss matters related to mental health and mental illness. According to one Spanish speaking focus group participant:

“I think that us Latinos are not really prepared to talk about mental health.”

Another participant from the Farsi focus group reported that the concept of mental illness had not yet reached the Iranian culture. According to this individual:

“Mental issues haven't reached in our culture yet. They say “you're crazy”. For example, when I had a conflict with my husband and I told him that we have to go to a therapist, and he responded “You're crazy and And I am wise”. It hasn't reached in our culture yet.”

Mental health stigma. Participants across all focus groups described how the stigma of having a mental illness was among the most difficult service barriers to address. According to one participant from a provider/advocate focus group:

“I think the biggest one is that people don't readily admit that they have a mental illness or that they're struggling with a mental health issue. Someone said, one of you said, you know, talked about the stigma attached to that. And if people don't acknowledge that they need that kind of assistance, then, you know, how can you begin to offer it?”

Participants from provider/advocate focus groups described how experiences of stigma around mental illness can vary by sub-population. For example, individuals that serve veterans reported the pervasiveness of stigma among veterans and military connected families. To

address this barrier in Orange County, veteran serving organizations frequently conduct outreach to military connected families and children, rather than conducting outreach directly to veterans.

“I think maybe one thing for our program is the focus on like the children in the family because sometimes it’s easier for someone to say, ‘it’s not that I need help.’ It’s that my child needs help.”

Focus group participants across several cultural/linguistic communities also noted how individuals can avoid seeking mental health care due to the shame associated with having a mental illness. According to one service provider who participated in a Korean language focus group, Korean community members often worry that if they access services, they will then be considered “crazy.” According to this provider:

“When we talk about mental health, people say ‘I have stress,’ or ‘I have a lot of stress,’ but it’s hard for us to say what or how it is affecting the individual. It’s very hard to bring these people to come for a therapy or a consultation. People worry by thinking, ‘if I get a therapy, then am I a crazy person?’...”

Participants from the cultural/linguistic minority focus groups also described how stigma towards psychiatric medication in their communities has created mistrust of these medications. Some participants described psychiatric medication as an “addicting” and “unsustainable” way of life. These individuals articulated that they preferred for their mental illnesses to be treated without medications. According to one Spanish speaking focus group participant:

“Pain can be cured by a doctor, but I don’t want too many pills so... If we need to go to the psychologist or therapist, but I don’t want to have too many pills.”

Across cultural/linguistic minority focus groups, participants explained how high levels of stigma of mental illness in the community can lead to a lack of discussion related to mental illness and mental health treatment. This, in turn, can undermine community members’ intentions to access mental health services. According to a Chinese focus group participant:

“The community in general has this image with going to see a counselor. And so, there’s I think there’s fear associated with. . .especially if you’re not talking to your parents and you’re not talking to your friends, and you’ve never heard anybody who’s done this then that’s very scary... You hear others getting mammograms, you hear organizations supporting it, so you don’t really feel that shame that you had a mammogram, right, but it feels like with mental

health it's like if you have a problem that's kind of weird, right, if you're in the community, so I think normalization is pretty important in that regard..."

A Khmer focus group participant also described how taboos surrounding the discussion of mental health create barriers to seeking support for mental health needs in the Cambodian community:

There are many stigmas around talking about mental health in Cambodian communities. According to our culture, when you talk about mental health, it's called crazy. That is a crazy person if you talk about mental health. There are a lot of shames around it and people are willing to live in the shadow rather than coming out talking about mental health issues.

Fear of discrimination. In addition to stigma of mental illness, providers and advocates reported that many LGBT persons avoid participating in mental health services at the LGBT Center out of fear that their sexual orientation or gender identity will be “outed” to their family or community.

So one of the barriers to accessing services is coming out, right? If you're going to ask the LGBT Center that implies that—in fact the fact is that a lot of the folks that are served especially by our mental health department aren't LGBT. So they serve everybody and so we offer sliding scale mental health services for the community, not just the LGBT community. So there are people who come that are LGBT but for some people who are LGBT they're not going to have—because they might not want anyone to know that they come. So outing is a big barrier. Being outed is one barrier.

As a result of being outed, these individuals may face discrimination, violence, bias, and rejection from family and community members. This fear results in a culture of secrecy surrounding mental health services for LGBT populations. In an effort to maintain the confidentiality of the LGBT identity of potential clients, participants reported they will not label services as “LGBT” specific. Consequently, however, this strategy produces adverse outcomes since outreach efforts do not adequately reach LGBT people in need of mental health services and thus these persons are unserved despite a need for mental health care. According to one provider, this fear is especially powerful for LGBT immigrants:

“Part of the issue in our community is that LGBT folks, especially if they are also coming from this area and especially if they happen to also be immigrants or undocumented, they're not accessing services because they're afraid they're not safe. We need to provide safe spaces for folks where they know they can come and get legal help, ask for medical care and those things in a

way that they're not going to end up being turned over to ICE or that people are going to understand who they are in terms of their sexual orientation or gender identity and so people don't access services."

Social Isolation. Cultural/linguistic minority focus group participants also described how social isolation can create barriers to accessing care, and noted that isolation can also result from having limited access to mental health services. One Chinese focus group participant acknowledged that older adults are especially prone to social isolation and thus have few people with whom to discuss their mental health needs, which is an important first step in accessing mental health care.

"I think way of life is a big factor as well. As you age you tend to stay at home more. There are people who have a religion and actively participate in their religion, but they are living in a limited space. Some people think they're a loser for having these illnesses so they can't openly talk about it."

10.2 Engagement and Retention of Vulnerable Populations Relies on Genuine and Trusting Relationships

Participants across provider/advocate focus groups and cultural/linguistic minority focus groups consistently reported that successful client engagement relies on having a trusting relationship with a mental health provider who is able to understand population-specific mental health needs and cultural contexts that can influence need for and engagement with mental health services. Participants reported that these population-specific needs vary according to an individual's identity, their experience with trauma, whether they have a disability or mobility impairment, and the extent to which they fear for their safety due to identifying as sexual or gender minority, or are a survivor of intimate partner violence. Focus group participants identified three main factors that promote successful engagement among the populations they represent, noting that engagement: 1) begins with an inclusive clinic environment; 2) involves working with providers who share certain identity characteristics; and 3) requires provider attention to population-specific needs, which are summarized in Table 24.

Table 24: Factors that Promote Successful Client Engagement Identified in Focus Groups

Factors	Characteristics
An inclusive clinic environment	<ul style="list-style-type: none"> Posters, pamphlets, and psychoeducation materials that reflect consumer/community characteristics (e.g., language, accessible to visual/hearing impaired) support engagement at the first visit.
Providers who share certain identity characteristics	<ul style="list-style-type: none"> Mental health consumers from cultural/minority sub-populations (e.g., racial/ethnic, LGBTQ) value providers that are gender and/or racially concordant and share identity characteristics/life experiences. Peer support is potential way to promote engagement while honoring the cultural/linguistic traditions of mental health consumers
Provider attention to population-specific needs	<ul style="list-style-type: none"> Long-term engagement with vulnerable populations requires taking the time to understand specific client needs, which vary by sub-population and from person to person For example, trauma from incarceration among justice-involved persons, or financial hardship/chronic pain among older adults

Engagement begins with an inclusive clinic environment

Some provider/advocate participants described how the process of engagement of vulnerable populations *“actually starts on the phone,”* and noted the importance of having posters, pamphlets, and psychoeducation materials that reflects characteristics of their consumers and those in the community in order to engage an individual during their first visit. According to one provider:

“So you walk into a space and is there literature that represents—are there flyers? Are there brochures? Oh LGBT center brochures are there. Things about mental health and the LGBT community or trans services health are there, if there are posters are the posters all of gender white, heterosexual people or are they reflective of the community?”

Providers and advocates also described the importance of an inclusive clinic environment for individuals who are deaf/hard of hearing or have impaired vision. According to one participant:

“There may be materials available that aren't available in the alternate formats, you know, like digital or braille or large print or whatever, that people would need. So, we always have to keep saying that because even though we've made progress in that arena, the varieties are still there.”

Engagement involves working with providers who share certain identity characteristics

Focus group participants described how health providers are an extension of the clinic environment and, therefore, the clinic should include staff that represent the population being served. Mental health consumers that belong to different cultural and minority sub-

populations (e.g., racial/ethnic, LGBTQ) place tremendous value on having providers that are gender and/or racially concordant, share certain identity characteristics, and life experiences. When describing the needs of the LGBT community, one provider described the importance of this concordance:

“Having providers who are—who outwardly identify like us, like someone who is trans or someone who is a lesbian or gay like that for me is a really important and helpful too. It doesn’t mean a straight person couldn’t or a straight gender person couldn’t help one of us but it’s nice, it’s more comforting to go to someone from your own community.”

Similarly, providers and advocates representing veterans described the importance of having providers sharing in certain aspects of the US military culture. According to one stakeholder:

“So even if I talked to somebody that had a good heart and they were trying to help me, they still didn’t understand the culture, they didn’t kind of didn’t understand the lingo and I kind of felt disconnected with them so we still – a lot of us would shut down but I think that’s what makes this group so unique is the peer navigating because -you feel a lot more...the interventions feel a lot more comfortable. Even if you’re not a veteran like with everybody here that’s not a veteran, they’re military connected so they’re familiar with the culture.”

A female Farsi focus group participant noted the importance of both linguistic and gender concordance, as well as a shared experience of parenthood:

“First of all, I will take a female therapist. Because she will understand my feelings better. And then she has to have working experience. So when I tell her about my child, and if she hasn’t a child, how can she understand what I am talking about? So she has to have working experience and she has to have the same language as mine. So she knows my culture to understand what I am talking about. And the other thing, which is so important to me is, she must have UNDERSTANDING.”

Some participants suggested that peer support is potential way to promote engagement while honoring the cultural/linguistic traditions of mental health consumers. One participant of the Khmer focus group described his/her satisfaction with the peer services available at their mental health program:

The program is very important to me because the program is offered in my language and also program offer an approach that build on peer support. Peer

support is people around here that I can mingle with and speak the same language and understand the culture. So the peer support is very important for me because I'm able to share my happiness, to share my concern, to share my challenges with all people in my language and those people understand my culture as well.

Engagement requires provider attention to population specific needs

Focus group participants explained that a mental health provider's ability to promote long-term engagement with vulnerable populations requires taking the time to understand specific client needs, which vary by sub-population and from person to person.

Military and their families. Providers and advocates that serve veterans and military families described an individual provider's willingness to invest time in developing a relationship as essential for this population.

"I think the most important factor probably is time. It takes time to establish yourself as friends to the veteran population even if you are one. And I think probably working out or us reaching out to certain places as outreach has been most effective in bringing people into the program and stay in the program, give the best benefit of the program and without that peer navigation piece which is our innovation piece of this program."

Justice-involved persons. Advocates for justice involved individuals also described population specific needs that are essential for providers to understand, including needs that are rooted in traumas experienced in prison—these frequently go unacknowledged by service providers who work with this population. Focus group participants noted that to engage justice involved persons in mental health care, providers must be aware of this trauma and willing to address it. According to one stakeholder:

"We (society) see prisoners as prisoners, and not as traumatized victims of what they experienced inside prison. And they come out and some have, or appear to be, PTSD from being in there and going through the process of trauma. And when they come out, they are not cared for as trauma patients, they're seen as released prisoners or detainees."

Older adults. Individuals who work and advocate for older adults described challenges in motivating older adults to seek care and reported on the importance of understanding factors that need to be addressed to improve motivation among this population.

“So, motivating older adults to do many things...Getting them out of their house. That's a big problem. But motivating older adults for a lot of reasons makes it difficult. Maybe it's difficult because they don't have the finances. Maybe it's difficult because they don't have the energy. Maybe it's difficult because they are in chronic pain. There can be a lot of reasons why motivating older adults is difficult.”

10.3 Need for Expansion of Existing Successful Service Delivery Strategies in Orange County

Providers and advocates reported that the service strategies that are working to engage hard to reach and vulnerable populations into mental health services are precisely those services and strategies that Orange County should expand. According to one mental health advocate:

“The things that are working are those things that helped, the things that create cohesiveness, the things that can aid coordination or help you navigate or the FSPs [Full Service Partnerships], anything that does more than just one little piece. Anything that taps into multiple areas seems to be working better...”

Specifically, at the county level, providers and advocates expressed a need to expand inpatient psychiatric and crisis stabilization units, housing for all persons with mental illness, and community mental health education campaigns to alleviate stigma of mental illness and educate the community about the importance of accessing mental health services when in need (Table 25). Additionally, at the individual agency level, participants described a need to increase family involvement, deliver more integrated whole-person approaches to care, enhance care coordination through peer-based services, and increased use of social media to promote awareness of available counseling and mental health support services.

Table 25. Service Delivery Strategies to Expand at the County and Agency Levels Identified in Focus Groups

Service Delivery Strategies to Expand	
County Level	<ul style="list-style-type: none"> • Inpatient psychiatric beds • Crisis stabilization units • Transitional and long-term supportive housing • Community education campaigns
Agency Level	<ul style="list-style-type: none"> • Family involvement • Integrated whole-person approaches to care • Care coordination • Peer-based services • Targeted outreach • Social media to promote awareness of services

Service Delivery Strategies to Scale-Up at the County Level

Inpatient psychiatric and crisis stabilization units. At the County level, providers described several instances when people living with mental illness have benefitted from stays in inpatient psychiatric and crisis stabilization units. Several focus group participants lauded the opening of Children’s Hospital of Orange County’s (CHOC) inpatient unit for children under the age of twelve, though participants from several groups also lamented that space in such units in Orange County is very limited for adults.

“We don’t have long-term beds now. There’s a tremendous shortage...Our hospitals basically are triage. So, when someone comes in, they’re in the ER. They get handcuffed to a gurney or sat in a chair for the police officer or security guard there until they can find a bed. We don’t have enough acute care beds. And then, when you get an acute care bed, it’s three to five days. They hit you with a bunch of meds and they throw you back on the street.”

Housing. Providers and advocates also described the importance of addressing homelessness in Orange County by increasing the availability of housing for persons with mental illness, as well as noted sub-populations that are affected by or are at risk for homelessness. While mental illness is a risk factor for homeless in general, participants noted that veterans and justice-involved persons are especially vulnerable. To meet the needs of these populations, participants recommended increasing the availability of transitional and long-term supportive housing. According to one mental health advocate:

“We have plenty of housing opportunities. But the problem is we do not have any care system in place or a full partnership, wrap-around program that’s actually assisting the clients when they do get their places.”

Community mental health education campaigns. Providers and advocates representing several different mental health communities also described the effectiveness of community mental health education campaigns aimed at reducing mental health stigma and increasing awareness of mental health resources in Orange County. Some mental health advocates commented on the need to scale up structured efforts to educate professionals who interact with persons living with mental illness or the mental health system, such as primary care providers, and persons working in law enforcement, especially police officers. For example, one group described a program offered by NAMI wherein healthcare professionals are trained to approach patients and family members of patients with mental health needs with empathy. According to one mental health advocate:

“Every time I’ve heard anything about the folks who participated in [NAMI’s provider training], they all say, ‘oh my god. There’s insights here that I didn’t

get from my academic training, I didn't get from my licensing, I didn't get from my experience in the clinical setting,' because it's meant to and it accomplishes providing insights for a level of empathy and understanding for what the families are going through and what the peer is going through in a way that, as the curriculum was written, the healthcare folks don't get this."

Service Delivery Strategies to Scale-Up at the Agency Level

Family member involvement. Providers and advocates also described several strategies that are suitable for expansion at the individual agency level. Mental health advocates described the need to enhance opportunities for family member involvement in all mental health care being delivered in Orange County, since family members are frequently the primary care support for persons living with mental illness. According to one mental health advocate:

"The largest group that provides ongoing, continuous care for the mentally ill are family members. 100%, hands-down."

Providers and advocates, in general, agreed about the importance of family involvement in the care for persons with mental illness. NAMI's Family-to-Family group psychoeducational program was identified as an evidence-based resource that agencies can promote to families of all mental health consumers in Orange County. One mental health advocate described Family-to-Family as:

"30 hours of curriculum that's really constantly updated. It has a dozen topics within that 30 hours of curriculum. It meets in groups of 25 or 30 people, led by two NAMI-trained, co-teachers, in 12 sessions of about two-and-a-half hours each, once a week... We offer it to hundreds of people throughout the county... on an average year, we probably do 25 or 30 Family-to-Family programs."

Integrated and whole-person approaches to care. Several providers and advocates described the need for integrated and whole-person approaches to care, such as wraparound programs, and programs that transition individuals in recovery out of services.

Peer-based services. Providers and advocates also described the utility of and need for enhanced care coordination strategies, such as peer-based services to support client navigation of the mental health system and allied systems of care. These strategies would help to reduce stigma and to reduce recidivism in psychiatric inpatient units. The utility of peer-based services was described as useful across several different focus groups including those that serve veterans, survivors of intimate partner violence, justice involved populations and the mental health population in general. One participant described a NAMI program in Alameda County called "Mentors on Discharge."

“They have a Mentors on Discharge program. Where, somebody who's in the psych unit develops a relationship with somebody living with mental illness. And when they're released, that mentor, if you will, maintains contact with them. And it also has a very high success rate in terms of reducing recidivism.”

While having lived experience with mental illness is often considered a core element of peer support, some providers and advocates described other types of “lived experience,” such as navigating the Veterans Health Administration’s mental health services that are critical for veterans. As one provider that serves military connected families commented:

“I think is really important that all the peers come from that place of lived experience. That’s kind of a fundamental way that our peer navigators can connect with our veteran military families.”

Another individual described the role of a veteran navigator, noting that their work emphasizes both navigation and familial involvement:

“If a family comes in and does an intake, they get paired up with the clinical case manager and a peer navigator. The peer navigator goes in and they build a family plan with the families, just their basic needs and any of the barriers or anything that they are going through. The peer navigator looks on with them and helps them to get through and get linkage to the different resources that they need in order to become stable. These resources could be housing, it could be employment, it could be benefits, it could be domestic violence services, it could be travel, it could be food service.”

Targeted outreach strategies. Efforts to reach and engage persons in need of mental health services should be enhanced to increase agency capacity to promote awareness of mental health programs among persons in need. These outreach strategies are most effective when they are population specific and will, therefore, vary by agency. According to one provider who engages persons with disabilities and mental illness:

“One of the things that we do that other agencies might not [do] is targeted outreach. So, if we identify a specific group of people or disability-related, then we would try and go to the spaces that those people are in...In order to find people who would benefit from Deaf Services, we go to places where deaf people frequent.”

Persons who work with veterans described a potential way to conduct outreach to veterans and veteran spouses that involves outreaching through industries known to hire veterans:

“Identify the top five employers of veterans once they left the military and the veteran spouses once they left military in the terms of industry. And then go to talk to those industries about industry training groups, or leaders in the industry or whatever, and talk to them about what a diagnosis means, and how if somebody has a PTSD diagnosis.”

Social media. Participants identified social media as an important outreach strategy that is essential for providers aiming to promote awareness of programs that serve specific consumers of social media in Orange County. According to one provider:

“If there’s something happening with our programs, we put up a post on Facebook and we’ll get 100 people here. Because people now trust the work we do. There’s a personal relationship with a lot of us.”

For example, focus group participants that serve LGBT persons in Orange County described social media as especially important for reaching this population.

“We have one part time marketing person who runs our social media. I think that we could have more—we’d like to have a full-time social media person and a communications person. So we don’t have that.”

Social media and electronic communication might be especially important for LGBT persons and other populations that are hidden. LGBT youth, who must keep their identities secret, and have limited transportation options often rely on mental health and social support services that are available through their schools. To maintain confidentiality and to promote participant safety, the LGBT center will often obscure that these programs are focused on LGBT students. According to one provider:

“I know we did a therapy group in a school this past year, but we didn’t put LGBT anywhere in its title because there were a couple of really vulnerable youth who had really dangerous home situations around that issue. So it just didn’t get—we even created a different email address, just a regular Gmail address for facilitator so—because our email is LGBT center. So covert operation. And that’s covert operation. I mean obviously the school knew because we did have an advisor and the principal were very much in favor of us being there.”

Smart-Phone Applications. Focus group participants also suggested promoting the NAMI’s “Mental Health U” smartphone application as another source of psychoeducation in the mental health community in Orange County. Mental Health U can promote awareness of mental health in general and also create awareness of services available in the community. One mental health advocate described Mental Health U as:

“...a technologically-based tool to help folks navigate the mental health landscape. Here in Orange County. Give me basic insight into information. You know, what's a mental health condition and how is it diagnosed, that sort of thing..... And then, that tool needs to be ubiquitously available and people need to be aware of it, so that they can then begin to use it. And the tool needs to include a feature that I'm working with the innovation team for the last several months. We're going to spend \$15 million on this. To the extent that it makes sense, medically, to provide some kind of interactive support through this tool.”

DISCUSSION AND RECOMMENDATIONS

Discussion

Comparison to the 2018 CalOptima Member Health Needs Assessment Report

CalOptima is a county-organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. In March 2018 they published findings from their Mental Health Needs Assessment, which included findings on mental health. The project included 5,815 surveys and 31 focus groups with CalOptima members, and 24 key stakeholder interviews with leaders from community-based organizations.¹ Although the CalOptima report focused entirely on the needs of Medi-Cal and other publicly insured individuals, some comparisons may be made with UC San Diego's Needs and Gaps Analysis presented in this report. However, please note that any comparison between these two reports is limited due to differences in how mental health symptoms and the need for mental health treatment were assessed between the two reports.

Prevalence of Mental Health Symptoms: We found that 6.7% of Orange County adults exhibited serious psychological distress, while the CalOptima report found that 13.5% of their members reported a need to see a mental health specialist. There are several reasons that these numbers may differ:

- **Sample Differences:** The CalOptima report focuses on all individuals on Medi-Cal of all ages, who may have greater need for mental health services due to known relationships between mental health need and low socioeconomic status,^{2,3} whereas this UC San Diego finding focuses on all adults age 18 and older in Orange County regardless of insurance type. However, our analysis did not reveal significant differences in serious psychological distress between those who had insurance vs. those who were uninsured.
- **Measurement Differences:** The CHIS data used to estimate “serious psychological distress” (i.e., the Kessler 6 scale), while still self-report data, comes from a more diagnostic measure with a cut-off point, whereas the CalOptima survey item asked

¹ CalOptima. (2018). Member Health Needs Assessment Final Report: March 2018. https://www.caloptima.org/~media/Files/CalOptimaOrg/508/Community/CommunityGrants/2018_MHNAFinalReport.a shx

² Adelman, P. K. (2003). Mental and substance use disorders among Medicaid recipients: prevalence estimates from two national surveys. *Administration and Policy in Mental Health and Mental Health Services Research*, 31(2), 111-129.

³ Chapel, J. M., Ritchey, M. D., Zhang, D., & Wang, G. (2017). Prevalence and medical costs of chronic diseases among adult Medicaid beneficiaries. *American journal of preventive medicine*, 53(6), S143-S154.

respondents to indicate if they felt they needed to see a mental health specialist, without considering the level of psychological distress. It is possible that the CHIS data did not include individuals with more mild psychological distress who may have been captured by CalOptima's survey question. In general, there are differing approaches to identify individuals who have experienced mental health symptoms and are in need of services (i.e., self-identified vs. defined by diagnostic tool),⁴ which contributes to differing population estimates.

Access to Mental Health Treatment and Unmet Need: Of the 6.7% of Orange County adults with serious psychological distress, 54.1% received any treatment (i.e., 19.7% received minimally adequate treatment [MAT] defined as 4 or more visits with a health professional in the past year and the use of prescription medication for mental health in the past year and 34.4% received some treatment but not MAT) , and 45.9% received no treatment. In the CalOptima report, of the 13.5% of members who reported needing to see a mental health specialist, 73.3% saw a mental health specialist, and 24.8% did not.

- **Sample Differences:** The CHIS sample includes uninsured and insured individuals, whereas CalOptima includes all insured individuals; those with health insurance have better access to care, which may explain why a greater proportion of CalOptima respondents who needed mental health treatment received it. Although the difference was not statistically significant, the CHIS data indicated that a greater proportion of insured Orange County adults with serious psychological distress received treatment compared to their uninsured counterparts, especially regarding receipt of MAT (i.e., uninsured receiving MAT: 13.9%, insured receiving MAT: 21.7%).
- **Measurement Differences:** Patients who self-identify as needing to see a mental health specialist (i.e., they recognize a need for treatment), as they did in the CalOptima survey, may be more likely to seek and obtain mental health specialist care, whereas those individuals who were identified as having serious psychological distress in the CHIS dataset may not recognize that they need mental health services, and therefore be less likely to seek help. It is also possible that CalOptima may simply be better than the county average in terms of helping connect their members to needed mental health care.

Barriers to Accessing Mental Health Treatment: The CalOptima report found that lack of knowledge was a major barrier to accessing mental health care, as was fear of stigma,

⁴ Mechanic D. (2003). Is the Prevalence of Mental Disorders a Good Measure of the Need for Services? *Health Affairs*. 22(5): 8-20.

especially among specific language groups, which were very similar to the findings from the UC San Diego focus groups' individual-level findings.

Recommendations

This section of the report includes recommendations on how Orange County might address the behavioral health services needs and gaps identified through the findings from each part of the report.

Part 1. Prevalence of Mental Health Issues and Service Utilization

Continue to Engage MHSA Priority Populations in Mental Health Outreach and Care. In many cases, the findings in Part 1 of this report reflect known issues across California; Orange County TAY and LGBT populations are at greater risk of psychological distress, as are adults and TAY with lower education levels, unemployed adults, Latino/African American TAY, and unsheltered homeless adults. LGBT adults were more likely to receive MAT than straight adults, which may be a reflection of greater outreach and engagement to the LGBT community in recent years. Orange County should continue to focus on engaging these populations in mental health services, and many of these populations (e.g., TAY, LGBT) have already been identified as MHSA priority populations.

Develop a dedicated workgroup to explore creating or supporting programs addressing African-American community's mental health needs in Orange County. Based on the findings regarding lower treatment rates for African American adults and TAY, and greater psychological distress among African American TAY, the study team attempted to coordinate a focus group with individuals representing the African American population of Orange County. After comprehensive outreach efforts to local service providers and mental health advocates, we learned that there is likely not a mental health organization in Orange County that serves members this population or has programs that target African Americans. In light of this, we recommend that Orange County develop a dedicated workgroup to explore the possibility of contracting with an organization to create programs that focus on the needs of the African American population.

Part 2. Geographic Distribution of Behavioral Health Services

Add BHS resources in Capistrano Beach, San Juan Capistrano, and Trabuco Canyon which are areas with higher levels of publicly insured and/or uninsured residents with no BHS treatment facilities:

We found a lack of BHS treatment facilities in specific zip codes with higher rates of publicly insured and/or uninsured individuals in and around San Juan Capistrano (ZCTAs 92675 and 92624).^{*} Further, while there may be private mental health facilities available in affluent areas such as San Juan Capistrano, publicly insured and uninsured individuals may lack the ability to access non-County mental health services due to inability to pay the out of pocket fees. Capistrano Beach may also be in need of BHS facilities as it has a high proportion of uninsured individuals, no BHS facility, very few private facilities, and an above-county average prevalence of serious psychological distress.

Relocate or Support Increased Availability of Bilingual Staff in Facilities where Speakers of Korean, Chinese, Farsi, Tagalog and Khmer Reside. For some linguistic groups, including Korean, Chinese, Farsi, Tagalog, and Khmer, there was inadequate coverage of BHS facilities equipped to provide services in these respective languages based on where the majority of speakers of these languages reside throughout Orange County.

- **Korean:** Only 7 out of 35 facilities with Korean-speaking staff were located in zip codes with many Korean-speaking residents. Additional facilities with Korean-speaking staff are needed in cities bordering Los Angeles County (Seal Beach, Cypress, La Habra, and Brea) in the north, as well as the city of Irvine.
- **Chinese:** Only 1 out of 8 facilities with Chinese-speaking staff were located in zip codes with many Chinese-speaking residents. Additional facilities with Chinese-speaking staff are needed in the northeast (Fullerton, Brea, and Yorba Linda), south (Irvine and Laguna Niguel), and northwest/central regions (Cypress, Garden Grove).
- **Farsi:** Only 9 out of 47 facilities with Farsi-speaking staff were located in zip codes with many Farsi-speaking residents. Additional facilities with Farsi-speaking staff are needed in the Northeastern part of the county (Yorba Linda, Fullerton, Anaheim Hills, Villa Park).
- **Tagalog:** Only 5 out of 10 facilities with Tagalog-speaking staff were located in zip codes with many Tagalog-speaking residents. Additional facilities with Tagalog-speaking staff are needed in the southern part of the county (Lake Forest, Rancho Santa Margarita, Aliso Viejo).
- **Khmer:** Only 1 out of 3 facilities with Khmer-speaking staff were located in zip codes with many Khmer-speaking residents. Additional facilities with Khmer-speaking staff are needed in the northeast (Brea, Yorba Linda) and northwest/central regions (Westminster, Santa Ana, Irvine, Orange).

^{*}Note: At the time of the analysis, the BHS CalWORKS program at the Mariposa Women and Family Center in San Juan Capistrano (ZCTA 92675) was not registered in the SAMHSA or OC HCA database.

Part 3. Barriers to Accessing Behavioral Health Services from Provider/Advocate and Cultural/Linguistic Minority Group Perspectives

Strive to develop a mental health work force that reflects the population it serves. Both the cultural/linguistic minority and provider/advocate focus groups consistently noted that mental health consumers value working with mental health providers who share their identity characteristics and genuinely understand their population-specific needs. Providers that serve veterans and military connected families, persons who are LGBT, and others described the need to increase the numbers of cultural and identity concordant providers and specialists who are able to work with diverse persons living with mental illness. All community member focus groups emphasized the importance of having linguistically concordant services. Building on the existing strengths of Orange County’s mental health work force in this way could increase the availability of culturally and linguistically appropriate services and thus service engagement across a range of sub-populations and cultural/linguistic communities. According to participants of the mental health provider focus groups, Orange County could alleviate this shortage by recruiting trainees and students in Orange County’s universities for employment in the Orange County mental health system.

Increase availability of mental health peer supports across more programs, with a focus on cultural concordance. Respondents from provider and community member focus groups described the potential utility of peer supports for engaging hard-to-reach populations in mental health care and for honoring mental health consumers’ cultural/linguistic traditions while also supporting consumers in accessing services from different sectors of care. Some stakeholders also noted that peer providers can engage hard-to-reach populations in mental health services by normalizing experiences with mental illness. However, focus group participants noted that peer support services are available to some populations but not consistently across programs. In mental health settings across the US, peer supports have been included in mental health teams to motivate consumers to achieve their recovery goals, to reduce consumers’ feelings of mental health stigma, to conduct outreach for vulnerable populations, and to serve as “navigators” of the service system. Mental health peer supports should also be more culturally concordant to promote the engagement of under-represented cultural/linguistic minority groups.

Expand opportunities for professional development related to empathy and building trust with diverse mental health sub-populations. Focus group participants consistently described the importance of providers understanding the highly specific needs of each population they serve, which also vary from person to person. Some participants described the importance of a) using inclusive language when delivering care to sex and gender minorities, b) awareness

that certain aspects of military culture can influence an individual's decision to seek mental health care, c) understanding that justice involved persons frequently have experienced trauma, d) having basic skills for working with persons who are visually impaired or have other disabilities, and e) otherwise understanding the cultural and contextual factors that can influence engagement with mental health services. To help providers develop the skills to learn how an individual's identity or cultural characteristics might impact their experience with seeking mental health services, some organizations have developed and implemented trainings for local service providers working with LGBT persons. Likewise, providers that serve the other mental health sub-populations included in these focus groups described how all types of mental health providers across are in need of such skill-building opportunities. According to mental health providers who participated in the focus groups, such skill building opportunities are available through NAMI in Orange County. These services are available to providers and others within the mental health system who work with underserved populations such as LGBTQ persons, persons with disabilities, and cultural/linguistic minority groups.

Scale up educational strategies to address mental illness stigma in Orange County. Providers and community member participants across all focus groups described the pervasiveness of culturally-nuanced stigma in the community and across various sub-populations, noting that stigma presents a substantial barrier to recognizing and addressing symptoms of mental illness and engaging with mental health services. Community member focus group participants emphasized that these stigmas are culturally nuanced and deeply entrenched in their communities. The pervasiveness of stigma across communities in Orange County suggests a need for increased availability of psychoeducation in the community. To alleviate stigma, focus group participants also described the importance of promoting awareness of mental illness, educating the community about mental illness, and increasing opportunities for interaction between persons with and without mental illness. According to a focus group participant from NAMI:

“First, there needs to be awareness that there is such a thing as stigma and there is such a thing as mental illness. And then, **second, there needs to be education about mental illness.** So, awareness is kind of a subtle things. It can come in a variety of forms. Education really involves some individual or group of individuals communicating information to others and their willingness to receive that information. **And then, third, and this is critically important, there needs to be contact.** ‘I need to meet someone (with a mental illness)’”
(NAMI focus group participant)

APPENDICES

Appendix- Part 1

Appendix 1A: Estimated Population

Appendix Table A: Estimated Population of Adults, age 18 or older, with Past Year Serious Psychological Distress in Orange County by Demographic subgroups, CHIS 2011-2016 (Total Annual Averages)

Demographics (Adult)	Adults with Serious Psychological Distress	
	%	Estimated Population
Overall	6.7%	158,686
Gender		
Male	5.5%	62,988
Female	7.9%	95,698
Age (years)		
18-24	10.4%	33,782
25-34	8.3%	39,449
35-44	6.3%	25,392
45-54	7.1%	32,393
55-64	5.2%	18,181
65+	2.7%	9,488
Race/Ethnicity		
Latino	8.4%	61,344
White (non-Latino)	6.5%	70,449
African American (non-Latino)	7.8%	4,783
API (non-Latino)	4.4%	19,964
Other (non-Latino)	5.5%	2,146
Limited English Proficiency		
No	6.7%	26,954
Yes	7.3%	131,732
Marital Status		
Married	3.8%	45,104
Not Married	9.7%	113,582
Sexual Orientation		
Straight/heterosexual	6.6%	135,383
Gay/Lesbian/Homosexual/Bisexual	18.3%	14,926
Education		
Less than High School	6.3%	19,685
High School	9.4%	44,487
Some College	8.1%	46,478
Bachelor's degree or higher	4.9%	48,036
Employment		
Unemployed	9.2%	69,256
Employed	5.6%	89,429
Health Insurance Status		
Uninsured in past year	9.4%	40,652
Insured all past year	6.0%	118,034
Served in Armed Forces		
Served	4.4%	2,867
Did not serve	7.0%	155,819

NOTE: Statistical estimates are based on 6-waves of CHIS, (2011-2016) and an adult sample size, n = 358

- NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.
- NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)
- NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.
- NOTE: Estimated population total for straight/heterosexual and Gay/Lesbian/Bisexual does not sum to the overall estimated population total since some surveyed participants refused to answer the question on sexual orientation or identified themselves as celibate.

Appendix Table B: Estimated Population of Past Year Serious Psychological Distress among TAY, age 18–24 years, by Demographic subgroups, CHS 2011-2016 (Annual Averages)

Demographics (TAY)	TAY with Serious Psychological Distress in Orange County	
	%	Estimated Population
Overall	10.4%	33,782
Gender		
Male	9.7%	16,837
Female	10.8%	16,945
Race/Ethnicity		
Latino	16.6%	18,218
White (non-Latino)	9.0%	7,137
African American (non-Latino)	12.8%	529
API (non-Latino)	9.4%	7,224
Other (non-Latino)	*	*
Limited English Proficiency		
No	96.0%	32,419
Yes	4.0%	1,364
Sexual Orientation		
Straight/heterosexual	8.7%	26,163
Gay/Lesbian/Homosexual/Bisexual	39.7%	7,619
Education		
Less than High School	13.5%	1,886
High School	14.1%	14,434
More than HS	8.7%	17,462
Employment		
Unemployed	10.2%	11,395
Employed	10.6%	22,387
Health Insurance Status		
Uninsured in past 12 months	9.5%	7,552
Insured all past 12 months	10.3%	26,230

NOTE: Statistical estimates are based on the TAY sample, n = 465

* Low precision; no estimate reported.

Appendix Table C: Estimated Population of Mental Health Service Utilization in the Past Year among Adults with Serious Psychological Distress in Past Year, CHIS 2011-2016 (Annual Averages)

Mental Health Service Utilization	Adults with Serious Psychological Distress in Orange County	
	%	Estimated Population
Type of Health Professional Seen for Mental Health in the Past Year		
Primary Care Physician (PCP)	10.0%	15,802
Psychiatrist, counselor, social worker	20.6%	32,720
Both (PCP and Psychiatrist/Counselor/Social Worker)	19.2%	30,400
Did not see a health professional	50.3%	79,764
Number of Visits to a Health Professional for Mental Health in the Past Year		
4 or more visits	28.8%	45,700
Fewer than 4 visits	13.9%	22,034
No visits	57.3%	90,952
Took Prescription Medication for Mental Health in the Past Year		
Yes	36.1%	57,216
No	63.9%	101,470
Minimally Adequate Treatment		
No treatment	45.9%	72,907
Some treatment	34.4%	54,502
MAT	19.7%	31,277

NOTE: Statistical estimates are based on a subset of the adult sample, which is limited to adults with serious psychological distress, n = 358

Appendix Table D: Estimated Population of Adults in Orange County with Serious Mental Health Illness that have Access to Minimally Adequate Treatment (MAT), by Demographic subgroups, CHIS 2011-2016 (Annual Averages)

Adults with Serious Mental Health Illness in Orange County						
Demographics	No Treatment		Some Treatment		MAT	
	%	Estimated Population	%	Estimated Population	%	Estimated Population
Overall	45.9%	72,907	34.4%	54,502	19.7%	31,277
Gender						
Male	57.6%	36,248	31.1%	19,563	11.4%	7,177
Female	38.3%	36,659	36.5%	34,939	25.2%	24,100
Age (years)						
18-24	57.7%	19,485	28.7%	9,693	13.6%	4,603
25-34	52.9%	20,884	31.2%	12,292	15.9%	6,273
35-44	33.0%	8,370	40.3%	10,227	26.8%	6,795
45-54	41.2%	13,360	31.6%	10,219	27.2%	8,814
55-64	47.0%	8,542	35.0%	6,370	18.0%	3,270
65+	23.9%	2,267	60.1%	5,700	16.0%	1,521
Race/Ethnicity						
Latino	59.6%	36,578	28.1%	17,257	12.2%	7,509
White (non-Latino)	29.0%	20,411	40.8%	28,708	30.3%	21,331
African American (non-Latino)	48.1%	2,300	35.4%	1,692	16.6%	792
API (non-Latino)	65.7%	13,117	30.5%	6,083	3.8%	765
Other (non-Latino)	23.4%	501	35.6%	763	41.1%	881
Limited English Proficiency						
No	42.2%	55,618	36.3%	47,850	21.5%	28,263
Yes	64.1%	17,289	24.7%	6,651	11.2%	3,014
Marital Status						
Married	46.6%	20,996	31.5%	14,196	22.0%	9,911
Not Married	45.7%	51,911	35.5%	40,305	18.8%	21,366
Sexual Orientation						
Straight/heterosexual	47.4%	64,222	35.6%	48,162	17.0%	22,998
Gay/Lesbian/Homosexual/Bisexual	44.4%	6,622	7.5%	1,112	48.2%	7,192
Education						
Less than High School	47.0%	9,246	31.8%	6,252	21.3%	4,187
High School	56.4%	25,075	29.1%	12,946	14.5%	6,466
Some College	35.2%	16,376	37.2%	17,267	27.6%	12,835
Bachelor's degree or higher	46.2%	22,210	37.6%	18,037	16.2%	7,789
Employment						
Unemployed	36.0%	24,902	37.6%	26,026	26.5%	18,328
Employed	53.7%	48,005	31.8%	28,475	14.5%	12,949
Health Insurance Status						
Uninsured in past 12 months	50.0%	20,310	36.2%	14,709	13.9%	5,633
Insured all past 12 months	44.6%	52,597	33.7%	39,793	21.7%	25,644

NOTE: Statistical estimates are based on a subset of the adult sample, which is limited to adults with serious psychological distress, n = 358. Estimated population total for straight/heterosexual and Gay/Lesbian/Bisexual does not sum to the overall estimated population total since some of the respondents did not answer the question on sexual orientation or identified themselves as celibate.

Appendix Table E: Estimated Population of Adolescents, ages 12-17 years, with Serious Psychological Distress in the Past Month, by Demographic subgroups, CHIS 2011-2016 (Total Annual Averages)

Demographics	Past Month Serious Psychological Distress among Adolescents	
	%	Estimated Population
Overall	4.2%	11,264
Gender		
Male	3.6%	5,218
Female	5.4%	6,046
Age (years)		
12-14	6.7%	8,194
15-17	4.3%	3,070
Latino Ethnicity		
non-Latino	3.4%	4,301
Latino	6.0%	6,963
Received psychological or emotional counseling in the past year		
Received Treatment	36.5%	4,112
Received No Treatment	63.5%	7,152

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and a CHIS adolescent sample size of n = 352

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

Appendix Table F: Estimated Population of Children, ages 4-11, with Abnormal Mental Health Development in the Past Six Months, by demographic groups, CHIS 2005-2009 (Total Annual Averages)

Demographics	Abnormal Mental Health Development among Children in Orange County	
	%	Estimated Population
Overall	5.9%	24,238
Gender		
Male	6.2%	12,846
Female	5.5%	11,392
Latino Ethnicity		
Non-Latino	3.8%	8,590
Latino	8.3%	15,648
Received psychological or emotional counseling in the past year		
Received Treatment	43.4%	10,526
Received No Treatment	56.6%	13,712

NOTE: Orange County statistical estimates are based on 6-waves of CHIS, (2011-2016) and a CHIS child sample size of n = 59

NOTE: Due to small sample size Native Hawaiians and Pacific Islanders were grouped with Asians (API)

NOTE: Due to small sample size American Indians and Alaska Natives and adults reporting ≥2 races were grouped in the 'Other' category.

NOTE: Race is defined according to the California Department of Finance where Latino is considered a race category. All other racial groups are non-Latino.

Appendix 1B: Methodology

A quantile classification method was applied to the maps displaying the prevalence of SPD. Under the quantile method, the prevalence of SPD was grouped into three categories with approximately the same number of zip codes assigned to each category. When moving from one class to the next, the prevalence of SPD linearly increased (or decreased) and hence the classes were defined as low ($SPD \leq 6.6\%$), medium ($6.6\% \leq SPD \leq 7.3\%$), or high ($7.31\% \leq SPD \leq 8.6\%$).

Data

The California Health Interview Survey (CHIS) was used to examine the current state of mental health in Orange County. CHIS collects data on the civilian, noninstitutionalized population of California through a multistage sampling design using random digit-dial of land and cellular telephone numbers. CHIS also provides representative data on counties and across sub-county geographic regions. Reflecting California's diversity, a significant proportion of the CHIS respondents are from diverse racial/ethnic groups. CHIS is fielded in multiple languages, enabling non-English speakers to be represented.

This report analyzed CHIS data covering years 2011-2016 for adults, veterans, transitional-aged youth, and adolescents, and among children years 2005-2009. Earlier waves of CHIS were selected for children due to the limited availability of data on emotional and behavioral issues in subsequent waves of CHIS. Further, although the sample is limited to civilian populations, participants were asked about their service in the armed forces and responses to this question was used to identify veterans in Orange County.

Measures

Serious psychological distress among adolescents, transitional-aged youth, adults, and veterans was assessed with the Kessler 6 (K6) scale, a validated measure of mental health outcomes. The K6 scale is comprised of six questions in which respondents are asked about the frequency of feeling nervous, hopeless, restless or fidgety, sad or depressed, that everything was an effort, and worthless in the past 12 months. Responses were measured on a five-point Likert-scale score from 1 "none of the time" to 5 "all of the time". Items are summed across the six questions to generate a composite score. The lowest possible score is 6 (no distress) and the maximum possible score is 30 (severe distress). This report uses the widely accepted cut-point of $K6 \geq 13$ to identify past year serious psychological distress.³

Emotional and behavioral problems in children was assessed through a screening instrument for identifying emotional and behavioral problems in children called the brief Strengths and Difficulties Questionnaire (brief SDQ). Parents responded to five individual items about conduct problems, emotional symptoms, hyperactivity, and peer problems and the overall level of severity of the child's emotional and behavioral problems in five areas: emotions, concentration, behavior, or getting along with other people, by choosing between three response options (not true, somewhat true, or always true) about the child's behavior in the past six months. The five symptom questions were summed, and the total score was

categorically classified as being within the ‘normal’, ‘borderline’, or ‘abnormal’ clinical range. Children were identified as having mental health symptoms if they scored within the “abnormal” range of the brief SDQ (i.e., abnormal mental health development).

Mental health service utilization was assessed with CHIS questionnaire items that were limited in scope for children and adolescents in comparison to adults. Adolescents (ages 12-17) and the parents of children (ages 4-11) were asked if they received any psychological or emotional counseling in the past year (yes/no) with no additional questions on mental health service utilization. Conversely, adult participants were asked about mental health service utilization in the past year across three areas including (1) whether they saw either their primary care physician, general practitioner or other health professional, such as a counselor, psychiatrist or social worker, for problems with mental health (yes/no), (2) among those who saw a health professional, the number of visits in the past year for problems with their mental health and (3) use of prescription medicine, such as an antidepressant or sedative, almost daily for two weeks or more, for an emotional or personal problem (yes/no).

Statistical Analysis

Direct Estimation at County-level. We generated weighted prevalence estimates of individuals in Orange County with (1) serious psychological distress in the past year (among transitional-aged youth, adults, and veterans measured and among adolescents, serious psychological distress in the past 6 months), (2) abnormal mental health development in the past six months (among children), and (3) mental health service utilization. Weighted prevalence estimates were generated by pooling CHIS data files across six waves of data collection (2011-2016). Pooling multiple survey years increased the overall sample size and thus the stability of the prevalence estimates. Weights applied in the estimation process accounted for the probability of selection, non-response, under-coverage, and survey design with corresponding standard errors generated through a replication method for variance estimation.

Indirect Estimation by Demographic Groups. An indirect estimation approach was applied to estimate the prevalence of serious psychological distress by race/ethnicity and veteran status due to the small sample size after pooling multiple waves of CHIS data. We built a two-level random intercept logit model (i.e., individuals nested in counties) that included individual- and county-level variables hypothesized to have an association with mental health outcomes. This included gender, age, marital status, immigration status, insurance status, race/ethnicity, and an indicator variable capturing residents of Orange County vs. the remaining California counties. The two-level random intercept logit model was built in blocks by first including individual-level variables and adding county-level variables. After building the two-level random intercept logit model, we used the regression coefficients to simulate 10,000 model-based probabilities of past year serious psychological distress for specific racial/ethnic groups and veterans in Orange County. The demographic specific probabilities were multiplied to census population counts in Orange County to generate the final model-based prevalence estimate of serious psychological distress.

Limitations

The California Health Interview Survey is a household survey that is designed represent California's diverse non-institutionalized population. As such, the survey does not capture the mental health need and unmet need of individuals residing in groups quarters (such as prisons) or who are homeless. Further, estimating mental health need and unmet need was limited for certain subpopulations due to small sample sizes and hence unstable estimates. Limitations with the CHIS data are discussed below. Additionally, we discuss limitations with defining homelessness and its effect on estimating mental health need among homeless persons in Orange County.

Insufficient data to generate mental health estimates among the Cambodian population.

Within Orange County, the majority of Asian participants were of Chinese (n=292), Japanese (n=151), Korean (n=270) and Vietnamese (n=593) ethnic heritage. As previously discussed, 6-years of CHIS data were pooled to increase sample size and produce more stable estimates. However, even after pooling multiple waves of CHIS data, Cambodians accounted for fewer than 5 of the 1,500 Asian adult respondents in Orange County. According to the U.S. Census, there were a total of 7,214 Cambodians residing in Orange County representing 7.6% of the total population of Cambodians in California. Yet in the CHIS sample, less than 1% of Asian respondents identified as Cambodians. Therefore, due to small sample sizes we are unable to generate stable estimates through either a direct or indirect estimation process among the Cambodian adult population.

Low frequency of mental health symptoms among Asian and Native Hawaiian and Other Pacific Islanders. Due to the low prevalence of serious psychological distress among Asians and Native Hawaiian/Other Pacific Islanders, this report combined the two racial groups to produce more stable estimates.

Insufficient data to explore demographic differences in mental health treatment utilization among TAY. Despite pooling 6-years of CHIS data to increase sample size, there continued to be an insufficient number of TAY respondents with serious psychological distress. Therefore, this report was unable to subsequently examine demographic differences in access to mental health treatment among TAY with serious psychological distress. Further, although an indirect estimation process was adopted for certain demographic groups, this was not feasible among the subpopulation of TAY. The limitation was with combining model-based probabilities with census population counts given that the population of TAY with serious psychological distress is unknown, rather this is a quantity being estimated in the report.

Insufficient data to explore demographic differences in mental health need among Veterans. Similarly, due to the small sample size of veterans in the CHIS sample and the low prevalence of serious psychological distress among veteran respondents, this report was unable to provide estimates of mental health need by veteran demographic groups, as was provided among the adult population (e.g., age groups, race/ethnicity, educational attainment, etc.).

Geographic variation of mental health illness may explain lower SMI among homelessness in Orange County. The 2017 Homeless Point-in-Time Count and Survey (PIT) in Orange County was used to estimate mental health need among homeless persons. The homeless count was conducted on the night of January 27, 2017. Surveys assessing serious mental illness (SMI) were administered to any adult who was counted, awake (not sleeping) and willing and able to consent to participation. Accordingly, the survey included individuals who were living on the streets, in vehicles, in abandoned buildings, tent/encampments or shelters. PIT excluded individuals who resided with friends/family, in a motel/hotel, and in a jail/hospital/treatment program. This report found SMI among homeless persons in Orange County was well below the national average (12% in Orange County vs. 20% in the United States). However, neighboring counties, San Diego and Riverside, had a similar prevalence of SMI as Orange County (14% and 12.8%, respectively); whereas neighboring Los Angeles County had a prevalence rate that exceeded the national average (27.2%). Future focus groups with community stakeholders may help to further explain discrepant findings between Orange County and the national average of SMI among homeless persons.

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Appendix Part 2

Appendix 2A: Methods

Geographic Data

The geographic location of BHS facilities was obtained from the Orange County Health Care Agency Behavioral Health Services (OC HCA BHS) Directory and the online facility locator database maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA).

The OC HCA BHS Directory identifies all programs available to Orange County residents through the OC HCA BHS Division, which include mental health and substance use disorder services. However, for the purpose of this report we excluded programs that only provided substance use disorder services. A total of n=186 facilities providing mental health services were obtained from the May 2018 directory.¹

The SAMHSA Behavioral Health Treatment Services Locator is an online database that provides information on treatment facilities for mental health problems.² The online database is updated annually from facility responses to SAMHSAs National Mental Health Services Survey, which collects information on all known public and private facilities in the United States providing mental health services.³ For this report, we used data that was downloaded from the online locator database on July 3, 2018 and excluded duplicate records that were already listed in the OC HCA BHS Directory. A total of n=15 facilities were obtained from the SAMSHA online database.

The physical location for each facility was recorded as a street address in both the OC HCA BHS Directory and the SAMHSA database. Addresses were converted to a geographic coordinate that could be mapped as a geographic point in Orange County and aggregated to a zip code in Orange County.

To supplement data obtained from OC HCA BHS Directory and the SAMSHA online facilitator database, we included zip code level data from the 2016 County Business Patterns (CBP) Survey; a survey administered by the U.S. Census.⁴ CBP is an annual survey of all US organizations with employees and provides subnational economic data by industry.⁵ For this report, we extracted 2016 CBP data on the number of establishments with at least one office-based psychiatrist or therapist that engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. To protect confidentiality, CBP does not publish data that could disclose the operations of an individual employer.⁵ Therefore, the smallest geographic unit that can be used to classify an establishment by its physical location is at the zip code level.

Due to potential overlap with identifying the physical location of mental health service facilities, we did not combine the 2016 CBP database with the OC HCA BHS Directory or the SAMHSA

online facilitator database. Rather we analyzed the 2016 CBP database separate from the other two databases. Exploratory spatial data analysis was performed with the ArcGIS 10 software (ESRI, Redlands, CA, USA).

Demographic Data

A demographic summary of the Orange County population was obtained from the U.S. Census American Community Survey (ACS), 5-year estimates (2012-2016). The ACS is an annual nationwide survey that collects demographic and housing information available at multiple geographic levels including age distribution, racial/ethnic composition, socioeconomic composition, and insurance coverage rates.⁶ Each year, the ACS sample compromises about 1% of the total population. In this report, we obtained publicly available ACS data at the zip code level. Statistical analysis of the ACS data was conducted by generating descriptive summaries in Orange County overall and stratifying descriptive summaries by a binary indicator identifying zip codes with and without a behavioral health facility (as captured in the OC HCA or SAMHSA databases). Statistical comparison was generated with the Wilcoxon-rank sum test statistic. All statistical analysis was carried out with STATA 14 (StataCorp LLC, College Station, TX, USA).

The population of non-English speakers in Orange County was also obtained from the ACS 5-year estimates (2011-2015). In this report, non-English speakers are defined as individuals who speak English less than “very well” and reported speaking a language other than English at home.

A quantile classification method was applied to the maps displaying the demographic data on insurance coverage and non-English speakers. Under the quantile method, the demographic data being mapped was grouped into three categories with approximately the same number of zip codes assigned to each category. When moving from one class to the next class, the demographic data linearly increased (or decreased) and hence the classes were defined as low, medium, or high.

Density of Services at the Zip Code Level

The statistical data mapped out in this report involves the density of BHS facilities. Using the number of BHS facilities tabulated over a zip code area, we constructed a density measure calculated as the number of BHS facilities in a zip code divided by the population total of that zip code.

We did not map out the number of BHS facilities since we were concerned that the number of facilities within a zip code may depend on population size. Areas with a larger population may have more facilities and conversely, less populated zip codes may have fewer facilities. Therefore, to make the zip codes more comparable, we constructed a density measure and used choropleth maps to visualize the geographic distribution of BHS facilities in Orange County.

A quantile classification method was applied to the maps displaying the density of BHS facilities. Under the quantile method, the density of BHS facilities was grouped into three categories with

approximately the same number of zip codes assigned to each category. When moving from one class to the next, the density of BHS facilities linearly increased (or decreased) and hence the classes were defined as low (BHS density = 0), medium ($0.01 \leq \text{BHS density} \leq 0.48$), or high ($0.49 \leq \text{BHS density} \leq 6.17$).

Prevalence of Serious Psychological Distress

The prevalence of mental health symptoms in Orange County was assessed with the California Health Interview Survey (CHIS). Methodology for estimating prevalence as well the CHIS data source was discussed in our previous Needs and Gaps Analysis report (June 2018). Briefly, the prevalence of mental health symptoms was measured by the Kessler-6 (K6) scale, which captures individuals who are likely to have experienced serious psychological distress in the past year. Validation studies have shown the K6 scale to be a predictor of serious mental illness.⁷⁻⁹ Using CHIS data, the prevalence of serious psychological distress was estimated at the zip code level for Orange County adult residents (age 18 years and older). Due to the small number of adolescents (ages 12-17 years) and children (ages 4-11 years) sampled in Orange County, we were unable to generate reliable zip code level estimates for these subpopulations.

In this report, we mapped out the prevalence of serious psychological distress (SPD) at the zip code level rather than the number of Orange County residents experiencing SPD. We used prevalence instead of number of cases because the number of residents experiencing mental health symptoms in a zip code may seem small until we account for population size. In several zip codes with low population density, we found the prevalence to be quite high despite a low number of cases. Therefore, to make the zip codes more comparable, prevalence estimates were mapped out to visualize the distribution of mental health symptoms in Orange County.

Appendix 2B: List of Facilities

Appendix Table G: Mental Health Programs Listed in the Orange County Health Care Agency Directory of Behavioral Health Services and/or the Substance Abuse and Mental Health Services Administration Database

KEY

***BHS Division:** AOABH=Adult and Older Adult Behavioral Health; AQIS=Authority and Quality Improvement Services; CYBH=Children and Youth Behavioral Health; NIT= Navigation, Innovation and Training Division; P&I=Prevention & Intervention; SAMHSA= Data obtained from Substance Abuse and Mental Health Services Administration, BHS Division unknown.

****Languages Spoken:** EN=English ONLY, SP=Spanish, VN=Vietnamese, FA=Farsi, KO=Korean, TG=Tagalog, CH=Chinese, AR=Arabic, KH=Khmer, OTH=Additional translation services available (e.g., telephone service), UNK=Language information unavailable.

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**														
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T H	U N K				
0	SSI Outreach - Mental Health Association	822 Town & Country Rd.	Orange	CA	92868	AOABH - Outpatient		X	X	X											
1	Patients' Rights Advocacy Services	405 W. 5th St.	Santa Ana	CA	92701	AQIS		X	X	X											
2	The Recovery Education Institute	401 S. Tustin St.	Orange	CA	92866	NIT		X	X	X											
3	Santa Ana Clinic	1200 N. Main St.	Santa Ana	CA	92701	CYBH		X		X											
4	Representative Payee Services - Mental Health Association	2416 South Main St.	Santa Ana	CA	92701	AOABH - Outpatient		X	X												
5	Aliso Viejo AOABHS Clinic (Access Point)	5 Mareblu	Aliso Viejo	CA	92656	AOABH		X			X										
6	AB 109 - AMHS	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient															X
7	Acute Psychiatric Inpatient Treatment - Anaheim Global Medical Center	1025 S. Anaheim Blvd.	Anaheim	CA	92805	AOABH - Inpatient		X	X	X											
8	Acute Psychiatric Inpatient Treatment - College Hospital	301 Victoria St.	Costa Mesa	CA	92627	AOABH - Inpatient		X	X	X											
9	Acute Psychiatric Inpatient Treatment - Royale Therapeutic Residential Center	1030 W. Warner Ave.	Santa Ana	CA	92707	AOABH - Inpatient		X	X	X											
10	Acute Psychiatric Inpatient Treatment - University of California at Irvine, Medical Center	101 The City Drive South	Orange	CA	92868	AOABH - Inpatient		X													
11	Administrative Services Organization (ASO)	405 W. 5th St.	Santa Ana	CA	92701	AOABH - Outpatient		X	X	X											

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N			
12	Adult/Older Adult Peer Mentoring - College Community Services	501 N. Brookhurst Street	Anaheim	CA	92801	AOABH - Outpatient		X		X										
13	Assisted Outpatient Treatment (AOT)	405 W. 5th St.	Santa Ana	CA	92701	AOABH - Outpatient		X	X											
14	Assisted Outpatient Treatment (AOT) Full Service Partnership (FSP)	615 W. Civic Center Drive	Santa Ana	CA	92701	AOABH - Outpatient														X
15	CalWORKs	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient														X
16	Crisis Assessment Team (CAT)	Lawson Way & Town & Country Rd	Orange	CA	92868	AOABH - Crisis														X
17	Integrated Community Services (ICS)- Community Home	8633 Knott Ave.	Buena Park	CA	90620	AOABH - Outpatient		X	X		X									
18	Integrated Community Services (ICS)- Community Home	9862 Chapman Ave., Suite B	Garden Grove	CA	92841	AOABH - Outpatient		X	X											
19	Integrated Community Services Program (ICS)- County Home	14140 Beach Blvd.	Westminster	CA	92683	AOABH - Outpatient														X
20	Integrated Community Services Program (ICS)- County Home	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient														X
21	Older Adult Recovery Services	1901 E. 4th St.	Santa Ana	CA	92705	AOABH - Outpatient														X
22	Pacific Asian Unit (PAU) Clinic	14140 Beach Blvd.	Westminster	CA	92683	AOABH - Outpatient			X											
23	Recovery Center - College Community Services, Camino Nuevo (Access Point)	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient		X												X
24	Recovery Open Access Costa Mesa	3115 Redhill Ave.	Costa Mesa	CA	92626	AOABH - Outpatient		X					X							X
25	Recovery Open Access North	303 W. Lincoln	Anaheim	CA	92805	AOABH - Outpatient		X	X								X	X		
26	Residential Rehabilitation (Program Administration)	405 W. 5th St.	Santa Ana	CA	92701	AOABH - Inpatient														X
27	Straight Talk/Start House	808 La Vergn Way	Santa Ana	CA	92703	AOABH - AOD														X
28	Telecare And Orange (TAO)	2531 W. Woodland Drive	Anaheim	CA	92801	AOABH - Outpatient		X	X			X	X	X	X	X	X	X		
29	Telecare and Orange (TAO) South	275 E. Baker St., Costa Mesa	Costa Mesa	CA	92626	AOABH - Outpatient		X	X			X								
30	Telecare Crisis Residential - South	Muirlands Blvd & Alicia Pkwy	Mission Viejo	CA	92691	AOABH - Crisis														X
31	Telecare Crisis Residential Program - Central	S. Tustin St. & E. La Veta Ave.	Orange	CA	92866	AOABH - Crisis														X
32	Telecare STEPS Orange County	2100 N. Broadway	Santa Ana	CA	92706	AOABH - Outpatient		X				X		X					X	

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**											
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N	
33	Whatever It Takes (WIT) /Telecare	1910 North Bush St.	Santa Ana	CA	92706	AOABH - Outpatient		X	X	X							X	
34	Avenida Villas	9602 Ball Road	Anaheim	CA	92804	AOABH - Outpatient												X
35	Alegre Apartments	3100 Visions Street	Irvine	CA	92618	AOABH - Outpatient												X
36	Capestone Apartments	9501 W. Cerritos	Anaheim	CA	92804	AOABH - Residential Services												X
37	Cotton's Point	2350 S. El Camino Real	San Clemente	CA	92672	AOABH - Residential Services												X
38	Depot at Santiago	923 N. Santiago St.	Santa Ana	CA	92701	AOABH - Residential Services												X
39	Diamond apartments	1310 W. Diamond St.	Anaheim	CA	92801	AOABH - Residential Services												X
40	Doria Apartments Phases I & II	1000 Crested Bird	Irvine	CA	92620	AOABH - Residential Services												X
41	Fullerton Heights	1220 E. Orangethorpe Ave.	Fullerton	CA	92831	AOABH - Residential Services												X
42	Henderson House	680 Camino de los Mares	San Clemente	CA	92805	AOABH - Residential Services												X
43	Oakcrest Heights	22744 Eastpark	Yorba Linda	CA	92887	AOABH - Residential Services												X
44	Rockwood Apartment Homes	1270 E. Lincoln Ave.	Anaheim	CA	92805	AOABH - Residential Services												X
45	Jackson Aisle	15432 Jackson St.	Midway City	CA	92655	AOABH - Residential Services												X
46	Caring Village	8912 Katella	Anaheim	CA	92804	AOABH - Residential Services		X				X						
47	Palm Village	13902 Clinton St.	Garden Grove	CA	92843	AOABH - Residential Services		X				X						
48	Leisure Towers II	174 W. Lincoln Ave.	Anaheim	CA	92805	AOABH - Residential Services		X				X						
49	Stanford Homes	410 E. Wilshire Ave.	Fullerton	CA	92832	AOABH - Residential Services		X				X						
50	Friendship Shelter	1335 S. Coast Hwy.	Laguna Beach	CA	92651	AOABH - Residential Services		X	X									
51	Grandma's House of Hope - Mental Health Shelter	1505 E. 17th St.	Santa Ana	CA	92705	AOABH - Residential Services		X	X									

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N			
52	Collette's Children's Home - Mental Health Shelter	7372 Prince Dr., #106	Huntington Beach	CA	92647	AOABH - Residential Services														X
53	CHOC co-occurring program	1120 W. La Veta Ave.	Orange	CA	92868	CYBH														X
54	Orange County Asian Pacific Islander Community Alliance (OCAPICA) - PROJECT FOCUS - Full Service Partnership Wraparound	12912 Brookhurst St.	Garden Grove	CA	92840	CYBH			X		X	X	X					X		
55	Orangewood Foundation	1575 17th St.	Santa Ana	CA	92805	CYBH														X
56	Pathways Community Services - Support Transitional Age Youth (STAY), Full Service Partnership (FSP)	1401 N Tustin Ave, #225	Santa Ana	CA	92705	CYBH		X	X	X	X									
57	Providence Community Services - Project RENEW (Reaching Everyone Needing Effective Wrap), Full Service Partnership (FSP)	3188 F Airway Ave.	Costa Mesa	CA	92626	CYBH														X
58	Seneca Family of Agencies OC Canyon Acres Ranch	233 S. Quintana Ave.	Anaheim Hills	CA	92807	CYBH														X
59	South Coast Children's Society - Out-Patient Clinic	2124 Main St.	Huntington Beach	CA	92648	CYBH		X	X								X			
60	South Coast Children's Society - Transitional Age Youth (TAY) Crisis Residential Program	3344 Nevada Ave.	Costa Mesa	CA	92626	CYBH - Crisis														X
61	South Coast Children's Society-Social Rehabilitation Program	590 Traverse Dr.	Costa Mesa	CA	92626	CYBH		X												
62	Touchstones Social Model Recovery	525 N. Parker St.	Orange	CA	92868	CYBH	X													
63	Wayfinders - (formerly CSP) Collaborative Courts, Full Service Partnership (FSP)	1821 E. Dyer Rd	Santa Ana	CA	92705	CYBH		X	X											
64	Wayfinders - (formerly CSP) Children's Crisis Residential Program, Huntington Beach	7291 Talbert Ave.	Huntington Beach	CA	92648	CYBH - Crisis		X												
65	Wayfinders - (formerly CSP) Youthful Offender Wraparound (YOW), Full Service Partnership (FSP)	1231 E. Dyer Rd.	Santa Ana	CA	92705	CYBH		X												

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N			
66	Wayfinders - (formerly CSP) Youthful Offender Wraparound (YOW), Full Service Partnership (FSP) Guidance Center	16580 Harbor Blvd.	Fountain Valley	CA	92708	CYBH		X	X											
67	Wayfinders- (formerly CSP) Children's Crisis Residential Program, Laguna Beach	980 Catalina,	Laguna Beach	CA	92651	CYBH - Crisis														X
68	Youth Reporting Center, Central	1001 S. Grand Ave.	Santa Ana	CA	92705	CYBH		X												
69	Youth Reporting Center, North	160 Cerritos Ave.	Anaheim	CA	92805	CYBH		X												
70	Behavioral Health Services for Independent Living - College Community Services	2001 E. 4th St.	Santa Ana	CA	92705	NIT														X
71	Strong Families Strong Children: Behavioral Health Services for Military Families - Child Guidance Center	525 N. Cabrillo Park Dr.	Santa Ana	CA	92701	NIT		X												
72	Veterans' Court Services	1300 S. Grand Ave.	Santa Ana	CA	92705	NIT	X													
73	Behavioral Health Intervention & Support Services (Phoenix House)	1585 17th St.	Santa Ana	CA	92705	P&I														X
74	Children's Support and Parenting Program (CSPP)	1200 N. Main St.	Santa Ana	CA	92701	P&I		X												X
75	Orange County Postpartum Wellness (OCPPW) Program	792 Town & Country Rd.	Orange	CA	92868	P&I		X	X	X										X
76	Parent Education Services- Olive Crest	2130 E. 4th St., Suite 200	Santa Ana	CA	92705	P&I		X	X	X	X			X						
77	School-Based Stress Management Services	200 Kalmus Dr.	Costa Mesa	CA	92626	P&I														X
78	School Based Behavioral Health Intervention & Support - Early Intervention Services (UCI)	19262 Jamboree Rd.	Irvine	CA	92612	P&I		X	X	X	X		X							
79	School Based Behavioral Health Interventions and Supports (Phoenix House)	1585 17th St.	Santa Ana	CA	92705	P&I	X													
80	School Based Mental Health Services (SBMHS) Program	878 W. Town & Country Rd.	Orange	CA	92868	P&I		X			X									X
81	School Based Violence Prevention Education (SBVPE)	200 Kalmus Dr.	Costa Mesa	CA	92626	P&I		X	X											

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N			
82	School Readiness - Orange County Child Abuse Prevention Center	2390 Orangewood Ave.	Anaheim	CA	92806	P&I		X	X											
83	Stress Free Families	1200 N. Main St.	Santa Ana	CA	92701	P&I		X	X		X									X
84	Youth As Parents	792 Town & Country Rd.	Orange	CA	92868	P&I														X
85	Santa Ana AOABHS Clinic (Access Point)	1200 N. Main St.	Santa Ana	CA	92701	AOABH		X	X	X	X									X
86	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) East	1200 N. Main St.	Santa Ana	CA	92701	AOABH		X	X	X	X									X
87	Wayfinders (Formerly CSP) Gang Reduction Intervention Partnership (GRIP)	1221 E. Dyer Rd. Suite 120	Santa Ana	CA	92705	P&I		X												
88	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) West	14140 Beach Blvd.	Westminster	CA	92683	AOABH		X	X	X	X									X
89	Westminster AOABHS Clinic (Access Point)	14140 Beach Blvd.	Westminster	CA	92683	AOABH		X	X	X	X									X
90	Westminster Clinic	14140 Beach Blvd.	Westminster	CA	92683	CYBH		X	X				X							
91	AB 109 Westminster Probation Office	14180 Beach Blvd.	Westminster	CA	92683	AOABH		X												
92	AB 109 Anaheim Probation Office	1535 E. Orangewood Ave.	Anaheim	CA	92805	AOABH		X												
93	BHS Outreach and Engagement	1725 W. 17th St.	Santa Ana	CA	92706	NIT														X
94	Western Youth Services - West	18350 Mount Langley St.	Fountain Valley	CA	92708	CYBH		X	X											
95	Recovery Center - College Community Services, Anaheim	1901 Center Street	Anaheim	CA	92805	AOABH		X	X	X	X									X
96	Western Youth Services - East	200 Santa Ana Blvd Ste. 801	Santa Ana	CA	92701	CYBH		X												
97	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) Anaheim	2035 E. Ball Rd.	Anaheim	CA	92806	AOABH		X	X	X	X									X
98	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) North	211 W. Commonwealth Ave.	Fullerton	CA	92832	AOABH		X	X	X	X									X
99	Wayfinders- (formerly CSP) Families First	2130 E. 4th St.	Santa Ana	CA	92705	CYBH		X												
100	Supported Employment (North County) - Goodwill Industries of Orange County	2250 S. Yale St.	Santa Ana	CA	92704	AOABH														X

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**											
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N K	
101	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) Costa Mesa	3115 Redhill Ave.	Costa Mesa	CA	92626	AOABH		X	X	X	X						X	
102	Western Youth Services - North	505 Euclid St.	Anaheim	CA	92801	CYBH		X										
103	AB 109 Santa Ana Probation Office	909 N. Main Street	Santa Ana	CA	92701	AOABH		X										
104	Psychiatric Emergency Response Team (PERT)	Lawson Way & Town & Country Rd.	Orange	CA	92868	AOABH												X
105	CalWORKs SSA North Regional Office	3320 E. La Palma Ave.	Anaheim	CA	92806	AOABH - Outpatient												X
106	College Community Services, CalWORKs	501 N. Brookhurst Street	Anaheim	CA	92801	AOABH - Outpatient		X	X									
107	Integrated Community Services Program (ICS)- County Home	2035 E. Ball Rd.	Anaheim	CA	92806	AOABH - Outpatient												X
108	Long Term Care - West Anaheim Therapeutic Residential Center	645 S. Beach Blvd.	Anaheim	CA	92804	AOABH - Inpatient												X
109	In-Home Crisis Stabilization - Orange County Child Abuse Prevention Center	2390 Orangewood Ave.	Anaheim	CA	92806	CYBH - Crisis												X
110	Pathways Community Services - North	711 E. Ball Rd.	Anaheim	CA	92805	CYBH		X										
111	Pathways Community Services - Project RENEW (Reaching Everyone Needing Effective Wrap), Full Service Partnership (FSP)	1360 S Anaheim Blvd, #101	Anaheim	CA	92805	CYBH		X	X	X	X							
112	Orange County-ACCEPT (Acceptance through Compassionate Care, Empowerment, and Positive Transformation)	2035 E. Ball Rd.	Anaheim	CA	92806	NIT		X										
113	Outreach and Engagement Services - Orange County Child Abuse Prevention Center	2390 Orangewood Ave.	Anaheim	CA	92806	P&I												X
114	Parent Education and Support Services - Orange County Child Abuse Prevention Center	2390 Orangewood Ave.	Anaheim	CA	92806	P&I												X
115	Aliso Viejo AOABHS Clinic (Access Point)	5 Mareblu	Aliso Viejo	CA	92656	AOABH - Outpatient		X	X	X	X						X	
116	Child Guidance Center, Inc.-Buena Park	6301 Beach Blvd.	Buena Park	CA	90621	CYBH		X		X	X							
117	Mental Health Collaborative Courts	3115 Redhill Ave.	Costa Mesa	CA	92626	AOABH - Outpatient												X

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**										
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N K
118	Telecare and Orange (TAO) South	275 E. Baker St.	Costa Mesa	CA	92626	AOABH - Outpatient		X	X				X				
119	Costa Mesa Clinic	3115 Redhill Ave.	Costa Mesa	CA	92626	CYBH		X	X								
120	Resilient Mindful Learner K-12	200 Kalmus Dry	Costa Mesa	CA	92626	P&I											X
121	Dana Point Clinic	24242 La Cresta	Dana Point	CA	92629	CYBH		X									
122	Program for Assertive Community Treatment (PACT) North	211 W. Commonwealth Ave.	Fullerton	CA	92832	AOABH - Outpatient		X	X								X
123	Child Guidance Center, Inc.-Fullerton	680 Langsdorf Dr Ste. 200	Fullerton	CA	92832	CYBH		X									
124	Peer Support and Wellness Center (West) - Mental Health Association	11277 Garden Grove Blvd.	Garden Grove	CA	92843	AOABH - Outpatient											X
125	Opportunity Knocks (OK)	11277 Garden Grove Blvd.	Garden Grove	CA	92843	AOABH - Outpatient		X	X								X
126	Pathways Community Services - West	12966 Euclid St.	Garden Grove	CA	92840	CYBH		X	X								
127	Outreach and Engagement Services - Orange County Asian Pacific Islander Community Alliance	12912 Garden Grove Blvd., Suite. 400	Garden Grove	CA	92843	P&I											X
128	Early Intervention Services for Older Adults-Council on Aging	2 Executive Circle, Suite 175	Irvine	CA	92614	P&I		X	X	X	X			X			
129	Children and Youth Behavioral Health Services Main Office	21632 Wesley Dr.	Laguna Beach	CA	92651	CYBH		X									
130	CalWORKs SSA South Regional Office	23340 Moulton Pkwy.	Laguna Hills	CA	92653	AOABH - Outpatient											X
131	Peer Support and Wellness Center (South) - Mental Health Association	23072 Lake Center Drive	Lake Forest	CA	92630	AOABH - Outpatient		X	X	X	X						
132	Program for Assertive Community Treatment (PACT) South	23228 Madero	Mission Viejo	CA	92691	AOABH - Outpatient		X	X								X
133	Long Term Care - Royale Mission Viejo Mental Health Rehabilitation Center (MHRC)	23228 Madero	Mission Viejo	CA	92691	AOABH - Inpatient		X	X	X							
134	Recovery Open Access South	23228 Madero	Mission Viejo	CA	92691	AOABH - Outpatient											X
135	Supported Employment (South County) - Goodwill Industries of Orange County	23871 Via Fabricante	Mission Viejo	CA	92691	AOABH - Outpatient											X
136	Transitional Age Youth/Program for Assertive Community Treatment (TAY PACT) Mission Viejo	23228 Madero	Mission Viejo	CA	92691	AOABH - Outpatient		X	X	X	X						X

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N			
137	Western Youth Services - South	26137 La Paz Rd., Suite 230	Mission Viejo	CA	92691	CYBH		X		X										
138	Older Adult Support Intervention Systems (OASIS)	1855 W. Katella Ave.	Orange	CA	92867	AOABH - Outpatient		X	X	X		X								
139	Child Abuse Services Team (CAST)	401 The City Drive	Orange	CA	92868	CYBH		X												X
140	Children and Youth Behavioral Health /Program for Assertive Community Treatment (CYBH PACT) Orange	2200 W Orangewood Ave.	Orange	CA	92868	CYBH		X												X
141	Clinical Evaluation and Guidance Unit (Orangewood Children and Family Center)	301 The City Drive South	Orange	CA	92868	CYBH		X	X											X
142	Continuing Care Placement Unit (CCPU)	800 N. Eckhoff	Orange	CA	92868	CYBH		X												
143	CYBH Crisis Assessment Team (CYBH CAT)	401 The City Drive South, Classroom 1	Orange	CA	92868	CYBH - Crisis		X												
144	Mental Health Association (MHA)- Project Together Mentor Program	822 Town & Country Rd.	Orange	CA	92868	CYBH		X	X	X	X	X	X							
145	On-site Engagement in Collaborative Courts - Mariposa Women and Family Center	812 Town & Country Rd.	Orange	CA	92868	NIT		X												
146	Community Counseling and Supportive Services	1040 W. Town and County Rd.	Orange	CA	92868	P&I		X	X		X				X					
147	Placentia Clinic	377 East Chapman Ave.	Placentia	CA	92870	CYBH		X	X	X	X									
148	CalWORKs SSA East Regional Office	1928 S. Grand Ave.	Santa Ana	CA	92705	AOABH - Outpatient														X
149	College Community Services, CalWORKs	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient		X	X											
150	Continuum of Care Permanent Supportive Housing	405 W. 5th St.	Santa Ana	CA	92701	AOABH -Crisis and Residential Services		X	X											
151	Crisis Stabilization Unit (CSU) formerly known as ETS	1030 W. Warner Ave.	Santa Ana	CA	92707	AOABH - Crisis		X	X	X	X	X								
152	Homeless Multi-Service Center-Mental Health Association	2416 South Main St.	Santa Ana	CA	92707	AOABH - Outpatient		X		X										
153	Lanternman Petris Short (LPS) Mental Health Unit	1300 S. Grand Ave.	Santa Ana	CA	92705	AOABH - Inpatient														X
154	Long Term Care - Royale Therapeutic Residential Center	1030 W. Warner Ave.	Santa Ana	CA	92707	AOABH - Inpatient		X	X	X										

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**													
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N K			
155	Pacific Asian Unit Program for Assertive Community Treatment (PAU PACT)	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient			X											
156	Program for Assertive Community Treatment (PACT) Central	1200 N. Main St.	Santa Ana	CA	92701	AOABH - Outpatient	X	X	X	X									X	
157	Short-Term Housing Services	405 W. 5th St.	Santa Ana	CA	92701	AOABH - Residential Services														X
158	Child Guidance Center, Inc.-Santa Ana	525 N. Cabrillo Park Dr.	Santa Ana	CA	92701	CYBH	X													
159	Pathways Community Services - East	1633 E. 4th St.	Santa Ana	CA	92701	CYBH	X													
160	Seneca Family of Agencies OC Outpatient	1801 Park Court Place, Bldg. H	Santa Ana	CA	92701	CYBH														X
161	Wayfinders (formerly CSP) -Youthful Offender Wraparound (YOW), Full Service Partnership (FSP)	1231 E. Dyer Rd.	Santa Ana	CA	92705	CYBH	X													
162	OC4Vets	1300 S. Grand Ave.	Santa Ana	CA	92705	NIT	X													X
163	Office of Consumer and Family Affairs	200 W. Santa Ana Blvd.	Santa Ana	CA	92701	NIT	X	X	X											X
164	Connect the Tots Program	1200 N. Main St.	Santa Ana	CA	92701	P&I	X	X		X										X
165	Early Intervention Services for Older Adults	1971 E. 4th St.	Santa Ana	CA	92705	P&I														X
166	Early Intervention Services for Older Adults	1505 E. 17th St., Suite 123	Santa Ana	CA	92705	P&I														X
167	Employment WORKS (North County) - Goodwill Industries of Orange County	2250 S. Yale St.	Santa Ana	CA	92704	P&I	X	X	X	X										
168	Family Support Services	2223 E. Wellington Ave.	Santa Ana	CA	92701	P&I														X
169	Family Support Services - NAMI	1810 E. 17th St.	Santa Ana	CA	92705	P&I														X
170	School Based Behavioral Health Interventions and Supports - Phoenix House	1207 E. Fruit St.	Santa Ana	CA	92701	P&I	X													
171	Survivor Support Services and Crisis Prevention Hotline	2000 E. 4th St., Suite 110	Santa Ana	CA	92705	P&I	X	X	X											X
172	Seneca/Kinship Center East	18302 Irvine Blvd.	Tustin	CA	92780	CYBH														X
173	College Community Services, CalWORKs	13950 Milton Ave.	Westminster	CA	92683	AOABH - Outpatient	X	X												
174	Long Term Care - Westminster Therapeutic Residential Center	206 Hospital Circle	Westminster	CA	92683	AOABH - Inpatient														X

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**										
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O T	U N
175	Program for Assertive Community Treatment (PACT) West	14140 Beach Blvd.	Westminster	CA	92683	AOABH - Outpatient		X	X								X
176	Recovery Center - Mental Health Association, Costa Mesa	3540 Howard Way, Suite 150	Costa Mesa	CA	92626	AOABH		X	X	X	X						X
177	Anaheim AOABHS Clinic (Access Point)	2035 E. Ball Rd.	Anaheim	CA	92806	AOABH		X	X	X	X						X
178	Program for Assertive Community Treatment (PACT) South, Costa Mesa	3115 Redhill Ave.	Costa Mesa	CA	92626	AOABH		X	X								X
179	Pathways Community Services - South	1503 South Coast Drive	Costa Mesa	CA	92626	CYBH		X		X							
180	Recovery Center - Mental Health Association, Garden Grove	12755 Brookhurst St	Garden Grove	CA	92840	AOABH		X	X	X	X						X
181	Recovery Center - Mental Health Association, Lake Forest	22471 Aspan St.	Lake Forest	CA	92630	AOABH		X	X	X	X						X
182	Outreach and Engagement Services - Western Youth Services	26137 La Paz Rd.	Mission Viejo	CA	92691	P&I											X
183	Peer Support and Wellness Center (Central) - College Community Services	401 S. Tustin St.	Orange	CA	92866	AOABH		X	X	X	X						
184	Peer Support and Wellness Center (South)- Mental Health Association	23072 Lake Center Drive	Lake Forest	CA	92630	AOABH		X	X	X	X						
185	CalWORKs SSA South Regional Office	23340 Moulton Pkwy	Laguna Hills	CA	92653	AOABH											X
186	St Joseph's Hospital	1100 West Stewart Drive	Orange	CA	92868	SAMHSA											X
187	Long Beach VAMC	12453 Lewis Street	Garden Grove	CA	92840	SAMHSA		X									
188	Chapman Global Medical Center	2601 East Chapman Avenue	Orange	CA	92869	SAMHSA		X	X	X	X	X	X	X			
189	College Hospital Cerritos	1488 East Lincoln Avenue	Anaheim	CA	92805	SAMHSA											X
190	Nsight Psychology and Addiction	4000 Birch Street	Newport Beach	CA	92660	SAMHSA		X									
191	Center for Adolescent	1210 North Jefferson Street	Anaheim	CA	92807	SAMHSA											X
192	West Anaheim Medical Center	3033 West Orange Avenue	Anaheim	CA	92804	SAMHSA		X	X		X	X					
193	Sandys Place	1509 Orange Avenue	Costa Mesa	CA	92627	SAMHSA											X
194	Straight Talk Counseling Clinic	5712 Camp Street	Cypress	CA	90630	SAMHSA		X		X			X	X			
195	Hoag Hospital Mental Health Center	307 Placentia Avenue	Newport Beach	CA	92663	SAMHSA		X		X							

#	Program Name	Address	City	State	Zip Code	BHS Division*	Languages Spoken**														
							E N	S P	V N	F A	K O	T G	C H	A R	K H	O H	U N				
196	La Palma Intercommunity Hospital	7901 Walker Street	La Palma	CA	90623	SAMHSA		X													
197	Los Alamitos Medical Center	3751 Katella Avenue	Los Alamitos	CA	90720	SAMHSA															X
198	Friends of Family Health Center	501 South Idaho Street	La Habra	CA	90631	SAMHSA		X													
199	Mission Hospital Laguna Beach	31872 Pacific Coast Highway	Laguna Beach	CA	92651	SAMHSA															X
200	Body Mind Spirit Intensive OP Prog	665 Camino De Los Mares	San Clemente	CA	92673	SAMHSA															X

Appendix 2C: References

1. OC Health Care Agency Behavioral Health Service Directory. May 2018. <https://cms.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=21580>. Accessed June 1, 2018.
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3. National Mental Health Services Survey. <https://www.samhsa.gov/data/data-we-collect/nmhss-national-mental-health-services-survey>. Accessed June 30, 2018.
4. U.S. Census. County Business Patterns. <https://www.census.gov/programs-surveys/cbp/data.html>. Accessed June 25, 2018.
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7. Kessler RC, Barker PR, Colpe LJ, et al. Screening for serious mental illness in the general population. *Archives of General Psychiatry* 2003; 60(2): 184-9.
8. Khajuria H, Bengeri S. Percentage of Adults Aged \geq 25 Years with Serious Psychological Distress, by Education Level and Sex - National Health Interview Survey, United States, 2010-2013. *Morbidity and Mortality Weekly Report* 2014; 63(40): 911.
9. Kessler RC, Green JG, Gruber MJ, et al. Screening for serious mental illness in the general population with the K6 screening scale: results from the WHO World Mental Health (WMH) survey initiative. *International Journal of Methods in Psychiatric Research* 2010; 19: 4-22.

Appendix Part 3

Appendix 3A: References

1. Miles MB, Huberman AM: *Qualitative Data Analysis: An Expanded Sourcebook*, 2nd ed. Thousand Oaks, CA, Sage, 1994

Appendix 3B: Methodology

Participants and Data Collection

Provider/Advocate Focus Group Organizations

Between January and October 2018, focus group interviews were conducted with 10 stakeholder organizations (i.e., mental health providers/advocates). Table H summarizes the participating stakeholder organizations and populations that they represented.

Appendix Table H. *Participating Provider/Advocate Stakeholder Organizations*

Organization	Population Represented
Orange County Mental Health Board	Persons with mental illness
National Alliance for Mental Illness (NAMI)	Persons with mental illness and families
Orange County Older Adults Mental Health Board	Older Adults
Orange County Children and Families	Children and Families
Dayle McIntosh Center	Persons with disabilities with or at risk for mental illness
The LGBT Center OC	Persons who are lesbian, gay, bisexual, or transgender (LGBT) with or at risk for mental illness
OC Women’s Health Project	Women who have experienced intimate partner violence
California Department of Corrections Day Reporting Center	Justice-involved adults
Orange County Re-entry Partnership & Phoenix House	Justice-involved adults
Child Guidance Center, Inc.	Children and youth with or at-risk for mental illness

Cultural/Linguistic Minority Focus Group Populations

Between September and November of 2018, nine focus group interviews were conducted with stakeholders representing six cultural/linguistic minority communities in Orange County. Table I summarizes the communities represented by each focus group and number of participants.

Appendix Table I. *Cultural/Linguistic Minority Focus Group Populations and Participants*

Population and Language Represented	Number of Participants
-------------------------------------	------------------------

Vietnamese	8
Spanish 1	10
Spanish 2	12
Spanish 3	7
Chinese	7
Korean 1	7
Korean 2	9
Khmer	9
Farsi	9
Total Groups = 9	Total Participants = 78

Interview Guides

Provider/Advocate Interview Guide

Evaluation project personnel scheduled the focus group sessions with leaders from each stakeholder organization. The organization leaders then recruited key-informants to participate in each group. Focus groups occurred on-site at stakeholders’ organization facilities in Orange County, and included mental health practitioners, advocates, family members, and administrative and support staff. Focus groups lasted approximately 60 minutes. The group interviews were audio-recorded and professionally transcribed verbatim. In total, 62 individuals were interviewed across ten focus groups. Participants shared diverse professional and personal experiences about the mental health and service needs of particularly vulnerable populations in Orange County, as well as Orange County’s service delivery strengths. Participants were asked the following questions during the focus groups (Table J):

Appendix Table J. Provider/Advocate Focus Group Interview Guide

- | | |
|----|----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | What has worked or is working to get hard to reach and vulnerable persons into mental health services in Orange County? |
| 2. | Are there particularly vulnerable or underserved groups that you think would benefit most from receiving emotional or mental health services in Orange County? |
| 3. | What types of mental health services are most needed in Orange County? |
| 4. | What are barriers to accessing mental health services in Orange County? |
| 5. | Are there any geographical areas of Orange County that have a scarcity of mental health services for the community that you represent? |
| 6. | What are some of the things that make an experience with a mental health provider a positive one? |

Cultural/Linguistic Minority Interview Guide:

The process of identifying focus group participants occurred in two stages. The first stage involved the identification of community-based organizations that would host the focus groups and recruit focus group participants. The study team utilized a snow-ball sampling approach to identify these organizations, whereby one community-based organization was identified who then provided the names of additional community-based organizations that serve cultural/linguistic groups and would likely be interested in hosting a focus group and recruiting

participants. Once an agency agreed to host a focus group, providers from that agency then recruited their current clients and staff members for participation by word-of-mouth. Individuals who were 18 years and older and either a client or a staff member of the participating organization were eligible to participate. Following each focus group, study participants were offered a \$35 gift card. In total, this report includes data from 9 focus groups that occurred with 78 participants. During focus groups, participants were asked the following questions (Table K):

Appendix Table K: Cultural/Linguistic Minority Community Member Focus Group Guide

1. How is mental health talked about in your community?
2. Can you describe some instances in which you think it would be a good idea for members of your community to get emotional or mental health support?
3. Who or what kinds of resources do people turn to when support is needed for mental health?
4. What are some of the challenges that people in your community face in finding and using the services they need?
5. What are some of the things you think would make an experience with a mental health provider a positive one?

The exact method of facilitation and English translation varied by service population. The Korean, Farsi, and Vietnamese focus groups, and one Spanish focus group were facilitated by individuals working at the community organizations where the focus groups occurred. These focus groups were conducted in their respective languages, professionally translated into English during transcription, and then analyzed in English. The Cambodian Interview was also conducted in the Khmer language. However, rather than translating the entire focus group during the transcription process, each participant response was instead translated into English by an interpreter at the time of the focus group. In the Khmer language focus group, only the English translations was transcribed and analyzed.

The Chinese focus group was also facilitated by an individual employed at the community based organization but was in English at the request of the study participants. Focus group facilitators held such professional titles as Director of Programs, Program trainer, President/CEO, Care Coordinator. Each facilitator participated in a brief training conducted by Harder +Company Community Research to describe the project and to otherwise prepare them to facilitate the focus group. The remaining two Spanish language focus groups were facilitated in Spanish by Spanish-speaking members of the evaluation team. These interviews were professionally transcribed and then analyzed in Spanish by a Spanish-speaking member of the study team.

Data Analysis

Provider/Advocate Groups

To facilitate comparisons within and between each focus group, two coders reviewed each transcript. A case summary matrix¹ was developed, which enabled review of points of convergence or divergence regarding the service strengths, unmet needs, and barriers to

accessing mental health services in Orange County. Three themes and several sub-themes emerged from the ten provider and community advocate focus groups.

1. *Orange County needs expansion of successful service delivery strategies.*
2. *Barriers to accessing and using mental health care exist at multiple levels of the service delivery system*
3. *Successful engagement and retention of vulnerable populations rely on genuine and trusting relationships with clinical settings.*

These themes and sub-themes will be described and supported with quotes from focus group participants in the results section.

Cultural/Linguistic Minority Groups

To facilitate comparisons within and between each focus group, a case summary matrix (1) was developed. This method of data analysis enabled the evaluation team to review of points of convergence or divergence regarding beliefs about community mental health needs, barriers to accessing mental health care, and positive experiences in accessing mental health care in the community. Four themes and several sub-themes emerged from the nine community member focus groups.

1. *Community members want mental health information, but stigma can undermine dialogue about mental health*
2. *Early intervention is essential but can be challenging*
3. *Barriers to accessing mental health care exist at the individual/family, community, and service delivery levels of care*
4. *Successful engagement hinges on genuine understanding of a community's cultural context*