LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS - CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – CY 2019

Criteria 1-8

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
OFFICE OF ADMINISTRATIVE OPERATIONS - CULTURAL COMPETENCY UNIT

2019 CULTURAL COMPETENCE PLAN UPDATE

EXECUTIVE SUMMARY

The Los Angeles County Department of Mental Health (LACDMH) updates its Cultural Competence Plan annually per the California Department of Health Care Services' (DHCS) Cultural Competence Plan Requirements, Title IX – Section 1810.410 statutes, and the National Standards for Culturally and Linguistically Appropriate Services and Healthcare (CLAS) provisions.

The Department utilizes the Cultural Competence Plan as a tool to promote and evaluate system progress in terms of service planning, integration, and delivery toward the reduction of mental health disparities and the enactment of equitable, culturally inclusive, and linguistically appropriate services.

The Cultural Competency Unit annually updates the Cultural Competence Plan and makes it available to the LACDMH Executive Management, Directly Operated and Contracted/Legal Entity Providers, and departmental Stakeholder groups such as the Service Area-based Quality Improvement Committees and Cultural Competency Committee. It is also included in various activities of the Ethnic Services Manager and the Cultural Competency Unit such as trainings for new employees and technical assistance to LACDMH programs. Additionally, the Cultural Competence Plan updates are posted on the departmental Cultural Competency webpage.

LACDMH endorses the eight criteria listed below as vital elements to advance service quality standards for the cultural and linguistically diverse communities of Los Angeles County

- Criterion I: Commitment to Cultural Competence
- Criterion II: Updated Assessment of Service Needs
- Criterion III: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- Criterion IV: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
- Criterion V: Culturally Competent Training Activities
- Criterion VI: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- Criterion VII: Language Capacity
- Criterion VIII: Adaptation of Services

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OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 1

Commitment to Cultural Competence

August 2019

Criterion 1: Commitment to Cultural Competence

The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States. LACDMH's provider network is composed of Directly Operated and Contracted programs that serve Los Angeles residents in more than 85 cities and approximately 300 co-located sites. More than 250,000 residents of all ages are served every year. LACDMH believes that wellbeing is possible for all persons and that interventions need to include assisting constituents achieve personal recovery goals, find a safe place to live, use time meaningfully, thrive in healthy relationships, access public assistance, overcome crises successfully and attain optional health. LACDMH strives to reduce the negative impacts of untreated mental illness by providing services based on whole person care, cultural and linguistic responsiveness, equity for all cultural groups, partnerships with communities, integration with social service providers, and openness to sustained learning and improvement.

I. County Mental Health System Commitment to Cultural Competence Policy and Procedures

LACDMH continues implementing Policies and Procedures (P&Ps) to ensure effective, equitable and responsive services for constituents, while providing a solid and supportive infrastructure for its workforce. The following chart provides a snap shot of the P&Ps currently in place that are related to cultural competence:

Policies and Procedures and Other Documents	
Overarching Policies and Practice Parameters	• Policy No. 1100.01 – Quality Improvement Program • Parameters for Clinical Assessment ○ 2.2 Initial Psychiatric Assessment of Older Adults ○ 2.6 Discharge Planning for Older Adults ○ 2.7 Co-Occurring Cognitive Impairment Assessment Parameters ○ 2.8 Co-Occurring Cognitive Impairment Treatment • Parameters for Clinical Programs ○ 4.5 Parameters for Treatment of Co-Occurring Substance Abuse ○ 4.8 Delivery of Culturally Competent Clinical Services ○ 4.13 Parameters for Peer Advocates ○ 4.15 Parameters for Spiritual Support ○ 4.16 Parameters for Family Inclusion ○ 4.18 Parameters for Assessment and Treatment of Individuals with Co-Occurring Intellectual Disabilities
Policies and Procedures Related to Cultural Competence	• Policy No. 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community • Policy No. 200.03 – Language Translation and Interpretation Services

Policies and Procedures and Other Documents	
	• Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Procedures for Screening, Treating, and Preferring Veterans to Ensure Appropriate Services • Policy No. 200.09 – Culturally and Linguistically Inclusive Services (Draft) • Policy No. 201.02 – Nondiscrimination of Beneficiaries • Policy No. 201.03 – Limiting Access to DMH Sensitive Locations by Law Enforcement Officers Engaged in Immigration Enforcement/Investigative Activities • Policy No. 305.01 – Assessment and Treatment of Co-Occurring Substance Abuse • Policy No. 310.01 – HIV and AIDS Clinical Documentation and Confidentiality • Policy No. 311.01 – Integration of Spiritual Interests of Clients in the Provision of Mental Health Services and Support • Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services
Human Resource Training and Recruitment Policies	• Code of Organizational Conduct, Ethics, and Compliance • Los Angeles County Policy of Equity (CPOE) • Just Culture • Implicit Bias and Cultural Competence

Key to the provision of culturally and linguistically responsive services is the aim to continuously assess the quality and effectiveness of departmental operations. LACDMH has a well-established Quality Improvement Program within the Office of Administrative Operations (OAO), previously known as Program Support Bureau, which develops goals and monitors plans in the following six domains:

- Service delivery capacity and organization
- Service accessibility
- Beneficiary satisfaction
- Service delivery system and meaningful clinical issues affecting beneficiaries
- Coordination and continuity of care with other human service agencies
- Beneficiaries grievances and appeals

The OAO-QID shares the responsibility to maintain and improve a service delivery infrastructure characterized by continuous quality improvement; progressive cultural and

linguistic competence; elimination of mental health disparities; and integration of mental health services with approaches that foster recovery, wellbeing, as well as consumer and family member involvement. The OAO-QID includes the Cultural Competency Unit (CCU) and the Underserved Cultural Communities (UsCC) Unit. The CCU provides training and technical assistance necessary to integrate cultural competency and implement the Cultural Competence Plan Requirements in all departmental operations. The UsCC Unit implements one-time projects to build the capacity of the system and increase service accessibility for underserved populations.

Additionally, the OAO-QID has administrative responsibility over the departmental Quality Improvement Council (QIC) monthly meetings, which are attended by representatives from the eight (8) Service Area-based Quality Improvement Committees (SA QICs); Office of the Medical Director; Cultural Competency Unit; Patients' Rights Office; Compliance, Privacy and Audit Services Bureau; Office of Consumer and Family Affairs; Consumer and Family representatives; and other programs required for clinical quality improvement discussions. The Departmental QIC guides, supports, and responds to concerns raised by the service providers, and implements performance improvement projects that impact the LACDMH system of care.

II. County Recognition Value and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within the System

LACDMH recognizes and values the racial, ethnic, cultural and linguistic diversity of its communities. The vision of the Department is to "build a Los Angeles County unified by shared intention and cross-sector collaboration that helps those suffering from serious mental illness heal, grow and flourish by providing easy access to the right services and the right opportunities at the right time in the right place from the right people." The LACDMH mission is to "optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery but also connectedness and community reintegration." LACDMH's vision and mission drive the Strategic Plan, which contains four goals that specifically delineate our commitment to advancements in cultural competence, reducing disparities and partnering with communities. These strategic goals include:

Goal I: Enhance the quality and capacity, within available resources, of mental health services and supports in partnership with consumers, family members, and communities to achieve hope, wellbeing, recovery and resiliency.

- Strategy 1: Develop a system that provides a balanced and transformed continuum of services to as many clients throughout the County as resources will allow
- Strategy 2: Provide integrated mental health, physical health and substance use services in order to improve the quality of services and wellbeing of mental health clients
- Strategy 3: Support clients in establishing their own recovery goals that direct the process of mental health service delivery

- Strategy 4: Ensure that families are accepted as an important component of the recovery process and provide them with the support to achieve that potential

Goal II: Eliminate disparities in mental health services, especially those due to race, ethnicity and culture.

- Strategy 1: Develop mental health early intervention programs that are accessible to underserved populations
- Strategy 2: Partner with underserved communities to implement mental health services in ways that reduce barriers to access and overcome impediments to mental health status based upon race, culture, religion, language, age, disability, socioeconomics, and sexual orientation
- Strategy 3: Develop outreach and education programs that reduce stigma, promote tolerance, compassion and lower the incidence or severity of mental illness

Goal III: Enhance the community's social and emotional wellbeing through collaborative partnerships.

- Strategy 1: Create partnerships that advance an effective model of integration of mental health, physical health, and substance use services to achieve parity in the context of health care reform
- Strategy 2: Create, support, and enhance partnerships with community-based organizations in natural settings such as park and recreational facilities to support the social and emotional wellbeing of communities
- Strategy 3: Increase collaboration among child-serving entities, parents, families, and communities to address the mental health needs of children and youth, including those involved in the child welfare systems
- Strategy 4: Further strengthen the partnerships among mental health, the courts, probation, juvenile justice and law enforcement to respond to community mental health needs
- Strategy 5: Support and enhance efforts to provide services in partnership with educational institutions from pre-school through higher education
- Strategy 6: Develop partnerships with faith-based organizations to enhance opportunities for clients to utilize their spiritual choices in support of their recovery goals

Goal IV: Create and enhance a culturally diverse, consumer and family driven, mental health workforce capable of meeting the needs of our diverse communities.

- Strategy 1: Train mental health staff in evidence-based, promising, emerging and community-defined mental health practices
- Strategy 2: Recruit, train, hire and support mental health clients and family members at all levels of the mental health workforce
- Strategy 3: Create and provide a safe and nurturing work environment for all employees that supports and embodies consumer-centered, family-focused,

community-based, culturally and linguistically competent mental health services
- Strategy 4: Identify and support best practices for recruitment and retention of diverse and well-qualified individuals to the mental health workforce

LACDMH Reorganization Efforts

In early 2017, LACDMH initiated a process of internal reorganization focusing primarily on restructuring upper management. The previous organizational structure was implemented around clinical services geared toward specific age groups (Children, Transition Age Youth, Adults, and Older Adults). This structure no longer exists as it was deemed to sustain significant fragmentation, especially in the Department's outpatient services. The new executive management reorganization strategies include:

- *Implementation of the LACDMH Office of the Discipline Chiefs:* Five Discipline Chiefs were hired during CY 2018 representing Psychiatry, Psychology, Social Services, Nursing and Peer services. The Discipline Chiefs are the highest-level subject matter experts for their respective disciplines. They are responsible for leading departmental efforts to develop the staffing, programs, and policies
- *Consolidation of Clinical Operations:* LACDMH clinical operations have been consolidated under a Chief Deputy Director of Clinical Operations. All clinical services have been reorganized into divisions focused on the primary clinical functions of the Department, namely: prevention services; outreach, engagement and triage services (including access and linkage services); outpatient services; intensive care services; and public guardian services. These new divisions are more clearly aligned with traditional mental health levels of care and will allow for a more efficient standardization and provision of quality services
- *Centralization of Administrative Operations:* LACDMH administrative operations have been reorganized under a Chief Deputy Director to support the significant expansion of clinical services with standardized and efficient processes related to contract monitoring, risk management, facilities development, and budgetary allocations
- *Establishment of the LACDMH Strategic Planning and Communications Operations:* The office of strategic communications is under the leadership of a specialized Deputy Director who is responsible for leading departmental efforts related to strategic planning, departmental advocacy services, stakeholder engagement processes, and public relations

Stakeholder Engagement

During FY 17-18, LACDMH initiated a process of revamping its former System Leadership Team (SLT) structure and activities to function as an advisory "community-driven process that engages the cultural and linguistic diversity of Los Angeles County toward a shared goal of hope, recovery, and wellbeing." Efforts focus on establishing active partnerships with stakeholder groups, consumers, families, and community members to impact mental health policy; budget allocations; program planning monitoring and evaluation; and quality improvement.

After extensive consultation with stakeholders, LACDMH decentralized its original stakeholder system and started to implement the new proposed stakeholder engagement process named “YourDMH”. The process of restructuring the SLT under a new identity and purpose will continue into FY 18-19, LACDMH has broadened its external stakeholder engagement by hosting multiple community-based events, reinvigorating existing stakeholder groups, and disseminating more than 250 grants throughout the county to support the engaged of community agencies.

During FY 17-18, LACDMH sponsored a considerable number of community engagement events including conferences, local health fairs, policy forums and special events highlighting cultural diversity of Native Americans, Latinos, veterans, the faith-based communities, and law enforcement teams. The Department also sponsored an award ceremony for students who created one-minute films about mental health. “May is Mental Health month” culminated in a three-week event attended by over 30,000 students, consumers, advocates, influencers and leaders engaged in a multitude of activities related to mental health: *WERISE*.

WERISE

The Department launched a youth-targeted social media campaign, “We Rise/Why We Rise,” with an emphasis on empowering youth and increasing awareness of mental health. Targeted to reach youth ages 14-24, the social marketing campaign commenced midway through Mental Health Month, from May 19, 2018 to June 10, 2018. The WERISE event was held in Los Angeles Downtown Arts District and offered an immersive cultural experience with performances, interactions, and a world-class art exhibition. The event was curated to provoke new conversations and support the empowerment of young people regarding their own mental health and current issues that may impact it. The campaign’s message was conveyed by various methods including visual art and spoken word poetry. The campaign was also promoted through social media including Facebook, Instagram, and Twitter.

LACDMH in partnership with the California Mental Health Services Authority, commissioned the RAND Corporation to evaluate the campaign outcomes. The RAND team surveyed WERISE attendees in person, analyzed Twitter conversations related to mental health, mental illness and wellbeing, and conducted a web-based survey of a broader population of L.A. County youth ages 14-24 targeted by the campaign. Findings include:

- More than 1,000 L.A. County youth found that as many as one in five (22%) young people in the 14-24 age group were aware of WERISE campaign
- The campaign attendees had positive perceptions of the event: 91 percent of teens and 95 percent of adults said they would recommend the event to a friend
- At the event, 90 percent or more of teens and adults said it made them want to be more supportive of persons experiencing mental illness and that they felt more empowered to take care of their own mental wellbeing
- Attendees reported an increased awareness of the challenges persons with mental illness face, from stigma to treatment access. In addition, the social

media campaign was associated with increased discussion of mental health among Twitter users in L.A. County.
- The RAND team concluded that, overall, L.A. County's mental health community engagement campaign had impressive outcomes.
- WERISE campaign will be an ongoing project

Additionally, a new LACDMH Intranet was launched for internal stakeholders to access training opportunities, job postings, and other tools. The LACDMH external website was also rebuilt and launched with a streamlined content and new features, focusing on stakeholder engagement.

The SLT revamping, creation of "YourDMH", and community engagement endeavors demonstrate the implementation of CLAS standards Nos. 2, 10, and 13.

Examples of Initiatives and Programs Focused on Cultural Competence

LACDMH's commitment to advance cultural and linguistic inclusion and responsiveness is infused in a plethora of programs and activities that advance cultural competence and equity in its system of care. The summary below briefly introduces these efforts:

Health Agency Strategic Priorities

The Health Agency became effective on August 11, 2016. The primary goal of the Health Agency is to improve the health and wellbeing of the Los Angeles County residents through the provision of integrated, comprehensive, culturally appropriate services, programs, and policies that promote healthy living and healthy communities. The Health Agency accomplishes its mission by coordinating the efforts of the Departments of Health Services (DHS), Mental Health (DMH), and Public Health (DPH) in partnership with various stakeholders such as: consumers, family members, local communities, organized labor, faith-based organizations, community providers and agencies, health plans, and academia, among others. The Health Agency has established priorities relevant to health and wellbeing of L.A. County residents while allowing the three Departments to maintain their individual missions and activities.

The eight original Health Agency priorities included:

- Consumer Access and Experience
- Housing and Supportive Services for Homeless Consumers
- Overcrowding of Emergency Departments by Individuals in Psychiatric Crisis
- Access to Culturally and Linguistically Competent Programs and Services
- Diversion of Corrections Involved Individuals to Community-Based Programs and Services
- Implementation of Expanded Substance Use Disorder Benefit
- Vulnerable Children and Transition Age Youth
- Chronic Disease and Injury Prevention

The Health Agency Model based on the priorities identified above was evaluated by the Chief Executive Office's (CEO) temporary Integration Advisory Board (IAB) via semi-annual reports. The IAB provided its last report on November 15, 2017. The evaluation outcomes indicated achievements and advantages of the Health Agency Model, namely improved and increased collaboration, communication, integration of information technology, collective crisis response and a move toward integrated services with new program development. During CY 2018, the Board proposed the revision of Health Agency's priorities with the goal of improving consumer outcomes through the integration of services and operations. The revised priorities reflect the Health Agency's focus on the benefits of health care integration and continued collaboration.

The revised strategic priorities are listed below:

- Ensure Access to Integrated Health Services
- Maximize Clinical Resources
- Enhance Health Equity and Reduce Health Disparities among Vulnerable Populations
- Implement Just Culture
- Improve Administrative and Operational Effectiveness and Efficiencies
- Respond to Emerging Threats
- Engage and Pursue Business Partnerships with Bioscience Community

Cultural competence efforts are concentrated under the "Ensure Access to Integrated Health Services" strategic priority. During CY 2018, the former "Access to Culturally Competent and Linguistically Appropriate Programs and Services" workgroup reorganized with former and new members to implement the Cultural and Linguistic Competency initiative under the Health Agency's Center for Health Equity. Conferred with this new identity and led by the LACDMH Ethnic Services Manager (ESM), the group met for the first time on April 4, 2018 to determine the name for the Institute, conceptualize its mission statement, and provide feedback on the framework model proposed by the ESM.

Named "Institute for Cultural and Linguistic Inclusion and Responsiveness" (ICLIR), this collaboration will create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the Health Agency's ability to meet the needs of Los Angeles County communities.
See additional information regarding ICLIR on pp. 32-33.

The Recovery, Resilience, and Reintegration – Community-Designed Integrated Services Management Model (RRR-ISM)

This program promotes collaboration and community-based partnerships to integrate health, mental health, and substance use services with needed non-traditional care to support recovery. Starting July 1, 2017, the formerly known Integrated Care Program/Community-Designed Integrated Services Management Model became the RRR-ISM following the consolidation of the 24 original work plans of the original CSS Plan into six. The RRR-ISM is now organizationally placed under the Recovery, Resilience and Reintegration Work Plan.

The RRR-ISM is designed to increase the quality of services, specifically for underserved ethnic communities by building on the strengths of a particular UsCC. The RRR-ISM envisions models of care that are defined by and grounded in the UsCC communities. The RRR-ISM requires collaboration and partnerships between formal and non-traditional service providers, and community-based organizations (e.g. faith-based organizations, voluntary associations, grassroots organizations, etc.) and places a strong emphasis on non-traditional services and training peers to perform the outreach and engagement, education, linkage, and advocacy services to the stated UsCC communities. "Formal" providers (i.e., mental health, substance use, physical health, child welfare, and other formal service providers) are traditionally recognized and funded through public and private insurance. "Non-traditional" providers are those that offer community-defined services but may not have credentials that permit reimbursement from public or private insurance.

This model was implemented for five (5) ethnic groups: AAA, AI/AN, API, EE/ME, and Latino. The RRR-ISM providers include: University Muslim Medical Association Community Clinic, United American Indian Involvement, Asian Pacific Healthcare Venture, Pacific Clinics, Barbour & Floyd, Pacific Asian Counseling Services, Korean American Family Service Center, Koreatown Youth and Community Center, Special Services for Groups (with three providers specializing services for the AAA and Korean communities), Didi Hirsch Psychiatric Services, Alma Family Services, the Los Angeles Child Guidance Clinic, St. Joseph Center, and Tarzana Treatment Center. The practice of collaborating and taking into account the expertise of community-based providers demonstrates the implementation of CLAS standard Nos. 1, 9 and 13.

1) Values and Principles of the RRR-ISM service delivery
   The RRR-ISM providers shall adhere to the following values and principles:
   - Services are designed to assist individuals achieve their wellbeing and recovery/resiliency goals
   - Services are voluntary and focus on helping individuals integrate into the community
   - Services are provided in an individual's preferred language and in a culturally congruent manner
   - Services support doing whatever it takes to improve mental and physical health and decrease substance use/abuse by including, but not limited to, non-traditional services and culturally and linguistically appropriate outreach and engagement
   - Programs will be voluntary and provide consumer-centered services that are driven by a consumer's own goals and interests
   - Programs will work within and actively strengthen the natural support systems of specific UsCC communities, so that these supports can be part of a consumer's recovery process

- Programs will encourage consumers and their family members, parents, and caregivers to inform service providers on what is helpful and needed to assist him/her toward recovery
- Programs will advocate for a consumer's needs and for changes in the system of care that will better support the integration of services and improved outcomes for the consumer
- Programs will provide mental health, substance use and physical health promotion, and awareness through culturally competent outreach, education, and engagement strategies

2) RRR-ISM Culturally and Linguistically Appropriate Services
The RRR-ISM required that Prime Contractor and Partnering Contractor(s) and Subcontractor(s) ensure that all mental health, physical health, substance use, and non-traditional services are fully integrated and culturally and linguistically appropriate. Culturally and linguistically appropriate services are respectful of and responsive to the consumers' cultural and linguistic needs based on their cultural identity. Cultural identity may involve ethnicity, race, language, age, country of origin, level of acculturation, gender, socioeconomic class, disabilities, religious/spiritual beliefs, and/or sexual orientation. Culturally competent services require the importance of the consumers' cultures, an assessment of cross-cultural relations, vigilance of the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs and incorporating into all levels of service provision. Prime Contractor, Partnering Contractor(s) and Subcontractor are expected to ensure that all staff has the ability to provide culturally and linguistically appropriate services.

3) Target population
LACDMH has identified specific UsCC communities, based on existing penetration and enrollment rates, that will be targeted by the RRR-ISM providers and include the following: AAA, AI/AN, API, EE/ME, and Latino. The integrated services provided (mental health, substance use, physical health and non-traditional services) must be culturally competent and tailored to meet the service needs of one targeted UsCC community. As well, staff must be trained to be linguistically and culturally competent in working with the targeted UsCC community.

Based on existing penetration and enrollment rates, LACDMH has determined the following target enrollment numbers per FY for each specific UsCC community: AAA - 116 consumers; AI/AN - 88 consumers; API - 54 consumers; EE/ME - 60 consumers; Latino - 92 consumers. The target number is the minimum number of consumers to be served. Prime and Partnering Contractor(s) may serve more consumers and must maximize their budget in order to meet the demand for services within each UsCC community. While each RRR-ISM targets a specific UsCC community, service cannot be denied based on race/ethnicity.

These populations include:

- Individuals/Families who have a history of dropping out of mental health, substance use and physical health services
- Linguistically-isolated individuals/families
- Individuals/Families that have not accessed mental health, substance use and physical health services due to stigma
- Individuals/Families that have not benefitted from mental health, substance use and physical health services or have received inappropriate services
- Individuals/Families who are indigent/uninsured RRR-ISM programs will serve all age groups. It is recommended that 25-50% of the consumers enrolled are indigent/uninsured

Capacity-Building Projects by the Underserved Cultural Communities (UsCC)

The Department established an internal unit to empower Under Represented Ethnic Populations (UREP) in June 2007. As of January 2016, the UREP Unit was renamed as Underserved Cultural Communities Unit (UsCC) to be inclusive of all cultural communities beyond those based on race and ethnicity. The UsCC Unit has established subcommittees dedicated to working with the various underrepresented ethnic and cultural populations in order to address their service accessibility needs.

The subcommittees include: African/African American (AAA); American Indian/ Alaska Native (AI/AN); Asian Pacific Islander (API); Deaf, Hard of Hearing, Blind, and Disabilities; Eastern European/Middle Eastern (EE/ME); Latino; and Lesbian/ Gay/Bisexual/Transgender/Questioning/Intersex/Two-Spirit (LGBTQI2-S). Each UsCC subcommittee is allotted $100,000 per Fiscal Year (FY) to focus on Community Services and Supports (CSS) based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach. The following are projects implemented during FY 17-18:

AAA

1) <u>African American Mental Health Radio Campaign</u>
   African American Mental Health Radio Campaign was launched on October 16, 2017 and was completed on January 7, 2018. A local radio station was contracted to produce and broadcast five (5) 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community. The PSAs successfully helped to reduce stigma, increase mental health awareness and access among African American community members. In total, 124 PSAs were aired and a total of 342,000 radio impressions were delivered. The digital display banners on the radio station's website delivered approximately 332,934 impressions. A total of 883,000 impressions and audio streaming were delivered under contract.

Additional impressions were delivered as bonuses, with a grand 2,650,800 impressions. The e-blast total was 116,121 impressions.

2) Life Links: Resource Mapping Project
This project has been implemented for five consecutive years. Funds were allocated to develop a community resource directory called "Life Links." Community resources, service providers, and agencies were identified in South L.A. County, where there is a large AAA population. This directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers.

AI/AN

1) AI/AN Bus Advertising Campaign
The bus advertising campaign took place in SA 1 for 12 weeks from January to April, 2018. It included the following: 15 taillight bus displays, 12 king-size bus posters, 5 queen-size bus poster, and 80 interior bus cards. It also included an additional 80 interior bus cards for 12 weeks from April to June 2018 at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in L.A. County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members. 12,346,100 impressions were delivered.

2) AI/AN Mental Health Conference
One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2017 American Indian / Alaska Native Mental Health Conference: "Bridging the Gaps – Systems, Cultures, and Generations." The conference took place on November 14, 2017. The purpose of the conference included to inform participants of mental health issues unique to the AI/AN community; to improve participants' ability to recognize when to refer an AI/AN community member for mental health services; to provide participants with useful information on available mental health resources for AI/AN community members; and to improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. The voluntary and anonymous survey was handed out to all participants at the start of the conference. In total, 119 out of 265 individuals attended the conference-completed surveys.
   - 95% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community
   - 88% agreed or strongly agreed the conference improved their ability to recognize when to refer an AI/AN community member for mental health services
   - 95% agreed or strongly agreed they received useful information on mental health resources for AI/AN community members

- 97% agreed or strongly agreed, as a result of the conference, they had a better understanding of where to refer AI/AN community members for mental health services
- 95% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to AI/AN consumers

API

1) API Youth Video Contest: "Go Beyond Stigma!"
This project was implemented on January 1, 2018 and is scheduled to be completed on March 30, 2019. The API Youth Video Contest project included the recruitment and training of API Youth on mental health issues and resources as well as technical assistance to support the development of video (maximum of 3 minutes) on how mental health issues impact his/her life. The videos were submitted as part of a Video Contest and were showcased at an Awards Ceremony, which was part of a community event. The purpose of this project is to provide API youth (ages 16-25) an opportunity to share how mental health issues influence their life, family, and community, in order to increase awareness and knowledge of signs and symptoms of mental illness and improve access to mental health services for API Youth in L.A. County.

2) Samoan Outreach and Engagement Program
LACDMH utilized MHSA – Community Services and Support CSS funds to continue the Samoan Outreach and Engagement Program in order to improve awareness, of mental health issues, knowledge of resources, and increase referrals and enrollment into mental health services by the Samoan community. LACDMH contracted with Special Services for Groups (SSG) who partners with two (2) Samoan community-based agencies to conduct individual and group outreach, engagement, and referral activities with the Samoan community in SA 8, which has the largest concentration of Samoans within the County of Los Angeles. This program completed its third year of implementation on June 30, 2018 during which community outreach was conducted at some colleges, churches, IMDs, hospitals, jail and other community gathering sites. Starting July 1, 2017, the program started focusing more on referrals and enrollments.

3) API Mental Health Awareness Media Campaigns
This project includes seven (7) separate campaigns that were implemented in May 2018 and are scheduled to be completed in April 2019. The goals of this project were to target various API communities in L.A. County and educate them about signs and symptoms of mental illness, mental health resources, reduce mental illness related stigma, and reduce gaps in mental health service delivery in the various API communities by using media to help link them to the public mental health system. LACDMH targeted the following API communities: Cambodian (Khmer), Chinese (Mandarin and Cantonese), Indian (Hindi and English), Filipino (Tagalog and English), Japanese, and Korean. Each Media Company developed and aired at least one (1) PSA for the

respective target community. LACDMH banners were developed and posted in their station website, with a link to the LACDMH website. Some media companies also provided interview segments, outreach events, and community mental health surveys. Social media was utilized where possible. All PSAs, segments, etc. were posted onto the LACDMH website and used for future outreach purposes.

The Deaf, Hard of Hearing, Blind, and Physical Disabilities

1) The Deaf, Hard of Hearing, Blind, and Physical Disabilities UsCC subcommittee was established on January 1, 2018 and held its first meeting on January 30, 2018. The goals of this subcommittee are to reduce disparities and increase mental health access for the deaf, hard of hearing, blind, and physically disabled community. This group works closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery oriented services specific to the targeted communities, and to develop capacity-building projects. As of June 30, 2018, this subcommittee has identified four (4) capacity-building projects for the next Fiscal Year, has a membership roster of over 50 individuals, and is actively recruiting new members.

EE/ME

1) Armenian Talk Show Project Part II
   The Armenian Talk Show Project Part II was aired to inform the Armenian community about common mental health issues and how to access services in Los Angeles County. The show included mental health topics such as eating disorders, terminal illness and mental health, intergenerational conflict, mental illness and family support and caregiver stress. The most popular 44 episodes of the Armenian Mental Health Show from two seasons were re-aired from April 15, 2017 to September 9, 2017.

2) Mental Health Farsi Language Radio Media Campaign
   This project consisted of producing and airing three (3) different PSAs in the Farsi language. The PSAs aired on a Farsi radio station 5-8 times daily, from May 4, 2017 to July 30, 2017. The PSAs targeted Iranian/Persian communities of Los Angeles County. Each PSA provided culturally sensitive information, education, and resources about a specific mental health topic. The topics included mental health awareness and domestic violence.

3) Mental Health Russian Language Television Media Campaign
   This project consisted of four (4) different PSAs in the Russian language. The PSAs helped educate the Russian community and increase awareness of the signs and symptoms of mental illness, as well as reduce the stigma associated with mental health conditions with this underserved subgroup. The PSAs aired in a rotation and one (1) PSA aired at least six (6) times a day for three (3) months, from April 25, 2017 to July 29, 2017. The PSAs included mental health education and information on topics such as general mental health information,

depression, and anxiety. The PSAs informed consumers of existent mental health issues in the Russian community and resources available within LACDMH.

Latino

1) Latino Media Campaign

The Latino media campaign was launched on May 1, 2017 and was completed on July 16, 2017. The PSAs were aired on KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran 138 television PSAs, a 2-day Homepage takeovers and Univision.com geo-LA/Local Los Angeles Rotation – in banner, video, and Social Media. KLVE, KRCD, and KTNQ radio stations ran 501 PSAs, and a 2-day Homepage takeovers and social media. In addition, 3-minute interviews on different mental health topics with the LACDMH Ethnic Services Manager (ESM) were aired weekly on Dr. Eduardo Lopez Navarro's program at KTNQ – 1020 am Radio Station for nine (9) weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview for PSA was aired on four (4) radio stations on June 12, 2017 and June 25, 2017. The KMEX report shows that the television campaign delivered 14,501,956 impressions (the total number of times households were exposed to the PSAs). The KLVE, KRCD, and KTNQ reports show that the radio campaign delivered 12,200 impressions. Digital campaign delivered 1,106,234 impressions. A gross 15,620,390 impressions were delivered.

2) Latino Bus Advertising Campaign

A Bus Advertising Campaign was implemented to promote mental health services, increase the capacity of the public mental health system, and reduce mental health stigma within the Latino community. The campaign began on February 27, 2017 and ended on October 8, 2017. It included the following: 172 taillight bus displays, 56 king-size bus posters, and 4,000 interior bus cards for a total of 32 weeks (that includes an additional 2,000 interior bus cards for 12 weeks at no additional cost). The campaign delivered 21,919,004 impressions.

LGBTQI2-S

1) LGBTQI Iranian Outreach and Engagement Project

The objective of the LGBTQI Iranian Outreach and Engagement Project was to engage, empower, enlist, and enlighten the LGBTQI and non-LGBTQI Iranian community, as well as to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. This would enable the underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services. The project involved two phases: Phase 1 included eight (8) health and wellness workshops, which provided outreach to Iranian LGBTQI community members and their families, as well as Iranian Student Clubs at local high schools and colleges; and Phase 2 included a media campaign targeting Iranian LGBTQI and non-LGBTQI community

members through local Iranian talk shows, magazines, newspapers, and radio programs.

- A total of 244 individuals attended the health and wellness workshops and 213 attendees completed the pre/post tests. The results of the pre/post tests showed a significant shift in participants' beliefs and knowledge about LGBTQ issues.
- Six (6) magazine articles were published in local Iranian magazines. One article was featured on the cover of Tehran Magazine and it was the first time an article related to the LGBTQ community was on the cover of a mainstream Iranian magazine.
- A total of three (3) PSAs were recorded and aired 200 times on local Iranian radio station, KIRN 670am, between February 19, 2018 and September 6, 2018. In addition to the airing of the PSAs, KIRN 670am also broadcast 26, 23-minute radio programs every Sunday from February 25, 2018 through September 2, 2018. The radio programs featured over 18 Iranian LGBTQ allies, activists, and celebrities.

2) <u>LGBTQI2-S Mental Health Conference</u>

One of the recommendations of the LGBTQI2-S UsCC subcommittee was to plan and coordinate the 2018 LGBTQI2-S Mental Health Conference, "Unraveling the Rainbow–Embracing Our Diversity." The conference took place on June 6, 2018. The purpose of the conference included the following: to inform participants of mental health issues unique to the LGBTQI2-S community; to improve participants' ability to recognize when to refer an LGBTQI2-S community member for mental health services; to provide participants with useful information on available mental health resources for LGBTQI2-S community members; and to improve participants' ability to provide culturally appropriate mental health treatment to LGBTQI2-S consumers. A survey was handed out to all participants at the start of the conference, which was anonymous and voluntary. In total, 303 individuals attended the conference and of those, 168 completed surveys.

- 93% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the LGBTQI2-S community
- 87% agreed or strongly agreed that the conference improved their ability to recognize when to refer an LGBTQI2-S community member for mental health services
- 91% agreed or strongly agreed that they received useful information on mental health resources for LGBTQI2-S community members
- 92% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to LGBTQI2-S consumers

The Faith-based Advocacy Council (FBAC)

Formerly known as the Clergy Advisory Committee (CAC), the Faith-Based Advisory Council (FBAC) allows LACDMH to collaborate with faith leaders from various religious affiliations. This council operates under the following values:

- Caring for the whole person
- Utilizing spirituality as a resource in the journey of wellbeing, recovery and resilience
- Networking and mobilizing a life-giving community
- Respecting diversity in life experience, worldview, ways of communication, and one's spirituality
- Developing initiatives that support integrating spirituality into the LACDMH

The Council meets on a monthly basis at various community-based locations with the goal of inviting faith-based organizations and clergy to participate in discussions regarding mental health, recovery and overall wellbeing.

Countywide Community Mental Health Promoters Expansion

The Community Mental Health Promoters Program is a countywide expansion of the "Promotores de Salud" Project originally implemented by the Latino UREP (now UsCC) subcommittee. This countywide program builds system capacity and access to integrated services by utilizing Mental Health Promoters to increase the community's knowledge about mental health through outreach, engagement, community education, social support, and advocacy activities. The Countywide Community Mental Health Promoters are recruited from the community and once crossed trained; they disseminate information and provide services by effectively bridging gaps between governmental and nongovernmental systems and the communities they serve. The practice of recruiting community mental health promoters as natural leaders within their communities demonstrates the implementation of CLAS standards Nos. 1, 3, and 13. Community Mental Health Promoters function with a solid understanding of their communities, often sharing similar cultural backgrounds including but not limited to ethnicity, language, socio-economic status, and daily-living experiences. They provide leadership, prevention education and linkage services in a culturally and linguistically appropriate manner to underserved ethnic communities.

Community Mental Health Promoters provide education on topics such as Mental Health Stigma; Stages of Grief and Loss; Domestic Violence Prevention; Drug and Alcohol Prevention; Symptoms and Treatments of Depression; Symptoms and Treatment of Anxiety Disorders; Suicide Prevention; Child Abuse Prevention; and Childhood Disorders, at various community organizations. As a strategy to reduce mental health disparities, Community Mental Health Promoters amplify the Department's outreach and engagement efforts to four additional UsCC populations and languages, increase service accessibility, fight stigma, and increase UsCC penetration rates.

During FY 17-18, the Latino Mental Health Promotores/Promotores de Salud program continued expanding to all SAs. The Latino Promoters went through an intensive training, which included the foundational training (two weeks); advanced training (six days); and booster session (three hours monthly). The program consists of 133 Latino Mental Health Promoters, who are active in Service Areas 2, 3, 4, 6, 7, & 8. There is a wide diversity of Latino backgrounds among the Mental Health Promoters. Although they share Spanish language proficiency, they come from different Latin American countries and have different educational backgrounds.

Conversations are underway regarding the possible expansion of the Mental Health Promoters program to other cultural groups. The focus of these conversations include identifying funding, target languages, number of health promoters for each cultural group. For example, adding Chinese-speaking promoters to various SAs that need them or creating a specialized, Directly Operated Chinese speaking Promoters group to function Countywide is also being considered. Another topic of discussion involves allowing the Somalian contract to do only countywide work is considered to implement since Promoters with this cultural expertise may not be easy to find and a Somalian agency will have more ties with the community.

Mental Health Academy

LACDMH recognizes the important role that spirituality plays in the process of mental health recovery. The Mental Health Academy was implemented in January 2014 to bring faith-based leaders and mental health professionals into a collaborative effort to build faith partnerships for hope, wellbeing, and recovery. Together, they advocate for the rights of consumers, fight stigma and discrimination, and service improvement. The goal of the Mental Health Academy is to build healthier communities by promoting mental health awareness, reducing stigma associated with mental illness, and increasing access to quality mental health services. Through the Mental Health Academy, faith leaders attend free presentations and trainings on various mental health topics. Faith leaders can customize their training experience by choosing among 29 topics. The general areas of training involve Mental Health 101, psychological first aid, common mental health conditions (e.g., depression, anxiety, posttraumatic stress disorder, and substance use), crisis management and suicidality, and effective communication and conflict management, support groups, healthy work environment, bereavement, and gangs. Some of the courses are available in Spanish and Mandarin. The partnerships that were formed between the Department and faith-based leaders demonstrate the implementation of CLAS standards Nos. 4 and 13. Please refer to Criterion 5 for a detailed list of all training topics.

Additionally, LACDMH has sponsored an annual Mental Health and Spirituality Conference since 2001. This conference originated in response to the desires of consumers to integrate spirituality into their recovery process. The conference highlights the diversity in spiritual practices and is a resource for clinicians,

consumers, health providers, spiritual care providers, family members, and the clergy alike.

Veterans Full Service Partnership (FSP)

The formerly known Veterans and Loved Ones Recovery (VALOR) Program transitioned into a Full Service Partnership (FSP) serving homeless veterans who may not qualify for veteran affairs healthcare benefits. This FSP brings opportunities for hope, wellbeing, and recovery to Los Angeles County veterans and their families in need of mental health services. A strong emphasis is placed on reducing homelessness, providing linkages to housing and mental health services, and building partnerships with other service providers.

The Veterans FSP activities and service coordination with social service providers demonstrate the implementation of CLAS standards Nos. 1, 2, 3, 10, and 13.

Outreach and Engagement (O&E)

The SA-based O&E Teams represent one of LACDMH's primary approaches to reduce stigma and mental health disparities. Funding is set aside for O&E coordinators to provide promotional items, snacks and refreshments, and professional items necessary to engage communities in mental health awareness and education, linkage to LACDMH services and networking with community-based organizations.

O&E endeavors also take place within various LACDMH programs. For example, the Homeless Outreach and Mobile Engagement (HOME) Team provides countywide, field-based, and dedicated outreach and engagement services to adult, TAY and older adult homeless populations. HOME staff function as the "first link in the chain" to connect homeless mentally ill persons to recovery and mental health wellbeing services through a collaborative effort with other caregiving agencies and County entities. The HOME team focuses especially on SAs 4 and 6, which have the largest population of homeless individuals in Los Angeles County. Homeless outreach is also conducted by the SB 82 Mobile Triage Teams. These teams reach out to homeless mentally ill adults and provide them with supportive services. The Veterans FSP serves homeless veterans as a specialty within the Countywide SB-82 Mobile Crisis Response Teams. It provides a full range of services to homeless veterans who have a Serious Mental Illness (SMI) and substance use disorders. Furthermore, the Integrated Mobile Health Team (IMHT) aims to reduce homelessness, incarcerations, and medical and psychiatric emergency room visits by persons with SMI. Taking into consideration the vulnerabilities that homeless persons may present due to age, number of years homeless, substance use and/or other physical health conditions, IMHT services are provided in the field by a multidisciplinary staff. The IMHT includes a licensed mental health professional, psychiatrist, physical health physician, certified substance use counselor, peer advocate, and case managers. The IMHTs use evidence-based practices including Housing First, permanent supportive housing, harm reduction, and motivational interviewing.

Furthermore, LACDMH collaborates with various community organizations in the implementation of initiatives that raise awareness on the importance of mental health, highlight the impact of untreated mental illness, and convey a message of hope.

The collective O&E efforts of the Department demonstrate the implementation of CLAS standards Nos. 1, 2, 3, 9, 10, and 13.

Whole Person Care (WPC)

WPC is a California Medi-Cal 2020 waiver pilot program and five-year initiative for vulnerable Medi-Cal recipients to improve their health outcomes and reduce the utilization of high-cost services (e.g., emergency department, inpatient hospitalization). According to the California Department of Health Care Services (DHCS), the overarching goal of WPC is the "coordination of health, behavioral health, and social services in a patient-centered manner with goals of improved beneficiary health and wellbeing through more efficient and effective uses of resources."

Kin Through Peer (KTP) Program

This program serves consumers who are eligible for LACDMH's WPC Intensive Service Recipient (ISR) or Residential and Bridging Care (RBC) programs. The KTP program serves severely mentally ill or regular transitioning in and out of psychiatric emergency rooms/hospitals. While lack of access to housing, as well as chronic medical problems, co-morbid substance use disorders, and a myriad of psychosocial stressors drive these problematic phenomena, a lack of healthy family relations are also core to the problem. As such, KTP participants are expected to benefit tremendously with ongoing support from a peer substituting as family to provide a surrogate "kin" function. They desperately need longer-term social support through Community Health Workers (CHW) who can provide long-term kinship and serve as surrogate family. CHWs focus on intense relationship-building and long-term sustainable community reintegration to preserve healthy wellbeing.

Studies have shown that individuals who receive peer support use inpatient services less, have more engagement with treatment providers and community, improve their social functioning, have a better quality of life and are more hopeful. With shared experience as a family-like bond, peers can be effective in building a trusting relationship that is crucial to maintain the road to recovery and reintegration. With an enduring role, peers can also mitigate the trauma that consumers experience in transitioning between programs. Furthermore, CHWs as advocates can improve participants' long-term adherence to care plans, increase the accountability of the network of care providers across the county, and decrease recidivism in and out of psychiatric inpatient units, the streets, and prison.

In November 2017, LACDMH began establishing WPC-KTP teams comprised of a clinical supervisor and five (5) CHWs in each of eight (8) SAs. The KTP teams reached out to a subset of ISR and RBC program consumers to identify 400 of the highest-need recipients of WPC-LA services that would also benefit from longer-term, peer navigator services to act as kin support. KTP staff do not provide clinical or case management services, but rather work closely with mental health service providers to address the participants' needs and promote recovery, facilitate case conferencing with other service providers, conduct home visits, and serve as their support system for up to 12 months after enrollment into the KTP program. Disenrollment occurs when the individual has established an enduring relationship that provides with the kin support needed to achieve personal recovery and pursue community reintegration, or when the participant no longer desires to engage in the program.

Mental Health Court Linkage Program

Court Liaison Program

The Court Liaison Program is a problem-solving collaboration between LACDMH and the L.A. County Superior Court. It is staffed by a team of mental health clinicians who are co-located at courts countywide. This recovery-based program serves adults who have a mental illness or co-occurring disorder, and are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health system, improve access to mental health services and supports, and enhance continuity of care. The Court Liaison Program further aims to provide ongoing support to families and to educate the court and the community at large regarding the specific needs of these individuals. Participation is voluntary and available to persons 18 years old and older. Services include the following: outreaching on-site courthouse defendants; assessing individual service needs; informing consumers and the Court of appropriate treatment options; developing diversion, alternative sentencing, and post-release plans that take into account best fit treatment alternatives and Court stipulations; linking consumers to treatment programs and expediting mental health referrals; advocating for the mental health needs of consumers throughout the criminal proceedings; and assisting defendants and families in navigating the court system.

Community Reintegration Program (CRP)

CRP offers an alternative to incarceration for defendants who have a mental illness including those with co-occurring substance use. The goal of the CRP is to reintegrate consumers into the community with the skills and resources necessary to maintain stability and avoid re-arrest. The CRP provides admission to two (2) specialized mental health contract facilities for judicially involved individuals with mental illness who voluntarily accept treatment in lieu of incarceration. The CRP provides mental health screening, triage, assessment and linkage to community-based mental health services for offenders with mental health conditions who are being released from the

California Department of Corrections and Rehabilitation. CRP staff collaborate with the Probation Department on release planning for individuals identified for release from prison. The staff also work alongside specialized community mental health agencies and Directly Operated programs to assist them with reentry to their communities.

The Court Liaison Program and Community Reintegration Program activities including the collaboration with other County departments and community-based organizations demonstrate the implementation of CLAS standards Nos. 1, 2, 3, 10, and 13.

Mental Health – Law Enforcement Teams (MH-LET)

The LACDMH Emergency Outreach Bureau (EOB) expanded the MH-LET program to provide field-based crisis intervention services in the eight SAs for community members of all ages who come into contact with law enforcement. The program is based on the premise that diversion from arrest/incarceration into community-based treatment facilities connects community members, who have a mental health condition, to the care they need. The goals of this program include: 1) provide timely access to mental health services to individuals in acute crises who come to the attention of law enforcement through 911 system or patrol; 2) reduce the risk of incarceration of individuals who are in acute crisis when they come into contact with law enforcement; 3) decrease the potential for officer involved use-of-force incidents; and 4) provide individuals with an immediate clinical assessment and mental health services (i.e. acute inpatient hospitalization, linkage, and intensive case management).

The MH-LET teams are composed of one licensed mental health clinician partnered with a law enforcement officer. Together, they respond to 911 calls or patrol car requests for assistance when persons suspected of having a mental condition are involved in an incident. The teams provide crisis intervention including assessment for WIC 5150, de-escalate potentially violent interactions between consumers, family members and police, make appropriate referrals to community agencies, and facilitate hospitalization. The teams decrease the need for inpatient psychiatric hospitalization by providing immediate field-based services.

Furthermore, clinical staff provides training to law enforcement officers on mental health conditions and engagement strategies. The expansion of the MH-LET Program has allowed the Department to establish a collaborative with 36 law enforcement agencies, including the Sheriff's Department. LACDMH added six additional MH-LET teams, five of these work closely with the L.A. County Sheriff's Department and on has been assigned to Beach Cities. The goal of the Department is to incorporate Community Health Workers/Peers as additional MH-LET resources to assist community members to navigate the system. The expansion of MH-LET demonstrates the implementation of CLAS standards 1, 2, 3, and 13.

Continuum of Care (CCR)

The purpose of CCR is to augment existing intensive mental health services provided to children/youth involved with Los Angeles County Department of Children and Family Services (DCFS) and/or the Probation Department (Probation), while residing in Short Term Residential Therapeutic Program (STRTPs) and their affiliated aftercare placements. CCR mandates providers to follow these children/youth as they reintegrate into communities to ensure successful transition and continued access to Specialty Mental Health Services. CCR services are meant to stabilize youth requiring placement in STRTPs and provide support as they move into community placements.

The following are the five fundamental principles of CCR services:

- All children deserve to live with a committed, nurturing and permanent family that prepares youth for a successful transition into adulthood.
- The Child and Family Team (CFT) is essential to ensure the child, youth and family's voice is represented throughout assessment, placement and service planning process.
- Children should not have to change placements to get the services and supports needed. To this end, CCR ensures trauma-informed and culturally relevant behavioral and mental health services are available to children and youth in short-term residential therapeutic programs, as well as in home-based settings.
- Collaboration among all agencies serving children and youth including, child welfare, probation, mental health, education and other community service providers is crucial to ensure timely access to necessary services.
- The goal for all children in foster care is "normalcy in development" while establishing permanent life-long family relationships.

The CCR Division has established the following four units:

1) Interagency Placement Committee (IPC)
   IPC ensures that the youth are placed in the most appropriate and least restrictive setting and that it is capable of meeting their needs. The decision on where the youth are placed is made collaboratively between LACDMH, DCFS, and Probation Department. IPC team utilizes screening tools, assessment report, previous placement, treatment experiences, and other relevant information to facilitate a dialogue on what STRTP would best meet the needs of the client.

2) Performance Oversight and Outcome Unit
   This Unit monitors the Mental Health Services of the STRTP agencies. The unit has two (2) main functions: to utilize qualitative review tools to provide technical assistance; and gather outcome data. The reviews concentrate on how STRTP providers are implementing the integrated Core Practice Model in their daily practice. Outcome data is collected utilizing the Child Adolescent

Needs Strengths (CANS) and Pediatric Symptom Checklist (PSC) to better understand how to assist STRTP providers and increase positive outcomes for clients.

3) Mental Health Program Approval (MHPA) Unit
   This Unit is changed with reviewing and approving all STRTP MHPA Applications as well as Policies and Procedures, and conducting the initial and yearly on-site visits to verify the provider is meeting the State regulations. Under CCR, STRTPs must demonstrate the capacity to provide culturally relevant, trauma informed and medically necessary intensive specialty mental health services. Ongoing clinical review of the type and level of mental health services provided to ensure appropriateness and timely access is required in the CCR legislation. Additionally, the MHPA Unit provides technical assistance to providers who are new to LACDMH. All STRTPs have one year from the date of their initial licensure to contract with LACDMH and obtain Medi-Cal Certification.

4) Training and Coaching Unit
   This Unit provides training to Foster Family Agencies (FFA), STRTP, group homes converting to STRTP and Resource Parents, DCFS, Probation and LACDMH Workforce on topics such as Child and Family Teaming, Integrated Core Practice Model, Trauma Informed Care and Burnout prevention, which are required under the CCR legislation. These trainings are being provided at two levels: one level addresses the needs of STRTP, Group Homes converting to STRTP, Contract Providers, DCFS, and Probation staff. The second level of trainings addresses the needs of Resource Parents.

Specialized Foster Care (SFC) Program

This program consists of a multidisciplinary team, which is co-located in each of the DCFS offices throughout Los Angeles County. This co-location enables both Departments to work collaboratively and effectively in coordinating efforts to ensure that children and their families receive appropriate linkage to the mental health services, decrease placement disruptions, and that these collaborative services are driven by the needs of each child and his/her family. The SFC teams consist of mental health clinical supervisors, psychiatric social workers, and clinical psychologist.

Immigrant Protection and Immigration Task Force

During CY 2018, the Department adopted the Los Angeles County Sensitive Policy Location P&P to safeguard persons receiving services and limit disruption in their mental health care delivery, except in cases involving judicial warrants. The Department launched a multipronged effort to inform consumers and the community of this commitment. Key departmental staff participated on multiple forums (e.g. Channel 52 Phone Bank, radio programming, and Facebook Live Sessions) to educate the community on legal and mental health services and distributed “Know Your Rights” materials in different languages.

Additionally, LACDMH was actively involved in the Immigration Task Force weekly meetings and worked closely with the Office of Immigration Affairs' staff to assist Unaccompanied Minors and their families/sponsors. As a result of its involvement in the Immigration Task Force, the Department coordinated Sensitive Location Trainings and Public Charge trainings for staff.

Homeless Initiatives: Countywide expansion of the Homeless Outreach Mobile Engagement (HOME) Program

Through the countywide expansion process, the HOME Program continued fulfilling its mission to assist the most vulnerable homeless persons are re-integrated into their community. To maximize outcomes for homeless persons, the Department dedicated 161 staff to the HOME teams. The majority of the staff functions revolved around engaging homeless persons and connecting them with various community resources, e.g., benefit establishment, housing, and family reunification.

The individuals targeted by the HOME program have severe and persistent mental illness. HOME teams receive referrals from professionals, neighbors, family members, and the faith-based community, among others. Persons served by the HOME Program may live on the streets, parks, and abandoned vehicles.

School Threat Assessment Response Team (START) Program Expansion

The START Program provides comprehensive threat prevention and management services to educational institutions in collaboration with school districts, colleges, universities and technical schools, as well as local and Federal law enforcement agencies. START staff have formed active partnerships with the educational institutions, law enforcement agencies, local Federal Bureau of Investigation Office, and other community organizations to prevent and mitigate campus threats in the Los Angeles County. The focus of the program is on persons with moderate to high threat levels, either on or off school campuses, and persons exhibiting a pattern of maladaptive behaviors that may be conducive to acts of violence. To ensure timely response, all incoming referrals are centralized and tracked from LACDMH headquarters prior to forwarding to the respective supervisors for case assignment. Services include consultation, trainings, screenings, assessment, psychoeducation, skill building, case management, crisis intervention, and monitoring.

In addition, LACDMH collaborates with the Federal Bureau of Investigations (FBI), the Joint Regional Intelligence Center (JRIC) as a cooperative effort between federal, state, local law enforcement, and public safety agencies to centralize appropriate dissemination of terrorism-related threat intelligence for Los Angeles County. The goal of the collaborative is to develop trainings on Targeted Violence Prevention for clinicians, law enforcement, educators, and the public at large.

School Partnership Initiative (SPI)

LACDMH has partnered with the Los Angeles County Office of Education (LACOE), and various school districts to provide assessment and linkage to mental health services. Five Los Angeles Unified School District Early Education sites and 15 LACOE middle/high schools have been identified for Regional Teams to build mental health networks to provide assessments and linkage to services.

Cultural Competence Trainings

LACDMH offers a considerable number of cultural competence trainings designed to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge and cross-cultural skills, all of which are essential to effectively serve our culturally and linguistically diverse communities. The trainings offered by the OAO-Workforce Education and Training (WET) Division incorporate a multiplicity of cultural competency elements as listed below:

- Ethnicity
- Age
- Gender
- Sexual orientation
- Commercially sexually exploited youth (CSECY)
- Forensic population
- Homeless population
- Hearing impaired population
- Human Immunodeficiency Virus Positive (HIV+)/ Acquired Immunodeficiency Syndrome (AIDS) population
- Spirituality
- Consumer culture
- Language interpreters
- Utilization of language interpreters

See Criterion 5 for a detailed list of cultural competence trainings offered in FY 17-18. In addition to cultural competence trainings available through the WET Division, other trainings take place at the SA and program level. LACDMH recognizes the importance of providing a comprehensive repertoire of cultural competence-related trainings. By availing its workforce of on-going cultural competence trainings, the Department demonstrates the implementation of CLAS standard No. 4.

Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan

The MHSA has provided an opportunity to engage L.A. County communities in informing, developing, and promoting impactful mental health resources through LACDMH. There have been many service expansions in L.A. County, some of which depend on funding primarily from MHSA. For Example:

- Resourcing and leveraging partners to increase access to care via home visits, schools, libraries, parks, health clinics, and other community platforms to mitigate the development and progression of mental illness and intervene as early as possible
- Expanding mobile outreach, engagement, and triage to homeless populations
- Doubling down and optimizing the investment in FSP to keep those suffering from mental illness out of the hospitals, off of the streets, and out of prison
- Increasing the inventory of interim, permanent supportive board and care housing
- Utilizing technology to diversity mental health treatment options

Workforce Education and Training (WET)

Several WET Programs support the LACDMH commitment to strengthen partnerships with community organizations and partners, and support the integration of peers and parent advocates into our system of care. This practice demonstrates the implementation of CLAS standard No. 13. Examples of WET projects and programs include the following:

1) Homeless Outreach Peer Enhancement Specialists (HOPES) Program
   This program trained mental health peers and family members who volunteer in a shelter setting to identify early recovery goals related to mental health, physical health, substance use, and stability. The training consisted of both didactic and experiential components that incorporate informative learning, role-playing activities, group dynamics, shadowing, coaching, and onsite internship activities.

2) Independent Consumer Training Program
   Peer Actions 4 Change (PA4C) group was developed through the Independent Consumer Association Development Training Program (ICADTP). The following activities were completed by PA4C with the support of SHARE (contractor lead): 1) Monthly contract consultations between LACDMH Program Director, SHARE, and PA4C, 2) SHARE hosted several Toastmasters meetings to support the Speakers Bureau component of the group. As a result, several members participated in speaking engagements, 3) Implementation of a Job Fair Conference Committee, which met monthly and coordinated a successful conference held on September 9, 2018, and 4) Members also participated in the NAMI Walk and trained on Legislative Advocacy.

3) Parent Partners Training Program
   This training program was intended to provide knowledge and technical skills to Parent Advocates/Parent Partners who are committed to: providing family support services; promoting employment of parents, caregivers of children, and youth consumers; and/or fostering wellness through techniques that are grounded in parent advocate/parent partner empowerment.

4) Parent Partner Training Symposium
The 3-day symposium was held twice and was attended by approximately 200 parent partners. These training opportunities covered a wide range of topics such as integrating care/co-occurring disorders, criminal justice issues, crisis intervention and support strategies, education, employment, homelessness, housing, inpatient/hospitalizations, LGBTQI issues, older adults, residential and group homes, and suicide prevention, among others.

5) Parent Partner/Parent Advocate Certification Exam, Training Program Evaluation, and Outcomes Report and Presentation
During this reporting period, a vendor developed program evaluation tools and provided outcome data reports. The vendor also developed a certification examination for participants whereby drafting minimum competency standards for the County of Los Angeles.

6) Macro Peer Advocacy Program
This program targeted on peers, family advocates and members to effectively promote and empower the consumer voice and advocate for continued support of MHSA recovery, resilience, and wellness tenets. Components include the legislative process, communication strategies for both written and in person presentation with county and state constituents, and development of successful political collaborative/ relationship approaches.

7) Individual Placement and Support (IPS)
As an evidence-based approach, the IPS program was implemented to support individuals in their efforts to achieve steady, meaningful employment in mainstream competitive jobs, either part-time or full-time. A key feature of IPS is the integration of employment and mental health services. IPS is based on eight (8) principles. Mental health agencies that implement IPS, aim to follow these principles in delivering vocational services:
- Every person with severe mental illness who wants to work is eligible for IPS supported employment
- Employment services are integrated with mental health treatment services
- Competitive employment is the goal
- Personalized benefits counseling is provided
- The job search starts soon after a person expresses interest in becoming employed
- Employment specialists systematically develop relationships with employers based upon their client's preferences
- Job supports are continuous
- Client preferences are honored

8) Expanded Employment and Professional Advancement Opportunities for Family Members in the Public Mental Health System
These trainings prepared family members of consumers to develop or augment skills related to community outreach, advocacy and leadership, and decrease barriers to employment. Topics covered in these trainings included public speaking, navigating systems, and resource supports for consumers and families.

Prevention and Early Intervention (PEI)
The LACDMH PEI Program consists of 13 programs, which collectively provide prevention services targeted to individuals at risk for developing a mental illness as well as to persons who are at risk for suicide. Additionally, an array of early intervention evidence-based, promising and community-defined evidence practices have been implemented for persons across the age spectrum experiencing early symptoms of a mental illness.

Each of the 13 programs has implemented specific Evidence-Based Practices (EBPs). The five (5) top evidence-based practices delivered in the L.A. County by age group are as follows:

1) Adult
- Individual Cognitive Behavioral Therapy
- Seeking Safety
- Assertive community treatment
- Improving mood - promoting access to collaborative treatment
- Interpersonal Psychotherapy for depression

2) Children
- Managing and Adapting Practice
- Trauma-Focused CBT
- Triple P – Positive Parenting Program
- Seeking Safety
- Child parent psychotherapy

3) Older Adult
- Interpersonal psychotherapy for depression
- Seeking safety
- Individual cognitive behavioral therapy
- Assertive community treatment
- Improving mood-promoting access to collaborative treatment

4) TAY
- Seeking Safety
- Managing and Adapting Practice
- Trauma-Focused CBT
- Individual Cognitive Behavioral Therapy
- Interpersonal Psychotherapy for depression

During FY 17-18, LACDMH moved toward a more vigorous approach to PEI services. While the focus of early intervention continues to be evidence-based practices, promising practices and community-defined evidence practices, the Department engaged in prevention strategies in settings such as schools and libraries where access platforms were established. The goals of these platforms were: to build on protective factors such as social connectedness and engagement, raise awareness on the importance of mental and emotional wellbeing, increase understanding regarding the impact of trauma, develop organizational and community capacity to promote wellbeing and resiliency, and build bridges to mental health care.

LACDMH contracted with RAND Corporation to develop a prevention measure for services that were in various stages of development and implementation. In addition, LACDMH worked with various county partners to customize measures for specific populations and settings.

Health Neighborhoods (HN)

The HN initiative is a countywide initiative led by LACDMH in partnership with the Department of Public Health (DPH) and Department of Health Services (DHS) to increase health equity and access of quality services through integrated care and community collaboration. The vision for the HN is to function as a network of coalitions comprised of diverse stakeholders including mental and public health providers, community and city-based agencies, educational institutions, housing services, social service providers, faith-based groups, and community members. The HN mission is to create and sustain a collective impact to improve clinical and community supports in designated neighborhoods throughout Los Angeles County and promote the incorporation of whole-person care.

A total of 13 Health Neighborhoods across the eight (8) SAs were implemented by the end of FY 17-18. The following cities currently have Health Neighborhoods: Antelope Valley, Northeast San Fernando (formerly known as Pacoima), El Monte, San Gabriel Valley, Boyle Heights, Hollywood, Mar Vista Palms, Pico-Robertson, Venice-Marina Del Rey, South Los Angeles, Southeast Los Angeles, Central Long Beach. This collaborative practice demonstrates the implementation of CLAS standard No. 13.

III. Cultural Competence/Ethnic Services Manager (ESM) responsible for cultural competence

Sandra Chang, Ph.D. is the LACDMH ESM. Dr. Chang is also the Program Manager for the departmental Cultural Competency Unit (CCU). Additionally, in CY 2018, she became the lead for the Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) and Cultural Intelligence Workgroup. This organizational structure within the Department allows for cultural competence to be integrated into the Department's quality improvement roles and responsibilities. It also places the ESM and the CCU in a position to actively collaborate with several LACDMH programs and Health Agency Departments. In her ESM role, Dr. Sandra

Chang has administrative oversight of the departmental Cultural Competency Committee (CCC) and is invested in making the Cultural Competence Plan Requirements (CCPR), the CLAS standards, and California Reducing Disparities Report (CRDP) recommendations active components in LACDMH's framework to integrate cultural competency in service planning, delivery and evaluation.

Examples of how the ESM accomplishes these tasks include:

- Serving as the lead for the development of annual Cultural Competence Plans (CCP)
- Answering to all inquiries and requests for documentation regarding cultural competency at the triennial Medi-Cal Reviews and the annual External Quality Review Organization (EQRO) Site Reviews
- Providing trainings on cultural competence at the LACDMH New Employee Orientation, SA QICs and community-based organizations as requested
- Serving as the lead for the implementation of the LACDMH Cultural Competence Organizational Assessment
- Reviewing service utilization data and actively participating in local mental health planning projects that respond to the needs of the county's racial, ethnic and cultural populations
- Promoting knowledge of local and state cultural competence projects at various departmental venues
- Leading and/or participating in CCC ad hoc workgroups formed to draft recommendations for the inclusion of cultural competency into departmental functions
- Developing procedures related to cultural and linguistically competency. For example, templates to capture CCP update information and a procedure for the field testing of LACDMH forms, brochures and correspondence translated into the threshold languages by LACDMH consumers and family members /care takers
- Providing technical assistance to diverse LACDMH programs regarding cultural competence in general, CCPR compliance, and procedures for language translation and interpretation services
- Participating in the Department's Quality Improvement Council monthly meetings as a standing member to provide updates related to the CCU as well as the CCC projects and activities
- Representing the CCU in various departmental committees such as the Faith-based Advisory Council, MHSA Implementation, UsCC subcommittees, and System Leadership Team meetings. The ESM is also a member of the UsCC and CCC Leadership Groups
- Collaborating with LACDMH programs/Units to increase the accessibility of mental health services to underserved communities. For example, she assisted the Latino media campaign and agreed to complete nine (9) live radio interviews on various mental health topics in Dr. Eduardo Lopez Navarro's program at KTNQ-1020 am.

- Collaborating all other Southern Region ESMs in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee

Additionally, under the oversight of the ESM, the most salient activities of the CCU for CY 2018 include:

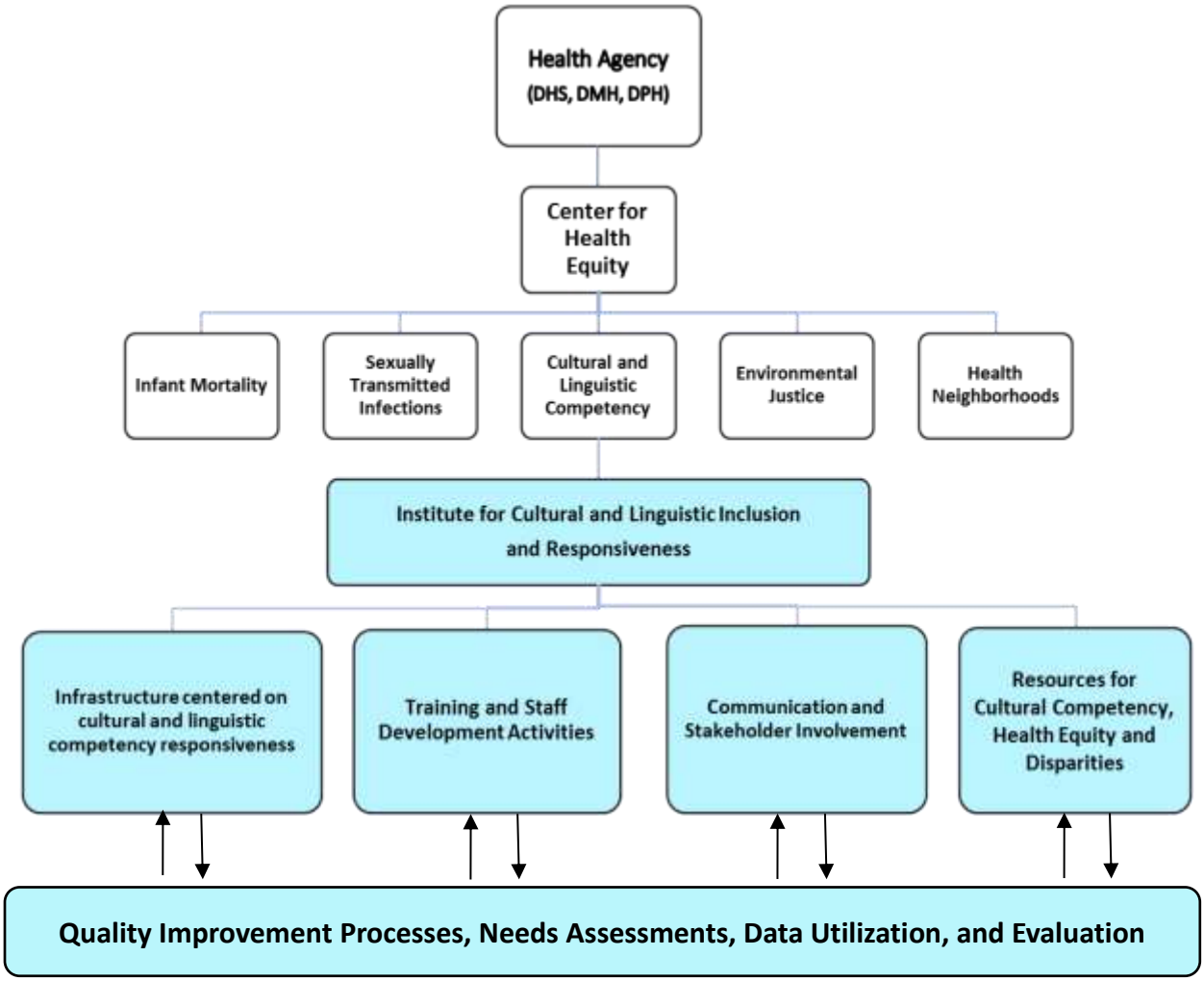
1) Implementation of the Health Agency's (HA) Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR)

   Implemented in April 2018, the goal of the Institute is to create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the HA's ability to meet the needs of Los Angeles County communities. The framework for ICLIR was developed by the LACDMH ESM and the CCU provides administrative support for ICLIR's monthly meetings and objectives. The ICLIR framework consists of four (4) strategic domains:

   A. Infrastructure centered on cultural and linguistic competency responsiveness – ensures active collaboration among the three (3) Departments to:
      - Identify and respond to cultural and linguistic service delivery gaps within the HA
      - Establish appropriate goals in accordance with the Departments' cultural and linguistic competency reporting requirements and ICLIR's mission statement
      - Assess the functionality of cultural competence-related policies and procedures for ICLIR
   B. Training and staff development activities – endows Department of Health Services, Department of Mental Health, and Department of Public Health staff with additional skill sets that enhance cross-cultural awareness, sensitivity, and humility, and decrease implicit bias
   C. Communication and stakeholder involvement mechanisms – focuses on collaborative efforts to:
      - Build effective processes for the transmission of information related to CC and linguistic appropriateness within Departments and across the HA
      - Gather and respond to feedback received from stakeholders including consumers, family members, peers, advocates, Promotores de Salud, and staff
   D. Resources for cultural competency, health equity and disparities – comprises a virtual repository for useful literature and toolkits pertinent to cultural competence, health equity, and health disparities which inform service planning, delivery, and evaluation

   The ICLIR domains are sustained by the following commitments:
   - Improve the HA's quality of culturally and linguistically competent services
   - Respond to gaps in service delivery
   - Fulfill needs assessment follow-up actions
   - Utilize data to identify and evaluate the effectiveness of interventions
   - Build cross-departmental responsibility to share resources

Figure 1
Institute for Cultural and Linguistic Inclusion and Responsiveness Framework



2) <u>Implementation of the HA's Labor Management Transformation Council's (LMTC) Cultural Intelligence Workgroup</u>
The mission of the Cultural Intelligence Workgroup is to increase cultural sensitivity, understanding and humility within the HA in order to enhance the quality of interpersonal human relationships for all individuals connected to the County of Los Angeles. During CY 2018, the workshop reviewed the Consumer Perception Survey data specific to the item "Staff was sensitive to my cultural background." This data was utilized for the planning of a cultural sensitivity campaign for the three (3) HA Departments in CY 2019.

3) LACDMH Cultural Competence Organizational Assessment
This project is a system wide assessment of staff perceptions regarding the Department's responsiveness to the cultural and linguistic needs of the Los Angeles County diverse communities. As the lead for this project, the CCU worked closely with the hired consultant to implement the survey in December 2018. Strategic survey completion reminders were sent to the entire LACDMH workforce to encourage participation. The survey outcomes and recommendations from the CC Organizational Assessment are expected by Spring 2019. This information will inform future cultural and linguistic competence strategies to reduce mental health disparities. The Department will utilize these recommendations to improve its system of care in the area of cultural and linguistic competency.

4) Network Adequacy: Annual Completion of Cultural Competence Training
To assist in the implementation of the Network Adequacy requirements pertinent to annual completion of cultural competence training, the CCU developed a "Frequently Asked Questions" handout, which was widely utilized to guide clinical and administrative programs seeking technical assistance. It was made available to all LACDMH programs and providers via the QID webpage. Additionally, the CCU released two departmental memoranda for Directly-Operated (DO), Legal Entities/Contracted Providers, and Administrative Programs to a) clarify the differences between the two provisions under which CC training must be completed: the federal Medicaid Managed Care "Final Rule" Network Adequacy requirements under Title 42 and the State's Medi-Cal regulations under Title 9 – CCP, and b) move the system toward a standardized mechanism to track cultural competence training completion by staff until the Network Adequacy Certification Tool (NACT) became operational.

5) Tracking of Cultural Competence Training Completed by the LACDMH Workforce
The CCU developed two levels for tracking the completion of annual cultural competence training. For the first level, the CCU coordinated efforts with the Quality Assurance Division (QAD) to access attestations received via Quarterly Reports submitted by DO and Legal Entities/Contracted Providers. The second level involved the distribution and tracking of completed training attestation forms specifically designed for reporting by executive management, DO and Legal Entities/Contracted Providers, and Administrative Programs. After completing an analysis of the quarterly reports and attestation forms received, the Unit generated SA-specific summary reports, which were disseminated to the SA QIC chairs for follow-up on training requirements. Additionally, the CCU collaborated with QAD to ensure that the NACT included a field for reporting and tracking of completed annual cultural competence training. Two items were added to the NACT: "Cultural Competence Training (select "yes" or "no") for receiving training in the past 12 months" and "Percentage of workforce members trained in Cultural Competence."

6) External Quality Review Organization (EQRO) Review
The CCU actively participated in the annual EQRO Review in September 2018. The Unit coordinated the collection of reports from twenty-five (25) programs regarding

strategies to reduce mental health disparities, consumer utilization data, and cultural competence staff trainings. The CCU also provided technical assistance to these programs for the proper completion of these reports. The collective information gathered was utilized for the 2018 LACDMH CCP Update and EQRO evidentiary documentation. Additionally, the ESM provided a presentation on the CCU's activities in the disparities session of the EQRO Reviews.

7) Cultural Competency Trainings and Community Presentations

A. New Employee Orientation (NEO)

The CCU participated in NEO by providing bi-monthly one-hour long CC trainings that introduce new employees to the functions of the CCU, the CLAS Standards, the CCPR, the County of Los Angeles demographics and threshold languages, and the Department's strategies to reduce mental health disparities.

B. Cultural Competence Plan (CCP) presentations at all Service Area Quality Improvement Committees

The CCU developed and delivered a total of nine (9) presentations on the criteria of the CCP at SAs 1-8 and countywide QICs. The presentation covered the following topics:

- What is the CCP?
- Why does LACDMH develop an annual CCP?
- How is the CCP developed?
- What are the requirements and components of the CCP?
- Sample content for the CCP criteria

C. Service Area 2 Cultural Competency presentations

The Ethnic Services Manager (ESM) and supervisor for the CCU provided a series of three presentations for parents and community members from Morningside, Haddon Avenue Stream Academy and Hubbard Street Elementary Schools in March 2018. Each presentation was conducted in Spanish and had a two-hour long duration. The evaluation forms gathered from participants reported high levels of satisfaction with the content relevance and applicability to family life and social relations.

D. Cultural Competency and Cultural Humility presentation for the HA's LMTC

In May 2018, the ESM delivered this presentation to an audience composed of the HA Directors from the Departments of Mental Health, Health Services and Public Health as well as representatives from Labor Unions. This presentation marked the starting point for the implementation of the LMTC's Cultural Intelligence Workgroup (please refer to item 2) for detailed information.

E. Cultural Competency and Cultural Humility training for Students of Social Work and Psychology

This training was developed and delivered by the ESM for approximately 20 Master level students in October 2018. Training topics included:

- Introduction and definitions
- Federal, State and County regulations pertinent to cultural competency
- The CLAS Standards
- LACDMH strategies to reduce mental health disparities
- Cultural humility
- The client culture and stigma
- Elements of cultural competency in service delivery
- County of Los Angeles and LACDMH demographics

8) LACDMH Integrated Health Multicultural Conference Planning Oversight

Starting in October 2018, the CCU led the planning efforts for the implementation of the first LACDMH Integrated Health Multicultural Conference, scheduled for June of 2019. The conference addresses models of health integration for less-recognized yet well-established underserved populations such as veterans, foster care youth, immigrants and asylum seekers, persons experiencing homelessness, older adults, persons who are incarcerated or recently released from prison, persons with disabilities, and persons who have substance use disorders, among others.

9) Cultural Competency Committee (CCC) Administrative Oversight

The CCU continued providing on-going technical assistance and administrative oversight conducive to the attainment of the Committee's goals and objectives. The ESM monitored all activities pertaining to the CCC and provided updates on the CCU's projects as well as cultural competency initiatives at the State and County levels during CCC meetings. The ESM also participated in the CCC Leadership meetings with the Co-Chairs and the OAO Director to plan meeting agendas, objectives and activities of the committee. Additionally, the ESM developed the CCC annual report which included demographics regarding the ethnicity, gender, cultural expertise, and languages represented by the membership as well as the goals and activities of the committee.

10) Cross-County Department Collaboration in Cultural Competency Initiatives

The CCU collaborated in initiatives that involved a consortium of County Departments with the goal of advancing cultural competence, cultural humility and language justice. Examples include:

A. Government Alliance for Racial Equity (GARE)
B. 2018 Riverside County CC Summit Planning Committee
C. 2019 Countywide Equity Summit Planning Committee.

11) Data Collection, Analysis and Reporting of Preferred Language Requests

The CCU continued the collection and analysis of all the preferred language requests reported by LACDMH providers via their Initial Request & Referral Logs for Culture Specific Mental Health Services. The Unit produced monthly and annual summaries of the total requests for preferred threshold and non-threshold languages by SA. These reports are utilized to track the language requests from Limited English Proficiency consumers at the time they access mental health services.

IV. Budgetary allocations for cultural competent activities

LACDMH has a robust budget for cultural competence activities, including trainings, outreach and engagement activities, language translation and interpretation services, employee bilingual compensation, and program expansions, among many others. Examples for FY 17-18:

- $600,500 was dedicated to cultural competence trainings coordinated by the WET Division
- $100,000 for Human Resources trainings such Cultural Diversity, Employee Discrimination Prevention, and Sexual Harassment Prevention
- $62,150 for co-occurring intellectual disability trainings for clinical staff and supervisors from Directly Operated and Contracted providers to optimize service delivery for various cultural groups
- $53,200 for the commercially sexually exploited youth trainings
- $17,200 for the LGBTQI2-S trainings
- $62,876 for language interpretation trainings which continue to be offered annually
- $410,000 for the UsCC Recruitment program
- $860,000 for the Countywide Community Mental Health Promoters project, which adapts the Health Promoters model to four other ethnic groups: AAA, AI/AN, API, and EE/ME allotted per FY
- $700,000 for the capacity building projects of the seven UsCC subcommittees (Each subcommittee receives one-time funding in the amount of $100,000 per FY)
- $263,000 for un-accompanied minors
- $200,000 annually for telephonic interpretation services provided via the ACCESS Center and Directly Operated programs.
- $53,264 for language interpretation services, which allows consumers to participate in various departmental meetings and conferences
- $79,324 for language translation services
- $165,000 American Sign Language (ASL) services offered to consumers from both DO and contracted clinics
- Approximately 500 bilingual employees receive a monthly compensation ranging between $85 and $100. LACDMH pays bilingual bonus for 39 different languages, inclusive of threshold and non-threshold languages.

MHSA Budget Summary for FY 17-18

A considerable amount of additional funding is dedicated for cultural competence activities under the MHSA Plans. The following tables summarize MHSA Plans specific budget allocations for:

- Community Services and Supports (CSS)
- Prevention Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)

CSS Component Worksheet, FY 17-18

Programs	CSS Funding
FSP Programs	
1. Planning Outreach & Engagement	4,423,041
2. Full Service Partnerships	141,612,691
3. Alternative Crisis Services	29,835,884
4. Non-Full Service Partnerships	18,969,170
5. Linkage	9,503,174
6. Housing	5,151,228
Non-FSP Programs	
1. Planning Outreach & Engagement	10,828,824
2. Alternative Crisis Services	45,189,080
3. Non-Full Service Partnerships	155,385,226
4. Linkage	9,442,361
5. Housing	9,902,532
CSS Administration	32,771,784
Total CSS Program Expenditures	473,014,995

PEI Component Worksheet, FY 17-18

Programs	PEI Funding
PEI Programs - SUICIDE PREVENTION	
PEI-01 Suicide Prevention	6,339,293
PEI Programs – STIGMA DISCRIMINATION REDUCTION	
PEI-02 Stigma Discrimination Reduction Program	4,720,497
PEI Programs – PREVENTION	
PEI-03 Strengthening Family Functioning	7,593,000
PEI-04 Trauma Recovery Services	1,650,050

PEI-05	Individuals and Families Under Stress	11,262,710
Cont.	**Programs**	**PEI Funding**
PEI-06	At-Risk Youth	7,034,450
PEI-07	Vulnerable Communities	10,898,000
PEI Programs -	EARLY INTERVENTION	
PEI-03	Strengthening Family Functioning	10,421,836
PEI-04	Trauma Recovery Services	26,711,427
PEI-05	Individuals and Families Under Stress	37,746,312
PEI-06	At-Risk Youth	12,698,875
PEI Administration		12,604,902
Total PEI Program Expenditures		149,681,352

Innovation Component Worksheet, FY 17-18

Programs	INN Funding
INN Programs	
1. Evaluation	1,000,000
2. Innovation #2	20,000,000
INN Administration	2,008,720
Total INN Program Expenditures	23,008,720

WET Component Worksheet, FY 17-18

Programs	WET Funding
WET Programs	
1. Training and Technical Assistance	1,935,142
2. Mental Health Career Pathway	4,550,380
3. Financial Incentive	14,931,130
WET Administration	1,183,348
Total WET Program Expenditures	22,600,000

V. CLAS standards implementation progress at a glance

LACDMH actively pursues the implementation and sustenance of the CLAS standards in all its operations. The following chart summarizes the Department's on-going progress in implementing the CLAS standards.

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
1. Promote effective, equitable, understandable, and respectful quality of care and services	1 - 8	• Health Agency and departmental mission and vision statements, strategic plan, policies, and procedures provider manual and parameters that guide clinical care • Implementation of Health Agency workgroups targeting cultural related service needs, such as cultural and linguistic responsiveness, homelessness, jail diversion, vulnerable youth, and co-occurring disorders • Comprehensive budget allocations for cultural competence activities • Quality Improvement Program connection with the departmental Cultural Competency Unit • Culture and language specific outreach and engagement • Tracking of penetration rates, retention rates and mental health disparities • Implementation of culture-based programs and strategies that address mental health disparities • Trainings on cultural competence, sensitivity and cultural humility

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
2. Governance and leadership promotes CLAS	1, 4, 5, and 6	• Well-established Stakeholder Engagement Process • Departmental Strategic Plan • Policies and procedures that guide culturally and linguistically competent service provision • Review and discussions regarding the CLAS standards with departmental leadership, SA QIC, and CCC
3. Diverse governance, leadership and workforce	1, 6, and 7	• Culturally-diverse stakeholder process • Utilization of demographical and consumer utilization data in program planning, service delivery, and outcome evaluation • Presence of committees that advocate for the needs of cultural and linguistically underserved populations • Efforts to recruit culturally and linguistically competent staff who represent the communities and cultural groups served • Development of paid employment opportunities for peers and persons with lived experience, such as Community Mental Health Promoters
4. Train governance, leadership and workforce in CLAS	1 and 5	• Accessible cultural competence trainings • Opportunities for Program Managers to request cultural competence trainings needed by their respective staff • Inclusion of the CLAS standards in the cultural competence trainings provided at NEO • Trainings for language interpreters and for the use of

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		language interpreters in mental health settings • Trainings specifically designed for peers and persons with lived experience
5. Communication and language assistance	5 and 7	• Established P&Ps for bilingual certification, language translation and interpretation services, interpreter services for the Deaf and Hard of Hearing community, and culturally and linguistically inclusive services • 24/7 ACCESS Center • Listings of bilingual certified staff by language • On-line Provider Directories translated into threshold languages • Translation of consent forms that require consumer signage in the threshold languages • Usage of posters informing the public of the availability of free of cost language assistance services
6. Availability of language assistance	7	• Monitoring ACCESS Center language assistance operations • Hiring and retention of bilingual certified staff • Mechanisms for Contracted providers to establish contracts with language line vendors
7. Competence of individuals providing language assistance	6 and 7	• Bilingual certification testing • Offering of trainings for language interpreters (beginning and advance levels) • Offering of trainings on medical terminology in several threshold languages

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
8. Easy to understand materials and signage	1, 3, and 7	• Translation of consent forms, program brochures and fliers in the threshold languages • Partnering with the community for the creation of brochures that are culturally meaningful and linguistically appropriate
9. CLAS goals, policies, and management accountability	1	• On-going evaluation of consumer satisfaction outcomes • Program-specific reporting on service utilization and strategies that address mental health disparities
10. Organizational assessments	3 and 8	• Monitoring the impact of cultural and language-specific outreach and engagement activities • Partnering with the community to identify capacity-building projects for underserved cultural communities • Conducting cultural competence assessments related to CCPR • Conducting program-based needs assessments • Conducting workforce/discipline – specific needs assessments • Conducting program outcome evaluations and reporting on the progress made in service accessibility, and improvements in penetration and retention rates
11. Demographic data	2, 4 and 8	• Compiling and reporting of the Los Angeles County demographics, consumer utilization data by ethnicity/race, age group, language, gender, and SA

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Monitoring of consumer utilization data to identify emerging cultural and linguistic populations • Compiling and tracking of penetration rates, retention rates and mental health disparities
12. Assessments of community health assets and needs	3 and 8	• Presence of Committees that advocate for the needs of cultural groups, underserved populations and faith-based communities • Funding for capacity building projects for underserved populations • Expansion of programs such as Community Mental Health Promoters and Service Extenders • Monitoring the use of innovative programs by the community, such as tele psychiatry services • Monitoring the effectiveness of medication practices • Innovation 2 Health Neighborhoods
13. Partnerships with community	1, 3, and 4	• Media campaigns to increase access to mental health services and decrease stigma in partnership with community-based organizations • Presence of various stakeholder committees such as “YourDMH”, CCC, UsCC subcommittees, Faith-based Advocacy Council • Provision of stipends and scholarships for consumers and family members to attend stakeholder meetings and conferences • Collaborations with agencies that specialize in services to Veterans

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Implementation of Health Neighborhoods and other innovation programs based on partnerships with community-based organizations • Partnerships and collaborations with the faith-based communities • Partnerships and collaborations with other county departments for specialized programs such as Whole Person Care
14. Conflict and grievance resolution processes	8	• Development of online Patient's Rights Office apps • Monitoring of consumers/family satisfaction with services received • Monitoring of beneficiary requests for change of provider • Monitoring the quality of services provided by the ACCESS Center and contracted language lines • Monitoring of grievances, appeals and request for State Fair Hearings
15. Progress in implementing and sustaining the CLAS standards	1	• The Cultural Competence Plan is accessible to LACDMH clinical and administrative programs, the Executive Management Team, various stakeholders such as the CCC, UsCC subcommittees, and SA QICs. Additionally, it is posted in the departmental Cultural Competency Unit webpage • On-going stakeholder process and other committee meetings monthly meetings with the community • Cultural Competence Organizational Assessment

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – CY 2019

Criterion 2

Updated Assessment of Services Needs

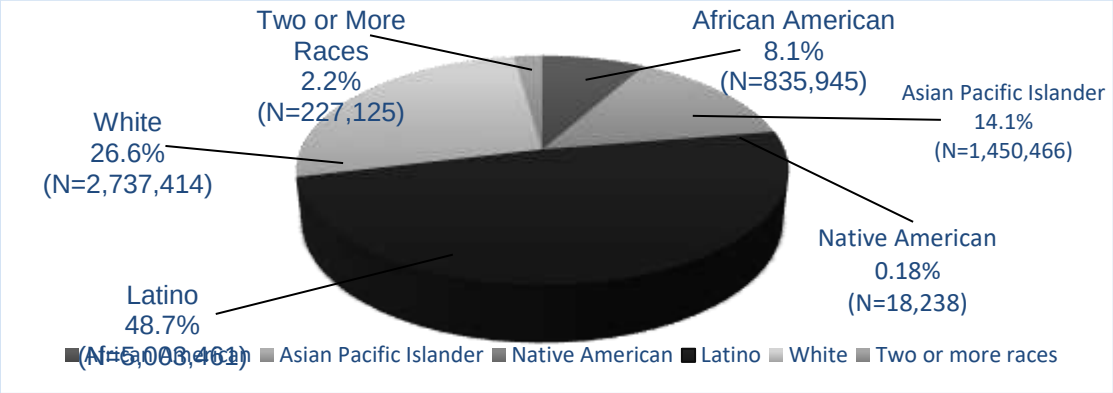
August 2019

Criterion 2: Updated Assessment of Services Needs

I. General Population: County Total Population

A. This section summarizes the county's general population by race/ethnicity, age, and gender.

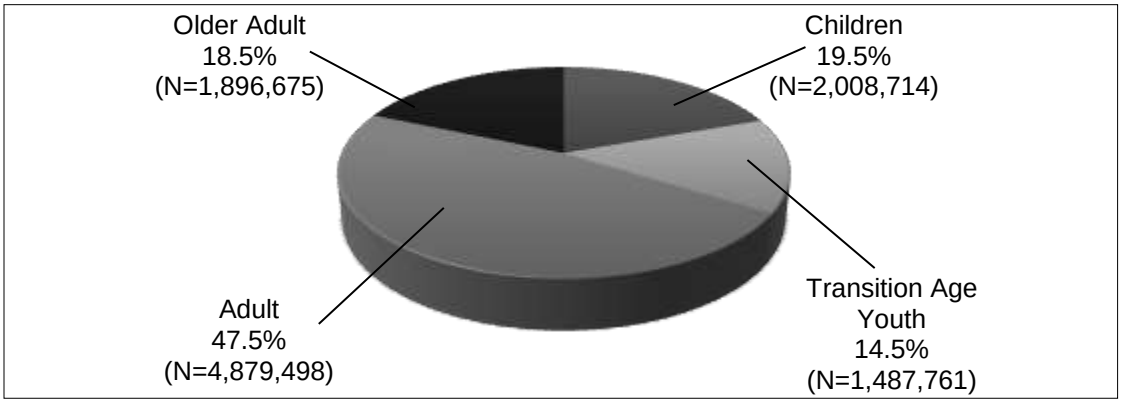
FIGURE 2: POPULATION BY RACE/ETHNICITY
CY 2017 (N = 10,272,648)



Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2018.

Figure 1 shows population by race/ethnicity. Latinos are the largest group at 48.7%, followed by Whites at 26.6%, Asian/Pacific Islanders (API) at 14.1%, African Americans at 8.1%, and Native Americans at 0.18%.

FIGURE 3: POPULATION BY AGE GROUP
CY 2017 (N = 10,272,648)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Figure 2 shows population by age group. Adults make up the largest group at 47.5%, followed by Children at 19.5%, Older Adults at 18.5%, and Transition Age Youth (TAY) at 14.5%.

TABLE 1: POPULATION BY RACE/ETHNICITY AND SERVICE AREA CY 2017

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	60,074	15,302	178,838	1,442	125,645	11,164	392,465
Percent	15.3%	3.9%	45.6%	**0.37%**	32.0%	2.8%	100.0%
SA 2	76,613	253,510	916,337	3,597	950,319	58,287	2,258,664
Percent	3.4%	11.2%	40.6%	0.16%	42.1%	2.6%	100.0%
SA 3	63,420	503,804	836,668	2,862	360,440	34,106	1,801,299
Percent	3.5%	**28.0%**	46.4%	0.16%	20.0%	1.9%	100.0%
SA 4	59,505	205,093	618,280	2,002	282,493	21,039	1,188,412
Percent	5.0%	17.3%	52.0%	0.17%	23.8%	1.8%	100.0%
SA 5	37,242	91,422	108,963	945	404,894	28,365	671,830
Percent	5.5%	13.6%	**16.2%**	0.14%	**60.3%**	**4.2%**	100.0%
SA 6	278,788	19,519	731,879	1,420	25,681	11,263	1,068,550
Percent	**26.1%**	**1.8%**	68.5%	**0.13%**	**2.4%**	**1.1%**	100.0%
SA 7	38,652	118,205	969,850	2,541	170,477	15,024	1,314,749
Percent	**2.9%**	9.0%	**73.8%**	0.19%	13.0%	**1.1%**	100.0%
SA 8	221,650	243,611	642,646	3,428	417,466	47,878	1,576,679
Percent	14.1%	15.5%	40.8%	0.22%	26.5%	3.0%	100.0%
Total	835,945	1,450,466	5,003,461	18,238	2,737,414	227,125	10,272,648
Percent	8.1%	14.1%	48.7%	0.18%	26.6%	2.2%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

The highest percentage of African Americans was in SA 6 (26.1%) compared to SA 7 (2.9%) with the lowest percentage.

The highest percentage of Asian/Pacific Islanders was in SA 3 (28.0%) compared to SA 6 (1.8%) with the lowest percentage.

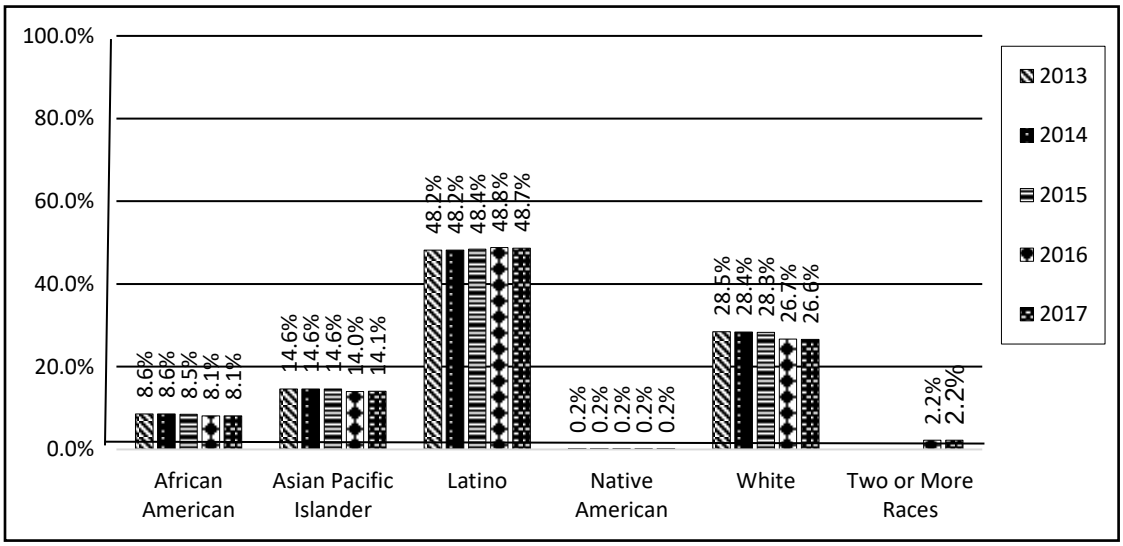
The highest percentage of Latinos was in SA 7 (73.8%) compared to SA 5 (16.2%) with the lowest percentage.

The highest percentage of Native Americans was in SA 1 (0.37%) compared to SA 6 (0.13%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (60.3%) compared to SA 6 (2.4%) with the lowest percentage.

The highest percentage of Two or More Races was in SA 5 (4.2%) compared to SAs 6 and 7 (1.1%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT CHANGE BY RACE/ETHNICITY CY 2013- 2017



Note: The "Two or More Races" ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of African Americans (AA) in the County has decreased by 0.5 percentage points (PP) over the past five years. AA represented 8.6% of the total population in CY 2013 and 8.1% of the population in CY 2017.

The percentage of Asian Pacific Islanders (API) in Los Angeles County has decreased by 0.5 PP over the past five years. API represented 14.6% of the total population in CY 2013 and represented 14.1% in CY 2017.

The percentage of Latinos in Los Angeles County has increased by 0.5 PP over the past five years. Latinos represented 48.2% of the total population in CY 2013 and represented 48.7% in CY 2017.

The percentage of Native Americans (NA) in Los Angeles County has remained the same over the past five years. NA represented 0.2% of the total population in CY 2013 and in CY 2017.

The percentage of Whites in Los Angeles County has decreased by 1.9 PP over the past five years. Whites represented 28.5 of the total population in CY 2013 and represented 26.6% in CY 2017.

The percentage of Two or More Races in Los Angeles County remains the same over the past two years. Two or more races category represent 2.2% of total population in CY 2017.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2017

Service Area (SA)	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	107,823	13,667	35,620	172,624	21,722	41,009	392,465
Percent	27.5%	3.5%	**9.1%**	**44.0%**	5.5%	10.4%	100.0%
SA 2	509,543	62,196	159,969	1,087,572	137,854	301,530	2,258,664
Percent	22.6%	2.8%	7.1%	48.2%	6.1%	13.3%	100.0%
SA 3	403,888	55,508	136,382	825,869	112,813	266,839	1,801,299
Percent	22.4%	3.1%	7.6%	45.8%	**6.3%**	14.8%	100.0%
SA 4	244,409	27,224	73,845	638,090	61,286	143,558	1,188,412
Percent	20.6%	**2.3%**	**6.2%**	**53.7%**	5.2%	12.1%	100.0%
SA 5	120,204	22,971	41,549	340,661	40,633	105,812	671,830
Percent	**17.9%**	3.4%	**6.2%**	50.7%	6.0%	**15.7%**	100.0%
SA 6	316,275	40,075	97,022	476,381	46,518	92,279	1,068,550
Percent	**29.6%**	**3.8%**	**9.1%**	44.6%	**4.4%**	**8.6%**	100.0%
SA 7	342,561	41,852	107,360	597,266	68,134	157,576	1,314,749
Percent	26.1%	3.2%	8.2%	45.4%	5.2%	12.0%	100.0%
SA 8	377,894	44,413	114,225	741,035	91,717	207,395	1,576,679
Percent	24.0%	2.8%	7.2%	47.0%	5.8%	13.2%	100.0%
Total	2,422,597	307,906	765,972	4,879,498	580,677	1,315,998	10,272,648
Percent	23.6%	3.0%	7.5%	47.5%	5.7%	12.8%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018

The highest percentage of individuals between 19 and 20 years old was in SA 6 (3.8%) compared to SA 4 (2.3%) with the lowest percentage.

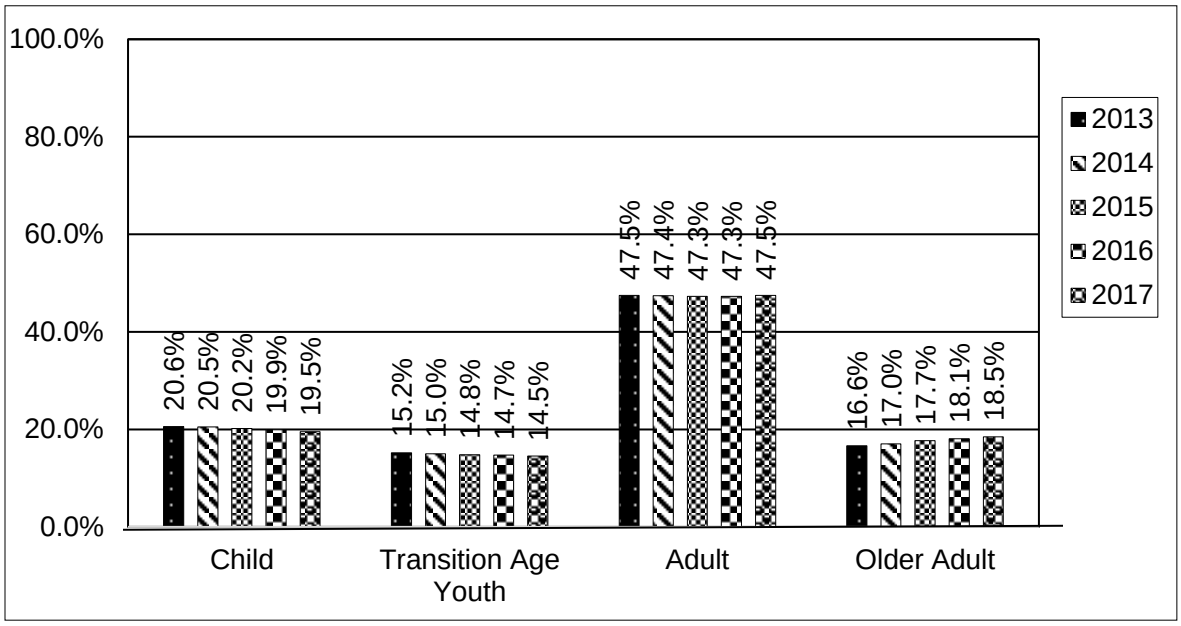
The highest percentage of individuals between 21 and 25 years old was in SA 6 (9.1%) compared to SA 5 (6.2%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (53.7%) compared to SA 1 (44%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 3 (6.3%) compared to SA 6 (4.4%) with the lowest percentage.

The highest percentage of individuals 65+ years old was in SA 5 (15.7%) compared to SA 6 (8.6%) with the lowest percentage.

FIGURE 5: POPULATION PERCENT (PP) CHANGE BY AGE GROUP CY 2013-2017



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of Children in the County has decreased by 1.1 PP over the past five years. Children represented 20.6% of the total population in CY 2013 and 19.9% in CY 2016.

The percentage of Transition Age Youth (TAY) in the County has decreased by 0.7 PP over the past five years. TAY represented 15.2% of the total population in CY 2032 and 14.5% in CY 2017.

The percentage of Adults in the County remains the same over the past five years. Adults represented 47.5% of the total population in CY 2013 and in CY 2019.

The percentage of Older Adults in the County has increased by 1.9 PP over the past five years. Older Adults represented 16.6% of the total population in CY 2013 and 18.5% in CY 2017.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA CY 2017

Service Area (SA)	Males	Females	Total
SA 1	194,913	197,552	392,465
Percent	49.7%	50.3%	100.0%
SA 2	1,117,894	1,140,770	2,258,664
Percent	49.5%	50.5%	100.0%
SA 3	879,280	922,019	1,801,299
Percent	48.8%	51.2%	100.0%
SA 4	610,270	578,142	1,188,412
Percent	**51.4%**	**48.6%**	100.0%
SA 5	325,718	346,112	671,830
Percent	**48.5%**	**51.5%**	100.0%
SA 6	521,324	547,226	1,068,550
Percent	48.8%	51.2%	100.0%
SA 7	646,209	668,540	1,314,749
Percent	49.2%	50.8%	100.0%
SA 8	771,433	805,246	1,576,679
Percent	48.9%	51.1%	100.0%
Total	5,067,041	5,205,607	10,272,648
Percent	49.3%	50.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS,
US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Gender

The highest percentage of Males was in SA 4 (51.4%) compared to SA 5 (48.5%) with the lowest percentage.

The highest percentage of Females was in SA 5 (51.5%) compared to SA 4 (48.6%) with the lowest percentage.

Estimated Population Living at or Below 138% Federal Poverty Level (FPL)

TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY RACE/ETHNICITY AND SERVICE AREA CY 2017

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	18,141	2,830	56,357	443	25,299	2,930	105,999
Percent	17.1%	2.7%	53.2%	**0.40%**	23.9%	2.7%	100.0%
SA 2	15,231	40,099	251,339	674	134,142	9,806	451,292
Percent	3.4%	8.9%	55.7%	0.15%	29.7%	2.2%	100.0%
SA 3	11,353	89,638	193,954	528	46,052	5,102	346,627
Percent	3.3%	**25.9%**	56.0%	0.15%	13.3%	1.5%	100.0%
SA 4	14,537	56,873	219,483	743	53,363	5,029	350,028
Percent	4.2%	16.2%	62.7%	0.20%	15.2%	1.5%	100.0%
SA 5	5,130	15,470	17,328	122	48,538	3,879	90,466
Percent	5.7%	17.0%	**19.2%**	**0.13%**	**53.7%**	**4.3%**	100.0%
SA 6	95,821	8,784	325,720	719	8,974	4,123	444,141
Percent	**21.6%**	**2.0%**	73.3%	0.16%	**2.0%**	0.9%	100.0%
SA 7	7,326	16,209	274,318	567	23,376	2,143	323,939
Percent	**2.3%**	5.0%	**84.7%**	0.18%	7.1%	**0.7%**	100.0%
SA 8	63,013	44,312	210,444	840	47,087	8,791	374,488
Percent	16.8%	11.8%	56.2%	0.22%	12.6%	2.4%	100.0%
Total	230,552	274,213	1,548,943	4,637	386,832	41,803	2,486,980
Percent	9.3%	11.0%	62.2%	0.19%	15.6%	1.7%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (21.6%) compared to SA 7 (2.3%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 9.3% self-identified as AA.

The highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL was in SA 3 (25.9%) compared to SA 6 (2.0%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 11.0% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (84.7%) compared to SA 5 (19.2%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 62.2% self-identified as Latino.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.40%) compared to SA 5 (0.13%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 0.19% self-identified as NA.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (53.7%) compared to SA 6 (2.0%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 15.6% self-identified as White.

The highest percentage of Two or More Races living at or below 138% FPL was in SA 5 (4.3%) compared to SA 7 (0.7%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 1.7% self-identified as White.

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TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA CY 2017

Service Area (SA)	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	40,481	3,692	9,599	40,136	4,216	7,875	105,999
Percent	38.2%	3.5%	9.1%	37.8%	4.0%	7.4%	100.0%
SA 2	143,180	12,910	34,711	198,719	19,383	42,389	451,292
Percent	31.7%	2.9%	7.7%	44.0%	4.3%	9.4%	100.0%
SA 3	108,569	10,370	27,661	144,053	15,700	40,274	346,627
Percent	31.3%	3.0%	8.0%	41.6%	**4.5%**	**11.6%**	100.0%
SA 4	104,794	8,332	23,908	164,368	13,822	34,804	350,028
Percent	29.9%	**2.4%**	**6.8%**	47.1%	3.9%	9.9%	100.0%
SA 5	15,388	3,417	11,279	46,268	3,974	10,140	90,466
Percent	**17.0%**	**3.8%**	**12.5%**	**51.1%**	4.4%	11.2%	100.0%
SA 6	184,698	15,225	40,606	165,774	14,231	23,607	444,141
Percent	**41.6%**	3.4%	9.1%	**37.3%**	**3.3%**	**5.3%**	100.0%
SA 7	125,757	9,751	25,608	125,036	11,873	25,914	323,939
Percent	38.8%	3.0%	7.9%	38.6%	3.7%	8.0%	100.0%
SA 8	133,270	11,242	29,699	154,593	14,742	30,942	374,488
Percent	35.6%	3.0%	7.9%	41.3%	3.9%	8.3%	100.0%
Total	856,137	74,939	203,071	1,038,947	97,941	215,945	2,486,980
Percent	34.4%	3.0%	8.2%	41.8%	3.9%	8.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Age Group

The highest percentage of individuals between 0 and 18 years old estimated to be living at or below 138% FPL was in SA 6 (41.6%) compared to SA 5 (17.0%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old estimated to be living at or below 138% FPL was in SA 5 (3.8%) compared to SA 4 (2.4%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old estimated to be living at or below 138% FPL was in SA 5 (12.5%) compared to SA 4 (6.8%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old estimated to be living at or below 138% FPL was in SA 5 (51.1%) compared to SA 6 (37.3%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old estimated to be living at or below 138% FPL was in SA 3 (4.5%) compared to SA 6 (3.3%) with the lowest percentage.

The highest percentage of individuals age 65 years old and over estimated to be living at or below 138% FPL was in SA 3 (11.6%) compared to SA 6 (5.3%) with the lowest percentage.

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TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2017

Service Area (SA)	Males	Females	Total
SA 1	49,941	56,058	105,999
Percent	**47.1%**	**52.9%**	100.0%
SA 2	215,567	235,725	451,292
Percent	47.8%	52.2%	100.0%
SA 3	163,522	183,105	346,627
Percent	47.2%	52.8%	100.0%
SA 4	170,399	179,629	350,028
Percent	**48.7%**	**51.3%**	100.0%
SA 5	42,646	47,820	90,466
Percent	**47.1%**	**52.9%**	100.0%
SA 6	210,119	234,022	444,141
Percent	47.3%	52.7%	100.0%
SA 7	152,833	171,106	323,939
Percent	47.2%	52.8%	100.0%
SA 8	176,600	197,888	374,488
Percent	47.2%	52.8%	100.0%
Total	1,181,627	1,305,353	2,486,980
Percent	47.5%	52.5%	100.0%

Note: Bold values represent highest and lowest percentages within each gender and across all SAs. Data Source: ACS,
US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (48.7%) compared to SAs 1 and 5 (47.1%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SAs 1 and 5 (52.9%) compared to SA 4 (51.3%) with the lowest percentage

TABLE 7: PRIMARY LANGUAGES[1] OF ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY SERVICE AREA AND THRESHOLD LANGUAGE CY 2017

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA1	557	301	96	117	60,124	154	171	119	76	53	35,436	513	313	98,030
Percent	0.57%	0.31%	0.10%	0.12%	**61.33%**	0.16%	0.17%	0.12%	0.08%	0.05%	**36.15%**	0.52%	0.32%	100.00%
SA2	5,718	37,513	187	308	129,680	7,415	4,872	504	2,841	5,809	219,604	7,235	2,608	424,294
Percent	**1.35%**	**8.84%**	0.04%	0.07%	**30.56%**	**1.75%**	**1.15%**	0.12%	0.67%	**1.37%**	**51.76%**	**1.71%**	0.61%	100.00%
SA3	2,437	1,906	1,037	13,815	95,477	529	3,060	20,081	22,378	215	151,779	3,905	10,303	326,922
Percent	0.75%	0.58%	0.32%	**4.23%**	**29.20%**	0.16%	**0.94%**	**6.14%**	**6.85%**	0.07%	**46.43%**	**1.19%**	**3.15**%	100.00%
SA4	1,442	5,318	718	2,558	76,196	1,429	20,811	931	7,425	4,114	202,419	5,581	1,688	330,630
Percent	0.44%	**1.61**%	0.22%	0.77%	**23.05%**	0.43%	**6.29%**	0.28%	**2.25%**	**1.24%**	**61.22%**	**1.69%**	0.51%	100.00%
SA5	1,553	478	96	877	48,483	5,644	1,561	1,895	2,325	1,149	15,835	566	529	80,991
Percent	1.92%	0.59%	0.12%	1.08%	**59.86%**	**6.97%**	1.93%	2.34%	2.87%	1.42%	**19.55**%	0.70%	0.65%	100.00%
SA6	411	130	183	318	107,845	423	1,881	706	3,153	93	312,518	316	416	428,393
Percent	0.10%	0.03%	0.04%	0.07%	**25.17%**	0.10%	0.44%	0.16%	**0.74%**	0.02%	**72.95%**	0.07%	0.10%	100.00%
SA7	1,516	818	572	376	62,169	182	2,908	1,130	1,887	153	240,946	2,242	924	315,823
Percent	0.48%	0.26%	0.18%	0.12%	**19.68%**	0.06%	0.92%	0.36%	0.60%	0.05%	**76.29%**	0.71%	0.29%	100.00%
SA8	2,635	449	5,675	222	138,993	871	4,527	613	3,065	353	186,648	5,022	2,879	351,952
Percent	0.75%	0.13%	**1.61%**	0.06%	**39.49%**	0.25%	**1.29%**	0.17%	**0.87%**	0.10%	**53.03%**	**1.43%**	0.82%	100.00%
Total	16,269	46,913	8,564	18,591	718,967	16,647	39,791	25,979	43,150	11,939	1,365,185	25,380	19,660	2,357,035
Percent	0.69%	1.99%	0.36%	0.79%	30.50%	0.71%	1.69%	1.10%	1.83%	0.51%	57.92%	1.08%	0.83%	100.00%

Note: [1]Data reported only for LACDMH threshold languages. SA threshold languages are in bold. "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Arabic is a Countywide threshold language. Data Source: ACS, US Census Bureau and Henderson Demographic Services, 2018.

Table 7 shows the estimated population living at or below 138% Federal Poverty Level (FPL) whose primary language met the criteria for a threshold language.

A percentage 94.8% (N = 2,357,035) of the population (N = 2,486,980) living at or below 138% FPL spoke a LACDMH threshold language. Among these, 30.5% (N = 718,967) were English speaking, 57.9% were Spanish speaking (N = 1,365,185) and the remaining 11.5% spoke the other LACDMH threshold languages.
As applicable to LACDMH, below is a breakdown of the 138% FPL population's threshold languages:

SA 1 reported two (2) threshold languages: English (61.3%) and Spanish (36.2%).

SA 2 reported eight (8) threshold languages: Arabic (1.4%), Armenian (8.8%), English (30.6%), Farsi (1.8%), Korean (1.2%), Russian (1.4%), Spanish (51.8%) and Tagalog (1.7%).

SA 3 reported eight (8) threshold languages: Cantonese (4.2%), English (29.2%), Korean (0.9%), Mandarin (6.1%), Other Chinese (6.9%), Spanish (46.4%), Tagalog (1.2%) and Vietnamese (3.2%).

SA 4 reported seven (7) threshold languages: Armenian (1.6%), English (23.1%), Korean (6.3%), Other Chinese (2.3%), Russian (1.2%), Spanish (61.2%), and Tagalog (1.7%).

SA 5 reported three (3) threshold languages: English (59.9%), Farsi (7.0%), and Spanish (19.6%).

SA 6 reported three (3) threshold languages: English (25.2%), Other Chinese (0.7%) and Spanish (73.0%).

SA 7 reported two (2) threshold languages: English (19.7%) and Spanish (76.3%).

SA 8 reported six (6) threshold languages: Cambodian (1.6%), English (39.5%), Korean (1.3%), Other Chinese (0.9%), Spanish (53.0%), and Tagalog (1.4%).

TABLE 8: ESTIMATED PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY AND SERVICE AREA CY 2017

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	4,191	192	5,974	77	3,921	440	14,795
Percent	28.3%	1.3%	40.4%	**0.52%**	26.5%	3.0%	100.0%
SA 2	3,518	2,727	26,642	118	20,792	1,471	55,268
Percent	6.4%	4.9%	48.2%	0.21%	37.6%	2.7%	100.0%
SA 3	2,623	6,095	20,559	92	7,138	765	37,273
Percent	7.0%	**16.4%**	55.2%	0.25%	19.1%	2.1%	100.0%
SA 4	3,358	3,867	23,265	130	8,271	754	39,646
Percent	8.5%	9.8%	58.7%	0.33%	20.9%	1.8%	100.0%
SA 5	1,185	1,052	1,837	21	7,523	582	12,200
Percent	9.7%	8.6%	**15.0%**	**0.17%**	**61.7%**	**4.8%**	100.0%
SA 6	22,135	597	34,526	126	1,391	618	59,394
Percent	**37.3%**	**1.0%**	58.2%	0.21%	**2.3%**	1.0%	100.0%
SA 7	1,692	1,102	29,078	99	3,623	321	35,916
Percent	**4.7%**	3.1%	**81.0%**	0.28%	10.1%	**0.8%**	100.0%
SA 8	14,556	3,013	22,307	147	7,298	1,319	48,641
Percent	29.9%	6.2%	45.9%	0.30%	15.0%	2.7%	100.0%
Total	53,258	18,647	164,188	811	59,959	6,270	303,133
Percent	17.6%	6.2%	54.2%	0.27%	19.8%	2.1%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. The CHIS for the population living at or below 138% FPL, CY 2015 and CY 2016 provide estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Race/Ethnicity

Table 8 compares the prevalence of SED and SMI among the population living at or below 138% FPL for each ethnic group.

The highest rate of prevalence of SED and SMI among the African American (AA) group was in SA 6 (37.3%) compared to SA 7 (4.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian/Pacific Islander (API) group was in SA 3 (16.4%) compared to SA 6 (1.0%) with the lowest percentage.

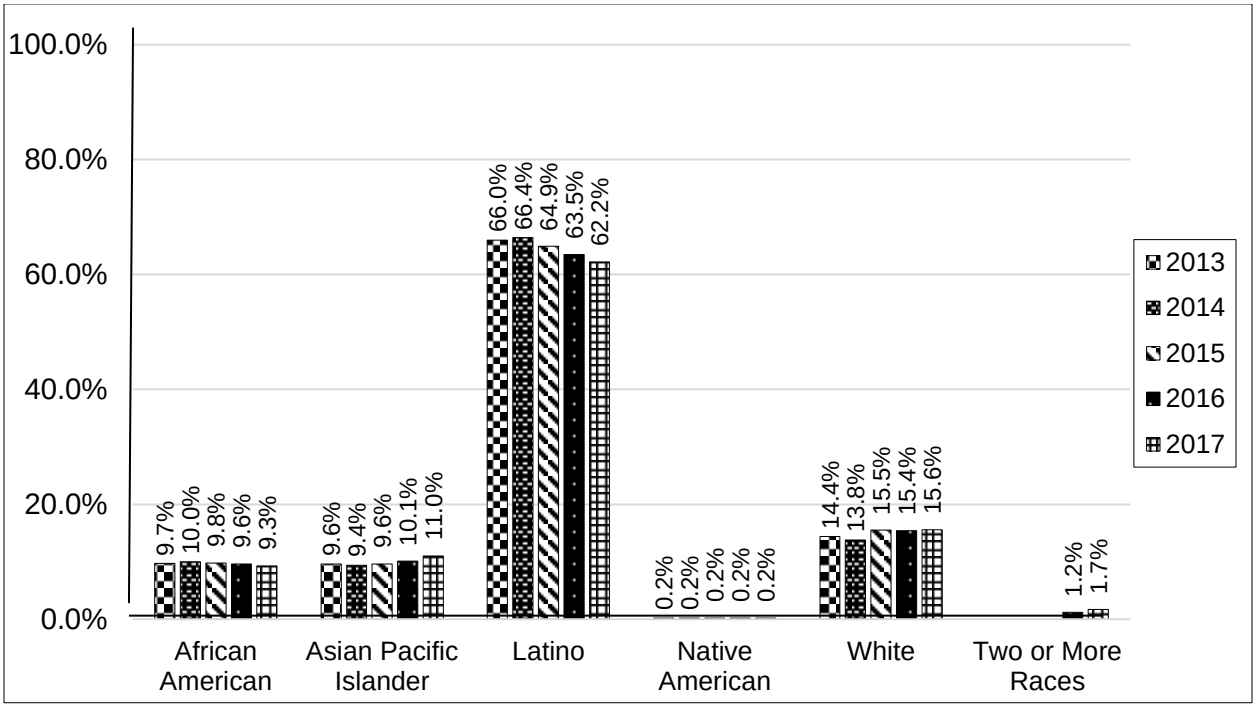
The highest rate of prevalence of SED and SMI among the Latino group was in SA 7 (81.0%) compared to SA 5 (15.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) group was in SA 1 (0.5%) compared to SA 5 (0.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White group was in SA 5 (61.7%) compared to SA 6 (2.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Two or More Races group was in SA 5 (4.8%) compared to SA 7 (0.8%) with the lowest percentage.

FIGURE 6: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY CY 2013–2017



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of African Americans living at or below 138% FPL has decreased by 0.4% from 9.7% in CY 2013 to 9.3% in CY 2017.

The percentage of Asian/Pacific Islanders (API) living at or below 138% FPL has increased by 1.4% from 9.6% in CY 2013 to 11.0% in CY 2017.

The percentage of Latinos living at or below 138% FPL has decreased by 3.8% from 66% in CY 2013 to 62.2% in CY 2017.

The percentage of Native Americans living at or below 138% FPL has remained unchanged at 0.2% from CY 2013 to CY 2017.

The percentage of Whites living at or below 138% FPL has increased by 1.2% from 14.4% in CY 2013 to 15.6% in CY 2017.

The percentage of category Two or More Races living at or below 138% FPL increased by 0.5 from 1.2% in CY 2013 to 1.7% in CY 2017.

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TABLE 9: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2017

SA	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	7,044	746	1,190	4,816	447	638	14,881
Percent	47.3%	5.0%	8.0%	32.4%	3.0%	4.3%	100.0%
SA 2	24,913	2,608	4,304	23,846	2,055	3,434	61,160
Percent	40.7%	4.3%	7.0%	39.0%	3.4%	5.6%	100.0%
SA 3	18,891	2,095	3,430	17,286	1,664	3,262	46,628
Percent	40.5%	4.5%	7.4%	37.0%	**3.6%**	7.0%	100.0%
SA 4	18,234	1,683	2,965	19,724	1,465	2,819	46,890
Percent	38.9%	**3.6%**	**6.3%**	42.1%	3.1%	6.0%	100.0%
SA 5	2,678	690	1,399	5,552	421	821	11,561
Percent	**23.2%**	**6.0%**	**12.1%**	**48.0%**	**3.6%**	**7.1%**	100.0%
SA 6	32,137	3,075	5,035	19,893	1,508	1,912	63,562
Percent	**50.6%**	4.8%	7.9%	**31.3%**	**2.4%**	**3.0%**	100.0%
SA 7	21,882	1,970	3,175	15,004	1,259	2,099	45,389
Percent	48.2%	4.3%	7.0%	33.1%	2.8%	4.6%	100.0%
SA 8	23,189	2,271	3,683	18,551	1,563	2,506	51,763
Percent	44.8%	4.4%	7.2%	35.8%	3.0%	4.8%	100.0%
Total	148,968	15,138	25,181	124,674	10,382	17,492	341,833
Percent	43.6%	4.4%	7.4%	36.5%	3.0%	5.1%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group and across all SAs. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2015 and 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

Differences by Age Group

Table 9 compares the prevalence of SED and SMI for population living at or below 138% FPL for each age group.

The highest rate of prevalence of SED and SMI in Age Group 0-18 was in SA 6 (50.6%) compared to SA 5 (23.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 19-20 was in SA 5 (6.0%) compared to SA 4 (3.6%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 21-25 was in SA 5 (12.1%) compared to SA 4 (6.3%) the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 26-59 was in SA 5 (48.0%) compared to SA 6 (31.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 60-64 was in SA 3 and SA (3.6%) compared to SA 6 (2.4%).

The highest rate of prevalence of SED and SMI in Age Group 65 and older was in SA 5 (7.1%) compared to SA 6 (3.0%) with the lowest percentage.

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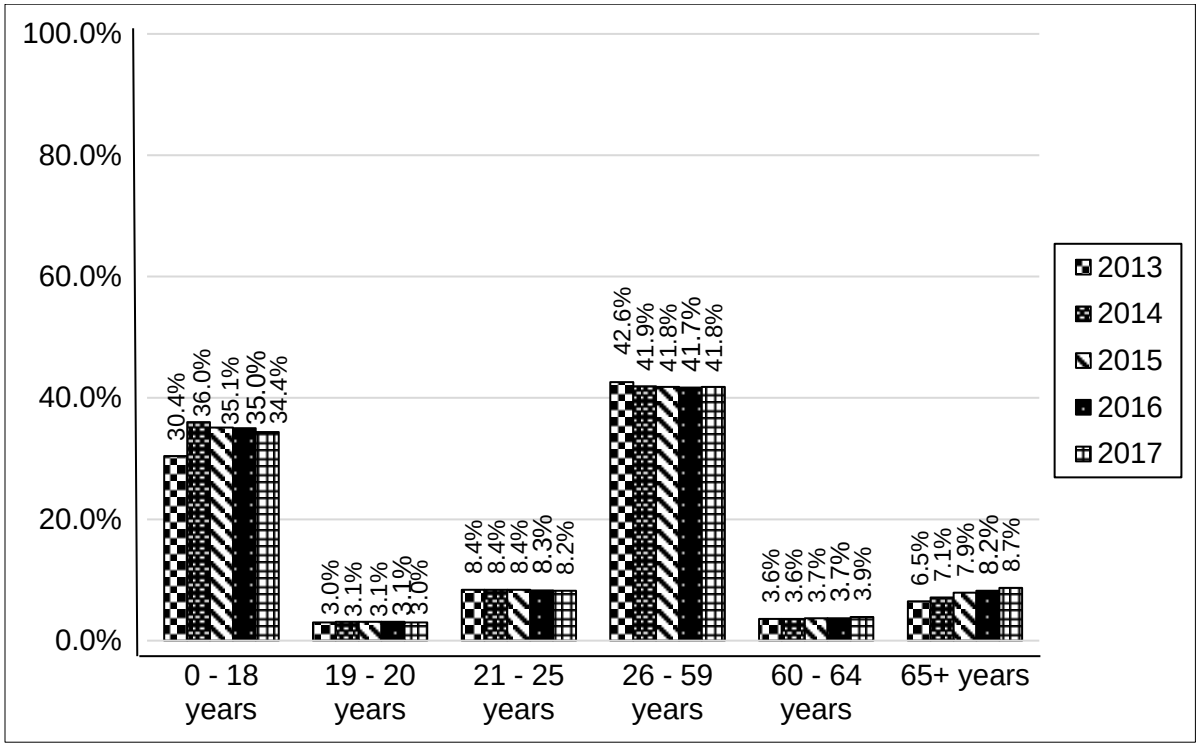
FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2013–2017



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of individuals between 0 and 18 years old, and estimated to be living at or below 138% FPL increased by 4 PP from 30.4% in CY 2013 to 34.4% in CY 2017.

The percentage of individuals between 19 and 20 years old, and estimated to be living at or below 138% FPL remained the same at 3.0% in CY 2013 and CY 2017.

The percentage of individuals between 21 and 25 years old, and estimated to be living at or below 138% FPL decreased by 0.2 PP from 8.4% in CY 2013 to 8.2% in CY 2017.

The percentage of individuals between 26 and 59 years old, and estimated to be living at or below 138% FPL decreased by 0.8 PP from 42.6% in CY 2013 to 41.8% in CY 2017.

The percentage of individuals between 60 and 64 years old, and estimated to be living at or below 138% FPL increased by 0.3 PP from 3.6% in CY 2013 to 3.9% in CY 2017.

The percentage of individuals age 65 and older, and estimated to be living at or below 138% FPL increased by 2.2 PP from 6.5% in CY 2013 to 8.7% in CY 2017.

TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA CY 2017

Service Area (SA)	Males	Females	Total
SA 1	6,143	6,615	12,758
Percent	**48.1%**	**51.9%**	100.0%
SA 2	26,515	27,816	54,331
Percent	48.8%	51.2%	100.0%
SA 3	20,113	21,606	41,720
Percent	48.2%	51.8%	100.0%
SA 4	20,959	21,196	42,155
Percent	**49.7%**	**50.3%**	100.0%
SA 5	5,245	5,643	10,888
Percent	48.2%	51.8%	100.0%
SA 6	25,845	27,615	53,459
Percent	48.3%	51.7%	100.0%
SA 7	18,798	20,191	38,989
Percent	48.2%	51.8%	100.0%
SA 8	21,722	23,351	45,073
Percent	48.2%	51.8%	100.0%
Total	145,340	154,032	299,372
Percent	48.5%	51.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence of mental illness for Los Angeles County are provided by CHIS for the population living at or below 138% FPL, CY 2015 and CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

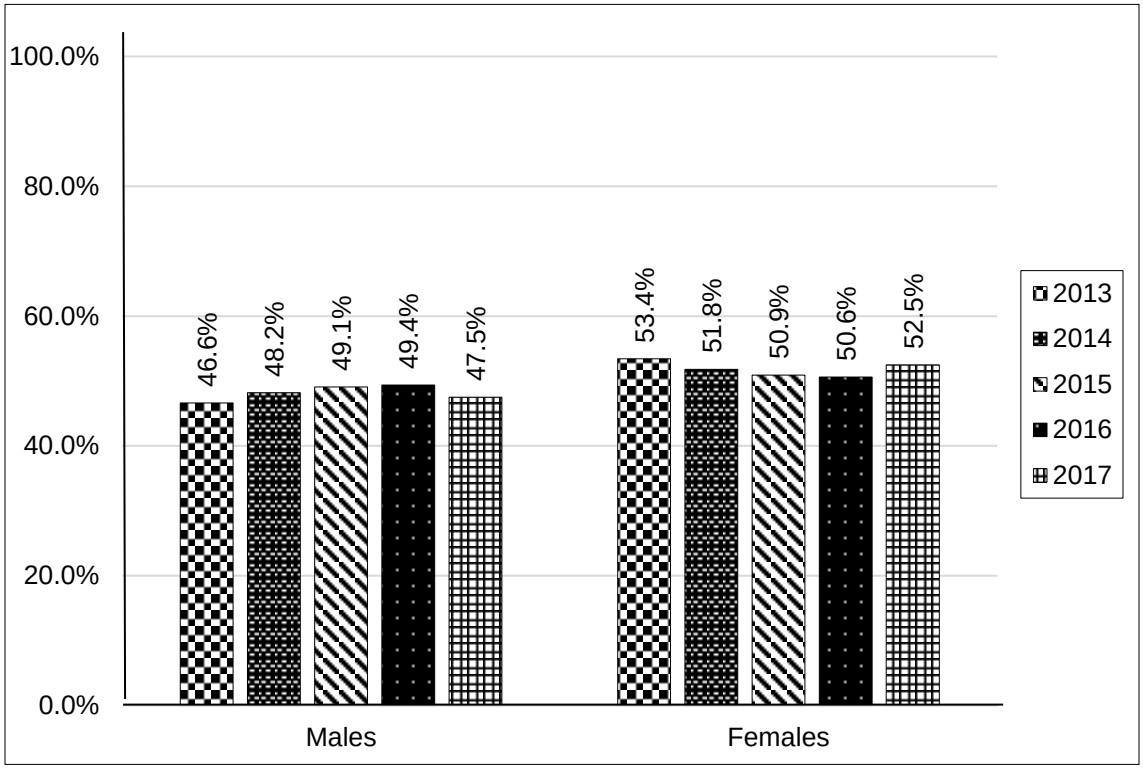
Differences by Gender

Table 10 compares the prevalence of SED and SMI for population living at or below 138% FPL for Males and Females.

The highest rate of prevalence of SED and SMI among Males was in SA 4 (49.7%) compared to SA 1 (48.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 1 (51.9%) compared to SA 4 (50.3%) with the lowest percentage.

FIGURE 8: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2013–2017



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2018.

The percentage of Males living at or below 138% FPL increased by 0.9% from 46.6% in CY 2013 to 47.5% in CY 2017.

The percentage of Females living at or below 138% FPL decreased by 0.9% from 53.4% in CY 2012 to 52.5% in CY 2017.

II. Medi-Cal Population Service Needs

A. This section summarizes the Medi-Cal population and client utilization data by race/ethnicity, language, age, and gender.

TABLE 11: POPULATION ENROLLED IN MEDI-CAL BY RACE/ETHNICITY AND SERVICE AREA MARCH 2018

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	40,268	4,072	97,299	322	29,608	171,569
Percent	**23.5%**	2.4%	56.7%	0.19%	17.3%	100.0%
SA 2	25,380	49,583	377,517	711	209,101	662,292
Percent	3.83%	7.49%	57.0%	0.11%	31.6%	100.0%
SA 3	19,929	154,105	318,141	557	52,147	544,879
Percent	3.7%	**28.3%**	58.4%	0.10%	9.6%	100.0%
SA 4	26,389	58,902	278,731	1005	58,433	423,460
Percent	6.2%	13.9%	65.8%	**0.24%**	13.8%	100.0%
SA 5	11,194	7,137	28,676	200	35,904	83,111
Percent	13.5%	8.6%	**34.5%**	**0.24%**	**43.2%**	100.0%
SA 6	133,616	5,614	421,443	511	13,390	574,574
Percent	23.3%	**1.0%**	73.3%	**0.09%**	**2.3%**	100.0%
SA 7	12,477	25,916	395,991	518	30,933	465,835
Percent	**2.7%**	5.6%	**85.0%**	0.11%	6.6%	100.0%
SA 8	86,052	50,532	263,987	791	50,477	451,839
Percent	19.0%	11.2%	58.4%	0.18%	11.2%	100.0%
Total	355,305	355,861	2,181,785	4,615	479,993	3,377,559
Percent	10.5%	10.5%	64.6%	0.14%	14.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Unknown SA (N= 456,423), Unknown Race/Ethnicity (N= 572), and "Other" Race/Ethnicity (N= 64,978) were not included in the Race/Ethnicity table. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Race/Ethnicity

The highest percentage of African Americans enrolled in Medi-Cal was in SA 1 (23.5%) compared to SA 7 (2.7%) with the lowest percentage.

The highest percentage of Asian/Pacific Islanders (API) enrolled in Medi-Cal was in SA 3 (28.3%) compared to SA 6 (1.0%) with the lowest percentage.

The highest percentage of Latinos enrolled in Medi-Cal was in SA 7 (85.0%) compared to SA 5 (34.5%) with the lowest percentage.

The highest percentage of Native Americans enrolled in Medi-Cal was in SAs 4 and 5 (0.24%) compared to SA 6 (0.09%) with the lowest percentage.

The highest percentage of Whites enrolled in Medi-Cal was in SA 5 (43.2%) compared to SA 6 (2.3%) with the lowest percentage.

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TABLE 12: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP AND SERVICE AREA - MARCH 2018

Service Area (SA)	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	76,885	6,625	15,061	67,700	6,490	11,490	184,251
Percent	**41.7%**	**3.6%**	**8.2%**	36.7%	**3.5%**	**6.2%**	100.0%
SA 2	236,145	20,707	49,797	284,006	35,322	94,132	720,109
Percent	32.8%	2.9%	**6.9%**	39.4%	4.9%	13.1%	100.0%
SA 3	206,056	18,381	43,211	226,187	29,080	78,986	601,901
Percent	34.2%	3.1%	7.2%	37.6%	4.8%	13.1%	100.0%
SA 4	135,138	12,315	32,156	195,513	23,471	63,705	462,298
Percent	29.2%	2.7%	7.0%	42.3%	5.1%	13.8%	100.0%
SA 5	23,568	2,374	6,989	46,531	5,382	14,597	99,441
Percent	**23.7%**	**2.4%**	7.0%	**46.8%**	**5.6%**	**14.7%**	100.0%
SA 6	249,741	20,671	47,596	229,915	23,644	43,804	615,371
Percent	40.6%	3.4%	7.7%	37.4%	3.8%	7.1%	100.0%
SA 7	195,960	16,743	37,852	181,123	19,917	50,127	501,722
Percent	39.1%	3.3%	7.5%	**36.1%**	4.0%	10.0%	100.0%
SA 8	183,249	16,016	39,273	198,481	22,175	47,510	506,704
Percent	36.2%	3.2%	7.8%	39.2%	4.4%	9.4%	100.0%
Total	1,306,742	113,832	271,935	1,429,456	165,481	404,351	3,691,797
Percent	35.4%	3.1%	7.4%	38.7%	4.5%	11.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Unknown SA (N=142,185). Due to rounding, some estimated totals and percentages may not add up correctly.
Data Source: State MEDS File, March 2018.

Differences by Age Group

The highest percentage of individuals between 0 and 18 years old enrolled in Medi-Cal was in SA 1 (41.7%) compared to SA 5 (23.7%) with the lowest percentage.

The highest percentages of individual between 19 and 20 years old enrolled in Medi-Cal were in SA 1 (3.6%) compared to SA 5 (2.4%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old enrolled in Medi-Cal was in SA 1 (8.2%) compared to SA 2 (6.9%) with the lowest percentage.
The highest percentage of individuals between 26 and 59 years old enrolled in Medi-Cal was in SA 5 (46.8%) compared to SA 7 (36.1%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old enrolled in Medi-Cal was in SA 5 (5.6%) compared to SA 1 (3.5%) with the lowest percentage.

The highest percentage of individuals 65 years old and older enrolled in Medi-Cal was in SA 5 (14.7%) compared to SA 1 (6.2%) with the lowest percentage.

TABLE 13: POPULATION ENROLLED IN MEDI-CAL BY GENDER AND SERVICE AREA - MARCH 2018

Service Area (SA)	Males	Females	Total
SA 1	85,130	100,348	185,478
Percent	45.9%	54.1%	100.0%
SA 2	332,242	391,945	724,187
Percent	45.9%	54.1%	100.0%
SA 3	276,876	328,703	605,579
Percent	45.7%	54.3%	100.0%
SA 4	219,141	245,635	464,776
Percent	47.1%	52.9%	100.0%
SA 5	47,444	52,388	99,832
Percent	**47.5%**	**52.5%**	100.0%
SA 6	282,901	337,093	619,994
Percent	45.6%	54.4%	100.0%
SA 7	226,802	278,255	505,057
Percent	**44.9%**	**55.1%**	100.0%
SA 8	233,711	276,237	509,948
Percent	45.8%	54.2%	100.0%
Total	1,704,247	2,010,604	3,714,851

Note: Due to rounding, some estimated totals and percentages may not add up correctly. Bold values represent the highest and lowest percentages within each gender and across all SAs. Unknown SA (N=119,131).
Data Source: State MEDS File, March 2018.

Differences by Gender

The highest percentage of Males enrolled in Medi-Cal was in SA 5 (47.5%) as compared with the lowest in SA 7 (44.9%).

The highest percentage of Females enrolled in Medi-Cal was in SA 7 (55.1%) compared to SA 5 (52.5%) with the lowest percentage.

TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY RACE/ETHNICITY AND SERVICE AREA MARCH 2018

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	11,476	330	10,800	114	4,708	27,428
Percent	41.8%	1.2%	39.4%	0.4%	17.2%	100.0%
SA 2	7,233	4,016	41,904	251	33,247	86,652
Percent	8.3%	4.6%	48.4%	0.29%	38.4%	100.0%
SA 3	5,680	12,483	35,314	197	8,291	61,964
Percent	9.2%	**20.1%**	57.0%	0.32%	13.4%	100.0%
SA 4	7,521	4,771	30,939	355	9,291	52,877
Percent	14.2%	9.0%	58.5%	**0.67%**	17.6%	100.0%
SA 5	3,190	578	3,183	71	5,709	12,731
Percent	25.1%	4.5%	**25.0%**	0.55%	**44.8%**	100.0%
SA 6	38,081	455	46,780	180	2,129	87,625
Percent	**43.5%**	**0.5%**	53.4%	**0.21%**	**2.4%**	100.0%
SA 7	3,556	2,099	43,955	183	4,918	54,711
Percent	**6.5%**	3.8%	**80.3%**	0.33%	9.0%	100.0%
SA 8	24,525	4,093	29,303	279	8,026	66,226
Percent	37.0%	6.2%	44.2%	0.42%	12.1%	100.0%
Total	101,262	28,825	242,178	1,629	76,319	450,213
Percent	22.5%	6.4%	53.8%	0.36%	17.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated numbers and percentages may not add up correctly. Data source: State MEDS File, March 2018.

Differences by Race/Ethnicity

Table 14 compares the prevalence of SED and SMI Medi-Cal enrolled population by race/ethnicity and SA.

The highest prevalence of SED and SMI in the African American (AA) group was in SA 6 (43.5%) compared to SA 7 (6.5%) with the lowest percentage.

The highest prevalence of SED and SMI in the Asian/Pacific Islander (API) group was in SA 3 (20.1%) compared to SA 6 (0.5%) with the lowest percentage.
The highest prevalence of SED and SMI in the Latino group was in SA 7 (80.3%) compared to SA 5 (25.0%) with the lowest percentage.

The highest prevalence of SED and SMI in the Native American (NA) group was in SA 5 (0.67%) compared to SA 6 (0.21%) with the lowest percentage.

The highest prevalence of SED and SMI in the White group was in SA 5 (44.8%) compared to SA 6 (2.4%) with the lowest percentage.

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TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP AND SERVICE AREA MARCH 2018

SA	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	14,685	1,458	1,807	9,072	896	873	28,791
Percent	**51.0%**	**5.1%**	**6.3%**	**31.5%**	**3.1%**	**3.0%**	100.0%
SA 2	45,104	4,556	5,976	38,057	4,874	7,154	105,720
Percent	42.7%	4.3%	**5.7%**	36.0%	4.6%	6.8%	100.0%
SA 3	39,357	4,044	5,185	30,309	4,013	6,003	88,911
Percent	44.3%	4.5%	5.8%	34.1%	4.5%	6.8%	100.0%
SA 4	25,811	2,709	3,859	26,199	3,239	4,842	66,659
Percent	38.7%	4.1%	5.8%	39.3%	4.9%	7.3%	100.0%
SA 5	4,501	522	839	6,235	743	1,109	13,950
Percent	**32.3%**	**3.7%**	6.0%	**44.7%**	**5.3%**	**8.0%**	100.0%
SA 6	47,701	4,548	5,712	30,809	3,263	3,329	95,360
Percent	50.0%	4.8%	6.0%	32.3%	3.4%	3.5%	100.0%
SA 7	37,428	3,683	4,542	24,270	2,749	3,810	76,483
Percent	48.9%	4.8%	5.9%	31.7%	3.6%	5.0%	100.0%
SA 8	35,001	3,524	4,713	26,596	3,060	3,611	76,504
Percent	45.7%	4.6%	6.2%	34.8%	4.0%	4.7%	100.0%
Total	249,588	25,043	32,632	191,547	22,836	30,731	552,377
Percent	45.2%	4.5%	5.9%	34.7%	4.1%	5.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Estimated prevalence rates of mental illness by age group for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Age Group

Table 15 compares the prevalence of SED and SMI among Medi-Cal enrolled population for each age group.

The highest prevalence of SED and SMI in Age Group 0-18 was in SA 1 (51.0%) compared to SA 5 (32.3%) with the lowest percentage.
The highest prevalence of SED and SMI in Age Group 19-20 was in SA 1 (5.1%) compared to SA 5 (3.7%) with the lowest percentage.
The highest prevalence of SED and SMI in Age Group 21-25 was in SA 1 (6.3%) compared to SA 2 (5.7%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 26-59 was in SA 5 (44.7%) compared to SA 1 (31.5%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 60-64 was in SA 5 (5.3%) compared to SA 1 (3.1%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 65 and older was in SA 5 (8.0%) compared to SA 1 (3.0%) with the lowest percentage.

TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY GENDER AND SERVICE AREA MARCH 2018

Service Area (SA)	Males	Females	Total
SA 1	12,599	11,941	24,541
Percent	51.3%	48.7%	100.0%
SA 2	49,172	46,641	95,813
Percent	51.3%	48.7%	100.0%
SA 3	40,978	39,116	80,093
Percent	51.2%	48.8%	100.0%
SA 4	32,433	29,231	61,663
Percent	52.6%	47.4%	100.0%
SA 5	7,022	6,234	13,256
Percent	**53.0%**	**47.0%**	100.0%
SA 6	41,869	40,114	81,983
Percent	51.1%	48.9%	100.0%
SA 7	33,567	33,112	66,679
Percent	**50.3%**	**49.7%**	100.0%
SA 8	34,589	32,872	67,461
Percent	51.3%	48.7%	100.0%
Total	252,229	239,262	491,490
Percent	51.3%	48.7%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence rates of mental illness by gender for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2015 and CY 2016. Due to rounding, some estimated numbers and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Gender

Table 16 compares the prevalence of SED and SMI among the Medi-Cal enrolled population for Males and Females by Service Area.

The highest prevalence of SED and SMI among Males was in SA 5 (53.0%) compared to SA 7 (50.3%) with the lowest percentage.

The highest prevalence of SED and SMI among Females was in SA 7 (49.7%) compared to SA 5 (47.0%) with the lowest percentage.

TABLE 17: PRIMARY LANGUAGE OF POPULATION ENROLLED IN MEDI-CAL BY SERVICE AREA AND THRESHOLD LANGUAGE MARCH 2018

Service Area	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	256	222	41	33	136,576	65	146	79	13	25	46,077	154	177	183,864
Percent	0.14%	0.12%	0.02%	0.02%	**74.28%**	0.04%	0.08%	0.04%	0.01%	0.01%	**25.06%**	0.08%	0.10%	100.00%
SA 2	2,688	65,076	188	283	373,424	10,156	4,876	593	122	6,099	245,178	3,158	3,695	715,536
Percent	0.38%	**9.09%**	0.03%	0.04%	**52.19%**	**1.42%**	**0.68%**	0.08%	0.02%	**0.85%**	**34.26%**	**0.44%**	**0.52%**	100.00%
SA 3	1,205	2,022	1,073	34,712	324,210	381	3,252	44,096	3,790	132	159,238	1,664	21,090	596,865
Percent	0.20%	0.34%	0.18%	**5.82%**	**54.32%**	0.06%	**0.54%**	**7.39%**	**0.63%**	0.02%	**26.68%**	0.28%	**3.53%**	100.00%
SA 4	256	6,597	622	7,703	214,816	641	18,814	1,291	449	5,195	196,549	2,904	1,584	457,421
Percent	0.06%	**1.44%**	0.14%	**1.68%**	**46.96%**	0.14%	**4.11%**	0.28%	0.10%	**1.14%**	**42.97%**	0.63%	0.35%	100.00%
SA 5	322	79	14	113	73,587	3,917	520	331	63	1,490	16,852	104	106	97,498
Percent	0.33%	0.08%	0.01%	0.12%	**75.48%**	**4.02%**	0.53%	0.34%	0.06%	1.53%	**17.28%**	0.11%	0.11%	100.00%
SA 6	78	15	106	113	313,730	37	1,646	77	16	49	298,664	123	90	614,744
Percent	0.01%	0.00%	0.02%	0.02%	**51.03%**	0.01%	0.27%	0.01%	0.00%	0.01%	**48.58%**	0.02%	0.01%	100.00%
SA 7	669	553	1,069	1,054	265,217	57	3,013	1,554	215	73	223,708	997	876	499,055
Percent	0.13%	0.11%	0.21%	0.21%	**53.14%**	0.01%	**0.60%**	0.31%	0.04%	0.01%	**44.83%**	0.20%	0.18%	100.00%
SA 8	669	109	5,643	437	326,773	479	3,588	793	146	256	158,965	1,976	3,046	502,880
Percent	0.13%	0.02%	**1.12%**	0.09%	**64.98%**	0.10%	**0.71%**	0.16%	0.03%	0.05%	**31.61%**	0.39%	**0.61%**	100.00%
Total	6,143	74,673	8,756	44,448	2,028,333	15,733	35,855	48,814	4,814	13,319	1,345,231	11,080	30,664	3,667,863
Percent	0.17%	2.04%	0.24%	1.21%	55.30%	0.43%	0.98%	1.33%	0.13%	0.36%	36.68%	0.30%	0.84%	100.00%

Note: "Threshold Language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. SA Threshold Languages are in bold. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. A total of 6,143 (0.2%) individuals enrolled in Medi-Cal reported Arabic as their primary language in March 2018. Unknown SA is (N = 119,131). A total of 7,843 (0.2%) individuals enrolled in Medi-Cal reported "Other" as a primary language. Data Source: State MEDS File, March 2018.

Table 17 shows the thirteen (13) LACDMH threshold languages by Service Area (SA). Of the twelve Non-English threshold languages spoken among the population enrolled in Medi-Cal, Spanish had the highest percentage across all eight SAs.

The SA with the highest percentage of Medi-Cal enrolled population with English as the primary language was SA 5 (75.5%) and the lowest percentage was SA 4 (47.0%).

The Service Area with the highest percentage of Medi-Cal enrolled population with Spanish as the primary language was SA 6 (50.0%) and the lowest percentage was SA 5 (17.3%).

The following information identifies the LACDMH threshold languages of Medi-Cal enrollees in each SA:

SA 1 has two threshold languages: English (74.3%) and Spanish (25.1%).

SA 2 has eight threshold languages: Armenian (9.1%), English (52.2%), Farsi (1.4%), Korean (0.7%), Russian (0.9%), Spanish (34.3%), Tagalog (0.4%), and Vietnamese (0.5%).

SA 3 has seven threshold languages: Cantonese (5.8%), English (54.3%), Korean (0.5%), Mandarin (7.4%), Other Chinese (0.6%), Spanish (26.7%), and Vietnamese (3.5%).

SA 4 has six threshold languages: Armenian (1.4%), Cantonese (1.7%), English (47.0%), Korean (4.1%), Russian (1.1%), and Spanish (43.0%).

SA 5 has three threshold languages: English (75.5%), Farsi (4.0%), and Spanish (17.3%).

SA 6 has two threshold languages: English (51.0%) and Spanish (48.6%).

SA 7 has three threshold languages: English (53.1%), Korean (0.6%), and Spanish (44.8%).

SA 8 has five threshold languages: Cambodian (1.1%), English (65.0%), Korean (0.7%), Spanish (31.6%), and Vietnamese (0.6%).

Countywide, the highest percentage of Medi-Cal Enrolled persons reported English as the primary language (55.3%) and the second highest percentage reported was Spanish (36.7%). All other threshold languages range between 0.1% (Other Chinese) and 2.0% (Armenian).

Consumers Served In Outpatient Programs

TABLE 18: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA FY 17–18

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	8,579	377	7,676	235	5,411	22,278
Percent	38.5%	1.7%	34.5%	**1.1%**	24.3%	100.0%
SA 2	3,996	1,821	21,080	191	12,018	39,106
Percent	10.2%	4.7%	53.9%	0.49%	30.7%	100.0%
SA 3	3,675	2,943	19,452	237	5,202	31,509
Percent	11.7%	**9.3%**	61.7%	0.75%	16.5%	100.0%
SA 4	7,326	2,820	19,868	232	5,686	35,932
Percent	20.4%	7.8%	55.3%	0.65%	15.8%	100.0%
SA 5	1,884	389	1,869	81	3,647	7,870
Percent	23.9%	4.9%	**23.7%**	1.03%	**46.3%**	100.0%
SA 6	21,294	569	20,763	165	2,166	44,957
Percent	**47.4%**	**1.3%**	46.2%	**0.4%**	**4.8%**	100.0%
SA 7	2,074	921	23,807	288	2,972	30,062
Percent	**6.9%**	3.1%	**79.2%**	0.96%	9.9%	100.0%
SA 8	11,283	2,488	14,308	294	6,795	35,168
Percent	32.1%	7.1%	40.7%	0.84%	19.3%	100.0%
Total	41,896	9,699	82,064	1,276	32,625	167,560
Percent	25.0%	5.8%	49.0%	0.76%	19.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group and across all SAs. The table excludes consumers served outside the SA (N=4,848), those whose race/ethnicity is unknown (N = 8,125) and "Other" (N =5,728). Total reflects an unduplicated count of consumers served. Data Source: LACDMH Integrated System (IS)-Integrated Behavioral Information Systems (IBHIS), December 2018.

Differences by Race/Ethnicity

Table 19 presents the unduplicated count of consumers served in outpatient programs by race/ethnicity and SA.

The highest percentage of African American consumers served in outpatient programs was in SA 6 (47.4%) as compared to SA 7 (6.9%) with the lowest percentage.

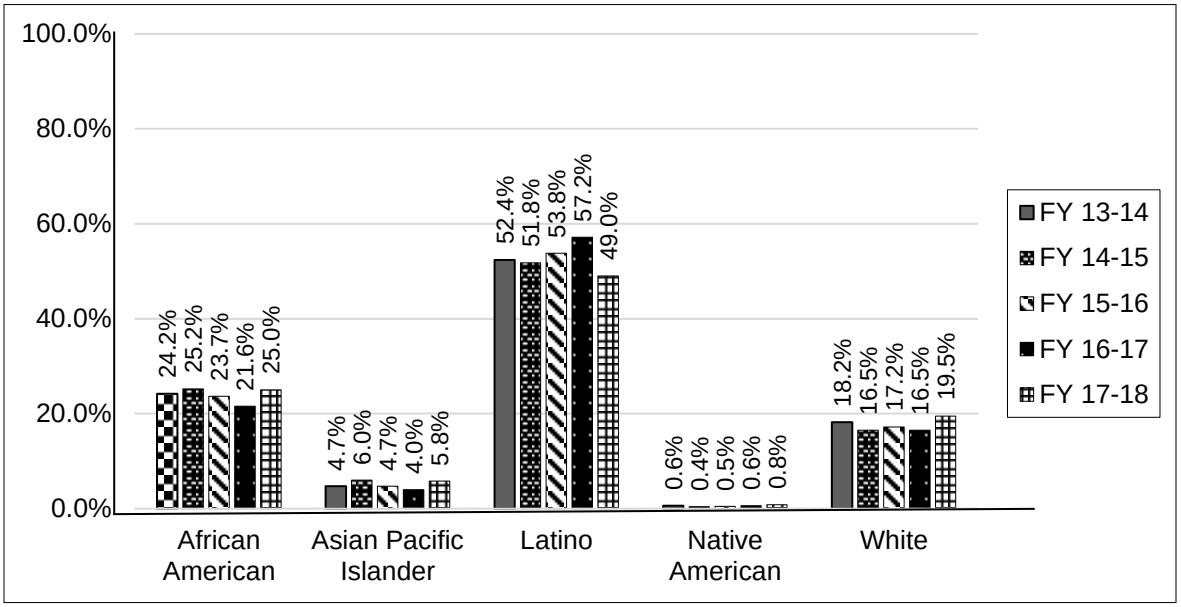
The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (9.3%) as compared to SA 6 (1.3%) with the lowest percentage.

The highest percentage of Latino consumers served in outpatient programs was in SA 7 (79.2%) as compared to SA 5 (23.7%) with the lowest percentage.

The highest percentage of Native American consumers served in outpatient programs was in SA 1 (1.1%) as compared to SA 6 (0.4%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (46.3%) as compared to SA 6 (4.8%) with the lowest percentage.

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY FY 2012- 2013 TO FY 2017-2018



Data Source: LACDMH, IS-IBHIS, December 2018

The percentage of African Americans (AA) served in outpatient programs increased by 0.8% from 24.2% to 25% between FY 13-14 and FY 17-18.

The percentage of Asian/Pacific Islanders (API) served in outpatient programs increased by 1.1% between FY 13-14 and FY 17-18 from 4.7% to 5.8%.

The percentage of Latinos served in outpatient programs decreased by 3.4% from 52.4% to 49.0% between FY 13-14 and FY 17-18.

The percentage of Native Americans (NA) served in outpatient programs increased by 0.2% from 0.6% to 0.8% from FY 13-14 and FY 17-18.

The percentage of Whites served in outpatient programs increased by 1.3% from 18.2% to 19.5% between FY 13-14 and FY 17-18.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP AND SERVICE AREA FY 17-18

Service Area (SA)	AGE GROUP				
	0-15	16-25	26-59	60+	Total
SA 1	8,015	4,283	9,968	1,429	23,695
Percent	33.8%	18.1%	42.1%	**6.0%**	100.0%
SA 2	14,430	10,404	17,188	4,159	46,181
Percent	31.2%	22.5%	37.2%	9.0%	100.0%
SA 3	15,985	10,087	12,413	2,717	41,202
Percent	38.8%	**24.5%**	**30.1%**	6.6%	100.0%
SA 4	11,173	7,856	18,232	4,513	41,774
Percent	26.7%	18.8%	43.6%	10.8%	100.0%
SA 5	1,563	1,504	4,892	1,403	9,362
Percent	**16.7%**	**16.1%**	**52.3%**	**15.0%**	100.0%
SA 6	17,905	10,661	20,171	4,098	52,835
Percent	33.9%	20.2%	38.2%	7.8%	100.0%
SA 7	14,571	8,077	11,869	2,475	36,992
Percent	**39.4%**	21.8%	32.1%	6.7%	100.0%
SA 8	12,278	7,378	17,148	4,124	40,928
Percent	30.0%	18.0%	41.9%	10.1%	100.0%
Total	69,623	40,653	85,114	20,411	215,801
Percent	32.3%	18.8%	39.4%	9.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Unknown/not reported and consumers outside the SA (N=33,603) were excluded from this table. Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, December 2018.

Differences by Age Group

Table 19 shows the unduplicated count of consumers served in outpatient programs by age group and SA.

The highest percentage of Children (0-15 years old) served was in SA 7 (39.4%) compared to SA 5 (16.7%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 2 (24.5%) when compared to SA 5 (16.1%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (52.3%) compared to SA 3 (30.1%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (15.0%) compared to SA 1 (6.0%) with the lowest percentage.

TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA
FY 17–18

Service Area (SA)	Males	Females	Total
SA 1	11,613	12,060	23,673
Percent	**49.1%**	**50.9%**	100.0%
SA 2	23,434	22,705	46,139
Percent	50.8%	49.2%	100.0%
SA 3	20,751	20,417	41,168
Percent	50.4%	49.6%	100.0%
SA 4	22,768	18,920	41,688
Percent	**54.6%**	**45.4%**	100.0%
SA 5	4,830	4,509	9,339
Percent	51.7%	48.3%	100.0%
SA 6	26,926	25,852	52,778
Percent	51.0%	49.0%	100.0%
SA 7	18,753	18,205	36,958
Percent	50.7%	49.3%	100.0%
SA 8	20,512	20,363	40,875
Percent	50.2%	49.8%	100.0%
Total	108,249	107,301	215,550
Percent	50.2%	49.8%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Table excludes consumers outside SA (N=4,848); Transgender Female to Male (N=107); and Male to Female (N=90); and Unknown/Not reported gender (N= 60). Data Source: LACDMH-IS-IBHIS, December 2018.

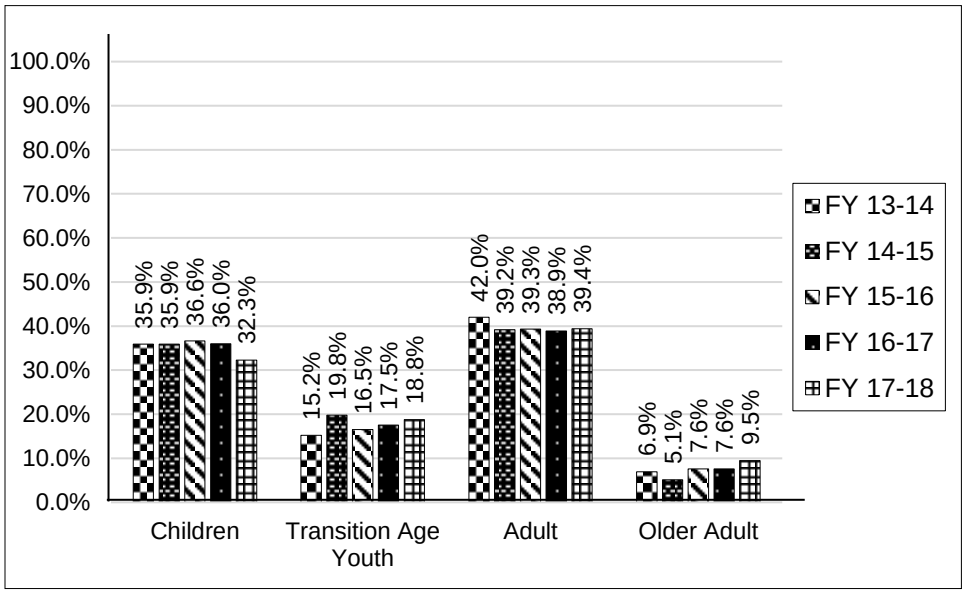
Differences by Gender

Table 20 presents the unduplicated count of consumers served in outpatient programs by gender and SA.

The highest percentage of Males served in outpatient programs was in SA 4 (54.6%) compared to SA 1 (49.1%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 1 (50.9%) compared to SA 4 (45.4%) with the lowest percentage.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP FY 13-14 TO FY 17-18



Data Source: LACDMH, IS-IBHIS, December 2018.

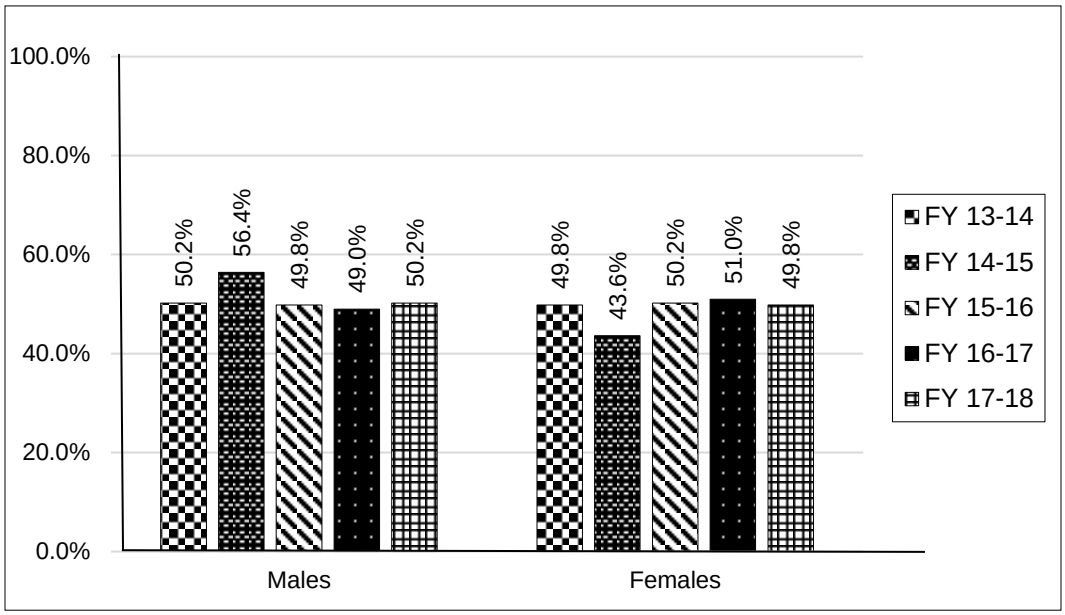
The percentage of Children served in outpatient programs decreased by 3.6% from 35.9% to 32.3% between FY 13-14 and FY 17-18.

The percentage of TAY served in outpatient programs increased by 3.6% from 15.2% to 18.8% between FY 13-14 and FY 17-18.

The percentage of Adults served in outpatient programs decreased by 2.6% from 42.0% to 39.4% between FY 13-14 and FY 17-18.

The percentage of Older Adults served in outpatient programs increased by 2.6% from 6.9% to 9.5% between FY 13-14 and FY 17-18.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER FY 13-14 TO FY 17-18



Data Source: LACDMH, IS-IBHIS, December 2018.

The percentage of Males in outpatient programs remained the same (50.2%) between FY 13-14 and FY 17-18.

The percentage of Females served in outpatient programs remained the same (49.8%) between FY 13-14 and FY 17-18.

TABLE 20: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE FY 17-18

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	8	14	3	0	21,785	9	2	5	0	5	1,448	9	3	23,291
Percent	0.03%	0.06%	0.01%	0.00%	**93.5%**	0.04%	0.01%	0.02%	0.00%	0.02%	**6.2%**	0.04%	0.01%	100.00%
SA 2	106	1,311	19	8	35,638	501	118	12	9	142	6,913	108	53	44,938
Percent	0.24%	**2.9%**	0.04%	0.02%	**79.3%**	**1.11%**	**0.3%**	0.03%	0.02%	**0.3%**	**15.4%**	**0.2%**	**0.1%**	100.0%
SA 3	25	42	65	529	31,648	10	79	501	96	6	6,704	37	341	40,083
Percent	0.06%	0.10%	0.16%	**1.32%**	**79.0%**	0.02%	**0.20%**	**1.3%**	**0.2%**	0.01%	**16.7%**	0.09%	**0.9%**	100.0%
SA 4	14	166	67	147	30,221	47	813	47	21	104	7,919	86	70	39,722
Percent	0.04%	**0.4%**	0.17%	**0.4%**	**76.1%**	0.12%	**2.05%**	0.12%	0.05%	**0.3%**	**19.9%**	**0.2%**	0.18%	100.0%
SA 5	9	4	0	3	8,087	145	19	9	0	21	566	4	5	8,872
Percent	0.10%	0.05%	0.00%	0.03%	**91.2%**	**1.63%**	0.21%	0.10%	0.00%	0.24%	**6.4%**	0.05%	0.06%	100.0%
SA 6	6	5	21	21	41,570	10	107	20	4	17	9,465	8	10	51,264
Percent	0.01%	0.01%	0.04%	0.04%	**81.1%**	0.02%	0.21%	0.04%	0.01%	0.03%	**18.5%**	0.02%	0.02%	100.00%
SA 7	23	9	92	20	27,003	2	63	27	9	2	8,747	25	35	36,057
Percent	0.06%	0.02%	0.26%	0.06%	**74.9%**	0.01%	**0.17%**	0.07%	0.02%	0.01%	**24.3%**	0.07%	0.10%	100.00%
SA 8	27	3	625	11	32,577	13	105	23	12	4	5,953	82	128	39,563
Percent	0.07%	0.01%	**1.6%**	0.03%	**82.3%**	0.03%	0.27%	0.06%	0.03%	0.01%	**15.1%**	0.21%	0.32%	100.00%
Total	185	1,446	860	617	164,492	638	98	561	131	261	37,582	298	603	207,772
Percent	0.09%	0.70%	0.4%	0.30%	79.2%	0.31%	0.05%	0.27%	0.06%	0.13%	18.1%	0.14%	0.29%	100.0%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the State MEDS File, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Primary languages for Medi-Cal enrollees (see Table 17) are in bold. A total of 8,035 consumers served in outpatient programs specified another non-threshold primary language show in Table 23. Another 1,316 consumers had primary languages that were "Unknown" or "Missing". Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. A total of 185 Arabic speaking consumers were served in FY 17-18. Data Source: LACDMH-IS-IBHIS, December 2018.

Table 20 shows the primary language of consumers served in outpatient programs by Service Area (SA) and threshold language.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 164,492 (79.2%) English speaking consumers were served followed by 37,582 (18.1%) Spanish speaking consumers. The remaining 5,698 (2.7%) consumers served spoke other LACDMH threshold languages. A total of 43,280 (20.8%) of the consumers served reported a primary language other than English.

SA 1 (93.5%) had the highest percentage of English speaking consumers, as compared to SA 7 (74.9%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (24.3%) and the lowest percentage was in SA 1 (6.2%).

The following information highlights the additional non-English threshold languages reported for consumers served in outpatient programs by SA:

- SA 1: Spanish (6.2%)
- SA 2: Armenian (2.9%), Farsi (1.1%), Korean (0.3%), Russian (0.3%), Spanish (15.4%), Tagalog (0.2%), and Vietnamese (0.1%)
- SA 3: Cantonese (1.3%), Korean (0.2%), Mandarin (1.2%), Other Chinese (0.2%), Spanish (16.7%), and Vietnamese (0.9%)
- SA 4: Armenian (0.4%), Cantonese (0.4%), Korean (2.0%), Russian (0.3%), and Spanish (19.9%)
- SA 5: Farsi (1.6%) and Spanish (6.4%)
- SA 6: Spanish (18.5%)
- SA 7: Korean (0.2%) and Spanish (24.3%)
- SA 8: Cambodian (1.6%), Korean (0.3%), Spanish (15.1%), and Vietnamese (0.32%)

B. Needs Assessment/Analysis of Disparities

Demographic profile of Los Angeles County is presented in the next section. This includes total population and population living at or below 200% FPL distribution by race/ethnicity, age group and gender in CY 2017 and consumers served in FY 2017-2018. The needs assessment section further analyzes the demographic distribution of the outpatient consumers served in the County Service Areas for FY 2017-2018 and compares it with population enrolled in Medi-Cal estimated with SED and SMI to assess the unmet need for mental health services in the County.

Disparity by Race/Ethnicity

TABLE 21: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED AFRICAN AMERICAN POPULATION WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	11,476	5,035	-6,441
SA 2	7,233	2,724	-4,509
SA 3	5,680	2,261	-3,419
SA 4	7,521	5,421	-2,100
SA 5	3,190	1,343	**-1,847**
SA 6	38,081	15,231	**-22,850**
SA 7	3,556	1,391	-2,165
SA 8	24,525	8,490	-16,035
Total	101,262	41,896	-59,366

Note: Bold indicates highest and lowest Total Disparity values**.** [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 21 shows that among the Outpatient African American (AA) consumers, the greatest disparity was in SA 6 with an estimated 22,850 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 1,847 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 59,366 Medi-Cal Enrolled AA individuals as the number of unduplicated consumers served was 41,896 while the estimated Medi-Cal Enrolled Population with SED and SMI was 101,262.

TABLE 22: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ASIAN/PACIFIC ISLANDER POPULATION WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	330	217	-113
SA 2	4,016	1,480	-2,536
SA 3	12,483	2,355	**-10,128**
SA 4	4,771	1,998	-2,773
SA 5	578	308	-270
SA 6	455	401	**-54**
SA 7	2,099	767	-1,332
SA 8	4,093	2,173	-1,920
Total	28,825	9,699	-19,126

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 22 shows that among the Outpatient Asian/Pacific Islander (API) consumers, the greatest disparity was in SA 3 with an estimated 10,128 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated 54 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 19,126 Medi-Cal Enrolled API individuals as the number of unduplicated consumers served was 9,699 while the estimated Medi-Cal Enrolled Population with SED and SMI was 28,825.

TABLE 23: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED LATINO POPULATION WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	10,800	4,840	-5,960
SA 2	41,904	15,729	-26,175
SA 3	35,314	12,593	-22,721
SA 4	30,939	14,208	-16,731
SA 5	3,183	1,452	**-1,731**
SA 6	46,780	15,055	**-31,725**
SA 7	43,955	16,729	-27,226
SA 8	29,303	11,458	-17,845
Total	242,178	92,064	-150,114

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 23 shows that among the Outpatient Latino consumers, the greatest disparity was in SA 6 with an estimated 31,725 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 1,731 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 150,114 Medi-Cal Enrolled Latino individuals as the number of unduplicated consumers served was 92,064 while the estimated Medi-Cal Enrolled Population with SED and SMI was 242,178.

TABLE 24: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED NATIVE AMERICAN POPULATION WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	114	143	(+)29
SA 2	251	147	-104
SA 3	197	171	-26
SA 4	355	183	**-172**
SA 5	71	56	**-15**
SA 6	180	127	-53
SA 7	183	229	(+)46
SA 8	279	220	-59
Total	1,629	1,276	-353

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 24 shows that among the Outpatient Native American consumers, the greatest disparity was in SA 4 with an estimated 172 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 15 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 353 Medi-Cal Enrolled Native American individuals as the number of unduplicated consumers served was 1,276 while the estimated Medi-Cal Enrolled Population with SED and SMI was 1,629.

TABLE 25: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED WHITE POPULATION WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	4,708	3,351	-1,357
SA 2	33,247	9,286	**-23,961**
SA 3	8,291	3,681	-4,610
SA 4	9,291	4,292	-4,999
SA 5	5,709	2,854	-2,855
SA 6	2,129	1,527	**-602**
SA 7	4,918	2,158	-2,760
SA 8	8,026	5,476	-2,550
Total	76,319	32,625	-43,694

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 25 shows that among the Outpatient White consumers, the greatest disparity was in SA 2 with an estimated 23,961 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated 602 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 43,694. Medi-Cal Enrolled White individuals as the number of unduplicated consumers served was 32,625 while the estimated Medi-Cal Enrolled Population with SED and SMI was 76,319.

Disparity by Language

TABLE 26: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED POPULATION WITH SED AND SMI BY LANGUAGE ESTIMATED FY 2017-2018

Language	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
Arabic	811	185	-626
Armenian	9,857	1,446	-8,411
Cambodian	1,156	860	**-296**
Cantonese	5,867	617	-5,250
English	267,740	164,492	-103,248
Farsi	2,077	638	-1,439
Korean	4,733	934	-3,799
Mandarin	6,443	561	-5,882
Other Chinese	635	131	-504
Russian	1,758	261	-1,497
Spanish	177,570	37,582	**-139,988**
Tagalog	1,463	298	-1,165
Vietnamese	4,048	603	-3,445
Total	484,158	208,608	-275,550

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 26 shows that among the Outpatient consumers in Los Angeles County, the threshold language with the greatest disparity need was Spanish with an estimated 139,988 (unduplicated) Spanish-speaking individuals in need of services. The least disparity was Cambodian with an estimated 296 (unduplicated) Cambodian-speaking individuals in need of services. Overall, at the county level, there was an estimated unmet service need based on language for 275,550 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 208,608 while the estimated Medi-Cal Enrolled Population with SED and SMI was 484,158.

Disparity by Age Group

TABLE 27: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED CHILDREN (0-15) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	5,818	4,945	-873
SA 2	17,734	10,825	**-6,909**
SA 3	15,387	11,063	-4,324
SA 4	10,174	8,140	-2,034
SA 5	1,762	1,195	**-567**
SA 6	19,055	13,218	-5,837
SA 7	14,796	10,571	-4,225
SA 8	13,887	9,666	-4,221
Total	98,614	69,623	-28,991

Note: Estimated prevalence rates for mental illness provided by California Health Interview Survey (CHIS) for the population for CY 2015 and CY 2016 were used. Bold indicates highest and lowest Total Disparity values**.** [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 27 shows that among the Outpatient Children consumers, the greatest disparity was in SA 2 with an estimated 6,909 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 567 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 28,991 Medi-Cal Enrolled individuals as the number of unduplicated Children consumers served was 69,623 while the estimated Medi-Cal Enrolled Population with SED and SMI was 98,614.

TABLE 28: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED TAY (16-25) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	5,445	2,463	-2,982
SA 2	17,612	7,106	**-10,506**
SA 3	15,541	6,399	-9,142
SA 4	10,708	5,288	-5,420
SA 5	2,155	1,102	**-1,053**
SA 6	17,040	7,205	-9,835
SA 7	13,826	5,549	-8,277
SA 8	13,530	5,541	-7,989
Total	95,856	40,653	-55,203

Note: Bold indicates highest and lowest Total Disparity values**.** [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 28 shows that among the Outpatient TAY consumers, the greatest disparity was in SA 2 with an estimated 10,506 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 1,053 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 55,203 Medi-Cal Enrolled individuals as the number of unduplicated TAY consumers served was 40,653 while the estimated Medi-Cal Enrolled Population with SED and SMI was 95,856.

TABLE 29: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ADULTS (26-59) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	9,072	6,213	-2,859
SA 2	38,057	13,678	**-24,379**
SA 3	30,309	9,535	-20,774
SA 4	26,199	13,691	-12,508
SA 5	6,235	3,837	**-2,398**
SA 6	30,809	15,093	-15,716
SA 7	24,270	8,897	-15,373
SA 8	26,596	14,170	-12,426
Total	191,547	85,114	-106,433

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 29 shows that among the Outpatient Adult consumers, the greatest disparity was in SA 2 with an estimated 24,379 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,398 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 106,433 Medi-Cal Enrolled individuals as the number of unduplicated Adult consumers served was 85,114 while the estimated Medi-Cal Enrolled Population with SED and SMI was 191,547.

TABLE 30: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED OLDER ADULTS (60+) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 2017-2018

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	1,708	948	-760
SA 2	12,298	3,684	-**8,614**
SA 3	10,266	2,235	-8,031
SA 4	8,282	3,558	-4,724
SA 5	1,898	1,181	-**717**
SA 6	6,408	3,266	-3,142
SA 7	6,654	1,947	-4,707
SA 8	6,620	3,592	-3,028
Total	54,134	20,411	-33,723

Note: Bold indicates highest and lowest Total Disparity values. [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 30 shows that among the Outpatient Older Adult consumers, the greatest disparity was in SA 2 with an estimated 8,614 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 717 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 33,723 Medi-Cal Enrolled individuals as the number of unduplicated Older Adult consumers served was 20,411 while the estimated Medi-Cal Enrolled Population with SED and SMI was 54,134.

Disparity by Gender

TABLE 31: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY GENDER ESTIMATED WITH SED AND SMI AND SERVICE AREA FY 2017-2018

	Male			Female		
	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	12,599	7,004	-5,595	11,941	7,549	-4,392
SA 2	49,172	17,393	**-31,779**	46,641	17,870	**-28,771**
SA 3	40,978	14,619	-26,359	39,116	14,587	24,529
SA 4	32,433	16,519	-15,914	29,231	14,097	15,134
SA 5	7,022	3,730	**-3,292**	6,234	3,570	**2,664**
SA 6	41,869	19,377	-22,492	40,114	19,368	20,746
SA 7	33,567	13,454	-20,113	33,112	13,486	19,626
SA 8	34,589	16,153	-18,436	32,872	16,774	16,098
Total	252,229	108,249	-143,980	239,262	107,301	131,961

Note: Bold indicates highest and lowest Total Disparity values**.** [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: State MEDS File, March 2018.

Table 31 shows that among the Outpatient Male consumers, the greatest disparity was in SA 2 with an estimated 31,779 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 3,292 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 143,980 Medi-Cal Enrolled individuals as the number of unduplicated Male consumers served was 108,249 while the estimated Medi-Cal Enrolled Population with SED and SMI was 252,229.

Among the Outpatient Female consumers, the greatest disparity was in SA 2 with an estimated 28,771 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,664 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 131,961 Medi-Cal Enrolled individuals as the number of unduplicated Female consumers served was 107,301 while the estimated Medi-Cal Enrolled Population with SED and SMI was 239,262.

III. 138% Below Federal Level of Poverty Population Service Needs

A. This section summarizes the CSS Population and client utilization data by race/ ethnicity, language, age, and gender.

TABLE 32: ESTIMATED COUNTYWIDE TOTAL POPULATION BY RACE/ETHNICITY TREND FOR CY 2015, CY 2016, AND CY 2017

Race/Ethnicity	Countywide Estimated Total Population					
	2015		2016		2017	
	N	%	N	%	N	%
African American	866,783	8.5%	831,669	8.1%	870,728	8.1%
Asian /Pacific Islander	1,488,355	14.6%	1,435,083	14.0%	1,505,337	14.1%
Latino	4,937,485	48.4%	4,987,274	48.8%	5,003,461	48.7%
Native American	19,703	0.2%	19,071	0.2%	18,345	0.2%
White	2,880,050	28.3%	2,733,351	26.7%	2,874,777	26.6%
Two or More Races			221,002	2.2%	227,125	2.2%
Total	10,192,376	100.0%	10,227,450	100.0%	10,272,648	100.0%

The African American population increased by 3,945 between CY 2015 and CY 2017, from 866,783 to 870,728 (percent remained the same at 8.5% of the total population). The African American population increased by 39,059 between CY 2016 and CY 2017, from 831,669 to 870,728 (percent increased by 0.2% from 8.3% to 8.5% of the total population).

The Asian/Pacific Islander population increased by 16,982 between CY 2015 and CY 2017, from 1,488,355 to 1,505,337 (increasing by 0.1% from 14.6% to 14.7% of the total population). The Asian/Pacific Islander population increased by 70,254 between CY 2016 and CY 2017, from 1,435,083 to 1,505,337 (increasing by 0.4% from 14.3% to 14.7% of the total population).

The Latino population increased by 65,976 between CY 2015 and CY 2017, from 4,937,485 to 5,003,461 (percent increased by 0.3% from 48.4% to 48.7% of the total population). The Latino population increased by 16,187 between CY 2016 and CY 2017, from 4,987,274 to 5,003,461 (percent decreased by 1.1% from 49.8% to 48.7% of the total population).

The Native American population decreased by 1,358 between CY 2015 and CY 2017, from 19,703 to 18,345 (percent remained at 0.2% of the total population). The Native American population decreased by 726 between CY 2016 and CY 2017, from 19,071 to 18,345 (percent remained the same at 0.2% of the total population).

The White population decreased by 5,273 between CY 2015 and CY 2017, from 2,880,050 to 2,874,777 (percent decreased by 0.3% from 28.3% to 28.0% of the total population). The White population increased by 141,426 between CY 2016 and CY 2017, from 2,733,351 to 2,874,777 (percent increased by 0.7% from 27.3% to 28.0% of the total population).

The Two or More Races population increased by 6,123 from CY 2016 and CY 2017 from 221,002 to 227,125 (percent remained the same at 0.2% of the total population).

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TABLE 33: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY TREND FOR CY 2015, CY 2016, AND CY 2017

Race/Ethnicity	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2015		2016		2017	
	N	%	N	%	N	%
African American	268,976	9.8%	243,674	9.6%	230,552	9.3%
Asian/Pacific Islander	264,984	9.6%	257,191	10.1%	274,213	11.0%
Latino	1,781,525	64.9%	1,613,257	63.5%	1,548,943	62.3%
Native American	5,293	0.2%	4,840	0.2%	4,637	0.2%
White	426,312	15.5%	392,124	15.4%	386,832	15.6%
Two or More Races			29,514	1.2%	41,803	1.7%
Total	2,747,090	100.0%	2,540,599	100.0%	2,486,980	100.0%

The African American population living at or below 138% FPL decreased by 38,424 between CY 2015 and CY 2017, from 268,976 to 230,552 (percent decreased from 9.8% to 9.6% of the total 138% FPL population). The African American population decreased by 13,122 between CY 2016 and CY 2017, from 243,674 to 230,552 (percent decreased from 9.6% to 9.3% of the total 138% FPL population).

The Asian/Pacific Islander population living at or below 138% FPL increased by 9,229 between CY 2015 and CY 2017, from 264,984 to 274,213 (percent increased from 9.6% to 11.0% of the total 138% FPL population). The Asian/Pacific Islander population increased by 17,022 between CY 2016 and CY 2017, from 257,191 to 274,213 (percent increased from 10.1 to 11.0% of the total 138% FPL population).

The Latino population living at or below 138% FPL decreased by 232,582 between CY 2015 and CY 2017, from 1,781,525 to 1,548,943 (percent decreased from 64.9% to 62.3% of the total 138% FPL population). The Latino population decreased by 64,314 between CY 2016 and CY 2017, from 1,613,257 to 1,548,943 (percent decreased from 63.5% to 62.3% of the total 138% FPL population).

The Native American population living at or below 138% FPL decreased by 656 between CY 2015 and CY 2017, from 5,293 to 4,637 (percent remained the same at 0.2% of the total 138% FPL population). The Native American population decreased by 203 between CY 2016 and CY 2017, from 4,840 to 4,637 (remaining at 0.2% of the total 138% FPL population).

The White population living at or below 138% FPL decreased by 39,480 between CY 2015 and CY 2017, from 426,312 to 386,832 (percent increased from 15.5% to 15.6% of the total 138% FPL population). The White population decreased by 5,292 between CY

2016 and CY 2017, from 392,124 to 386,832 (percent increased from 15.4% to 15.6% of the total 138% FPL population).

The Two or More Races population increased by 12,289 from CY 2016 and CY 2017 from 29,514 to 41,803 (percent increased by 0.5% from 1.2% to 1.7% of the total population).

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TABLE 34: ESTIMATED COUNTYWIDE TOTAL POPULATION BY AGE GROUP TREND FOR CY 2015, CY 2016, AND CY 2017

Age Group	Countywide Estimated Total Population					
	2015		2016		2017	
	N	%	N	%	N	%
0-18	2,478,146	24.3%	2,451,261	24.0%	2,422,597	23.6%
19-20	314,576	3.1%	309,197	3.0%	307,906	3.0%
21-25	777,232	7.6%	772,510	7.6%	765,972	7.5%
26-59	4,819,943	47.3%	4,834,292	47.3%	4,879,498	47.5%
60-64	535,795	5.3%	555,044	5.4%	580,677	5.7%
65 and older	1,266,684	12.4%	1,305,146	12.8%	1,315,998	12.8%
Total	10,192,376	100.0%	10,227,450	100.0%	10,272,648	100.0%

The Age Group 0-18 decreased by 55,549 between CY 2015 and CY 2017, from 2,478,146 to 2,422,597 (percent decreased by 0.75 from 24.3% to 23.6%). The Age Group 0-18 decreased by 28,664 between CY 2016 and CY 2017, from 2,451,261 to 2,422,597 (percent decreased by 0.4% from 24.0% to 23.6%).

The Age Group 19-20 decreased by 6,670 between CY 2015 and CY 2017, from 314,576 to 307,906 (percent decreased by 0.1% from 3.1% to 3.0%). The Age Group 19-20 decreased by 1,291 between CY 2016 and CY 2017, from 309,197 to 307,906 (percent remained the same at 3.0%).

The Age Group 21-25 decreased by 11,260 between CY 2015 and CY 2017, from 777,232 to 765,972 (percent decreased by 0.1% from 7.6% to 7.5%). The Age Group 21-25 decreased by 6,538 between CY 2016 and CY 2017, from 772,510 to 765,972 (percent decreased by 0.1% from 7.6% to 7.5%).
The Age Group 26-59 increased by 59,555 between CY 2015 and CY 2017, from 4,819,943 to 4,879,498 (percent increased by 0.2% from 47.3% to 47.5%). The Age Group 26-59 increased by 45,206 between CY 2016 and CY 2017, from 4,834,292 to 4,879,498 (percent increased by 0.2% from 47.3% to 47.5%).

The Age Group 60-64 increased by 44,882 between CY 2015 and CY 2017, from 535,795 to 580,677 (percent increased by 0.4% from 5.3% to 5.7%). The Age Group 60-64 population increased by 25,633 between CY 2016 and CY 2017, from 555,044 to 580,677 (percent increased by 0.3% from 5.4% to 5.7%).

The Age Group 65 and older increased by 49,314 between CY 2015 and CY 2017, from 1,266,684 to 1,315,998 (percent increased by 0.4% from 12.4% to 12.8%). The Age Group 65 and older increased by 10,852 between CY 2016 and CY 2017, from 1,305,146 to 1,315,998 (percent remained the same at 12.8%).

TABLE 35: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP TREND FOR CY 2015, CY 2016, AND CY 2017

Age Group	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2015		2016		2017	
	N	%	N	%	N	%
0-18	979,991	35.1%	888,095	35.0%	856,137	34.4%
19-20	86,736	3.1%	77,647	3.1%	74,939	3.0%
21-25	233,938	8.4%	212,367	8.4%	203,071	8.2%
26-59	1,165,249	41.8%	1,059,353	41.7%	1,038,947	41.8%
60-64	102,595	3.7%	95,214	3.7%	97,941	3.9%
65 and older	220,953	7.9%	207,923	8.2%	215,945	8.7%
Total	2,789,462	100.0%	2,540,599	100.0%	2,486,980	100.0%

Table 35 presents the estimated total population living at or below 138% FPL by Age Group for CY 2015, CY 2016, and CY 2017.

The Age Group 0-18 living at or below 138% FPL decreased by 123,854 between CY 2015 and CY 2017, from 979,991 to 856,137 (percent decreased by 0.7% from 35.1% to 34.4% of the total 138% FPL population). The Age Group 0-18 living at or below 138% FPL decreased by 31,958 between CY 2016 and CY 2017, from 888,095 to 856,137 (percent decreased by 0.6% from 35.0% to 34.4%).

The Age Group 19-20 living at or below 138% FPL decreased by 11,797 between CY 2015 and CY 2017, from 86,736 to 74,939 (percent decreased by 0.1% from 3.1% to 3.0% of the total 138% FPL population). The Age Group 19-20 living at or below 138% FPL decreased by 2,708 between CY 2016 and CY 2017, from 77,647 to 74,939 (percent decreased by 0.1% from 3.1% to 3.0%).

The Age Group 21-25 living at or below 138% FPL decreased by 30,867 between CY 2015 and CY 2017, from 233,938 to 203,071 (percent decreased by 0.2% from 8.4% to 8.2% of the total 138% FPL population). The Age Group 21-25 living at or below 138% FPL decreased by 9,296 between CY 2016 and CY 2017, from 212,367 to 203,071 (percent decreased by 0.2% from 8.4% to 8.2%).

The Age Group 26-59 living at or below 138% FPL decreased by 126,302 between CY 2015 and CY 2017, from 1,165,249 to 1,038,947 (percent remained the same at 41.8 of the total 138% FPL population). The Age Group 26-59 living at or below 138% FPL decreased by 20,406 between CY 2016 and CY 2017, from 1,059,353 to 1,038,947 (percent increased by 0.1% from 41.7% to 41.8%).

The Age Group 60-64 living at or below 138% FPL decreased by 4,654 between CY 2015 and CY 2017, from 102,595 to 97,941 (percent increased by 0.2% from 3.7% to 3.9% of

the total 138% FPL population). The Age Group 60-64 living at or below 138% FPL increased by 2,727 between CY 2016 and CY 2017, from 95,214 to 97,941 (percent increased by 0.2% from 3.7% to 3.9%).

The Age Group 65 and older living at or below 138% FPL decreased by 5,008 between CY 2015 and CY 2017, from 220,953 to 215,945 (percent increased by 0.8% from 7.9% to 8.7% of the total 138% FPL population). The Age Group 65 and older living at or below 138% FPL increased by 8,022 between CY 2016 and CY 2017, from 207,923 to 215,945 (percent increased by 0.5% from 8.2% to 8.7%).

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TABLE 36: ESTIMATED COUNTYWIDE TOTAL POPULATION BY GENDER TREND FOR CY 2015, CY 2016, AND CY 2017

Gender	Countywide Estimated Total Population					
	2015		2016		2017	
	N	%	N	%	N	%
Male	5,026,944	49.3%	5,048,390	49.4%	5,067,041	49.3%
Female	5,163,432	50.7%	5,179,060	50.6%	5,205,607	50.7%
Total	10,192,376	100.0%	10,227,450	100.0%	10,272,648	100.0%

Table 36 presents the estimated countywide total population by gender for CY 2015, CY 2016, and CY 2017.

The Male population increased by 40,097 between CY 2015 and CY 2017, from 5,026,944 to 5,067,041 (percent remained the same at 49.3%). The Male population increased by 18,651 between CY 2016 and CY 2017 from 5,048,390 to 5,067,041 (percent decreased by 0.1% from 49.4% to 49.3%).

The Female population increased by 42,175 between CY 2015 and CY 2017, from 5,163,432 to 5,205,607 (percent remained at 50.7%). The Female population increased by 26,547 between CY 2016 and CY 2017, from 5,179,060 to 5,205,607 (percent increased by 0.1% from 50.6% to 50.7%).

TABLE 37: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER TREND FOR CY 2015, CY 2016, AND CY 2017

Gender	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2015		2016		2017	
	N	%	N	%	N	%
Male	1,368,643	49.1%	1,255,563	49.4%	1,181,627	47.5%
Female	1,420,819	50.9%	1,285,036	50.6%	1,305,353	52.5%
Total	2,789,462	100.0%	2,540,599	100.0%	2,486,980	100.0%

Table 37 presents the estimated total population living at or below 200% FPL by gender for CY 2015, CY 2016, and CY 2017.

The Male population living at or below 138% FPL decreased by 187,016 between CY 2015 and CY 2017, from 1,368,643 to 1,181,627 (percent decreased by 1.6% from 49.1% to 47.5%). The Male population living at or below 138% FPL decreased by 73,936 between CY 2016 and CY 2017, from 1,255,563 to 1,181,627 (percent decreased by 1.9% from 49.4% to 47.5%).

The Female population living at or below 138% FPL decreased by 115,466 between CY 2015 and CY 2017, from 1,420,819 to 1,305,353 (percent decreased by 1.6% from 49.1% to 47.5%). The Female population living at or below 138% FPL increased by 20,317 between CY 2016 and CY 2017, from 1,285,036 to 1,305,353 (percent increased by 1.9% from 50.6% to 52.5%).

IV. MHSA Community Services and Supports (CSS) population Assessment and Service Needs

A. This section summarizes the MHSA CSS population and client utilization data by race/ethnicity, language, age, and gender.

TABLE 38: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA FY 2017 - 2018

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	2,794	25	2,133	47	1,789	6,788
Percent	41.2%	**0.4%**	31.4%	0.69%	26.4%	100.0%
SA 2	1,508	241	6,394	75	5,162	13,380
Percent	11.3%	1.8%	47.8%	0.56%	38.6%	100.0%
SA 3	1,281	188	6,872	79	2,162	10,582
Percent	12.1%	1.8%	64.9%	0.75%	20.4%	100.0%
SA 4	3,955	495	6,611	97	2,718	13,876
Percent	28.5%	**3.6%**	47.6%	0.70%	19.6%	100.0%
SA 5	823	59	726	28	1,657	3,293
Percent	25.0%	1.8%	**22.0%**	0.85%	**50.3%**	100.0%
SA 6	9,083	80	6,432	55	844	16,494
Percent	**55.1%**	0.5%	39.0%	**0.33%**	**5.1%**	100.0%
SA 7	994	93	7,712	118	1,317	10,234
Percent	**9.7%**	0.9%	**75.4%**	**1.15%**	12.9%	100.0%
SA8	5,567	221	5,537	102	3,163	14,590
Percent	38.2%	1.5%	38.0%	0.70%	21.7%	100.0%
Total	26,005	1,402	42,417	601	18,812	89,237
Percent	29.1%	1.6%	47.5%	0.67%	21.1%	100.0%

Note: Table excludes ethnic group 'Other' (N = 1,800), 'Unknown' (N=2,413) across the SAs. Total reflects unduplicated count of consumers served with the SAs. Clients served outside SAs (N = 197). Data Source: LACDMH-IS Database, July 2019.

Differences by Race/Ethnicity

The highest percentage of African American MHSA consumers served in outpatient programs was in SA 6 (55.1%) compared to SA 7 (9.7%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander (API) MHSA consumers served in outpatient programs was in SA 4 (3.6%) compared to SA 1 (0.4%) with the lowest percentage.

The highest percentage of Latino MHSA consumers served in outpatient programs was in SA 7 (75.4%) compared to SA 5 (22.0%) with the lowest percentage.

The highest percentage of Native American MHSA consumers served in outpatient programs was in SA 7 (1.15%) compared to SA 5 (0.33%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (50.3%) compared to SA 6 (5.1%) with the lowest percentage.

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TABLE 39: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 2017 – 2018

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	3,370	1,558	4,743	656	10,327
Percent	32.6%	15.1%	45.9%	**6.4%**	100.0%
SA 2	8,520	4,208	10,055	2,571	25,354
Percent	33.6%	16.6%	39.7%	10.1%	100.0%
SA 3	8,792	3,689	6,963	1,503	20,947
Percent	**42.0%**	**17.6%**	**33.2%**	7.2%	100.0%
SA 4	5,924	3,533	11,674	2,456	23,587
Percent	25.1%	15.0%	49.5%	10.4%	100.0%
SA 5	760	730	3,264	817	5,571
Percent	**13.6%**	**13.1%**	**58.6%**	**14.7%**	100.0%
SA 6	8,780	4,220	11,328	2,148	26,476
Percent	33.2%	15.9%	42.8%	8.1%	100.0%
SA 7	7,588	3,233	6,898	1,406	19,125
Percent	39.7%	16.9%	36.1%	7.4%	100.0%
SA 8	6,812	3,344	11,252	2,425	23,833
Percent	28.6%	14.0%	47.2%	10.2%	100.0%
Total	50,546	24,515	66,177	13,982	155,220
Percent	32.6%	15.8%	42.6%	9.0%	100.0%

Note: Total reflects unduplicated count of consumers served. Some consumers (N = 161) served outside SA. Data Source: LACDMH-IS Database, July 2019.

Differences by Age Group

The highest percentage of Children MHSA consumers 0-15 years old was in SA 3 (42.0%) compared with SA 5 (13.6%) with the lowest percentage.

The highest percentage of TAY MHSA consumers 16-25 years old was in SA 3 (17.6%) compared with SA 5 (13.1%) with the lowest percentage.

The highest percentage of Adult MHSA consumers 26-59 years old was in SA 5 (58.6%) compared with SA 3 (33.2%) with the lowest percentage.

The highest percentage of Older Adult MHSA consumers 60 years old and over was in SA 5 (14.7%) compared with SA 1 (6.4%) with the lowest percentage.

TABLE 40: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 2017 – 2018

Service Area (SA)	Male	Female	Total
SA 1	4,884	5,431	10,315
Percent	**47.3%**	**52.7%**	100.0%
SA 2	12,405	12,932	25,337
Percent	49.0%	51.0%	100.0%
SA 3	10,592	10,338	20,930
Percent	50.6%	49.4%	100.0%
SA 4	12,809	10,723	23,532
Percent	**54.4%**	**45.6%**	100.0%
SA 5	2,847	2,716	5,563
Percent	51.2%	48.8%	100.0%
SA 6	13,235	13,212	26,447
Percent	50.0%	50.0%	100.0%
SA 7	9,439	9,666	19,105
Percent	49.4%	50.6%	100.0%
SA 8	11,422	12,380	23,802
Percent	48.0%	52.0%	100.0%
Total	77,633	77,398	155,031
Percent	50.1%	49.9%	100.0%

Table excludes Transgender (N = 152), Unknown Gender (N=40) across the SAs. Total reflects unduplicated count of consumers served with the SAs. Clients served outside SAs (N = 208). Data Source: LACDMH-IS Database, July 2019.

Differences by Gender

The highest percentage of Male MHSA consumers served in outpatient programs was SA 4 (54.4%) compared with SA 1 (47.3%) with the lowest percentage.

The highest percentage of Female MHSA consumers served in outpatient programs was SA 1 (52.7%) compared with SA 4 (45.6%) with the lowest percentage.

TABLE 41: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY THRESHOLD LANGUAGE AND SERVICE AREA FY 2017-2018

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	6	10	1	0	9,510	4	2	3	0	2	656	6	1	10,201
Percent	0.06%	0.10%	0.01%	0.00%	**93.23%**	0.04%	0.02%	0.03%	0.00%	0.02%	**6.43%**	0.06%	0.01%	100.00%
SA 2	76	979	16	4	19,287	377	63	8	6	105	3,826	69	25	24,841
Percent	0.31%	**3.94%**	0.06%	0.02%	**77.64%**	**1.52%**	**0.25%**	0.03%	0.02%	**0.42%**	**15.40%**	**0.28%**	0.10%	100.00%
SA 3	16	24	46	368	15,470	7	51	350	73	4	3,823	22	243	20,497
Percent	0.08%	0.12%	0.22%	**1.80%**	**75.47%**	0.03%	**0.25%**	**1.71%**	**0.36%**	0.02%	**18.65%**	0.11%	**1.19%**	100.00%
SA 4	7	144	37	60	17,901	29	379	26	13	82	4,220	51	37	22,986
Percent	0.03%	**0.63%**	0.16%	**0.26%**	**77.88%**	0.13%	1.65%	**0.11%**	0.06%	**0.36%**	**18.36%**	**0.22%**	0.16%	100.00%
SA 5	10	2	0	2	4,862	107	15	2	0	15	368	4	3	5,390
Percent	0.19%	0.04%	0.00%	0.04%	**90.20%**	1.99%	0.28%	0.04%	0.00%	0.28%	**6.83**%	0.07%	0.06%	100.00%
SA 6	3	3	13	8	20,931	11	48	7	2	5	4,798	1	4	25,834
Percent	0.01%	0.01%	0.05%	0.03%	**81.02%**	0.04%	**0.19%**	0.03%	0.01%	0.02%	**18.57%**	0.00%	0.02%	100.00%
SA 7	14	5	199	12	14,006	1	36	17	9	3	4,465	32	31	18,830
Percent	0.07%	0.03%	1.06%	0.06%	**74.38%**	0.01%	0.19%	0.09%	0.05%	0.02%	**23.71%**	0.17%	0.16%	100.00%
SA 8	19	3	463	5	19,005	9	73	20	5	1	3,427	52	106	23,188
Percent	0.08%	0.01%	**2.00%**	0.02%	**81.96%**	0.04%	0.31%	0.09%	0.02%	0.00%	**14.78%**	0.22%	0.46%	100.00%
Total	151	1,170	775	459	120,972	545	667	433	108	217	25,583	237	450	151,767
Percent	0.10%	0.77%	0.51%	0.30%	**79.71%**	0.36%	0.44%	0.29%	0.07%	0.14%	16.86%	0.16%	0.30%	100.00%

Note: Total reflects unduplicated count of consumers served. Consumers (N = 208) were served outside the SAs. Data Source: LACDMH-IS Database, July 2019. Table 41 shows that Spanish and English are the most common languages in all of the Service Areas among the MHSA consumers. English was the most commonly spoken language at 79.7% followed by Spanish at 16.9 % of languages spoken. The following information highlights the threshold languages spoken among the MHSA population by Service Area.

SA 1 has two threshold languages: English (93.2%) and Spanish (6.4%).
SA 2 has eight threshold languages: Armenian (4.0%), English (77.6%), Farsi (1.5%), Mandarin (0.03%), Russian (0.4%), Spanish (15.4%), Tagalog (0.3%) and Vietnamese (0.1%).

SA 3 has seven threshold languages: Cantonese (1.8%), English (75.5%), Korean (0.3%), Mandarin (1.7%), Other Chinese (0.5%), Spanish (18.7%), and Vietnamese (1.2%)

SA 4 has seven threshold languages: Armenian (0.6%), Cantonese (0.3%), English (77.9%), Mandarin 0.1%), Russian (0.4%), Spanish (18.4%), and Tagalog (0.2%).

SA 5 has three threshold languages: English (90.2%), Farsi (2.0%), and Spanish (6.8%).

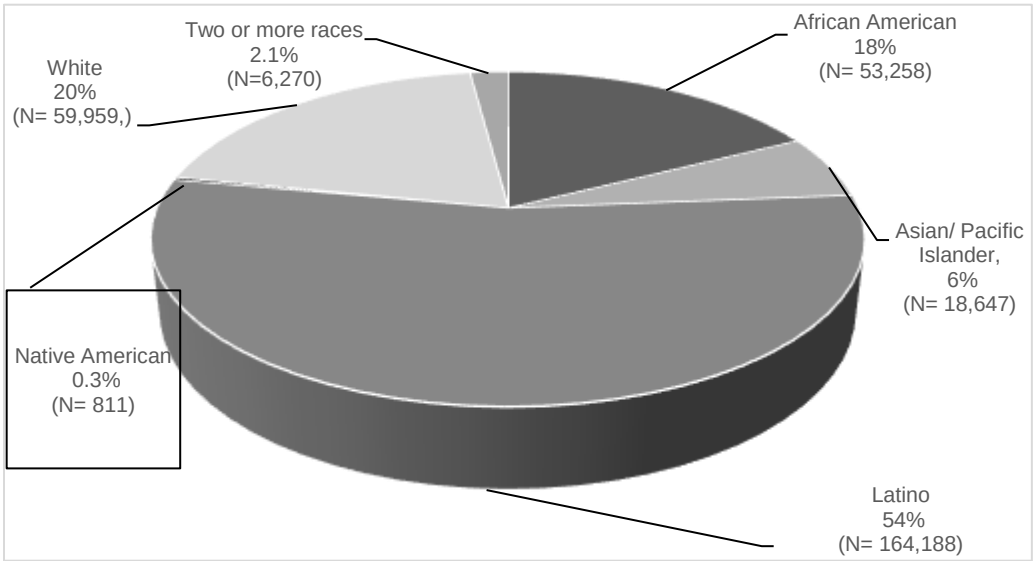
SA 6 has two threshold languages: English (81.0%) and Spanish (18.6%).

SA 7 has three threshold languages: English (74.4%), Korean (0.2%), and Spanish (23.7%).

SA 8 has three threshold languages: Cambodian (2.0%), English (82.0%) and Spanish (15.0%).

Analysis of Disparities

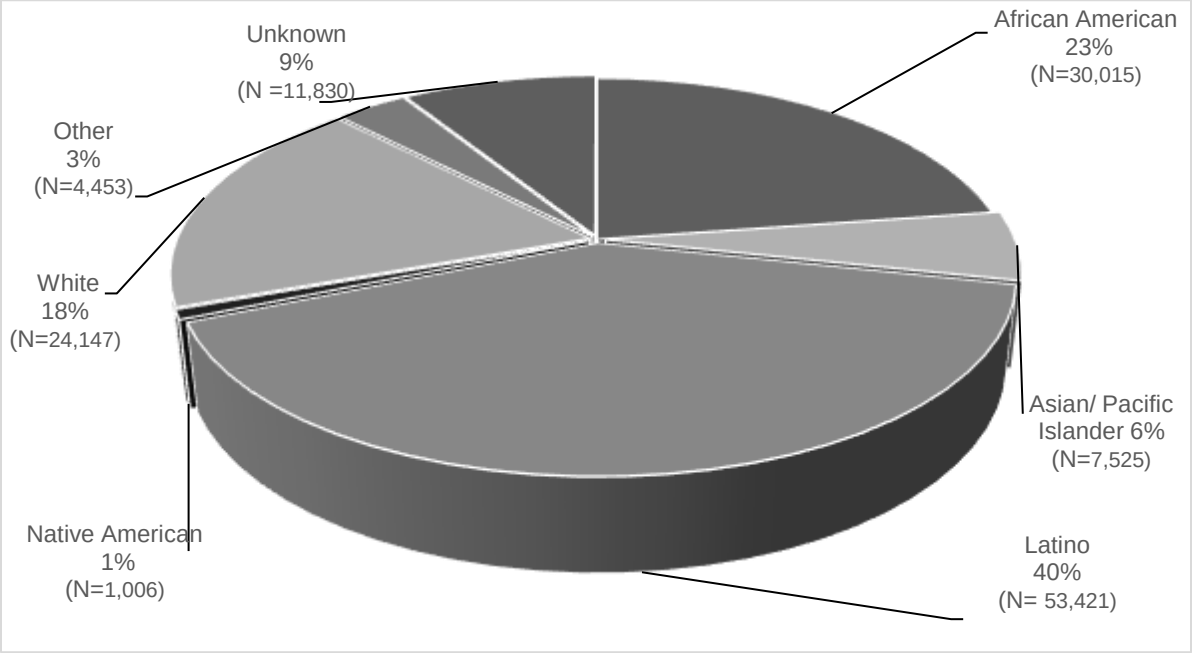
FIGURE 10: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2017



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2018.

Figure 10 shows the estimated population below or at 138% FPL in need of services by Race/Ethnicity. This compares with the proportion of CSS Consumers by Race/Ethnicity in Figure 11.

FIGURE 11: CSS CONSUMER POPULATION BY RACE/ETHNICITY FY 2017 – 2018



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2019-20

Figure 11 shows the CSS enrolled population by Race/Ethnicity. Latinos are the largest group at 40.0%, followed by African Americans at 23.0%, Whites at 18.0%, Asian/Pacific Islanders at 6.0%, Native Americans at 1.0%, Other race/ethnicity not specified at 3% and Unknown at 9%.

Figures 10 and 11 indicate the following:

African Americans constitute 18.0% of the population in need of services at or below 138% FPL and constitute 23.0% of the CSS consumers.

Asian/Pacific Islanders constitute 6.0% of the population in need of services at or below 138% FPL and constitute 6.0% of the CSS consumers.

Latinos constitute 54.0% of the population in need of services at or below 138% FPL and constitute 40.0% of the CSS consumers.

Native Americans constitute 0.3% of the population in need of services at or below 138% FPL and constitute 1.0% of the CSS consumers.

Whites constitute 20.0% of the population in need of services at or below 138% FPL and constitute 18.0% of the CSS consumers.

FIGURE 12: NEEDS ASSESSMENT SUMMARY FOR CSS PROGRAMS: PERCENTAGE AMONG THOSE IN NEED OF SERVICES FOR THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) COMPARED WITH PERCENTAGE OF CONSUMERS SERVED BY CSS PROGRAMS BY RACE/ETHNICITY FY 2017-2018

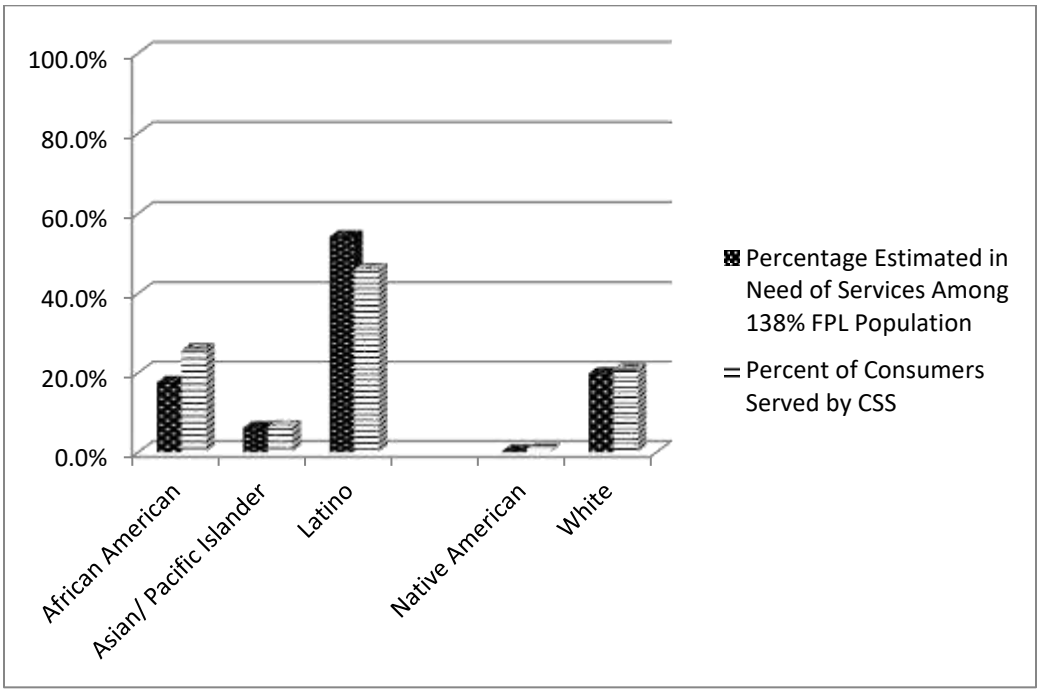


Figure 12 compares the information in Figures 10 and 11.

The percentage of African Americans receiving CSS services was the highest at 25.8% when compared with their population at or below 138%, FPL estimated in need of services at 17.6%.

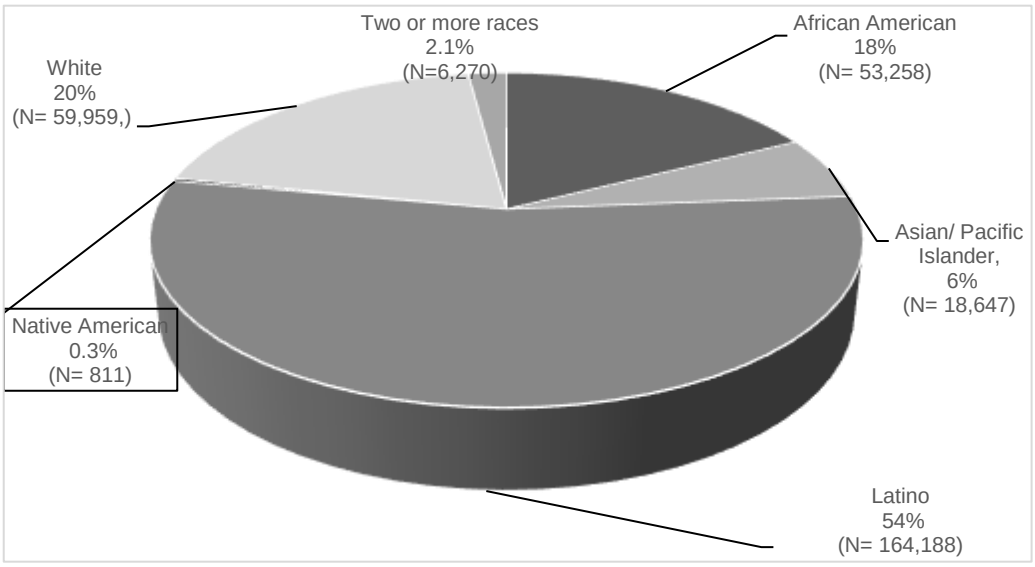
The percentage of Latinos receiving CSS services was 46.0% when compared to their population at or below 138%, FPL estimated in need of services at 54.2%.

The percentage of Whites receiving CSS services was 20.8% when compared with their population at or below 138%, FPL estimated in need of services at 19.8%.

The percentage of Asian/Pacific Islanders receiving CSS services was 6.5% when compared with their population at or below 138%, FPL estimated in need of services at 6.2%.

The percentage of Native Americans receiving CSS services was 0.9% when compared with their population of Native Americans at or below 138%, FPL estimated in need of services at 0.3%.

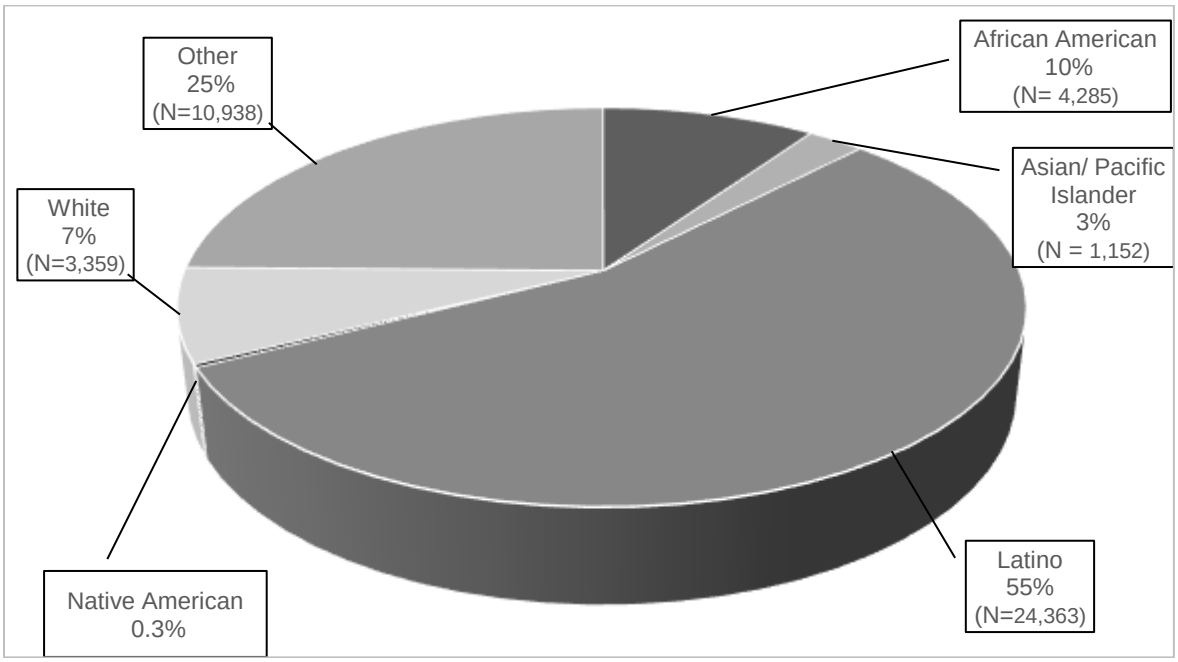
FIGURE 13: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2017



Estimated prevalence of mental illness by Race/Ethnicity for Los Angeles County is provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2015 and CY 2017. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2018.

Figure 13 shows the estimated population below or at 138% FPL in need of services by Race/Ethnicity. It is presented here to be compared with the proportion of PEI Consumers by Race/Ethnicity in Figure 14.

FIGURE 14: PEI CONSUMER POPULATION BY RACE/ETHNICITY
FY 2017 - 2018



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2019-20.

Figure 14 shows the PEI enrolled population by Race/Ethnicity. Latinos are the largest group at 55.0%, followed by African Americans at 10.0%, Whites at 7.0%, Asian/Pacific Islanders at 3.0%, Native Americans at 0.3% and Others at 24.7%.

Figures 13 and 14 indicate the following:

African Americans constitute 18.0% of the population in need of services at or below 138% FPL and constitute 10.0% of the PEI consumers.

Asian/Pacific Islanders constitute 6.0% of the population in need of services at or below 138% FPL and constitute 3.0% of the PEI consumers.

Latinos constitute 54.0% of the population in need of services at or below 138% FPL and constitute 55.0% of the PEI consumers.

Native Americans constitute 0.3% of the population in need of services at or below 138% FPL and constitute 0.3% of the PEI consumers.

Whites constitute 20.0% of the population in need of services at or below 138% FPL and constitute 7.0% of the PEI consumers.

FIGURE 15: NEEDS ASSESSMENT SUMMARY FOR PEI PROGRAM: PERCENTAGE AMONG THOSE IN NEED OF SERVICES FOR THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) COMPARED WITH PERCENTAGE OF CONSUMERS SERVED BY PEI PROGRAMS BY RACE/ETHNICITY FY 2017 - 2018

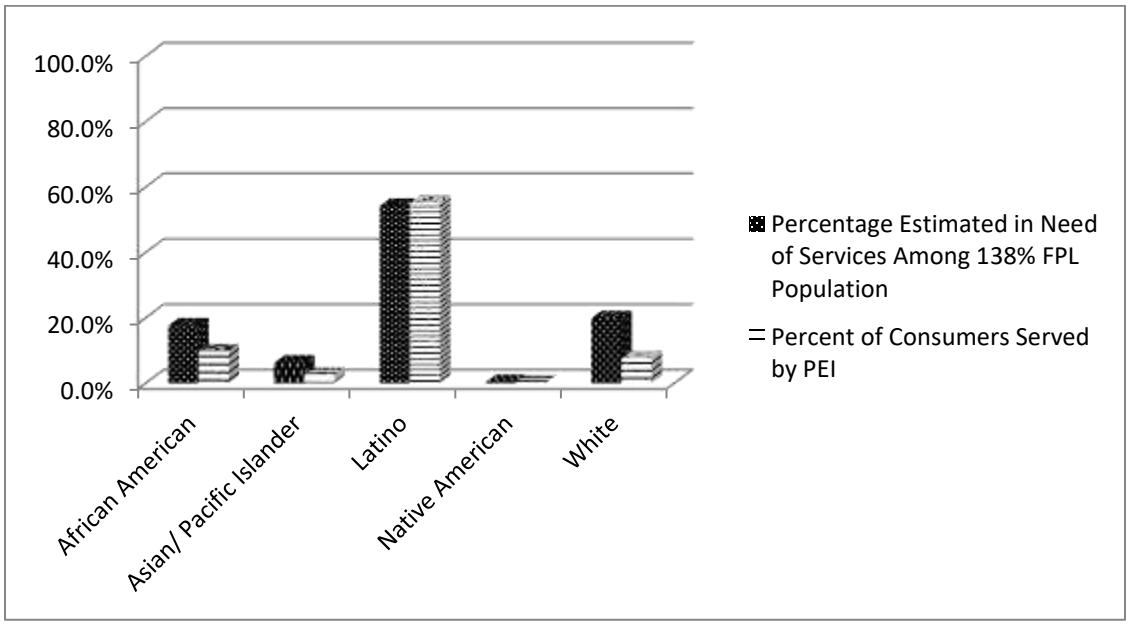


Figure 15 compares the information in Figures 13 and 14.

The percentage of Latinos receiving PEI services was the highest at 55.1% when compared to their population at or below 138%, FPL estimated in need of services at 54.2%.

The percentage of African Americans receiving PEI services was 9.7% when compared with their population at or below 138%, FPL estimated in need of services at 17.6%.

The percentage of Whites receiving PEI services was 7.6% when compared with their population at or below 138%, FPL estimated in need of services at 19.8%.

The percentage of Asian/Pacific Islanders receiving PEI services was 2.6% when compared with their population at or below 138%, FPL estimated in need of services at 6.2%.

The percentage of Native Americans receiving PEI services was 0.3% when compared with their population at or below 138%, FPL estimated in need of services at 0.3%.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 3

Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

August 2019

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

Identified unserved/underserved target population (with disparities)

I. List of Target Populations with Disparities

Using FY 17-18 data, the LACDMH target populations with mental health disparities by Service Area (SA) are as follows:

Medi-Cal population

By ethnicity

- African American in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Asian Pacific Islander (API) in SAs 2, 3, 4, 5, 6, 7, and 8
- Latino in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- American Indian/Alaska Native (AI/AN) in SAs 2, 4, and 6
- White in SAs 1, 2, 3, 4, 5, 6, 7, and 8

By language

- Arabic, Countywide disparity
- Armenian in SAs 2 and 4
- Cambodian in SA 8
- Cantonese in SAs 3 and 4
- English in SAs 2, 3, 5, and 7
- Farsi in SAs 2 and 5
- Korean in SAs 2, 3, 4, 7, and 8
- Mandarin in SA 3
- Other Chinese in SA 3
- Russian in SAs 2 and 4
- Spanish in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Tagalog in SA 2 and 4
- Vietnamese in SAs 2, 3, and 8

By age group

- Children in SAs 2, 5, 6, 7, and 8
- Transitional Age Youth (TAY) in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Adults in SAs 2, 3, 4, 5, 6, 7, and 8
- Older Adults in SAs 1, 2, 3, 4, 5, 6, 7, and 8

By gender

- Male in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Female in SAs 1, 2, 3, 4, 5, 6, 7, and 8

Identified disparities (within the target populations)

II. Community Services and Support (CSS) Plan

The CSS disparities are the same as Medi-Cal listed above because the populations served overlap.

By ethnicity

- African American in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Asian Pacific Islander (API) in SAs 2, 3, 4, 5, 6, 7, and 8
- Latino in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- American Indian/Alaska Native (AI/AN) in SAs 2, 4, and 6
- White in SAs 1, 2, 3, 4, 5, 6, 7, and 8

By language

- Arabic, Countywide disparity
- Armenian in SAs 2 and 4
- Cambodian in SA 8
- Cantonese in SAs 3 and 4
- English in SAs 2, 3, 5, and 7
- Farsi in SAs 2 and 5
- Korean in SAs 2, 3, 4, 7, and 8
- Mandarin in SA 3
- Other Chinese in SA 3
- Russian in SAs 2 and 4
- Spanish in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Tagalog in SA 2 and 4
- Vietnamese in SAs 2, 3, and 8

By age group

- Children in SAs 2, 5, 6, 7, and 8
- Transitional Age Youth (TAY) in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Adults in SAs 2, 3, 4, 5, 6, 7, and 8
- Older Adults in SAs 1, 2, 3, 4, 5, 6, 7, and 8

By gender

- Male in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- Female in SAs 1, 2, 3, 4, 5, 6, 7, and 8

Workforce, Education, and Training (WET)

By ethnicity

- API
- Latinos

By age group

- Older Adults over the age of 60

By language

- Arabic, Armenian, Cambodian, Cantonese, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, Vietnamese, and American Sign Language

Prevention Early Intervention (PEI) Priority Populations with Disparities

Underserved Cultural Populations

- Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex/2-Spirit (LGBTQI2-S)
- Deaf/Hard of Hearing
- Blind/Visually impaired
- AI/AN

Individuals Experiencing Onset of Serious Psychiatric Illness

- Young Children
- Children
- TAY
- Adults
- Older Adults

Children/Youth in Stressed Families

- Young Children
- Children
- TAY

Trauma-exposed

- Veterans
- Young Children
- Children
- TAY
- Adults
- Older Adults

Children/Youth at Risk for School Failure

- Young Children
- Children
- TAY

Children/Youth at Risk of or Experiencing Juvenile Justice

- Children
- TAY

Note:
This criterion contains detailed information on numerous programs. The information on each program follows this structure:

- Description
- Summary chart of strategies to reduce disparities
- Outcomes

A glossary of acronyms has been developed to guide the reading of this information (***See Attachment 1: Acronyms****).*

III. Identified Strategies: MHSA and LACDMH Strategies to Reduce Disparities

MHSA strategies include CSS, WET, and PEI plans, which are integrated into LACDMH's programs to reduce disparities. Additionally, LACDMH has implemented the following strategies to reduce mental health disparities, eliminate stigma and increase equity – service delivery

- Collaboration with faith-based and other trusted community entities/groups
- Multilingual/multicultural materials
- Co-location with other county departments, e.g. Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), and Department of Health Services (DHS)
- Community education to increase mental health awareness and decrease stigma
- Consultation to gatekeepers
- Countywide FSP Networks to increase linguistic/cultural access
- Creation of new committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery
- Designating and tracking ethnic targets for FSP
- EBPs/CDEs for ethnic populations
- Field-based services
- Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"
- Health Agency level collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health
- Implementation of capacity-building projects based on the specific needs of targeted groups via the Underserved Cultural Communities subcommittees (UsCC)
- Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services
- Implementation of new technologies to enhance the Department's service delivery
- Increasing mental health service accessibility to underserved populations
- Integrated Supportive Services
- Interagency Collaboration
- Investments in learning (e.g. Innovation Plan)
- Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E)

- Physical health, mental health, and substance abuse service integration
- Programs that target specific ethnic and language groups
- Provider communication and support
- School-based services
- Trainings/case consultation
- Utilizing community's knowledge and capacity to identify ways of promoting health and wellbeing

The chart below summarizes the endorsement of LACDMH strategies to reduce disparities by Program.

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NAME OF PROGRAM/ACTIVITY	Outreach and Engagement	Community Education	Multi-lingual materials	Faith-based collaboration	School-based services	Field-based services	Specific ethnic/language group	FSP-ethnic targets	FSP-enrollment flexibility	FSP-countywide networks	Integrated Supportive Services	Co-location of services	Interagency collaboration	Consultation to gatekeepers	Trainings/case consultation	Provider communication/support	Multi-cultural staff development	EBP's/CDE's for ethnic populations	Learning investments	Community partnerships	New technologies	Service accessibility	Integration of services	Policies & procedures	Committees & taskforces
1) Katie A.	X	X	X	X	X	X					X	X	X	X	X	X	X		X		X	X	X	X	X
2) Faith-based Advocacy Council		X	X	X										X			X			X					
3) Spirituality – Mental Health / Interfaith Clergy Roundtable		X	X	X										X	X					X					
4) Mental Health & Spirituality Conference		X	X	X								X					X	X		X					
5) DMH/DHS Collaboration Program	X	X	X	X			X					X	X	X	X	X	X	X	X		X		X	X	
6) Veterans FSP	X		X	X		X	X			X		X	X		X	X		X	X				X		
7) Integrated Mobile Health Team	X					X												X				X			
8) Prevention Early Intervention	X	X	X		X	X	X											X	X				X		
9) Promotores de Salud	X	X	X	X	X	X	X				X		X		X		X	X	X	X	X	X	X		
10) Recovery, Resilience and Reintegration	X	X	X	X			x				X		X	X	X	X	X		X	X		X	X		
11) Underserved Cultural Communities	X	X	X	X		X	X	X	X	X		X	X	X	X	X	X		X	X		X	X		X
12) WET Division	X	X	X	X			X								X		X	X				X	X		
13) Health Agency Partnerships												X	X	X	X					X			X	X	X
14) Health Neighborhoods	X	X		X		X					X	X	X			X			X	X		X	X		
15) Service Area Based Outreach and Engagement (O&E)	X	X	X	X			X					X	X							X		X			

The following section presents LACDMH programs that focus on various aspects of cultural diversity. In addition to a brief description, information is provided on consumers served by FY; strategies and objectives; and service delivery implementation. Thus, this content organization corresponds to sections IV and V of the CCPR, CR 3 structure.

Additional Strategies/Objectives/Actions

IV. Planning and Monitoring of Identified Strategies/Objectives/Actions/Timeliness to Reduce Mental Health Disparities

Department of Mental Health/Department of Health Services (DMH/DHS) Collaboration Program

DMH/DHS Collaboration Program is a MHSA PEI-funded program in which LACDMH staff are located on a full-time basis within DHS Comprehensive Care Centers (CHC) and Multi-service Ambulatory Care Centers (MACC). LACDMH staff provides short-term early intervention specialty mental health services within health settings as a means of improving access for individuals who may experience stigma in seeking services in traditional mental health clinics. The program ensures collaboration between the mental health and health care providers in the co-management of individuals referred by primary care providers to LACDMH staff.

The following tables show the consumers served by DMH/DHS Collaboration Programs during FY 17-18.

Consumers served for FY 17-18 by DMH/DHS Collaboration Program

Program/ Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
DMH DHS Collaboration El Monte CHC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	15	1	118	6	3		75	158	
	Other Ethnicities:								
	Other Asian (1) Other Black (1)						Unknown/Not reported/No Entry (88)		
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration Roybal CHC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	4		67	4	1		47	82	
	Other Ethnicities:								
	Unknown/Not Reported/No Entry (47)								
	Language of Staff:								
	English Cantonese		Mandarin Spanish						

Program/ Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
DMH DHS Collaboration Long Beach CHC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	5	12	45	2	1		28	81	
	Other Ethnicities:								
	Other Asian (1) Other Middle Eastern (1)		Unknown / Not Reported/No Entry (42)						
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration High Desert MACC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	15	20	15	1	2		22	54	
	Other Ethnicities:								
	Armenian (1)		Unknown/Not Reported/ No Entry (22)						
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration Mid Valley CHC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	12		43	5	2		30	67	
	Other Ethnicities:								
	Eastern European (2) Other White (1)						Unknown/Not Reported/No Entry (32)		
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration MLK OPC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	3	19	45				26	88	
	Other Ethnicities:								
	Other (2)						Unknown / Not Reported/No Entry (45)		
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration Lomita FHC	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	4	12	32	2			11	46	
	Other Ethnicities:								
	Other (1) Other White (1)		Other Non-White (1) Unknown / Not Reported/No Entry (4)						
	Language of Staff:								
	English		Spanish						

Program/ Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
DMH DHS Collaboration South Valley	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
		2	1				2	3	
	Other Ethnicities:								
	Other White (2)								
	Language of Staff:								
	English		Spanish						
DMH DHS Collaboration Total	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
	58	66	366	20	9		235	579	
	Other Ethnicities:								
	Armenian (1) Eastern European (2) Other (3)		Other Asian (2) Other Black (1) Other Middle Eastern (1)				Other Non-White (1) Other White (4) Unknown / Not Reported/No Entry (280)		
	Language of Staff:								
	Cantonese English		Mandarin Spanish						

The DMH/DHS Collaboration Program's projects and activities contribute to the Department's provision of culturally and linguistically competent services. The program was specifically designed to bring early intervention mental health services into primary care settings. Seeking treatment in a traditional mental health clinic is often stigmatizing for members from culturally diverse backgrounds. Due to fear of stigmatization, individuals in need of services may not seek the treatment in a timely manner, or may wait until their symptoms are debilitating, thereby requiring a more intensive approach. By delivering services in physical health care settings, the whole person may be treated and care among providers can be better coordinated. Additionally, many individuals do not seek treatment in a traditional mental health clinic in a timely manner or at all, and as a result, their symptoms may become debilitating. Accessing mental health services in a health setting is highly desirable to many persons and in fact, many consumers prefer to wait to be seen by mental health staff in a familiar DHS location rather than be referred elsewhere for a more timely appointment. The role of the primary care provider in endorsing mental health providers and interventions is essential and can increase compliance with mental health treatment goals.

Clinicians at all Collaboration Program sites, make regular rounds to the site's medical clinics to offer consultation, provide feedback to referring providers, and address questions related to mental health concerns. This activity increases the visibility of mental health services and consequently, improves potential access to care via provider referrals. Likewise, clinicians at the Martin Luther King Jr. site are integrated into Diabetes and Pain Management treatment groups offered by DHS providers.

They run a mental health module at each group meeting in order to educate consumers about the interplay between physical and mental health, to destigmatize mental health conditions and treatment, and to outreach potential consumers.

The High Desert, Martin Luther King Jr., El Monte, and Long Beach sites are located inside Health Neighborhoods. In those locations, the Collaboration Program's clinicians or supervisors attend the monthly Health Neighborhood meetings. Their attendance and participation in the Health Neighborhood expand awareness of the services to the larger community and improve access to care provided in a non-stigmatizing environment. When the Collaboration Program sites receive nonviable referrals, involvement in the Health Neighborhood allows the clinicians to link consumers to other providers for mental health treatment, thus improving access to care.

For example, a Chinese Wellness workshop implemented at the Roybal site is a non-threatening and non-stigmatizing strategy for reaching out to the local Chinese community to educate them on the importance of mental health and the availability of resources. This group is conducted on a bi-annual basis. The following table shows the examples of the DMH/DHS Collaboration projects and activities for FY 17-18.

DMH/DHS COLLABORATION		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1. At the Mid Valley site, the clinician is working with DHS providers to design and implement a disease management group focusing on Diabetes.	The group's structure and the forms to be used for information and documentation are still being determined.	There is no exact starting date for the group Fall 2019 has been discussed as a possibility.
2. A Wellness Education group for the Chinese consumers at the Roybal site, designed by the clinician and Medical Case Worker.	The group was held biannually at Roybal, and the PHQ-4/PHQ-9 was given and reviewed to identify possible mental health needs.	It was conducted in Mandarin and Cantonese, and offered a non-stigmatizing way to educate about overall health and to outreach and identify those needing mental health treatment, but facing cultural barriers to seeking it out. Anecdotal feedback continued to be positive. The DHS PCPs were becoming aware of the group and make referrals to it. The group was offered biannually on an ongoing basis.
3. The Collaboration sites at MLK, Lomita, and Roybal were involved in DHS's implementation of a Behavioral Health Integration model in their primary care settings.	This model will allowed patients to receive a complement of mental health and support resources, along with appropriate referrals and linkage, at their primary care location. The Collaboration was at	The initial launch of the BHI on a small scale happened at Lomita, Roybal, and MLK in June 2019. It was ramped up to include more providers at each site as the infrastructure developed.

DMH/DHS COLLABORATION		
	three of the five phase I sites, and actively participated in designing the work flows and referral/treatment logic.	Ongoing modifications are being made to work flows with regular input by the Collaboration team. BHI will launch at the rest of the DHS outpatient locations on a rolling basis.

Health Neighborhoods (HN)

Health Neighborhoods (HN) is a countywide initiative led by the LACDMH in partnership with the Department of Public Health (DPH) and Department of Health Services (DHS) in an effort to increase health equity and access of quality services through integrated care and community collaboration. The vision of HN is to create and sustain a network of coalitions comprised of diverse stakeholders including, mental and public health providers, community and city-based agencies, educational institutions, housing services, social service providers, faith-based groups, and community members. The mission of HN is to create and sustain a collective impact to improve clinical and community supports in designated neighborhoods throughout Los Angeles County and promote the incorporation of whole-person care.

During FY 17-18, the HNs enhanced their outreach and engagement to community partners and each neighborhood accomplished greater community engagement through new partnership agreements. Additionally, the capacity of HNs was increased. Specifically, Service Area 3 added the San Gabriel Valley HN and Service Area 8 added the Hawthorne/Lennox HN, totaling 13 HNs throughout Los Angeles County.

There are numerous benefits for HN providers and the community at large such as maximizing outcomes via collaborative efforts, greater ability to coordinate care among participating partners, elimination of duplicate services and costs, and improvements to linkage services that are culturally and linguistically supportive.

Projects/Activities/ Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
1) HN liaison collaborations and integration of services for across the 13 HNs via faith-based initiatives	Since the inception of HN in 2014, the liaisons have increased the community partnerships, outreach, relationship building and participation from a set of diverse stakeholders. The Department recognized the critical role of spirituality/faith in serving, assisting, and healing the whole person.	During this fiscal year most HN Liaisons engaged their faith-based communities and they increased their participation in monthly health neighborhood meetings. During this fiscal year various HN Liaisons participated in the Interfaith Clergy and Mental Health Roundtable Program, as well as quarterly meetings of the Service Area Clergy. The Roundtable brings together mental health and clergy staff to learn, understand, and expand the understanding of mental health and

Projects/Activities/ Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
		spirituality while building capacity in both communities in an effort to assist persons with mental health issues and support their recovery process. Once the Faith-Based Liaisons were in place in each of the County eight (8) SAs, they began to attend the monthly meetings of the Department's Faith-Based Advocacy Council (FBAC). The Council composed of representatives from diverse faiths and the members develop ways to collaborate in partnerships that serve individuals, families and the community. Through FBAC, the Liaisons have the opportunity to meet clergy and faith community leaders from their respective service areas and forge relationships that contribute to the connection to their assigned neighborhoods.
2) Increase community-driven health and wellness with a focus on policy and systematic community changes.		All HNs continue to develop and expand by increasing the numbers and diversity of participants.

Service Area Based Health Neighborhood Activities, FY 17-18

SA Health Neighborhood	Accomplishments

SA 1: **Antelope Valley (AV)**	*Service Delivery*
	• AV HN continues to develop and expand by increasing the numbers and diversity of participants this fiscal year including the following:
	  ○ Black Infant Health
	  ○ Health Net
	• The Alternative Resource Court is a collaborative project between Los Angeles County Superior Court and LACDMH providing centralized case management.
	• This has been successfully implemented for a year with HN agencies offering resources to Judge Christopher Estes for alternative sentencing. They have worked

SA Health Neighborhood	Accomplishments

	together to troubleshoot housing issues, mental health services, barriers to treatment, eligibility constraints, etc. to help individuals meet conditions for release.
	• The SA/FB HN Liaison is serving as coordinator for this program and is attending court monthly to assist with case management and linkage with many other HN Participants. Previous HN/Faith-based liaison is now in that new program full time.
	• The Teen Court program has been implemented in the High School and Middle School with LACDMH and AVHN linkage as primary support. It is the first of its kind in the County.
	• The SA/FB HN Liaison attended site visits with each HN participant. The liaison has been clarifying referral processes, program information, and learning about their services. She has also been sharing what she has learned with other agencies.
	• Assisted SAAC 1 in spreading the "Stay Woke" Suicide Prevention Campaign flyers to our participants by dropping off flyers to their agencies, supporting the billboards that were put around the AV for "May is Mental Health" Month.
	• Created four (4) workgroups to work on problem solving and program implementation including maternal health, internship & training, older adults, and teen court.
	• Applied for Kaiser Foundation 30k Grant for Maternal Health
	  ○ Received the award at the end of the month
	• Expanded membership to around 20 new agencies and programs.
	  ○ Totaling approximately 70-80 regular attendees
	
	Community Engagement
	• A representative from H&R Block was connected with the AV HN because of her involvement as a foster parent through DCFS. She came to a meeting and offered to go out to the different agencies to provide free presentations for consumers. Presentation topics include
	  ○ How to file income taxes
	  ○ How to claim children in the foster system, etc.
	• A farmer from La Mancha Dairy Farm presented her internship program at the February meeting enlisting TAY participants to join their summer program which includes:
	  ○ Learning how to care for, groom, and show dairy goats that will culminate with a goat show at the AV Fairgrounds.
	  ○ Learning about responsibility, accountability, and teamwork.
	• A representative from State Assemblyman Tom Lackey's office gave a presentation on current health legislation that they are working on including the following items:
	  ○ AB2341 Nursing Home Special Services
	  ○ AB 824 Transitional Housing for Homeless Youth
	  ○ State budget request for mental health training for all peace officers

SA Health Neighborhood	Accomplishments

SA 2: Northeast San Fernando Valley	*Service Delivery*
	• A successful connection was established between San Fernando High School and LA Family Housing in the hopes of continued relationship building.
	• North East Valley Health Corporation was connected with the DMH Program Head at Olive View Urgent Care to improve upon the access to these services.
	• The Victim's Assistance program in Pacoima, Office of the City Attorney, made multiple connections for resources for the victims she served from February's meeting.
	
	Community Engagement
	• In 2007 there was an External Quality Review Organization focus group. Some of the attendees included:
	  ○ Via Avanta, Child and Family Guidance Center, El Centro De Amistad, Hillview, DPH, as well as other members of DMH Directly Operated Clinics.
	• In 2017 the HN met with San Fernando High School to get more involved with LAUSD.
	• The HN met with a Community Outreach Strategy Manager from LA Family Housing to gain additional information on homeless services and at the same time to educate them on the HN.
	• A resource fair hosted by Olive View Mental Health Urgent Center in Sylmar, as part of May (2018) is Mental Health month, was attended by Health Neighborhood representatives with a designated booth
	  ○ Julie Jones, LMFT-Hillview Mental Health Center and Cynthia Hurtado, LCSW/PsyD.- former DMH Service Area 2 Health Neighborhood Liaison to support Olive View MH UCC and the community.

SA 3: El Monte	*Service Delivery* • Referral & Care Coordination Tracking Log Information ○ Success stories pertaining to referrals were discussed during each meeting in an effort to continue and promote the mission of the HN. *Community Engagement* • El Monte HN participated in the Custodial Provider Fair at the Century Regional Detention Facility (CRDF) (2017). Over 150 females were able to obtain resources for themselves, children, and family members. • Participated in the El Monte/South El Monte Community Alliance Resource Fair (2017). • El Monte HN participated at the Goodwill Southern California Job & Resource Fair in the city of El Monte (2017). • El Monte HN participated at the SPA 3 Community Coalition: Serving Families without Borders resource fair in the city of El Monte (2017). • El Monte HN participated at the Mountain View School District Community fair at Madrid Middle School in the city of El Monte (2017).

SA Health Neighborhood	Accomplishments
SA 3: San Gabriel Valley	*Service Delivery* • The SGV HN was organized this past year under the leadership of Service Area Chief Lisa Wong • HN participants are brainstorming and creating an online resource directory for all services and programs in Service Area 3. *Community Engagement* • HN Liaison, Evelyn Lemus, Presented at the Health Consortium of Greater SGV • Lisa Goodwin- Masonic Youth & Family Center presented at a Health Neighborhood meeting. • Joe Rocha- Mayor of Azusa presented at a Health Neighborhood meeting. • Luz Bustillos – Mission City Community Network presented at a Health Neighborhood meeting. • Mario Rodriguez Olmos- Your Voice Matters presented at a Health Neighborhood meeting. • Molly Tanner- San Gabriel Children's Center presented at a Health Neighborhood meeting. • Elizabeth Cope- DMH SB 82 presented at a Health Neighborhood meeting. • Carmen Aguilar- HALO presented at a Health Neighborhood meeting. • Sandra Abarca- Planned Parenthood presented at a Health Neighborhood meeting. • Marissa Gavinet- LA County Department of Public Health presented at a Health Neighborhood meeting**.** • Heather Jue Northover- DPH Center for Health Equity presented at a Health Neighborhood meeting. • Melissa Morales- Social Model Recovery Systems presented at a Health Neighborhood meeting**.**

SA 4: Boyle Heights	*Service Delivery*
	• The BH HN was reorganized the past year under the leadership of the new SA 4 Mental Health Clinical Program Manager III.
	  o The focus has been to increase collaboration between the BH HN participants and tenants of The Wellness Center at Historic General Hospital.
	  o The goal is to work on referral mechanisms and increase care coordination.
	• Tracking logs showed successful referrals for school-based services, DMH IFCCS, and other mental health services. The group is continuing to work on referral issues and strengthen relationships among participants.
	
	Community Engagement
	• HN participants attended The Wellness Center 4th Anniversary Celebration Health Fair, March 2018. This event provided free lunch and family-friendly activities, including fitness classes, cooking class, children's art activities, and live music.

SA Health Neighborhood	Accomplishments
SA 4: Hollywood	*Service Delivery* • Under the leadership of the new SA 4 Mental Health Clinical Program Manager III, the initial objective has been to re-engage the MOU signed providers to build partnership and solidify a common understanding to improve referral and care coordination. *Community Engagement* • Hollywood HN has invigorated attendance by sharing new ideas such as the website proposed by "Painted Brain". • There is an overall increased awareness of local community resources through presentations and case-vignette resource sharing.
SA 5: Mar Vista-Palms	*Service Delivery* • Since its inception, the agencies within the collaborative have successfully increased access to care through better coordination and services appear to be more robust visive identifying barriers to accessing care at every HN meeting. *Community Engagement* • This HN has been improving community health by developing surveys and other metrics to better identify and address social determinants of health in their specific geographic boundaries. • In regards to policy and system change, this HN was a part of the Summer Celebration in June after each HN was featured at our SAAC for the past four months including: ○ Presentation by Heather Jue Northover from the Center of Health Equity. • At the summer celebration, all three (3) HNs convened to assist mapping before segueing into identifying unmet needs, stakeholders not yet being engaged, and county/state policies that would improve the overall community health. • At the end of the summer celebration, a community member made the recommendation for older adults to be best served through the creation of another HN in the Westwood/Wilshire Corridor in West LA. • The SA/FB5 HN's have aligned themselves into four (4) distinct focal areas – Adults, TAY, Children & Families and Older Adults with the formation of a fourth HN being led by Westwood Presbyterian Church.
SA 5: Pico Robertson	*Service Delivery* • Referral tracking, barriers to linkage, success for collaboration, and care coordination were discussed monthly. • PR HN implemented two (2) quality life surveys to better identify the community needs. In regards to promoting awareness of the collaborative, the PRHN was an active participant in the SoRo Neighborhood council and was the lead entity in the neighborhood council's Quality of Life Committee.

SA Health Neighborhood	Accomplishments
	• PR HN was a part of the Summer Celebration in June after each HN was featured at the SAAC for the past four months, which also include a presentation by Heather Jue Northover from The Center of Health Equity. At the summer celebration, all three HN were convened to assist mapping and the process of identifying unmet needs, stakeholders not yet being engaged and county/state policies that if changed would improve the overall community health. At the end of the summer celebration, a community member recommended older adults be served through the creation of another HN in the Westwood/Wilshire Corridor in West LA. • PR HN attended the South Robertson Street Festival in full force. At this event, community members participated in games intending to educate and decrease stigma often associated with mental health issues. The PRHN disseminated information to well over 200 community members as well as assessed the community needs. One-hundred-seventeen surveys were collected, results indicating a need to address bullying in schools, addiction, mental health and health/nutrition issues. *Community Engagement* • Alcott and its partners solidified a partnership with LAPD. Members of LAPD attend monthly meetings, with Vista Del Mar to address the high need of LAPD presence, and creatively problem-solve to reduce the burden on an already overtaxed police department. • PATH's neighborhood outreach services co-located with JFS has proved beneficial. These connections within the health neighborhood have resulted in successful rehousing individuals who have recently become homeless, assisting difficult to engage persons in accessing mental health care as well as bridge housing. • Westside Children and Family Health Center utilized their mobile clinic to provide wellness exams free of charge to the community. • All of the providers associated with the Pico-Robertson HN utilized a community survey developed by the HN to assess the needs of the community. • Cedars-Sinai Grant Foundation and Kaiser West Los Angeles were awarded in the amount of $15,000 and $10,000, respectively.
SA5: Venice-Marina Del Rey (VMdR)	*Service Delivery* • VMdR HN improved community health by developing surveys and other metrics to better identify and address social determinants of health in their specific geographic boundaries. ○ This HN was a part of the Summer Celebration in June after each HN was featured at our the Service Area Advisory Council for the past four months, which also included a presentation by Heather Jue Northover from The Center of Health Equity.

SA Health Neighborhood	Accomplishments
	• At the summer celebration, all three HN were convened to assist mapping and the process of identifying unmet needs, stakeholders not yet being engaged and county/state policies that if changed would improve the overall community health. • At the end of the summer celebration, a community member recommended older adults be served through the creation of another HN in the Westwood/Wilshire Corridor in West LA. • VMdR aligned into four distinct focal areas - Adults, TAY, Children & Families and now Older Adults with the formation of a fourth HN led by Westwood Presbyterian Church. *Community Engagement* • The VMdR HN is a collaborative of health, mental health and substance abuse providers that work across agencies and disciplines to treat the whole person and build stronger families and communities. • During FY17-18, the VMdR HN made strides to increase cross agency collaboration by rotating the monthly meetings to the various agencies within the collaborative. • Rotating the Health Neighborhood meeting, gave participants the opportunity to become familiar with services provided by other agencies within the collaborative. • Through community engagement and listening sessions with the participants of the collaborative it was determined that this HN would be best served by switching the lead from Saint Joseph's Center to Safe Place for Youth (SPY) to realign the collaborative to better serve youth that are homeless in West LA, effective August 2018.
SA 6: South Los Angeles (SLA)	*Community Engagement* • In collaboration with DPH and Department of Parks and Recreation (DPR), 4 HN providers (LA Child Guidance Clinic, UMMA Community Clinic, Tessie Cleveland Community Services, and St. John's Well Child and Family Homeless Care) delivered "Park Therapy" as an innovative, non-traditional, and non-stigmatizing approach to engage residents in the SLA HN. • Activities to engage residents include: o LA Child Guidance Clinic's Fotonovela Series (Spanish Speaking Group) at Bethune Park o LA Child Guidance Clinic's Stress Management at Bethune Park o UMMA Community Clinic's Healthy Cooking Class at Jessie Owens Park o UMMA Community Clinic's Art Therapy Class at Ted Watkins Park o UMMA Community Clinic's Health Screening at Roosevelt Park o Tessie Cleveland Community Services Mobile Game Truck (targeting the youth and teens following sporting activities on Saturdays- Location varies) • SLA HN Liaison has taken the lead in coordinating Homeless Outreach at Leimert Park, in collaboration with Council District 10- Herb Wesson's Office, DMH (SA6 SB-82, HOME Team and SA6 Admin Team), St. John's Well Child and Family Center's Homeless Mobile Truck, DPR, LA Sanitation, NAMI - Urban Los Angeles, LAPD, Community Build, and

SA Health Neighborhood	Accomplishments
	LAHSA. The Home Team, SB82, LAHSA and SA6 Administration provide outreach/referral/linkage on the 2nd and 4th Thursday of the month. • Health Neighborhood partnered up with His Shelter Arms for their 25th Annual Thanksgiving Dinner and Celebration. The Health Neighborhood assisted with providing 15 agencies for the Resource Fair along with 12 volunteers. • On October 20, 2017, Health Neighborhood Liaison participated in the Community Education Partnership Breakfast at LA Southwest College which included presentation from various program providers in the community.
Service Area 7: Southeast Los Angeles (SELA)	*Service Delivery* SELA HN focused on improving care coordination processes and specific SELA HN Providers trained their staff internally to further improve referral and care coordination linkage. • Access to care was a top priority for the SELA HN participants. One active participant volunteered to develop the SELA HN website intended to bring awareness of the SELA HN partnership and provide information regarding the vast array of resources offered by the partnership to the community. SELA HN sponsored/co-sponsored a health fair and case management symposium in an effort to improve community services. *Community Engagement* • SELA HN held the "Celebrate Wellness" Health Fair (June 2017). o The SELA HN strongly believes in improving access to care and planned to use the family-friendly fair as a vehicle to provide an array of valuable services to the Southeast Los Angeles community. o SELA HN was pleased to welcome Senator Ricardo Lara's office and Assembly member Christina Garcia's office as well as over 60 county, city and community agencies who provided services including but not limited to: • Health, dental and vision screenings • Immigration rights services • Natural History Museum's Archaeological Dig Activity • Child identification cards provided by New York Life • Massages and posture screenings provided by Kaiser Permanente, Apple Care and United Integrated Healthcare • Free haircuts and mini manicures • Folklorico, Zumba, dance troop and karate group performances • Informational booths designed to promote health and wellness (including physical and behavioral health) program • 40 Promotoras joined DPH and other Health Agency partners (June 2017) at the "Let's Talk About Exide" – Community Health Outreach and provided door-to-door outreach to homes across Southeast LA

SA Health Neighborhood	Accomplishments
	• Spring Fling" Health Fair in May 2018. The event included over 60 vendors who provided important information about health, mental health, substance use, immigration and education. Participants enjoyed entertainment throughout the day and lunch was provided at no cost. o The fair provided an opportunity for the HN to strengthen bonds with the SA 7 community inclusive of providers and residents. o Tzu Chi provided vision and dental care, including making glasses while the person waited and completed dental work. o Professional Institute of Beauty provided free haircuts and manicures. • Considering the political climate and the high concentration of immigrants residing the SELA community, Immigration Rights quickly became a central focus for the SELA HN last year and participants took action to address this very important matter. o The SELA HN welcomed a series of county approved immigration rights organizations to present on legislative, budgetary and local advocacy initiatives. o The SELA HN accrued information from all presentations and created Immigration Rights packets for all members. o LACDMH SA 7 Chief joined the county's immigration rights task force and provided up-to-date information to the SELA HN members during monthly meetings. o Promotoras collaborated with a SELA HN Immigration Rights partner and received training on immigration rights. • The Homeless Count showed a 50% increase in homelessness in SA 7. SELA HN providers hosted a housing panel presentation and participants learned about important local housing resources, legislative measures focused on the expansion of affordable housing, and increased housing support services. o Developers are beginning to build affordable housing in SA 7, and several new developments are planned in the next few years, in Commerce/Bell Gardens (Salvation Army – Bell Shelter), in East L.A., and potentially in Bellflower. SELA HN will continue to partner with Housing affiliates in SA 7 to address this critical need. o Mosaic Gardens (LINC Housing) is the only current functional supported housing development for TAY. Mosaic Gardens has become an active member in the SELA HN and will help plan a Housing panel presentation for an upcoming SELA HN meeting. • SELA HN to participated in the DPH SPA 7 Regional Planning Network meetings to strengthen partnerships and further collaboration within this Service Area. • Through this partnership, SELA HN has assisted in the early planning of the DPH-Kaiser-PIH partnership collaborative and continues to participate as an active member.
SA 8: Central Long Beach	*Service Delivery* • The CLB HN continued to have a vested interest in improving care coordination processes. The SA/FB HN Liaison met with several CLB HN frontline staff to focus on

SA Health Neighborhood	Accomplishments
	troubleshooting referral and care coordination issues. These brainstorming sessions have allowed participants to learn from each other and suggest specific ways to improve the tracking log and begin capturing client care outcomes. • Monthly summary tracking log reports were distributed at each monthly CLB HN meeting and used as a tool for in-depth referral and care coordination discussions. The summary reports captured quantitative tracking for the previous month and highlight qualitative outcomes, such as tracking log comments about successful referrals and linkages. In addition, the CLB HN summary report included a list of new agencies being referred to and used this as a mechanism to identify potential new participants for the neighborhood. • The CLB HN reached a consensus to align its efforts with two SPA8 SAAC priorities: Homelessness and Trauma Informed Care, in order to connect the Health Neighborhood care coordination efforts with other existing coalitions. • The CLB HN increased participation in tracking logs with Long Beach Mental Health, Long Beach Child and Adolescent, Multicultural Health Association, The Children's Clinic. *Community Engagement* • The CLB HN was heavily involved in community outreach efforts to expand its reach and provided an overview on CLB HN progress to the following: o Councilmember Al Austin – 8th District o DPH Regional Network Meeting o Homeless Initiative Interfaith Conference –SPA8 Breakout Session o League of Women Voters o Long Beach Health & Human Services o Long Beach Public Health Conference o Supervisor Janice Hahn' Office o Trauma Informed Long Beach Task Force • The SPA8 Health Neighborhood Liaison created a new Health Neighborhood in SPA8. o Hawthorne-Lennox Health Neighborhood The following participants delivered presentations at monthly CLB HN meetings: • Department of Public Health Substance Abuse Prevention and Control • Department of Public Heath - Center for Health Equity • Department of Health Services -Whole Person Care • Ability First • Health Net • Star View Long Beach Urgent Care Center • Children's Medical Hub

Integrated Mobile Health Team (IMHT)

IMHT services are designed to decrease or reduce homelessness, incarcerations, and medical and psychiatric emergency visits for individuals with serious mental illness and who are highly vulnerable and have challenges accessing services. Vulnerabilities include but are not limited to age, years of homelessness, and substance use, and/or other physical health conditions that require ongoing primary care. IMHT services are provided in the field by a multidisciplinary staff that includes a licensed mental health professional, psychiatrist, physical health physician, certified substance use counselor, peer advocate, and case managers. The IMHTs use Evidence Based Practices (EBPs) including housing first, permanent supportive housing, harm reduction, and motivational interviewing. LACDMH is committed to the provision of mental health services to the homeless populations and makes efforts to reduce homelessness.

Consumers served for FY 17-18 by IMHT

Program/ Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
	White	African American	Latino	API	American Indian	Other Ethnicity	Male	Female	Unknown
Exodus Recovery, Inc.	4	17	11	2			23	11	
	Other Ethnicities:								
	Not Specified								
	Language of Staff:								
	English Farsi			German Hindi			Korean Spanish		
Mental Health America of Los Angeles	20	13	5			1	26	13	
	Other Ethnicities:								
	Not Specified								
	Language of Staff:								
	English			Spanish					
The People Concern	13	6	2				15	6	
	Other Ethnicities:								
	Not Specified								
	Language of Staff:								
	English			Spanish					
St. Joseph Center	14	6		1		4	17	8	
	Other Ethnicities:								
	Not Specified								
	Language of Staff:								
	English Hebrew			Japanese Korean			Russian Spanish		

The IMHT program contributes to LACDMH's provision of culturally and linguistically competent services by providing services to consumers who are homeless and have a co-occurring mental illness, substance use, and physical health conditions. Homelessness is considered a unique culture. Each team hires staff that reflect the

demographics of the homeless population and includes staff with lived experience of homelessness and/or mental illness.

The IMHTs increase access to mental health services by providing field-based and effective outreach and engagement. The goal of IMHTs is to assist individuals who are homeless and living on the streets in accessing mental health, physical health, substance use, and housing services. The services are brought to homeless persons, thereby removing many barriers that they experience in accessing clinic-based services.

IMHT		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
The IMHT FSPs' strategy is to provide field-based outreach and engagement, mental health, physical health, and substance use treatment services to individuals who are homeless.	The IMHT-FSP model has been successful.	LACDMH uses the Outcome Measures Application to monitor the IMHT-FSP outcomes. The IMHT-FSP outcomes: • 32.5% of participants transitioned from homelessness to permanent housing • There was a 28% reduction in incarcerations

Jail Transition and Linkage Services

Jail Transition and Linkage Services are designed to perform outreach and engage individuals involved in the criminal justice system who are receiving services from jail or jail related services (e.g. court workers, attorneys, etc.). The goal is to successfully link them to community-based services upon their release from jail. The program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the prison. Jail transition and linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits and other services as indicated by individual needs and situations. The goal of these services is to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services.

The table below shows consumers served per quarter by self-reported race/ethnicity. The final column shows the annual number of unduplicated consumers for FY 17-18.

Ethnicity	Q1 July-Sept 2017	Q2 Oct-Dec 2017	Q3 Jan-Mar 2018	Q4 Apr-June 2018	Unduplicated Client Total FY 17-18
African American	96	50	62	84	254
Latino	81	78	46	72	223
Asian Pacific Islander	2	1	1	11	12
Native American/ American Indian	0	0	0	0	0
Caucasian	52	39	31	48	134
Middle Eastern/ Eastern European	2	0	0	0	2
Unknown	9	5	1	1	14
Total	242	173	141	216	639

Katie A.

LACDMH, in collaboration with the Los Angeles County DCFS provides a variety of mental health services associated with the settlement agreement in the Katie A. class action lawsuit (2002). These services are targeted to children and youth in the county's child welfare system that have open DCFS cases, EPSDT eligibility, and meet the medical necessity requirement for full scope Medi-Cal. The program includes the mental health screening of all children and youth with open child welfare cases and the triaging of those who screen positive to LACDMH staff who are co-located in each of the 20 DCFS regional offices. The cases are then triaged on the basis of acuity to Directly Operated and Contracted children's mental health providers.

Key program areas include:

- A significant expansion of the County's Wraparound Program
- Intensive Field Capable Clinical Services
- The Treatment Foster Care Program
- Multidisciplinary Assessment Teams (MAT)

The County continues implementation of the Shared Core Practice Model (SCPM) as well as Intensive Care Coordination and Intensive Home Based Services consistent with the California Department of Health Care Services Medi-Cal Manual for these services. Outcomes associated with the County's efforts are monitored via performance on a set of child welfare data indicators, results of the Qualitative Services Review, and successful implementation of the Katie A. Strategic Plan (2008). Oversight for the implementation of these activities is provided by a Court-appointed Advisory Panel, plaintiff attorneys and the Federal District Court.

Katie A. utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to the communities served. Specific examples include:

Coaching

The Coaching Unit provided individualized coaching sessions with intensive mental health providers that focused on strategies to deliver services to children and families that are culturally and linguistically appropriate. The Coaching team has bilingual coaches who speak Spanish and model to providers' best practice as well as ways to incorporate culturally appropriate interventions into Child and Family Team Plans. The Coaching team provided training on cultural humility to address ways that providers can use skills such as self-reflection to contest implicit bias when working with a culturally diverse population. The Coaching Unit has developed a training on Culture, Privilege and Oppression and how power and personal biases can impact the relationship between the intensive mental health provider and the child and family.

Multidisciplinary Assessment Teams (MAT)

The MAT Program strives to address the cultural and linguistic needs of newly detained children and youth, providing services through a team of providers who maintain staff with linguistic and cultural diversity. Training for all new MAT assessors, including the MAT 101 training, training on Birth to five (0-5) populations, and other training offered through the Child Welfare Division addressing consumer engagement, shared core practice model, underlying needs, and child and family teaming, incorporate a dialogue regarding disproportionalities in detention rates among African American and Native American populations and utilization of cultural humility concepts. Additional training opportunities for staff are provided specifically around engagement of consumers who have significant family history of involvement with the system of care (e.g., DCFS, and partner agencies) and multi-generational histories of trauma.

Training

Child Welfare Division partners with other county departments and community groups to discuss and strategize on how to reduce racial and ethnic disparities for children served concomitantly by the LACDMH and DCFS. All trainings that are developed and/or acquired through outside vendors are reviewed to ensure that the content of trainings addresses cultural humility as well as cultural disparities throughout the County of Los Angeles.

LACDMH and DCFS developed a Shared Core Practice Model (SCPM) the Departments agreed to a common vision and a set of practice principles. Featured in this practice model is an agreement to provide culturally and linguistically competent services. Adherence to the model is evaluated using a Qualitative Service Review and Program Improvement Review process. For several years Katie. A has implemented a structured screening, assessment, and referral process, including the DCFS CSWs and co-located LACDMH staff. Through this

process, children and youth who may be in need of mental health services are quickly identified and linked to services. As part of the screening process and utilizing the SCPM, the cultural and ethnic background of the child/youth and their families are considered to ensure appropriate linkage to a mental health provider who can best serve them.

Consumers Served for FY 17-18

Program/Project/ Activity	# Consumers Served by Ethnicity and Gender										Language of Staff
	White	African American	Latino	API	American Indian	Other (Specify)	M	F	T	Un-known	
Katie A. N= 24,190	1,932	4,900	12,154	308	78	Multiple Ethnicity: 974 Other Ethnicity: 3,840	12,153	12,025		12	All of the threshold languages represented in the L.A. community.

*Due to the transition to one billing system from two, the ethnicity field is being reconfigured which caused a higher than average count of nulls. The county is in the process of resolving this issue.

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
1. <u>Coordinated Services Action Team (CSAT):</u> Mental health screenings of all children with open DCFS cases and referrals of those screening positive to LACDMH co-located staff for assessment and triage to Contracted children's mental health providers.	LACDMH and DCFS track and report on a monthly basis. In calendar year 2018, approximately 93% of DCFS children who were administered the Mental Health Screening Tool (MHST), screened positive and were referred to LACDMH staff that are co-located in each of the DCFS Regional Offices. These co-located LACDMH staff triage cases to community Mental Health Providers based upon acuity and service needs. LACDMH has Contracted with more than 64 Legal Entity providers to administer mental health services for those children in need.	Annual reports are prepared for the Board of Supervisors. The screening process has resulted in a significant improvement of the penetration rate for mental health services provided to DCFS involved children.
2. <u>Multidisciplinary Assessment Team (MAT), Child and Family Teaming Trainings:</u> • MAT/CFT Integration Roll Out SCPM and CFT Trainings	• Aligned with the roll out of the MAT/CFT process in SA 2, SA 5, and SA 6, these trainings were provided to MAT agencies serving the Santa Clarita, Chatsworth, Van Nuys, West LA, Compton, and	• Qualitative outcomes were tracked through regularly held feedback sessions throughout the MAT/CFT implementation process. Quantitative outcomes were

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
• MAT/CFT 101 Training – Culture of Foster Populations, Use of Cultural Humility as an approach to assessment and engagement, understanding of trans-generational impact of trauma • Birth – Five (0-5) Training on Trauma, developmentally and culturally-informed components to inform clinical assessments and case conceptualization.	Wateridge North DCFS regional offices • The MAT/CFT 101 training is provided to new MAT ASSESSORS across all eight Service Areas as needed. The training covers the Katie A. lawsuit and entitlements of children who belong to the Katie A. class. Additionally, new assessors were trained on the SCPM and the current policies and procedures of the MAT program. Trainings are held within the Service Areas and are coordinated with the Service Area LACDMH staff and DCFS MAT staff members when new MAT assessors have been hired by Contracted MAT providers. Typically, such trainings occur eight (8) to ten (10) times per fiscal year. • This training was developed for MAT assessors and 0-5 treatment providers across the system in order to increase capacity for service provision to young children involved in the Child Welfare system	tracked jointly by LACDMH and DCFS Countywide MAT staff. • Qualitative outcomes (e.g., quality and timely completion of MAT assessments) are regularly monitored by Service Area MAT Psychologists and DCFS MAT Coordinators. • Quantitative data (e.g., demographics, number of completed assessments, referral information, findings of medical necessity) was tracked by MAT Countywide Staff. The training continued to be provided to MAT staff, with all MAT Contracted and Directly Operated providers, as well as numerous DCFS staff, being trained throughout the course of FY 17-18
3. <u>Coaching/Trainings:</u> SCPM Trainings that address cultural humility and emphasize Engagement and Teaming to target lack of participation and disproportionality between American Indian and the African American population in foster care. Trainings, which emphasize the element of the family's voice and choice, and the family being viewed as the expert in the teaming process, and increasing cultural awareness and respect. Additionally, CFT Trainings emphasize the need to	• Conducted SCPM trainings to LACDMH staff and contract providers one to two times a month or as needed. • Delivered Child and Family Teaming trainings and intensive coaching to mental health providers, which included Wraparound, IFCCS, and FSP. • Delivered coaching support services to mental health providers/Wraparound agencies.	• Training Evaluations were provided to all participants. • The LACDMH Coaches administered a Coaching Agreement tool to document the participants' learning and mastery of skills during the coaching process.

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
accommodate the family's preference and delivery of services in the family's language. Coaches are bilingual in Spanish, Khmer, and Punjabi and able to deliver services in the preferred language of the families. The California Partners for Permanency Practice Model (CAPP) specifies 23 practices or guidelines on how staff can engage children and families in the Child Welfare System. The practices also guide staff on how to conduct assessments and plan interventions. These 23 guidelines were derived from focus groups held with families and community stakeholders, and have been incorporated into the SCPM Trainings. Coaching developed a training emphasizing the Role of the Clinician when working in a Child and Family Team. A section on cultural humility was included to highlight how a clinician should be culturally aware and culturally responsive in their practice. Coaching has developed a training plan to build capacity within the Coaching Program. Coaching Labs are designed for the training of staff. The labs assist with skills development that utilizes a cultural humility lens.	• Developed and conducted skill building workshops to enhance engagement, cultural awareness, safety, and trauma responsive interventions. • Coaching sessions focused on building a team that is more culturally sensitive and responsive to the child and family's needs. • Individual coaching sessions provided and emphasis on individualized plans and interventions that are aimed at the child and families unique values, strengths and cultural community.	
4. <u>Wraparound</u>: The Wraparound Practice Principles include: • Family Voice and Choice • Team–based • Collaboration • Community-based • Culturally Competent • Individualized • Strength based	• The Wraparound program continued to provide culturally and linguistically competent services by ensuring that services were provided in the families' preferred language. The Wraparound Program also required providers to attend annual cultural competency trainings in order to meet the	• The Wraparound Countywide Plan includes Countywide Administration monitoring of Wraparound Providers with special attention given to cultural sensitivity and responsiveness. • In January 2018, Wraparound began the

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
• Natural Supports • Persistent • Outcome-based These Principles of the Wraparound Program are reinforced by ongoing training and coaching on the SCPM for LACDMH staff and Contracted providers. Each new Wraparound employee is required to participate in trainings related to the Wraparound Model. This model of service delivery is culturally competent in that every principle is aimed at empowering consumers and families so that they may find solutions within the context of their unique values and beliefs, strengths, preferred supports, and unique communities.	special needs of the children and families served.	Children's Intensive Services Review (CISR) process, which is an adaptation of the Quality Service Review (QSR), to ensure quality of service provision and evaluate fidelity to the SCPM. The CISR process focuses on four (4) practice performance indicators, which include Engagement, Teamwork, Assess and Understanding, and Intervention Adequacy. The CISR specifically, looked at the team's considerations of the family's culture, cultural values, how the family identifies themselves, and whether services were rendered in the family's language preference. • In November 2018, LACDMH Wraparound Administration piloted a Caregiver and Child or Youth Satisfaction Survey in Service Areas 2 and 6. Effective January 2019, the surveys were administered in all service areas where the data is used to determine whether the services provided meet the cultural needs of the family.
5. <u>Intensive Treatment Foster Care (ITFC)</u>: • *Pre-Match consultations* incorporate culture as one of the elements discussed/considered at the time of matching youth with foster families and planning services. • *Routine announcements to agencies* about available trainings on cultural humility	• Agencies are considering ethnicity, language, local community, age, and experience with systems and mental health challenges when matching youth to foster families and treatment staff. • Agency staff attended some of the trainings through this announcement process.	• The Program Improvement Review (PIR) process is a qualitative process in which DCFS and LACDMH jointly evaluate how each ITFC agency has implemented the ITFC program and has demonstrated fidelity to Los Angeles County's Shared Core Practice Model. Each provider participates in one review every 12 months and is

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
and those that incorporate cultural competency (ex: Culturally Sensitive Practices, Commercial Sexual Exploitation of Children (CSEC) 101, LGBTQI2-S TAY Safe and Welcoming Environment, How Deaf Mental Health is Unique, Emotional CPR in Spanish, and Substance Use/Dual Diagnosis Conferences). • *Provider Roundtable meetings* schedule time for agencies to share information with one another about upcoming trainings and information obtained from trainings they attended. This has included topics such as developmental disabilities, CSEC, and LGBTQI2-S populations. • *Clinical Consultation* is offered as needed and includes discussion and support for the provision of culturally competent engagement and services. • *ITFC Outreach in the community.* ITFC Foster Family Agencies (FFA) outreach to faith-based communities to recruit Resource Parents for ITFC. Some ITFC agencies train, certify, are monolingual in Spanish or bilingual in English and Spanish. Spanish speaking youth are able to receive services in Spanish.	• Several agencies recruited foster parents that specifically want to work with special populations, youth and have matched youth into these homes for services. • Providers shared information on topics such as developmental disabilities, CSEC and LGBTQI2-S populations and trainings available through their agencies or community partners. • Several agencies offered specialized treatment services to meet the needs of special populations, youth • Clinical consultation was provided to support improvement with culturally appropriate services (e.g., culture of family violence and substance use, gang culture) • ITFC agencies continued to recruit and train staff and foster parents to provide care and services to youth in Spanish.	scored on nine (9) practice performance indicators of the SCPM with an overall score reflective of one of three zones (Maintenance, Refinement, and Improvement.) Each review consists of 1) Qualitative Interviews with CFT members, 2) CFT observations, 3) chart reviews (mental health and FFA), and 4) a feedback session. • Children's Intensive Services Review (CISR) have been incorporated on annual basis to include evaluation of the integration of culture in the treatment/services of the youth. This includes the incorporation of biological family as well as community of origin members in services. 6 CISRs were completed in FY 17-18
6. <u>Family Preservation (FP):</u> A. SCPM Trainings that incorporate the element of Cultural Humility.	• Multiple SCPM trainings were offered to FP LACDMH staff this fiscal year. The Family Preservation training 101 was provided to all of the LACDMH and Lead Agencies across all	• Quantitative outcomes were collected via participant's surveys at the completion of each training session. Such outcomes are tracked by via

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
B. Family Preservation 101	eight (8) SAs. This training incorporated the SCPM into the program. The training covers the Katie A. Lawsuit and entitlements of children who belong to the Katie A. Class. Additionally, the in-home outreach counselors and clinicians were trained on the SCPM and the current policies and procedures of the FP program and strategies to strengthen cultural competence in the FP program. Trainings were held within each SA and were coordinated with the Service Area FP Liaison, the DCFS FP staff members, and the Community Based Organizations contracted by DCFS to provide services to FP. Typically, such training occured eight to ten times per fiscal year.	the Child Welfare Division Training Coordinator. • A sign-in sheet is completed during each of the trainings and provided to the DCFS Family Preservation Program Monitors. Qualitative outcomes such as timely access to services, coordination and teaming conducted, strengths, and cultural considerations and humility are monitored during the FP survey visits conducted one time a year at each LACDMH provider site.
7. <u>Intensive Field Capable Clinical Services (IFCCS):</u> IFCCS is a field-based, countywide program developed in direct response to the State's expansion of services available to Katie A. Subclass members who have intensive mental health needs are best met in a home-like setting. The goal of these services is to incorporate a coordinated child and family team approach into service delivery and minimize psychiatric hospitalizations, placement disruptions, out-of-home placements and involvement with the juvenile justice system. This is achieved by engaging and assessing children and their families' strengths and underlying needs through a trauma informed lense and cultural awareness. In addition to assessing for current needs, IFCCS providers are encouraged to empower children and family's voice & choice around	• The IFCCS program continued to provide culturally and linguistically competent services by ensuring that services were provided in the families' preferred language. Target populations were consistently met every fiscal year.	• The Children's Intensive Service Review (CISR) process was implemented to evaluate the IFCCS Program. The purpose of the evaluation process was to ensure that IFCCS staff were adhering to the principles of the Shared Core Practice Model and consistently providing high quality mental health services to children and youth intensive needs. The CISR process was conducted by teams of two or more reviewers and may have included clinicians and administrators. The IFCCS providers were scored on the following performance indicators: Engagement, Teaming, Assessment and Understanding, and Intervention Adequacy. Child Well-Being is a performance indicator reviewed but is not scored. Through out the

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
their long-term view. Through the CY 2018, nine hundred and five (905) youth were provided IFCCS services. The IFCCS referral portals were expanded from thirteen (13) portals to fourteen (14) portals to include receiving them from Short Term Residential Treatment Placement (STRTP) Aftercare.		CISR process, evaluators assess IFCCS provider's use of a culturally humble approach and a trauma informed lense to inform practice. The CISR cases were randomly selected based on being enrolled for six (6) months. IFCCS Administration successfully completed twenty-two (22) CISR evaluations within the CY 2018.
8. <u>Katie A. Quality Services Review</u>	A total of 5 Quality Service Reviews were completed at various DCFS regional offices during FY 17-18 (Van Nuys, Compton, Vermont Corridor , Torrance, and Palmdale). LACDMH conducted 15 debriefing sessions to Mental Health Provider agencies, for a total of 72 participants, to continue supporting SCPM implementation (which includes a Cultural Competency component). In addition, LACDMH QRS staff provided the following trainings: 3 Shared Core Practice Model trainings; 12 QSR Foundational Trainings for Providers; and 11 Specialized Trainings for Countywide Providers including Family Preservation and DCFS Partners for a total of 26 trainings during FY 17-18.	• FY 17-18 falls in two (2) QSR Rounds, Round 3 and 4. Round 4 is currently set to be completed in early 2021 and data has not yet been fully tabulated. For the two offices that fell at the end of Round 3 in FY 17-18, Torrance and Palmdale, Emotional Well-being was in the 67% and 83% acceptable range, respectively. Overall Practice at the end of FY 17-18 for Round 3 was 42% acceptable and Teamwork continued to be the lagging indicator at 11% acceptable by the end of the FY. It should be noted that early results of efforts to increase training and staff development is being reflected in the offices reviewed in the upcoming Round. For example, preliminary data for the Van Nuys, Compton, and Vermont Corridor office indicate Teamwork at 25%, 17%, and 36%, respectively. These numbers are only preliminary and do not demonstrate the entire Round 4 which continues into the following fiscal year. Overall Practice by the end

KATIE A.		
Projects/Activities/Strategies	**Status/Progress**	**Monitoring/Outcomes/ Findings**
Cont.		of FY 17-18, which ended at the start of Round 4 with the Vermont Corridor Office, point to roughly 60%. • Cultural Humility and reducing disparity. The QSR Protocol outlines the need for children and youth to be in settings where they can be "connected to their preferred language and culture, community, faith, extended family, tribe, social activities, and peer groups." • Interview questions were designed to determine child and family status as well as the County's practice. Questions pertaining to the protocol and reviewer training emphasizes the need to remain neutral and practice cultural humility when meeting with families.

Outreach & Engagement (O & E)

LACDMH considers O&E to be critical activities that embody cultural competence within the framework of the Department's vision of hope, wellbeing, and recovery. Education is the primary purpose of these activities – in particular, educating the community about mental health issues in a manner that meets the audience where they are. For example, going into an ethnic community to talk about suicide may not be successful given the stigma associated with this topic. However, when O&E Teams go into the community, they present information in more accessible and less stigmatizing approaches to build stronger connections with residents.

The aim of O&E activities is to create an infrastructure that supports the commitment to forming partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations, and other County Departments to achieve the promise of the MHSA specially for underserved, unserved, inappropriately served, and hard-to-reach populations.

SA O&E Coordinators engage in the following activities:

- Targeted Outreach Activities
- Conduct one-on-one outreach focusing on mental health in each SA
- Attend community meetings in specific SA
- Attend and conduct outreach at health fairs and/or conferences
- Networking, Collaborating, and Partnering
- Network with agencies, schools, providers, and community groups to offer presentations to consumers
- Collaborate with various community organizations
- Represent the Department at various meetings
- Conduct presentations to community members regarding community mental health resources and mental health education
- Coordinate logistics for presentations and conduct follow-ups with agencies/organizations
- Prepare presentation information about mental health services and/or topics requested by the host
- Develop handouts to distribute at presentations or events for community members
- Educate community members on how to access resources
- Translation of presentation materials into the preferred language of the intended audience
- Conduct online research to compile resources for parents and community members
- Develop mental health presentations in response to specific requests received from the community

Examples of Multicultural Outreach & Engagement Team Activities
FY 17-18

SA	Activity Description	Number Outreach	Group Outreached
1	Back2School Event Lancaster School District	150	African American, Latino, White, Families, and Children
1	Desert Vineyard (faith-based) Event Desert Vineyard Church/Lancaster	100	African American, Latino, White, Families, and Children
1	AV Community Resource Event City Of Palmdale	750	African American, Latino, White, Families, and Children
1	AV College Job Fair Antelope Valley College/Lancaster	100	African American, Latino, White, and College Students
1	Community Collaboration-Holiday Jam event Antelope Valley Hospital-Lancaster	900	African American, Latino, White, Families, Consumers, and Children
1	SAAC- Holiday Event (Day of giving)	250	African American, Latino, White, Consumers, and Families
1	Tarzana Treatment Center Health Fair Lancaster	100	African American, Latino, White, Families, and Consumers
1	Bartz-Altadonna Mental Health Fair Lancaster	100	African, American, Latino, White, Families, and Consumers

SA	Activity Description	Number Outreach	Group Outreached
1	Desperately Seeking Attachment Understanding How Trauma & Neglect Disrupt Attachment-Community Training Antelope Valley Partners for Health-Lancaster	120	African American, Latino, and White
1	AVC College Job Fair AV College-Lancaster	300	African American, Latino, White, and College Students
1	Empowerment Youth Festival-School Districts Joe Walker Middle School-Lancaster	500	African American, Latino, White, Families, and Children
1	Antelope Valley College/CSUB/Various School sites Suicide Prevention Outreach & Engagement		African American, Latino, White, Families, and Children
1	Independent Living Center of SoCal event Lancaster	50	African American, Latino, White, and Individuals with various disabilities
1	Power Of Play-First5LA Event George Lane Park-Quartz Hill	250	African American, Latino, White, Families, and Children
1	H.O.P.E (Homeless, Outreach, Partnership, Event) Desert Vineyard Church-Lancaster	192	African American, Latino, White, Families, and Consumers
1	AV Re-entry Resource Fair Lancaster	150	African American, Latino, and White
1	Implicit Bias Workshop/Event Palmdale	85	African American, Latino, and White
1	Eastside School District Event Eastside, Lancaster	250	African American, Latino, White, Children and Families
2 2 2	Armenian Genocide NAMI Armenian Support Group Outreach and Engagement Activity Armenian Health Fair Events Fairs, Meetings, Translations, Visiting, Calls, etc.	78 19 106 144	Armenian, Middle Eastern, Europeans, White, Latino, African American, and Armenian
2	Clergy Breakfasts Clergy Round Table Meetings Clergy Facilitator Meeting Faith Based Advocacy Council Meeting - FBAC	31 55 59 361	Latino, White, African, American, Armenian, White, Latino, Armenian, African American, and Asian
2	Clergy Outreach to Promote Mental Health Mental Health and Spirituality Conference	660 300	Latino, Asian, African American, and White
2	S.A.A.C. May is Mental Health Month SA 2 Event “Reaching Out” Private Screening Event	600 106	Latino, Latino American, African American, Armenian, and White
2	Educational Mental Health Presentations at Elementary,/Middle School, High Schools	520	Latino and Latino American
2	Educational Mental Health Presentations at Mission College/schools NAMI Clases Pregúntele al Psiquiatra	300 92 30	Latino, White, and African American Latino, and African American
2	Multiple Community Health Fairs: NAMI Pathway Annual Recovery Fair School Health Fairs Back to School Annual Government Day Event Sheila Kuehl /Zev Yaroslavsky LGBTQI Population Homeless Connect Day Events	3570 280 512 560 259 170 48 297	Latino, Armenian, White, and African American

SA	Activity Description	Number Outreach	Group Outreached
	Older Adult NEVC 0 to 5 Brest Feeding Fest Event Head Start Resources Fair DCFS Resources Fair Kindship Program Resources Fair EXPO Disaster Preparedness EXPO Earth Day Resources Fair Parthenia Apartments Resources Fair NAMI Caregiver Summit. Summer Fest Health Fair/ Child 360 Best Start LA Resources Fair	59 150 135 90 100 150 130 150 130 200 150	
2	Community Collaborative Meetings	1448	Latino, White, Armenian, and African American
2	Multiple College Health Fair Events	280	Latino, African American, and Middle Eastern
2	Events in the Community Representing DMH	110	White, Latino, African American, and Middle Eastern
3	Faith-Based Advocacy Council Meeting	5	White, and/or Chinese and/or Latina and/or other Ethnic Group
3	Richard SALDANA	2	Latino
3	Asian Pacific Clinics-NAMI	2	Chinese
3	SAAC 3 Meeting	4	White, and/or Chinese and/or Latina and/or other Ethnic Group
3	Parks After Dark	16	Multiple
3	Collaborative Meeting at Los Angeles	5	White, and/or Chinese and/or Latina and/or other Ethnic Group
3	Parks After Dark at Loma Alta Park at Altadena	12	Multiple
3	Parks After Dark at Bassett Park at La Puente	8	Multiple
3	Faith-Based Advocacy Council Meeting	5	White, and/or Chinese and/or Latina and/or other Ethnic Group
3	Park After Dark at Pamela Park	20	Multiple
3	Park After Dark at Allen J. Martin Park	11	Multiple
3	48th Assembly District Community Health Fair	23	Multiple
3	Faith-Based Advocacy Council Meeting	2	White
3	Asian Pacific Clinics-NAMI	4	Asian
3	Los Angeles County Fair	63	Multiple
3	Cultural Competency Committee	4	Multiple
3	San Gabriel Valley Faith-Based Breakfast Meeting	10	Multi ethnic
3	Faith-Based Advocacy Council Meeting	2	White

SA	Activity Description	Number Outreach	Group Outreached
3	El Monte/S. El Monte Community Alliance Resource Fair	63	Multiple
3	Asian Pacific Clinics-NAMI	2	Asian
3	SGV Youth Summit	22	Asian
3	SAAC 3 Meeting	12	Multiple
3	22nd Annual Asian American Mental Health Conference	43	Multiple
3	MILES Conference	28	Multiple
3	Faith-Based Advocacy Council Meeting	2	Asian and Hispanic
3	SA 3 Clergy Roundtable	2	White and Latino
3	Asian Pacific Clinics-NAMI	1	White
3	Service Area Advisory Committee	2	White
3	Adelante Young Men 2016	78	Latino
3	River Community Thanksgiving Feast	8	Multiple
3	Faith-Based Advocacy Council Meeting	4	Multiple
3	SA 3 Providers Meeting	3	Multiple
3	ENKI	1	Latino
3	MacLaren Children's Center	1	Latino
3	SAAC 3 Meeting	8	Multiple
3	San Gabriel Valley Clergy Roundtable Meeting	4	Multiple
3	SA 3 Clergy Roundtable	14	Multiple
3	Cultural Competency Committee	2	African American and Latino
3	Clergy Roundtable Training	7	White, Latino, and African American
3	ENKI	1	Latino
3	Pacific Clinics	1	Latino
3	SPIRIT Family Services	1	Latino
3	Bridges Inc.	1	White
3	Foothill Family Services	1	Latino
3	Mission City Community Network	2	Latino

SA	Activity Description	Number Outreach	Group Outreached
3	California Mental Health Connection	3	Latino
3	City of Baldwin Park	1	Latino
3	Aegis Treatment Center	1	White
3	System Leadership Team Meeting (SLT)	2	White
3	Las Encinas Hospital	1	White
3	Heritage Clinic	1	White
3	Arcadia Mental Health Center	1	Latino
3	Monrovia Health Center	1	White
3	Sanamente	6	Latino
3	El Monte Comprehensive Health Center	1	Latino
3	Pacific Clinics	1	Latino
3	Five Acres	1	African American
3	City of El Monte	1	Latina
3	Social Model Recovery	1	White
3	Health Neighborhood/Faith Based Liaison Meeting	4	Latino and White
3	California Mental Health Connection	3	Latino
3	City of Baldwin Park	1	Latino
3	Aegis Treatment Center	1	White
3	System Leadership Team Meeting (SLT)	2	White
3	Las Encinas Hospital	1	White
3	Heritage Clinic	1	White
3	Arcadia Mental Health Center	1	Latino
3	Monrovia Health Center	1	White
3	Sanamente	6	Latino
3	El Monte Comprehensive Health Center	1	Latino
3	Pacific Clinics	1	Latino

SA	Activity Description	Number Outreach	Group Outreached
3	Five Acres	1	African American
3	City of El Monte	1	Latina
3	Social Model Recovery	1	White
3	Health Neighborhood/faith based Liaison Meeting	4	Latino and White
5	SAAC/Westside Mental Health Network	60	
5	SAAC/Westside Mental Health Network	93+	
5	Outreach and presentations to more than a dozen Churches in Service Area 5	100+	
5	Outreach to City and County Libraries in Service Area 5		
5	Outreach to more than 10 Community Resource Fairs and Events	1,500	
5	Outreach and Engagement with indigenous people	38	
5	Engagement with Women Infant and Children Office (WIC)		
5	Winter Shelter	100+	
5	Countywide Activity Fund (CAF)	20	
8	DPSS – Community outreach and engagement in Compton	15	African American and Monolingual Spanish
8	Children's Hub – Harbor UCLA – Community outreach	3	African American and Monolingual Spanish
8	Unity Church – Long Beach – faith-based outreach	10	Faith Based Leaders
8	Tri League Women's Meeting –outreach to women in the community as well as other providers in Torrance	15	Women
8	Annual Senior Briefing & Luncheon – community outreach	300	Older Adult
8	Community outreach with Pastors	10	African American and Faith Based Leaders
8	Clergy Round table – outreach and information to faith leaders	5	Faith Based Leaders
8	Community Meeting – Clergy Breakfast outreaching and educating faith leaders	7	Faith Based Leaders
8	Community Meeting – Michelle Obama Library Resource table for members of the city of Long Beach	25+	Individuals with disabilities
8	Community presentation at The Volunteer Center South Bay- Harbor – Long Beach	5	Children, Faith-based community
8	Outreach to faith leaders at DCFS Faith Council Meeting	15	Faith Based Leaders
8	DPSS – Community outreach and engagement in Compton	25	African American and Monolingual Spanish Speakers
8	Community Meeting – Clergy Breakfast outreaching and educating faith leaders	10	Faith Based Leaders
8	faith leaders – Outreach & Engagement	2	Faith Based Leaders

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach at Torrance Unified School District	15	School Aged Populations
8	Clergy Round table – outreach and information to faith leaders	5	Faith Based Leaders
8	Information and education to faith leaders in Long Beach	200	Faith Based Leaders
8	Collaborative with DCFS – South County, provided education and information	25	Social Workers and Children's Age Population
8	Monthly outreach to parent partners	10	Parent Support Group
8	Monthly outreach to parent partners	25	Parent Support Group
8	Community Meeting – DCFS – Resource Table	10	Parents of School Aged Children
8	Outreach to St. Joseph's staff and community	15	Monolingual Spanish, and Faith Based Leaders
8	Clergy Round table – outreach and information to faith leaders	25	Faith Based Leaders
8	Collaboration with Clergy and DCFS	20	Faith Based Leaders
8	Community Meeting – Clergy Breakfast outreaching and educating faith leaders	10	Faith Based Leaders
8	Resource fair Los Alamitos Library	10	Community at large
8	Outreach to faith leaders in North Long Beach	10	Faith Based Leaders
8	Outreach & Engagement – St. Mary's Hospital	5	Older Adult
8	Clergy Round table – outreach and information to faith leaders	8	Faith Based Leaders
8	Clergy Round table – outreach and information to faith leaders	12	Faith Based Leaders
8	Resource table at Long Beach Health Conference	100	Older Adults and Vulnerable Populations
8	Resource Fair – Inglewood	100	African American and Faith Based community
8	Outreach and education St. Margaret's Center Meeting	15	Monolingual Spanish
8	Community Meeting – Clergy Breakfast outreaching and educating faith leaders	25	Faith Based Leaders
8	Presentation to faith leaders in Inglewood	20	Faith Based Leaders and African American
8	Community Meeting – Maranatha Community Church Resource Fair	200 +	Asian American and Monolingual Spanish
8	Outreach to faith leaders at the DCFS Faith Council Meeting	20	Faith Based Leaders
8	Clergy Breakfast outreaching and educating faith leaders	15	Community Populations and African American
8	Outreach to community and providers at SBCC	18	Monolingual Spanish

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach to community at Augustus Hawkins Clinic	10	Monolingual Spanish and African American
8	Presentation – DCFS Staff Meeting	20	Older Adults and TAY
8	Outreach & Engagement Torrance	5	Faith Community and Pastors
8	Presentation to School Administrators at Torrance Unified School District	6	School-aged services
8	Presentation Impact Meeting	7	Children
8	Mental Health Workshops	48	Monolingual Spanish
8	Mental Health Workshops	16	Monolingual Spanish
8	Outreach & Engagement – Central Baptist Church	15	Faith Based Leaders
8	Outreach & Engagement – Provider – Presentation	15	Children, TAY, and Adult
8	Resource table at Los Angeles Faith in Action -LBGTQ	200	LBGTQ Populations and other Community Populations
8	Community Event – Fall Festival Mental Health Fair – Inglewood	30	African Americans, Monolingual Spanish, and Faith Community/Leaders
8	Outreach & Engagement Long Beach	5	Monolingual Spanish and Older Adults
8	Clergy Round table – outreach and information to faith leaders	6	Faith Based Leaders
8	Community Meeting	18	Community Populations
8	Outreach & Engagement – Provider - Presentation	10	Community Populations and Monolingual Spanish
8	Closed Meeting – Presentation – DCFS Staff Meeting	20	African American and Monolingual Spanish
8	Clergy Breakfast outreaching and educating faith leaders	15	Community Populations, Monolingual Spanish, and Asian American
8	Outreach & Engagement – Provider – Presentation	5	Children, TAY, and Adults
8	Presentation to School Administrators at Torrance Unified School District	6	School Services
8	Outreach & Engagement – Provider – Presentation	7	Children, TAY, and Adults
8	Outreach & Engagement – Central Baptist Church	15	Faith Based Leaders
8	Outreached to – Cal State University Dominguez Hills MSW Program – Spirituality and Mental Health	26	Faith Based Leaders and Monolingual Spanish
8	Outreach & Engagement – Provider – Presentation	15	Children, TAY, and Adult
8	Outreach & Engagement – Churches – Minister Alliance	10	Faith Based Leaders
8	Clergy Round Table - outreach and information to faith leaders	15	Faith Based Leaders
8	Round Table- Outreach and information to faith leaders	4	Faith Based Leaders

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach & Engagement – Inglewood	100+	African American and Monolingual Spanish
8	Outreach & Engagement – South Bay Community Church	2	African American and Faith Based Leaders
8	Clergy Breakfast outreaching and educating faith leaders	10	Community Populations and Monolingual Spanish
8	Resource Table & Organized -Community & Wellness Fair Expo 2018	10	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement –Saddle Back Church, Torrance	1	Faith Based Leaders and African American
8	A Bridge to a Healthier Life – Torrance Unified School District	150 +	School Services
8	Open Meeting – School Staff, Providers, DCFS Torrance	25	African American and Monolingual Spanish
8	Outreach & Engagement - Countywide Clergy Breakfast	10	African American, Community Population, and Monolingual Spanish
8	Countywide Health Neighborhood– Round Table	90	Community Populations
8	Outreach and Information to faith leaders	12	Community Populations and Monolingual Spanish
8	Closed Meeting, Outreach & Engagement - Career Expansions Inc.	10	Community Populations, African American, and White
8	Open Meeting – School Staff, Providers DCFS Torrance	15	African American and Monolingual Spanish
8	Clergy Breakfast outreaching and Educating faith leaders	10	Community Populations, African American, and Monolingual Spanish
8	Outreach & Engagement - Long Beach Human Trafficking Task Force, Torrance	36	Community Populations and Monolingual Spanish
8	Care Enough Form Medical, Dental – Inglewood	40	African American, Community Populations, and Faith Based Leaders
8	Presentation to School Administrators at Torrance USD Building Bridges	50	Community Populations, School Staff, and Monolingual Spanish
8	Outreach & Engagement - Long Beach Human Trafficking Task Force	35	Community Populations and Monolingual Spanish
8	Outreach and Information to faith leaders, Clergy Round Table	6	Faith Based Leaders
8	Outreach & Engagement -faith based Advocacy, Los Angeles	50	Faith Based Leaders, Monolingual Spanish, and Community Populations
8	Outreach & Engagement – faith based Pastors	10	Faith Based Leaders, African American, and Community Population
8	Outreach & Engagement - Regional Community Alliance DCFS Torrance	25	County Staff, Providers, Community Populations, and Monolingual Spanish
8	Outreach & Engagement Pastors	25	Community Populations, African American, and Faith Based Leaders

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach & Engagement – Meeting with Pastors	10	Community Populations, African American, and Faith Based Leaders
8	Outreach & Engagement - DCFS Torrance- Staff, Providers	15	Community Populations, African American, and Monolingual Spanish
8	Outreach & Engagement – Meeting with Pastors	5	African, American and Faith Based Leaders
8	Clergy Breakfast outreaching and educating faith leaders	15	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement – Long Beach Food Bank	2	Community Populations and Monolingual Spanish
8	Outreach & Engagement – Didi Hirsch – Inglewood	15	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement – Leuzinger High School – Resource Table	50+	School District, Staff, and Students
8	Outreach & Engagement – Harbor Regional Center – Torrance- Resource Table	100+	Community Populations, Monolingual Spanish, African American, and Intellectual Disabilities
8	Outreach & Engagement – St. Gregory's Church – Long Beach	15	Community Populations and Faith Based Leaders
8	Outreach & Engagement – Meet with Pastors – Long Beach	2	Community Populations and Faith Based Leaders
8	Community Engagement & Outreach – Long Beach Health Department	10	Community Populations, Monolingual Spanish, and African American
8	Engagement & Outreach – Resource Fair & Art Expo, Hawthorne	200 +	Community Population, Monolingual Spanish, and African American
8	Engagement & Outreach – Health Fair – Resource Table, Lomita	100+	Community Population, Monolingual Spanish, and African American
8	Monthly Outreach to Parent Partners – CAPP	4	Parent Support Group
8	outreach and information to faith leaders -Round Table	10	Faith Based Leaders
8	Engagement & Outreach – faith based leaders, Lennox	20	Faith Based Leaders
8	outreach and information to faith leaders -Clergy Round Table	10	Faith Based Leaders
8	outreaching and educating faith leaders - Clergy Breakfast	20	Community Population, Monolingual Spanish, and African American
8	Outreach & Engagement - Long Beach Career, Community & Wellness Fair Expo 2018	10	Community Population, Monolingual Spanish, and African American
8	Outreach & Engagement – faith leaders	15	Community Populations, African American, and Faith Based Leaders

SA	Activity Description	Number Outreach	Group Outreached
8	A Bridge to a Healthier Life - Resource Table – Lynwood	200+	African American Community Population, and Monolingual Spanish
8	Outreach & Engagement – DCFS Torrance	25	Staff, Community Populations, Monolingual Spanish, and African American
8	Mental Health Workshops	25	Community Populations and Monolingual Spanish
8	Mental Health – Workshops	326	Community Populations and Monolingual Spanish
8	Outreach & Engagement & Outreach – DCFS Torrance	20	Staff, Community Populations, Monolingual Spanish, and African American
8	Community Health Fair- Resource Table, Long Beach	250+	Community Populations, Monolingual Spanish, and African American
8	Outreaching and Educating faith leaders - Clergy Breakfast	15	Community Populations and Faith Based Leaders
8	Outreach and Information to faith leaders - Round Table	10	Faith Based Leaders
8	Community Engagement & Outreach – SBCC Collaborative- Wilmington	50	Community Populations, Monolingual Spanish, African American
8	Outreach & Engagement & Outreach – LA Metro	70	Community Populations, Monolingual Spanish, African American
8	Engagement & Outreach – Health Fair – Resource Table - Torrance	300+	Community Populations, Monolingual Spanish, and African American
8	Closed Meeting - Engagement & Outreach – Star View TAY Center – Presentation	30	TAY Center and Staff
8	O & E Meeting	10	Faith Based Leaders
8	Outreach & Engagement Special Population – PABC	6	Monolingual Spanish and Special Populations
8	Outreach & Engagement – faith based Advocacy Council	25	Faith Based Leaders and Community Populations
8	Mental Health Workshops	184	Monolingual Spanish
8	Outreach & Engagement -Health Fair, Gardena	100+	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement Special Population – PABC – Parent Partner Meeting	6	Parent Support Group
8	Outreaching and educating faith leaders - Clergy Meeting	15	Faith Based Leaders
8	O & E Churches	20	Faith Based Leaders
8	Outreach & Engagement Special Populations – National Ass. Of Counties- Long Beach	200	Community Populations

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach & Engagement – faith Council Meeting - Torrance	50	Community Populations, Faith Based Leaders, and Monolingual Spanish
8	O & E Churches	15	Faith Based Leaders
8	Outreach and Information to faith leaders - DPSS Roundtable	25	African American, Monolingual Spanish, and Community Populations
8	Mental Health Workshops	186	Monolingual Spanish
8	O & E Pastors Meeting	5	Faith Base Pastors
8	Outreach & Information to faith leaders – Clergy Roundtable	10	Faith Based Leaders and Monolingual Spanish
8	Outreach & Engagement - Meet with Pastor	1	Faith Based Leaders
8	Outreach & Engagement Special Populations – PABC Meeting	15	Community Populations, Providers, and Monolingual Spanish
8	Outreach & Engagement – faith based advocacy	25	Faith Based Leaders, Monolingual Spanish, and African American
8	Outreach & Engagement - Health Fair – Lennox	200+	Community Populations, Monolingual Spanish, and African American
8	Monthly Outreach to Parents – CAPP Meeting	15	Parent Support Group
8	O & E Community Church – St. Gregory's Church – Long Beach	5	Community Populations and Faith Based Leaders
8	Outreach & Engagement Monthly Meeting – Clergy Breakfast	20	Community Populations, Faith Based Leaders, and Monolingual Spanish
8	Outreach & Engagement - Meeting with Pastor	1	Faith Based Leaders
8	Outreach & Engagement - Community Housing Meeting Long Beach	15	Community Populations, African American, and Monolingual Spanish
8	Outreach & Engagement – Richstone Family Center	5	Community Populations
8	Mental Health Workshops	141	Monolingual Spanish
8	Outreach & Engagement Monthly Meeting – faith based	49	Faith Based Leaders, Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement Special Population – PABC	10	Community Populations and Monolingual Spanish
8	Monthly Outreach to Parents – CAPP	15	Parent Support Group
8	Outreach& Engagement - Churches – Inglewood	6	Faith Based Leaders, Community Populations, African American, and Monolingual Spanish
8	O & E Housing Support	20	Community Populations, Monolingual Spanish, and African American

SA	Activity Description	Number Outreach	Group Outreached
8	Community Resource Fair - Faith Base Centennial Celebration – Inglewood	150+	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement - Meeting with Pastor, Long Beach	1	Faith Based Leaders
8	Outreach & Engagement – Monthly Meeting faith Breakfast – DCFS	50+	Staff, Community Population, Monolingual Spanish, and African American
8	Monthly Parent Meeting - CAPP	10	Parent Support Group
8	Outreach & Engagement - Office of County Wide Communication	5	Community Providers, Monolingual Spanish, and Staff
8	Mental Health Workshop	329	Monolingual Spanish
8	Outreach & Engagement - Housing Meeting – San Pedro	15	Community Populations and Monolingual Spanish
8	Outreach & Engagement - Meet with Pastors	10	Faith Based Leaders, African American, and Community Providers
8	Monthly Outreach & Engagement - Clergy Outreach	4	Faith Based Leaders, Community Populations, and African American
8	Mental Health Workshops	108	Monolingual Spanish
8	Mental Health Workshops	10	Community Populations and Monolingual Spanish
8	Outreach & Engagement – Workshops – Long Beach	90	Community Population and Monolingual Spanish
8	Outreach & Engagement - School District Staff, Community Providers	25	Administrators, Community Populations, and Monolingual Spanish
8	Outreach & Engagement - Carson Homeless Task Force	18	Community Populations and Monolingual Spanish
8	Mental Health Workshops	326	Monolingual Spanish
8	Outreach & Engagement – School Staff Torrance Unified School District	50	School Staff, Community Populations, African American, and Monolingual Spanish
8	Outreach & Engagement - Community Mixer – Torrance	100	Community Populations and Monolingual Spanish
8	Outreach & Engagement - Community Event -6th Annual Churches – United Kingdom Initiative	151	African American, Monolingual Spanish, and Community Populations
8	Mental Health Workshops	99	Community Populations and Monolingual Spanish
8	Mental Health Workshops	21	Community Populations and Monolingual Spanish
8	Mental Health Workshops	18	Monolingual Spanish
8	Mental Health Workshops	33	Monolingual Spanish
8	Mental Health Workshops	97	Monolingual Spanish
8	Outreach & Engagement - Clergy Round Table	9	Faith Based Leaders

SA	Activity Description	Number Outreach	Group Outreached
8	Mental Health Workshops	1,339	Monolingual Spanish
8	Outreach & Engagement - faith base	50	Faith Based Leaders
8	Outreach & Engagement Monthly Meeting- Clergy Breakfast	5	Faith Based Leaders, Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement- Resource Fair Inglewood	100+	Community Populations, Monolingual Spanish, and African American
8	Mental Health Workshops	232	Monolingual Spanish
8	Outreach & Engagement - RCA Fair – Torrance	200+	Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement Parents – CAPP	10	Parent Support Group
8	Outreach & Engagement - faith Meeting – Los Angeles	60	Faith Based Leaders, Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement – School Torrance Unified School District	25	Community Populations and School Staff
8	Outreach & Engagement – Churches	20	Community Population and African American
8	Mental Health Workshops	505	Monolingual Spanish
8	Outreach & Engagement – Monthly Clergy Breakfast	15	Faith Based Leaders, Community Populations, Monolingual Spanish, and African American
8	Outreach & Engagement – Churches /faith leaders	25	Faith Based Leaders and Community Populations
8	Mental Health Workshops	276	Monolingual Spanish
8	Mental Health Workshops	2,207	Monolingual Spanish
8	Outreach & Engagement – Advisory Board Foster Care, Long Beach	15	DCFS Foster Parents and Community Populations
8	Outreach & Engagement Yearly Meeting– Intercultural faith Breakfast	200	Faith Based Leaders and Community Populations
8	Mental Health Workshops	3,158	Monolingual Spanish
8	Outreach & Engagement Monthly - DPSS Round Table	10	Community Populations, African American, and Monolingual Spanish
8	Mental Health Workshops	64	Monolingual Spanish
8	Outreach & Engagement Parents – CAPP	15	Parents Support Group
8	Mental Health Workshops	560	Monolingual Spanish
8	Outreach & Engagement – Calvary Presbyterian Church	25	Faith Based Leaders and Community Populations

SA	Activity Description	Number Outreach	Group Outreached
8	Outreach & Engagement Clergy Breakfast	10	Faith Based Leaders, Monolingual Spanish, and Community Populations
8	Outreach & Engagement - Closed Meeting – Housing Complex	10	Community Population, Staff, and Administrators
8	Community Meeting – Torrance Unified School District	15	Community Populations
8	Mental Health Workshops	456	Monolingual Spanish
8	Outreach & Engagement – HRC Resource Fair	100+	Community Populations and Intellectual Disabilities
8	Outreach & Engagement – Churches	10	Community Populations, African American, and White
8	Outreach & Engagement –School District Torrance Unified School District	25	Community Population, Staff, Monolingual Spanish, and African American
8	Outreach & Engagement – Stepping In Conference – Resource Table	200 +	Community Population, Monolingual Spanish, African American, and White
8	Outreach & Engagement Monthly – Clergy Round Table	10	Faith Based Leaders Community Populations, and Monolingual Spanish
8	Mental Health Workshops	701	Monolingual Spanish
8	Outreach & Engagement Monthly – Clergy Breakfast	10	Faith Based Leaders, Monolingual Spanish, and Community Populations
8	Outreach & Engagement Monthly – Round Table	15	Faith Based Leaders and Community Populations
8	Outreach & Engagement – Churches	10	Community Populations and African American
8	Outreach & Engagement – School District Torrance Unified School District	50	Community Populations and African American
8	Mental Health Workshops	412	Monolingual Spanish
8	Outreach & Engagement – Churches	5	Community Populations and African American
8	Outreach & Engagement – Interfaith Summit on Homeless Resource Table	90	Community Populations, Faith Based Leaders, and African Americans
8	Outreach & Engagement Monthly – Clergy Breakfast	10	Faith Based Leaders, Monolingual Spanish, and Community Populations
8	Outreach & Engagement – Whole Person Care Conference – Resource Table	100 +	Monolingual Spanish and Community Populations
8	Outreach & Engagement – Clergy Round table	5	Community Populations and Faith Based Leaders,
8	Outreach & Engagement – National Health Center Week Resource Table , Torrance	100	Community Populations and Monolingual Spanish
8	Outreach & Engagement Monthly – Clergy Breakfast	15	Community Populations, Monolingual Spanish, and African American

Prevention and Early Intervention
Prevention and early intervention (PEI) services include the following:

- Early Intervention
- Suicide Prevention
- Stigma and Discrimination Reduction
- Prevention
- Outreaching for Increasing Recognition of Early Signs of Mental Illness Program
- Program to Improve Timely Access to Services for Underserved Populations
- Access and Linkages to Treatment

Consumers Served for FY 17-18

# of Consumers Receiving a Direct Mental Health Service	# of New Consumers Receiving PEI services with no previous MHSA service
44,212	27,341

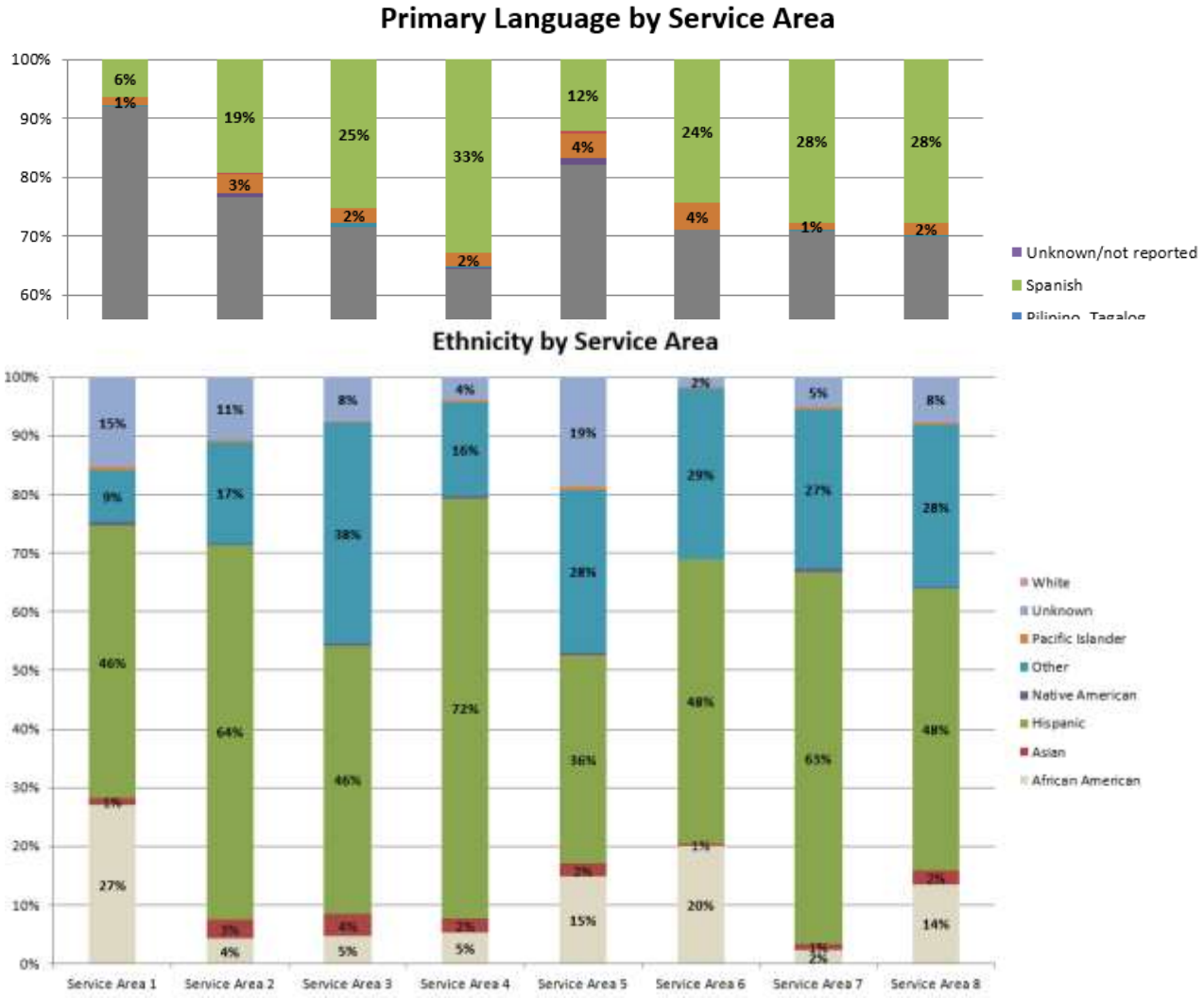
Consumers Served by Age Group for FY 17-18

Child	Transition Age Youth	Adult	Older Adult
30,840	8,473	4,691	1,074

Consumers Served by Ethnicity for FY 17-18

Ethnicity	Count	%
Hispanic	24,363	55%
African American	4,285	10%
White	3,359	8%
Unknown	---	---
Asian	996	2%
Other	10,938	25%
Native American	115	0.26%
Pacific Islander	156	0.35%

L.A. County Consumers served through PEI by SA, FY 17-18



PEI Consolidation

The original PEI plan identified thirteen (13) programs with overlapping evidence-based, promising and community defined evidence practices associated with each of thirteen (13) programs. This consolidation of programs into seven (7) represents a one-to-one correspondence between practices and the programs that counties are required to report on, increasing reporting accuracy.

The PEI Three (3) Year Plan for FY 17-18 to FY 19-20 was developed through a stakeholder process that consisted of four age groups (Children, TAY, Adults, and Older Adults) as well as a countywide special population workgroup. Stakeholders representing consumers, parents, family members, mental health provider, educational and social service providers and LACDMH staff, participated in the planning process that occurred in Fall 2016. As a result of this planning process, the following programs were developed and selected:

- 7 PEI Plan Programs (PEI – 01 to PEI 07 below)
- Total 79 LACDMH PEI programs/projects
- 32 Prevention Programs
- 38 Early Intervention Programs
- 16 Evidence-Based Programs
- 13 Promising Practices
- 9 Community- Defined Evidence Practices

PEI-01. Suicide Prevention

This Program provides suicide prevention services through multiple strategies by strengthening the capacity of existing community resources and creating new collaborative and comprehensive efforts at the individual, family, and community level. These services include: community outreach and education in the identification of the suicide risks and protective factors; linkage to direct services and improvements to the quality of care to individuals contemplating, threatening, or attempting suicide; access to evidence based interventions trained suicide prevention hotlines; and building the infrastructure to further develop and enhance suicide prevention programs throughout the county across all age groups and cultures.

Program Name	Type	Ages Served
• **<u>24/7 Crisis Hotline</u>** The 24/7 Crisis Hotline Services provide support to attempters and/or those bereaved by a suicide. Services are offered in English as well as Spanish; people in crisis can also receive Korean and Vietnamese language services most evenings and assistance consultation to law enforcement and first responders. There are multiple daily scheduled Warm Line coverage in L.A. County, and in order to minimize coverage gaps, the Warm Line coverage will be expanded. The program has built community capacity by offering training in the Applied Suicide Intervention Skills Training (ASIST) and safe TALK models to various staff to recognize and respond appropriately to suicide.	SP	All Ages
• **<u>Applied Suicide Intervention Skills (ASIST) Training</u>** ASIST is intended to help participants become ready, willing and able to provide suicide first aid to persons at risk of dying by suicide. ASIST instructs clergy, first responders, teachers, and others holding jobs in which they are likely to come in contact with people at risk for suicide. The training provides information on how to recognize risk factors, intervene, and link those at risk with appropriate resources.	SP	TAY, Adults & Older Adults
• **<u>Assessing and Managing Suicide Risk (AMSR) Training</u>** AMSR is a one-day training workshop for behavioral health professionals that are designed to help participants provide safer suicide care. Health care providers face many challenges when working with patients and clients at risk for suicide.	SP	TAY, Adults & Older Adults
• **<u>Latina Youth Program</u>** Pacific Clinics provides 24/7 bilingual (Spanish) emergency and information telephone counseling, consultation and education to	SP	All Ages

Program Name	Type	Ages Served
schools regarding suicide risk factors among teens. The primary goals of the Latina Youth Program are to 1) Promote prevention and early intervention for youth to decrease substance use and depressive symptoms which are major risk factors for suicide; 2) Increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services; 3) Increase access to services while decreasing barriers and stigma among youth in accepting mental health services; 4) Increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion; and 5) Enhance awareness and education among school staff and community members regarding substance abuse and depression.		
• **Partners in Suicide Prevention (PSP) Team for Children, TAY, Adults, and Older Adults** PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team is comprised of staff representing each of the four (4) age groups, and includes Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence based practices, and provides linkage and referrals to age appropriate services. Team members conduct countywide educational trainings, participation in suicide prevention community events, and collaboration with various agencies and partners.	SP	TAY, Adults & Older Adults
• **Question, Persuade and Refer (QPR) Training** QPR Training for Suicide Prevention is an educational program designed to teach lay and professional "gatekeepers" the warning signs of a suicide crisis and how to respond. Gatekeeper individuals are strategically positioned to recognize and refer someone at risk of suicide (e.g., parents, friends, neighbors, teachers, coaches, caseworkers, police officers). The process follows three (3) steps: (1) Question the individual's desire or intent regarding suicide; (2) Persuade the person to seek and accept help; and (3) Refer the person to appropriate resources. Trainees receive a *QPR* booklet and wallet card as a review and resource tool that includes local referral resources.	SP	TAY, Adults & Older Adults
• **Recognizing and Responding to Suicide Risk (RRSR) Training** Recognizing and Responding to Suicide Risk (RRSR) is a training, offered for the first time this fiscal year. Seven (7) staff completed the Train-the-Trainer program and provided five (5) trainings during this fiscal year. RRSR is an interrelated series of learning events based on a set of 24 core competencies that comprehensively define the knowledge, skill and attitudes required for effective clinical risk assessment and treatment of individuals at risk for suicide.	SP	TAY, Adults & Older Adults

PEI-02. Stigma and Discrimination Reduction

The purpose of the Stigma and Discrimination Reduction Program is to reduce and eliminate barriers that prevent persons from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through client-focused, family support and education and community advocacy

strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future.

Services include anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and client and family education and empowerment.

Program Name	Type	Ages Served
• **Children's Stigma and Discrimination Reduction Project** The project provides education to parents and to the community through two (2) distinct curricula. The first is a 10-week course, developed specifically to reduce stigma, includes healing and communication tools to promote mental wellness and creating a world that is empathic to children. The second is a 12-week course, developed by United Advocates for Children and Families, is an education course on childhood mental illnesses, and includes grief and loss, and navigating the multiple systems, e.g. mental health, juvenile justice, and DCFS.	SDR	TAY, Adults & Older Adults
• **Family-Focused Strategies to Reduce Mental Health Stigma and Discrimination** a. Adult System of Care Anti-Stigma and Discrimination Team b. Mental Health 101: NAMI Mental Health 101 is a presentation program designed for the general audiences with special attention centered on the uniqueness of multicultural communities including African American, LGBTQ, Latino, Asian and Pacific Islander, and Native Americans. c. Family to Family (English, Spanish and Korean): an EBP that delivers education, increases participants coping skills and empowers family members to become advocates for mental health. Family-to-Family is a 12-week course for family members/partners/friends of those with mental illness to facilitate a better understanding of mental illness and treatment. The class offers preventative measures for caregiver burnout and early stress signs for caregivers to seek help. d. Ending the Silence (language of trained speaker): an in-school presentation designed to teach middle school and high school students about the signs and symptoms of mental illness, how to recognize early warning signs and the importance of acknowledging need for help. e. Basics (English and Spanish): 10-week course aimed at parents/caregivers of children and adolescents with symptoms or diagnosis of mental illness to build similar skills as the Family to Family for adult family. f. Parents and Teachers as Allies: an in-service presentation designed for teachers and school personnel to raise awareness about mental illness. g. Provider Education: offers in-service training to line staff, emergency room staff, and other health care personnel to expand	SDR	All Ages

Program Name	Type	Ages Served
compassion for the individuals and families living with mental health conditions and to promote collaboration with mental health agencies. h. NAMI in the Lobby: an outreach effort within psychiatric hospitals, outpatient clinics, mental health urgent care centers, and community colleges about NAMI programs and resources as an effort to reduce the average number of years. In average it takes a family to find the resources in NAMI from 7 years. i. In Our Own Voice: presentations designed for the general public to promote awareness of mental illness and the possibility of recovery. These presentations are given by mental health consumers who have been trained and coached on telling their stories of mental illness and recovery in a specific format. The presentations put a face on the lived experience of mental illness and recovery. j. Family Voice: similar presentations for the general public to promote awareness of mental illness and the family involvement in recovery process, as told by family members. k. Basics: a six (6)-week course offered by ten (10) NAMI Affiliate locations two (2) times annually per Affiliate.		
• **Mental Health First Aid (MHFA)** MHFA is a public education program that helps parents, first responders, faith leaders, and other people identify, understand, and respond to signs of mental illnesses and substance use conditions. The training is intended to build skills for individuals need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis. MHFA teaches individuals to recognize the signs and symptoms of common mental illnesses and substance use disorders; de-escalate crisis situations safely; and initiate timely referral to mental health and substance use treatment resources available in the community. The Department both conducts MHFA training as well as train individuals as MHFA trainers.	SDR	TAY, Adults & Older Adults
• **Mental Health Promoters/Promotores Program** The program represents a promising approach to mental illness and disease prevention as it increases knowledge about mental illness, increases awareness about available mental health services, and promotes early use of mental health services. The program includes the use of community health workers who are not certified health care professionals, but have been trained to promote or provide preventive healthcare services within their community, including educational and awareness building activities. The Promotores/Promoters are familiar with the cultural needs/dynamics of the communities that they serve and they can speak the language of the community, which results in a greater impact. The Latino Promotoras program is being expanded to other service areas in L.A. County. Pilot projects will be initiated to determine the effectiveness of the Mental Health Promotors model in several underserved communities. During the first stage the Promoters model will be implemented for the following communities:	SDR	TAY, Adults & Older Adults

Program Name	Type	Ages Served
African (Somali), Armenian, Asian/Pacific Islander (Filipino), and Native American communities, and thereafter other underserved communities as well.		
• **Older Adults Mental Health Wellness Project** The Older Adult Anti-Stigma and Discrimination team conducts countywide educational presentation, community events and collaboration with various agencies. They provide workshops for seniors through the county and participate in health fairs, as well as provide MHFA training for non-clinical staff, volunteers, and people in the community.	SDR	TAY, Adults & Older Adults
• **Profiles of Hope Project** The Project has developed a set of 10-minute and 30-minute inspirational stories that spotlight high-profile individuals who candidly share how they overcame stigma and various obstacles to live successful and productive lives. The series was initiated as a vehicle in which to foster dialog and discussion on the issues related to mental health and recovery. This project is designed to help promote widespread tolerance and acceptance of those diagnosed with mental illnesses and/or addiction.	SDR	All Ages

PEI-03. Strengthening Family Functioning

The Strengthening Family Function Program builds competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies. Services are offered to a diverse population throughout the L.A. County. The project utilizes universal and selective intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on parental skill-building through a variety of training, education, individual, group parent, and family interaction methods.

Program Name	Type	Ages Served
• **Alternatives for Families- Cognitive Behavioral Therapy (AF-CBT)** AF-CBT is designed to improve the relationships between children and parents/caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	EI PP	Children (5-15) TAY (16-17)
• **Asian American Family Enrichment Network (AAFEN)** The AAFEN Program serves Asian immigrant parents and primary caregivers with inadequate parenting skills to effectively control and nurture their teenage children, who experience reduced family attachment, social functioning, as well as increased family conflict.	P CDE	Ages 12-18

Program Name	Type	Ages Served
The AAFEN Program aims at increasing the emotional and behavioral self-efficacy of the Asian parents/caregivers and enhancing the safety and healthy development of Asian immigrant youths. In particular, the AAFEN Program is designed to promote such protective factors as the stability of the Asian immigrant families, the confidence and competence of the Asian immigrant parents and/or primary caregivers in carrying out responsive and effective bicultural parenting and family management skills, and positive family bonding and relationship.		
• **Brief Strategic Family Therapy (BSFT)** This is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	EI EBP	Ages 10-16
• **Caring For Our Families (CFOF)** Adapted from the "Family Connections" model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	EI CDE	Children (5-11)
• **Family Connections (FC)** The goal of FC is to help families meet the basic needs of their children and prevent child maltreatment. Nine (9) practice principles guide FC interventions: community outreach; individualized family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, wellbeing, and permanency outcomes.	EI PP	Children (0-15) TAY (16-17)
• **Incredible Years (IY)** IY intervention is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on teachers' classroom	EI EBP	Children (0-12)

Program Name	Type	Ages Served
management strategies, promoting pro-social behaviors and school readiness.		
• **Loving Intervention Family Enrichment Program (LIFE)** An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	EI CDE	Children (4-15) TAY (16-19)
• **Making Parenting a Pleasure (MPAP)** MPAP is a group-based parent training program designed for parent educators of parents and/or caregivers of children from birth to eight (8) years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self-care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographic backgrounds. Age group is parents of children (ages 0-8 years).	P PP	Parents of Children (0-8)
• **Mindful Parenting Groups (MP)** MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.	EI	Parents of Children (0-3)
• **Parent-Child Interaction Therapy (PCIT)** PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	EI EBP	Young Children (2-7)
• **Reflective Parenting Program (RPP)** RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents/caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	EI	Children (0-12)

Program Name	Type	Ages Served
• **Positive Parenting Program (Triple P)** Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through the Los Angeles County Library Family Café Places, community-based organizations, Headstart, childcare providers, preschools and other early education programs. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by LACDMH directly operated and contract agencies.	EI EBP	Ages 0-18
• **Second Step** A classroom-based program, this practice teaches socio-emotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information- processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision-making process when emotionally aroused in developmentally and age appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.	P PP	Children (4-14)
• **UCLA Ties Transition Model** UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age three, interdisciplinary educational and pediatric consultation).	EI PP	Children (0-8)

PEI-04. Trauma Recovery Services

The Trauma Recovery Services Project provides: 1) short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and 2) more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events. The programs include outreach and education, psychosocial assessment, individual short-term crisis counseling, family counseling, youth and parent support groups, case management, and training for staff that are likely to work with trauma victims.

Program Name	Type	Ages Served
• **Child-Parent Psychotherapy (CPP)** CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. The practice is intended for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma. CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive-behavioral, and social-learning theories into a dyadic treatment approach.	EI EBP	Children (0-6)
• **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** This aims to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure. The practice serves children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of PTSD, depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff, as part of multi-disciplinary treatment teams.	EI CDE	Children (10-18)
• **Prolonged Exposure - Post Traumatic Stress Disorder (PE)** PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	EI EBP	Ages 18+
• **Seeking Safety (SS)** This is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	EI PP	Ages +13
• **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** TF-CBT is intended to reduce symptoms of depression and psychological trauma for children and TAY, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.). Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams.	EI EBP	Children (3-18)
• **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle** This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. The EBP includes traditional	EI EBP	Children (3-18)

Program Name	Type	Ages Served
aspects of healing with American Indians and Alaskan Natives from their worldview.		

PEI-05. Individuals and Families Under Stress

The purpose of this Project is to build competencies, capacity and resiliency in parents, family members and other caregivers by teaching a variety of strategies. The project utilizes universal and selective prevention intervention as well as early intervention approaches for children/youth in stressed families. The programs will address the risk factors and protective factors that promote positive mental health, concentrating on individual, parental, family, and caregiver skill-building through a variety of training, education, individual, group parent, and family interaction methods.

Program Name	Type	Ages Served
• **Crisis Oriented Recovery Services (CORS)** This short-term intervention is designed to provide immediate crisis interventions; address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.	EI	Ages 3+
• **Depression Treatment Quality Improvement (DTQI)** DTQI is a comprehensive approach to manage depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	EI EBP	Ages 12-20
• **Dialectical Behavioral Therapy (DBT)** DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	EI EBP	Ages 18+
• **Families Overcoming Under Stress (FOCUS)** Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor	EI EBP	Ages 5 + Couples &

Program Name	Type	Ages Served
communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole, with hopes of building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.		Families
• **Group Cognitive Behavioral Therapy (Group CBT)** Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.	EI EBP	Ages 18+
• **Group Individual Psychotherapy (Group IPT)** Group IPT is most effective when the group members all have a similar diagnosis or problem area, such as depression, cancer, or PTSD. Groups designed to prevent postpartum depression or depression during pregnancy, or groups for high-risk adolescents would also be highly suitable for treatment with IPT. The similarity in treatment focus fosters rapid development of group cohesion and support. Both are fostered within the group as quickly as possible; later sessions are designed to generalize these skills to the client's family and community, where they can apply them to interpersonal relationships to identify and develop the support they need during crises, and to resolve interpersonal conflicts or manage difficult transitions or losses.	EI PP	Ages 15+
• **Heathy IDEAS (Identifying Depression, Empowering Activities for Seniors)** This is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four (4) evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation. Behavioral activation is a brief, structured approach to help clients reduce depressive symptoms through increased involvement in meaningful activities, which are pleasurable or reduce stress.	P	Older Adults 60+
• **Individual Cognitive Behavioral Therapy (Ind CBT)** This practice is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure,	EI EBP	Ages 16+

Program Name	Type	Ages Served
cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.		
• **Individual Psychotherapy (IPT)** IPT is a short-term therapy (8-20 weeks) based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but also improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	EI EBP	Ages 12+
• **Managing and Adapting Practice (MAP)** MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners' easy access to the most current scientific information and providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A. County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	EI	Ages 0-21
• **Mental Health Integration Program (MHIP)** MHIP delivers specialty mental health services to Tier 2 PEI participants with mild to moderate mental health symptoms that are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse of symptoms.	EI	Ages 18+
• **Mindful Schools** This is a school-based pilot project that will provide mindfulness training and technical assistance for students, school staff and parents in school settings ranging from Headstart programs, preschools and K to 12 schools. The program results include improved attention, emotional regulation, less reactivity, improved behavior in schools, social skills, stress reduction, reduced anxiety, improved well-being, and better behavior in schools. For teachers the program focuses on reduced stress and burnout.	P	Children (0-15), TAY & Adults
• **Nurse Family Partnership (NFP)** This EBP provides home visits by registered nurses to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Nurses use their professional nursing judgment and increase or decrease the frequency and length of visits based on the client's needs. Clients are able to participate in the program for two-and-a-half years and the program is voluntary.	P EBP	Children (0-2), TAY & Adults

Program Name	Type	Ages Served
• **Problem Solving Therapy (PST)** PST has been a primary strategy in IMPACT/MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	EI PP	Older Adults 60+
• **Program to Encourage Active Rewarding Lives for Seniors (PEARLS)** PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	EI EBP	Older Adults 60+
• **Providing Alternative Thinking Strategies (PATHS)** A school-based preventive intervention for children in elementary school, this intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	EI EBP	Children (5-12)
• **School, Community, and Law Enforcement (SCALE) Program** This CDE intervention is designed for Asian immigrant adolescents and their families at risk to school failure and or juvenile justice involvement. Behavioral problems addressed include school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers). Core components include holistic family needs assessment, individualized life skills mentoring and counseling, family case management service linkage, community education and consultation.	P CDE	Ages 12-18
• **Senior Reach** Senior Reach is an innovative evidence-based program that provides behavioral health, case management, and wellness services to older adults age 60+ and older, who are isolated, frail and in need of support. Senior Reach focuses on identifying and engaging this high-risk target population via a population-based health intervention model. The program provides counseling and wellness services and trains individuals in the community to identify and refer seniors in need. Community and faith-based organizations, nontraditional mental health providers, and the County Community and Senior Services will provide services.	P PP	Older Adults 60+
• **The Mothers and Babies Course, Mamas y Bebes** Developed in both Spanish and English, prenatal intervention is designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The explicit goal of the intervention	EI PP	Ages 13+

Program Name	Type	Ages Served
is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program consists of a 12-week mood management course and four (4) booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas.		

PEI-06. At Risk Youth

The At-Risk Youth Project focuses on TAY to (1) build resiliency, increase protective factors, and promote positive social behavior; (2) address depressive disorders among TAY, especially those from dysfunctional backgrounds; and (3) identifies, supports, treats, and minimizes the impact for youth who may be in the early stages of a serious mental illness. Emancipating, emancipated, and homeless TAY are a special focus of this project.

Program Name	Type	Ages Served
• **<u>Aggression Replacement Training (ART)</u>** ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches pro-social skills. In anger control training, youths are taught how to respond to their hassles. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	EI PP	Children (5-15) TAY (16-17)
• **<u>American Indian Life Skills (AILS)</u>** This program serves American Indian children and youth in an urban environment. The program incorporates a school-based, culturally tailored curriculum for suicide prevention among American Indian youth. The intended outcomes are a reduction in feelings of hopelessness and improvement in suicide prevention skills for American Indian youth at risk of depression or suicide countywide. The program reaches out to children/families that lack information and access to resources, including culturally-relevant healthcare. Another vulnerable group includes youth and TAY suffering from child abuse, families with domestic violence, and families impacted by substance use.	P PP	Children (14-15) TAY (15-19)
• **<u>Boys and Girls Club Project LEARN</u>** This program involves enhancing the educational performance and well-being of low-income youth who are at-risk of school failure and involvement with the juvenile justice system. After school program services are offered at Boys and Girls Clubs through teams of local	P PP	Children (7-15) TAY (16-18)

Program Name	Type	Ages Served
BGCA staff, school staff, parents, and students. In addition to assistance with academic problems, activities focusing on conflict resolution, social and behavioral skills, anxiety and coping skills will be available.		
• **Center for the Assessment and Prevention of Prodromal States (CAPPS)** A "first break program", CAPPS is a family focused treatment program serving TAY and their families at high risk for developing psychosis or in danger of experiencing their first psychotic break (prodromal phase). Treatment includes psycho-education, skill building, and problem solving.	EI	TAY (16-25)
• **Coordinated Specialty Care Model for Early Psychosis (CSC-EP)** CSC-EP is a team-based, multi-element approach to treating early psychosis. CSC-EP serves youth experiencing the symptoms of early psychosis including: onset of psychotic symptoms in the past year, subthreshold symptoms of psychosis, and recent deterioration in youth with a parent/sibling with a psychotic disorder. This collaborative, recovery based treatment approach involves clients and treatment team members as active participants. The program includes various treatment components that focus on reducing and managing symptoms and distress and improving individuals' ability to achieve success in independent roles. Services include comprehensive clinical assessment, medication management, case management, individual and family psychoeducation and support groups including multifamily therapy, and peer and family advocate support. CSC-EP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with early psychosis. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.	EI	Children (12-15) TAY (16-25)
• **Early Identification and Prevention of Psychosis Outreach** Based on the Portland Identification and Early Referral (PIER) model, this outreach model relies heavily on community outreach and empowering community and family members to help detect early signs of serious mental illness in TAY. The PIER model was designed with a sole focus on clients in the prodromal phases and uses a three-pronged approach of community outreach, assessment and treatment to reduce symptoms, improve function, and decrease relapse. Outreach efforts are aimed at establishing and maintaining a community network of "early identifiers." Key activities involve community mapping and establishment of a steering council of key community members. The program develops and delivers outreach messages to target audiences (educational, medical and mental health professionals, community groups, media, youth and parent groups, multicultural communities), with a focus on outreach to schools, mental health clinicians and primary care physicians. Outreach efforts are continuously monitored and evaluated.	P Pilot	TAY (16-25)
• **Functional Family Therapy (FFT)** FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact	EI EBP	Children (10-15) TAY

Program Name	Type	Ages Served
the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.		(16-18)
• **Multidimensional Family Therapy (MDFT)** MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.	EI EBP	Children (12-15) TAY (16-18)
• **Multi-systemic Therapy (MST)** MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).	EI EBP	Children (12-15) TAY (16-17)
• **Olweus Bullying Prevention Program** The Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop. Goals of the program include: reducing existing bullying problems among students, achieving better peer relations at school, and preventing the development of new bullying problems. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community.	P PP	Children (5-15) TAY (16-18)
• **Positive Action** Positive Action is an integrated and comprehensive curriculum-based program that is designed to improve academic achievement, school attendance, and problem behaviors such as substance use, violence, suspensions, disruptive behaviors, dropping out, and sexual behavior. It is also designed to improve parent–child bonding, family cohesion, and family conflict. Cheaper for schools to sustain and materials are free online.	P PP	Children (12-15) TAY (16-18)
• **Safe Schools Ambassadors** The Safe School Ambassadors (SSA) program is a bystander education program that aims to reduce emotional and physical bullying and enhance school climate in elementary, middle, and high schools. The program recruits and trains socially influential student leaders from diverse cliques and interest groups within a school to act as	P	Children (5-15) TAY (16-18)

Program Name	Type	Ages Served
"Ambassadors" against bullying. A Train-the Trainer program facilitates sustainability of the program in schools.		
• **School Threat Assessment and Response Team (START)** The three (3) main objectives for START are: 1) Prevention and reduction of targeted school violence in Los Angeles County; 2) Provision of ongoing support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations; and 3) Establishment of partnerships with schools, law enforcement, and other involved community organizations. START has responded to thousands of incidents where law enforcement officials, school authorities and other individuals had concerns about potential violence in elementary schools, middle schools, high schools, and college campuses. START conducts threat assessments and develops interventions which include intensive case management strategies.	P	All Ages
• **Strengthening Families Program (SFP)** SFP is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	EI EBP	Children (3-15) TAY (16)
• **TAY Drop-In Center Targeted Outreach & Engagement Strategies** a. Peer Lead Support groups are held at the TAY MHSA Permanent Supportive Housing units to promote coping and life skills to minimize the need for emergency and/or ongoing intensive mental health services. The groups are efforts to build self-sufficiency, promote a sense of community and ultimately prevent TAY from losing their housing. b. The Painted Brain is a culturally relevant early intervention strategy for TAY transitioning out of justice or other institutional settings. The program increases social connectedness and engagement in mental health treatment through utilizing art, music, media and poetry.	P	TAY (16-25)
• **Why Try Program** The Why Try Program is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning. It utilizes a series of ten visual analogies that teach important life skills (e.g., decisions have consequences; dealing	P PP	Children (7-15) TAY (16-18)

Program Name	Type	Ages Served
with peer pressure; obeying laws and rules; plugging in to support systems).		

PEI-07. Vulnerable Communities

The Vulnerable Communities Program is intended to build resilience and increase protective factors among vulnerable individuals in Los Angeles County. Services are designed to 1) identify as early as possible individuals who are a risk for emotional and mental problems; 2) conduct outreach, education, and training; 3) promote mental wellness; and (4) provide culturally and linguistically appropriate early mental health intervention services.

Program Name	Type	Ages Served
• **Commercial Sexual Exploitation of Children and Youth (CSECY) Training** Training will be conducted to increase awareness and outreach to children and youth at risk of or involved in commercial sexual exploitation. Target audience include community groups, social service organizations, schools, and mental health providers. The workshops include topics on clinical identification and screening strategies used in assessing children and youth for possible sexual exploitation; a review of complex trauma as it applies to CSECY; clinical interventions or promising practices that are trauma-focused; special issues related to sexual exploitation such as LGBTQ, substance abuse and gender differences; and impact of race, culture and gender on treatment considerations for CSECY.	P	TAY, Adults & Older Adults
• **Domestic Violence and Intimate Partner Violence Services** This is a community-based outreach and engagement, educational prevention program to reduce and/or eliminate **domestic abuse, spousal abuse, battering, family violence**, and **intimate partner violence,** patterns and behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family. Educational awareness for at risk individuals, group and peer support meetings, and educational training for service providers working with victims will be initiated.	P	TAY & Adults
• **Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and 2-Spirit (LGBTQI2) Services** The goal of the LGBTQI2 services is to increase recognition of early signs of mental illness, increase community awareness, and increase access to community-based programs for LGBTQI2 TAY. Services include 1) Outreach and engagement to LGBTQ12 TAY; 2) Peer support groups; 3) Development of a Toolkit to support mental health providers and community-based organizations in developing the capacity to increase access; 4) Referrals and linkage services to mental health and other service providers; 5) Development of community partnerships with educational, health, law enforcement, faith-based, and other organizations; 5) Development of a training curriculum to educate the community and	P	TAY

Program Name	Type	Ages Served
providers about LGBTQ12 TAY issues; and 6) training of mental health providers on reaching out to and working with LGBTQ12 TAY including approaches such as LGBT Affirmative Therapy.		
• **PEI Supportive Housing Services** The goal of this model is to provide PEI services to the residents of Permanent Supportive Housing (PSH) that targets the risk factors with the goal of increasing the protective factors. The model includes a PEI Lead that will coordinate the services along with a team of clinical staff in each Service Area (SA). The SA PEI team will assess the needs for PEI interventions and supportive services in each of the PSH developments based on the population living there, identify appropriate PEI strategies and providers and/or provide the PEI services directly. Services will be provided onsite whenever possible, including mentoring/coaching, school help, life skills, and renting skills.	P	All Ages
• **Veterans Community Colleges Outreach and Case Management Services** Services will be provided by veterans to veterans attending Community Colleges in Los Angeles. The overall goals of the program are to: 1) increase access, coordinate care, and enhance the capacity of multiple organizations to work together in order to achieve better outcomes for military personnel and their families; 2) provide a newly trained cadre of case managers and faculty capable of helping military personnel and their families manage the pressures of combat-related stressors and post-war adjustments; and 3) develop peer support and training/employment opportunities for veterans. The collaboration with the colleges will focus on intensive case management as well as access to employment, housing and mental health resources to veterans who are suffering from PTSD and other emotional issues resulting from combat duty.	P	TAY & Adults
• **Veterans Mental Health Services** A range of services to Veterans countywide will be expanded and initiated, including services emphasizing peer support, female veterans' services, and suicide prevention, and retreats. Collaboration with and coordination of services public and private existing veterans service organizations both in the development and implementation of services will occur, with grants with community-based and faith-based organizations working with veterans. Supportive housing services for Veterans, their partners, children, caregivers, and other family members will be available onsite at Veteran Permanent Housing units.	P	TAY, Adults & Older Adults
• **Veterans Service Navigators** In collaboration with the County Department of Military and Veterans Affairs, this program utilizes military veterans to engage veterans and their families in order to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff follows up with the veterans and their families to ensure that they have successfully linked up and received the help they need. The Navigators engage in joint planning efforts with community partners, including veterans groups, veterans administration,	P	TAY, Adults & Older Adults

Program Name	Type	Ages Served
community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.		

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Prevention Activities

The following prevention activities and services are geared toward addressing, either through education or support, the risk factors associated with the onset of mental illness or emotional disturbances, including a focus on enhancing protective factors such as social connectedness and support. LACDMH contracted with RAND corporation to develop a prevention measure for services that were in various stages of development and implementation. Outcomes will be reported next fiscal year.

ASIAN AMERICAN FAMILY ENRICHMENT NETWORK (AAFEN)

Age Group: Children (12-15), TAY (16-18)

AAFEN Program is Asian immigrant parents and/or primary caregivers with inadequate parenting skills to effectively discipline and nurture their teenage children. Because of the cultural and linguistic barriers experienced by many of these immigrant parents, they often feel overwhelmed and incompetent in terms of effectively managing their family lives. Moreover, their teenage children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for those emotional and behavioral problems that would qualify them for such diagnostic impressions as "Oppositional Defiant Disorder" and "Substance Abuse Disorders." Their immigrant parents and/or primary caregivers are also at high risk for such diagnostic impressions as "Dysthymic Disorder" and "Major Depression," among others. In addition, they are at serious risk for being reported to DCFS for monitoring as they resort to such measures as corporal punishment in an attempt to discipline their children.

ACTIVE PARENTING

Age Group: Children (3-17)

Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, divorce, school success, and character education. Active Parenting classes can be delivered in 1, 3, 4, or 6 group sessions. Curriculum addresses: child development, appropriate discipline, communication skills, decision-making and prevention of risk behaviors.

AMERICAN INDIAN LIFE SKILLS (AILS)

Age Group: Children (14-15), TAY (15-19)

The American Indian Life Skills Development curriculum, also known as the Zuni Life Skills Development curriculum, is a school-based, culturally sensitive, suicide-prevention program for American Indian adolescents. Tailored to American Indian norms and values, the curriculum was designed to reduce behavioral and cognitive factors associated with suicidal thinking and behavior. The curriculum typically is delivered over 30 weeks during the school year, with students participating in lessons 3 times per week. Lessons are interactive and incorporate situations and experiences relevant to American Indian adolescent life, such as dating, rejection, divorce, separation, unemployment, and problems with health and the law. Most of the lessons include brief, scripted scenarios that provide a chance for students to employ problem solving and apply the suicide-related knowledge they have learned.

ARISE

Age Group: Children (4-15), TAY (16-25), Adult (26-59), Older Adult (60-64)

ARISE provides evidence-based life skills group based curricula and staff training programs. Programs are geared towards at-risk youth; however, the program is adaptable for adults as well. Program content focuses on: violence reduction, goal setting, anger management, drug and alcohol avoidance and other life management skills.

CHILDHELP SPEAK UP AND BE SAFE

Age Group: Children (3-15), TAY (16-19)

This is a child-focused, school-based curriculum designed to build safety skills within the child while addressing today's societal risks, such as bullying and Internet safety. The program helps children and teens learn the skills to prevent or interrupt cycles of neglect, bullying, and child abuse—physical, emotional, and sexual. The program focuses on enhancing the child's overall sense of confidence with regard to safety and promotes respect for self and peers that can be applied to general as well as potentially harmful situations. In addition to increasing children's ability to recognize unsafe situations or abusive behaviors and building resistance skills, lessons focus on helping children build a responsive safety network with peers and adults that the child identifies as safe.

COMMERCIAL SEXUAL EXPLOITATION OF CHILDREN AND YOUTH (CSECY) TRAINING

Age Group: TAY (16-25), & Adult (26-59)

Training will be conducted to increase awareness and outreach to children and youth at risk of or involved in commercial sexual exploitation. Target audience include community groups, social service organizations, schools, and mental health providers. The workshops include topics on clinical identification and screening strategies used in assessing children and youth for possible sexual exploitation; a review of complex trauma as it applies to CSECY; clinical interventions or promising practices that are trauma-focused; special issues related to sexual exploitation such as LGBTQ, substance abuse and gender differences; and impact of race, culture and gender on treatment considerations for CSECY.

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE SERVICES

Age Group: TAY (16-25), Adult (26-59)

This is a community-based outreach and engagement, educational prevention program to reduce and/or eliminate domestic abuse, spousal abuse, battering, family violence, and intimate partner violence, patterns and behavior which involves the abuse by one partner against another in an intimate relationship such as marriage, cohabitation, dating or within the family. Educational awareness for at risk individuals, group and peer support meetings, and educational training for service providers working with victims will be initiated. The program will target victims of domestic violence. The program will educate the people who are involved in an abusive relationship on signs and symptoms of domestic violence.

ERIKA'S LIGHTHOUSE: A BEACON OF HOPE FOR ADOLESCENT DEPRESSION

Age Group: Children (12-14)

The program is an introductory depression awareness and mental health empowerment program for early adolescence. The program educates school communities about teen depression, eliminates the stigma associated with mental illness and empower teens to take charge of their mental health. The Real Teenagers Talking about Adolescent Depression: A Video Based Study Guide is a depression and mental health school program designed for middle and high school classrooms and is listed in the Suicide Prevention Resource Center and the American Foundation for Suicide Prevention "Best Practices Registry for Suicide Prevention". The program: 1.Teaches students about depression; 2.Explores the stigma surrounding the illness; and 3. Teaches students how to cope with stress and maintain good mental health.

GUIDING GOOD CHOICES

Age Group: Children (9-14)

Guiding Good Choices is a five-session; parent involvement program that teaches parents of children ages 9-14 how to reduce the risk that their children will develop drug problems. The goal of the program is to prevent substance abuse among teens by teaching parents of preteens and younger adolescents the skills they need to improve family communication and family bonding. During the course of the Guiding Good Choices program, parents will learn specific strategies to help their children avoid drug use and other adolescent problem behaviors, and develop into healthy adults. Parents will learn to set clear family guidelines on drugs, as well as learn and practice skills to strengthen family bonds, help their children develop healthy behaviors, and increase children's involvement in the family.

HEATHY IDEAS (IDENTIFYING DEPRESSION, EMPOWERING ACTIVITIES FOR SENIORS)

Age Group: Older Adults (60+)

The is a community depression program designed to detect and reduce the severity of depressive symptoms in older adults with chronic health conditions and functional limitations. The program incorporates four evidence-based components into the ongoing service delivery of care/case management or social service programs serving older individuals in the home environment over several months. *Program components include screening and assessment of depressive symptoms, education about depression and self-care for clients and family caregivers, referral and linkage to health and mental health professionals, and behavioral activation. Behavioral activation is a brief, structured approach to help clients reduce depressive symptoms through increased involvement in meaningful activities, which are pleasurable or reduce stress.

INCREDIBLE YEARS (ATTENTIVE PARENTING)

Age Group: Parent

The Attentive Parenting program is a 6-8 session group-based "universal" parenting program. It can be offered to ALL parents to promote their children's emotional regulation, social competence, problem solving, reading, and school readiness.

LIBRARY CHILD, FAMILY, AND COMMUNITY PREVENTION PROGRAMS

Age Group: Young children and their parents, school-aged children, TAY and Older Adults **Participant Count:** 63,590

The Library Child, Family, and Community Prevention Program (Library Program) is intended to increase protective factors, mitigating the impact of risk factors assorted with serious psychiatric illness and negative outcomes. The Library Program is intended to serve four primary target populations residing in underserved communities experiencing adversity. The four target populations are: 1) young children and their parents/caregivers, 2) school aged children, 3) transitional aged youth, and 4) older adults. Program participants align with the PEI priority populations which include the following:

- Trauma Exposed Individuals
- Individuals experiencing onset of serious psychiatric illness
- Children and youth in stressed families
- Children and youth at risk for school failure
- Children and youth at risk of or experiencing Juvenile Justice involvement;
- Underserved cultural populations

LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING, INTERSEX, AND 2-SPIRIT (LGBTQI2) SERVICES

Age Group: TAY (16-25)

The goal of the LGBTQI2 services is to increase recognition of early signs of mental illness, increase community awareness, and increase access to community-based programs for LGBTQI2 TAY. Services include 1) Outreach and engagement to LGBTQ12 TAY; 2) Peer support groups; 3) Development of a Toolkit to support mental health providers and community-based organizations in developing the capacity to increase access; 4) Referrals and linkage services to mental health and other service providers; 5) Development of community partnerships with educational, health, law enforcement, faith-based, and other organizations; 6) Development of a training curriculum to educate the community and providers about LGBTQ12 TAY issues; and 7) training of mental health providers on reaching out to and working with LGBTQ12 TAY including approaches such as LGBT Affirmative Therapy.

LIFE SKILLS TRAINING (LST)

Age Group: Children (8-15), TAY (16-18)

LST is a group-based, substance abuse prevention program developed to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This comprehensive program utilizes collaborative learning strategies taught through lecture, discussion, coaching, and practice to enhance youth's self-esteem, self-confidence, decision-making ability and ability to resist peer and media pressure. LST provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.

LOVE NOTES

Age Group: Children (15), TAY (16-24)

The Love Notes is created for this vulnerable, high-risk audience. In 13 lessons they discover, often for the first time, how to make wise choices about partners, sex, relationships, pregnancy, and more. Love Notes appeals to the aspirations and builds assets in disconnected youth.

MAKING PARENTING A PLEASURE (MPAP)

Age Group: Parents of children (0-8)

Make Parenting a Pleasure is a 13 week, group-based, parent training program designed for parent educators of parents and/or caregivers of children from birth to eight years of age. The program is designed to address the stress, isolation, and lack of adequate parenting information and social support that many parents experience. The curriculum focuses first on the need for self -care and personal empowerment, and moves from an adult focus to a parent/child/family emphasis. Its content is adaptable and flexible to fit a wide range of parent education programs and has broad appeal to families from a wide spectrum of socioeconomic, educational, cultural and geographical background.

MINDFUL SCHOOLS

Age Group: Children (0-15), TAY (16-25), Adults (26-59)

This is a school-based pilot project that will provide mindfulness training and technical assistance for students, school staff and parents in school settings ranging from Headstart programs, preschools and K to 12 schools. The program results include improved attention, emotional regulation, less reactivity, improved behavior in schools, social skills, stress reduction, reduced anxiety, improved well-being, and better behavior in schools. For teachers the program focuses on reduced stress and burnout.

MORE THAN SAD

Age Group: Children (14-15), TAY (16-18)

This is a curriculum for teens, parents and educators to teach how to recognize the signs of depression. The program for teens teaches how to recognize signs of depression in themselves and others, challenges the stigma surrounding depression, and demystifies the treatment process. The program for parents teaches parents how to recognize signs of depression and other mental health problems, initiate a conversation about mental health with their child, and get help. This program for teachers teaches educators to recognize signs of mental health distress in students and refer them for help. The program complies with the requirements for teacher education suicide prevention training in many states.

NURSE FAMILY PARTNERSHIP (NFP) PROGRAM

Age Group: High-risk, low-income mothers pregnant with their first child **Participant Count:** 899

The program targets high-risk, low-income mothers pregnant with their first child. NFP aims to reduce risk factors and increase protective factors. The overall program goals are to improve pregnancy outcomes, improve child health and development, and improve mother's life course. The program screens for maternal mental health, supports, and assesses for the need for additional support. NFP practice requires the ongoing monitoring of mother and child for risk factors and/or symptoms by conducting routine screenings of mother and baby. Referrals for further assessment and intervention are made when a mother or child scores high on one or more of the screeners. NFP nurses can refer them to the Clinical Social Worker paid by this program or another DMH clinic for mental health services. Further, NFP nurses can refer children to Regional Services or Medical clinics if deemed necessary.

Primary Language	Number of Clients
Arabic	1
English	635
Other Chinese	3
Other	48
Russian	1
Spanish	209
Tagalog	1
Vietnamese	1

Race	Number of Clients
American Indian	28
Asian	21
Black or African American	101
Native Hawaiian or other Pacific Islander	4
White	600 (including Hispanic)
Other	0
More than one race	0
Unknown	145

Disability	Number of Clients
No	544
Yes:	345
Difficulty seeing	2
Difficulty hearing	4
Mental domain (not including a mental illness)	Not Collected
Physical/mobility domain	Not Collected
Chronic health condition	339

Age	Number of Clients
0-15	37
16-25	629
26-59	233

NATIONAL ALLIANCE ON MENTAL ILLNESS – LOS ANGELES PEI PROGRAMS

Participant Count: 4,855

Members of NAMI are people who lives with serious mental illness, and their friends and family. We provide a vast array of programs aimed at making their lives better and encouraging conversation and understanding about serious mental illness in the public space including in places or worship, or work, on junior high, high school and college campuses, at community clubs, mental health clinics, health fairs, community health centers. Stigma Reduction and Anti-Discrimination, Public Education Awareness: reducing the time it takes for an individual or family member to find appropriate help for mental illness, connecting individuals to mental health services as early as possible, increasing the understanding of the general public on mental illness and recovery and resources. Increasing participants coping skills and empowering family members and caregivers to become advocates for mental health treatment, learning how to recognize early signs and symptoms of mental illness. Outreach and engagement. Improving family and community involvement in mental health recovery .

OLWEUS BULLYING PREVENTION PROGRAM

Age Group: Children (5-15), TAY (16-18)

Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop. Goals of the program include: reducing existing bullying problems among students, achieving better peer relations at school, and preventing the development of new bullying problems. The program is based on an ecological model, intervening with a child's environment on many levels: the individual children who are bullying and being bullied, the families, the teachers and students with the classroom, the school as a whole, and the community.

PARKS AND RECREATION PARKS AFTER DARK (PAD) PROGRAM DMH AND THE COUNTY OF LOS ANGELES PARKS AND RECREATION (DPR)

Age Group: Children through Older Adults **Participant Count:** 7,978

Parks After Dark (PAD) is a program featuring extended park hours and activities for youth and families to increase physical activity, reduce violence, and enhance health and social well-being among community residents. By providing Prevention and Early Intervention (PEI) through mental health education, outreach, and early identification (prior to diagnosis), the Department of Mental Health can mitigate costly negative long-term outcomes for mental health consumers and their families.

Parks are often underutilized due to high levels of crime and fear of violence, which inhibit active living efforts, cause social isolation and lead to a wide range of mental and physical health problems. Parks After Dark was designed to address a number of critical service gaps that are seen in disadvantaged communities.

Parks After Dark targets children, TAY, adults and older adults who meet the following criteria:

- Underserved ethnic and cultural populations residing in high-risk and underserved communities within the County.
- Child, TAY, adults and older adults that could benefit from PEI services and supports;

It is intended that this effort will reduce risk factors and increase protective factors which is in support of the MHSA PEI Regulations. Parks possess great potential to address these service gaps by serving as community hubs where mental health and other organizations can provide education and outreach to vulnerable populations, and participants of all ages can easily access a diverse array of important services and resources in a fun and welcoming setting that is less stigmatized than a government building or mental health clinic.

PEACEBUILDERS

Age Group: Children (0-15)

PeaceBuilders is a violence prevention curriculum and professional development program for grades pre-K to 12. Its essence is a common language - six principles, taught, modeled and practiced: Start Early; Engage Parents Prior to Adolescence; Praise Good Behavior on a Daily Basis; Discourage Insults and Other Acts of Aggression.

PEI SUPPORTIVE HOUSING SERVICES

Age Group: All Ages

The goal of this model is to provide PEI services to the residents of Permanent Supportive Housing (PSH) that targets the risk factors with the goal of increasing the protective factors. The model includes a PEI Lead that will coordinate the services along with a team of clinical staff in each Service Area (SA). The SA PEI team will assess the needs for PEI interventions and supportive services in each of the PSH developments based on the population living there, identify appropriate PEI strategies and providers and/or provide the PEI services directly. Services will be provided onsite whenever possible, including mentoring/coaching, school help, life skills, and renting skills.

PERMANENCY PARTNERS PROGRAM (P3), UPRFRONT FAMILY FINDING (UFFF)

Age Group: Children , TAY **Participant Count:** 125

Research studies have shown that for Child Welfare system-involved children, placements with relatives help to minimize trauma; provides fewer placement changes; and increases better school stability than those placed with a foster family. Additionally, the consequences of instability and high risk factors, such as lack of positive social connections, for all children and youth, if not addressed early on in the life of a DCFS case, can result in higher risk for developing a potentially serious mental illness or systems involvement such as child welfare and juvenile justice systems. The P3 program can improve outcomes for children and youth by providing specific focus on engagement of family and NREFM in order to increase placement stability and provide opportunities for social connectedness for these children and youth since detention.

Primary Language	# of Clients
English	105
Spanish	20

Disability	# of Clients
No	23
Unknown	0
Yes:	102*
Difficulty seeing	4
Difficulty hearing	2
Mental domain (not including a mental illness)	12
Physical/mobility domain	5
Chronic health condition	23
Other	99
*some clients had more than one	

Veteran Status	# of Clients
Yes	0
No	21
Unknown	104

Race	# of Clients
Asian	4
Black or African American	48
White	70
Other	3

Age	# of Clients
0-15	119
16-25	6

Gender	Number of Clients
Assigned sex at birth:	
Male	70
Female	55
Unknown	0
Current gender identity	
Male	0
Female	1
Transgender	0
Genderqueer	0
Questioning or unsure of gender identity	0
Another gender identity	0
Unknown	0

POSITIVE PARENTING PROGRAM (TRIPLE P) LEVELS 2 AND 3

Age Group: Children (0-12), Parents/Caregivers

Triple P is intended for the prevention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Selected Triple P (Level 2 and 3) is a "light touch" parenting information presentation to a large group of parents (20 to 200) who are generally coping well but have one or two concerns. There are three seminar topics with each taking around 60 minutes to present, plus 30 minutes for question time. The Selected Triple P Seminar Series is designed to be a brief introduction to the Triple P strategies and will give the parents and caregivers you work with great ideas to take home and try out with their family.

PROJECT FATHERHOOD

Age Group: Children (0-15), TAY (16-18), Parents/Caregivers

Project Fatherhood program provides comprehensive parenting skills to men in caregiving roles using an innovative support group model. The program was developed to give urban, culturally diverse caregivers an opportunity to connect with their children and play a meaningful role in their lives. The program continues to be recognized nationally for effectively addressing the problem of absentee fathers. Through therapy, support, parenting education and other services, fathers learn to be more loving, responsible parents and active participants in their children's lives. Project Fatherhood helps fathers to be better parents through: Individual and family counseling; Group support; Significant others group; Therapeutic activities for children; Preventing child abuse and neglect; and Helping fathers to make healthier decisions in relationships. At the heart of the program is the Men in Relationships Group (MIRG), which provides comprehensive support at no cost for culturally diverse fathers.

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PSYCHOLOGICAL FIRST AID (PFA)

Age Group: All Ages

PFA is an evidence-informed approach for assisting children, adolescents, adults, and families in the aftermath of disaster and terrorism. The practice is a partnership between the National Child Traumatic Stress Network and the National Center for PTSD. The Core Actions of PFA include: Contact and Engagement; Safety and Comfort; Stabilization; Information Gathering: Current Needs and Concerns; Practical Assistance; Connection with Social Supports; Information on Coping; and Linkage with Collaborative Services. In addition to the English-language edition of Psychological First Aid (PFA), there are versions in Spanish, Japanese, and Chinese. Along with the several language translations, NCTSN members have worked to develop PFA adaptations for community religious professionals, Medical Reserve Corps members, and for staff at facilities for families and youth who are experiencing homelessness. The training for PFA and the Second Edition of Psychological First Aid Field Operations Guide and accompanying handouts are available online. PFA is also available in Spanish, Japanese, and Chinese. PFA for Schools and adaptations for community religious professionals, Medical Reserve Corps members, and for staff at facilities for families and youth who are experiencing homelessness is also available online.

SCHOOL, COMMUNITY, AND LAW ENFORCEMENT (SCALE) PROGRAM

Age Group: Children (12-15), TAY (16-18)

SCALE Program is intermediate school and high school age Asian male and female immigrant youths who are at high risk for, or are exhibiting the beginning signs of, delinquent behavioral problems. These behavioral problems include, but are not limited to, school truancy, academic failure, association with gang members, and early stages of law enforcement encounter and detention (such as by police or probation officers). The background characteristics of these youths often include their having recently moved to the United States (e.g. within five years), and are having difficulty dealing effectively with the stress of adapting to a new environment, culture, language, etc. Many of these youths also report a lack of family support, prosocial peer network, and/or school connectedness.

SECOND STEP

Age Group: Children (4-14)

A classroom-based program, this practice teaches socio-emotional skills (Vulnerable Population) aimed at reducing impulsive and aggressive behavior while increasing social competence. The program builds on cognitive behavioral intervention models integrated with social learning theory, empathy research, and social information- processing theories. The program consists of in-school curricula, parent training, and skill development. Second Step teaches children to identify and understand their own and others' emotions, reduce impulsiveness and choose positive goals, and manage their emotional reactions and decision making process when emotionally aroused in developmentally and age-appropriate ways. Group decision making, modeling, coaching, and practice are demonstrated in the Second Step lessons using interpersonal situations presented in photos or video format.

SENIOR REACH

Age Group: Older Adults

Senior Reach provides behavioral health, case management, and wellness services to older adults age 60+ and older, who are isolated, frail and in need of support. Senior Reach focuses on identifying and engaging this high-risk target population via a population-based health intervention model. The program provides counseling and wellness services and trains individuals in the community to identify and refer seniors in need. Services will be provided by community and faith-based organizations, non-traditional mental health providers, and the County Community and Senior Services.

SUBSTANCE USE DISORDER –TRAUMA INFORMED PARENT SUPPORT (SUD-TIPS

Age Group: Parents

The SUD-TIPS program targets adult parents identified by the Department of Children and Family Services (DCFS) as substance using. This includes parents who have open DCFS cases or Emergency Response referrals. Parental substance use may be a factor contributing to a child's involvement in the child welfare system. Substance use may also contribute to difficulty managing and regulating anger, cause physical or mental impairments, prevent healthy parent-child attachment, and negatively impact overall home life stability. Substance use may be the result of past trauma and individuals with untreated mental health disorders are at greater risk for substance use.

DCFS will refer identified parents to the co-located substance use disorder (SUD) counselors who are then complete the American Society of Addiction Medicine (ASAM) triage tool to determine need for SUD treatment. If during the screening they identify that the individual would benefit from mental health intervention, the individual is then linked to mental health services.

SHIFTING BOUNDARIES

Age Group: Children (10-15)

Shifting Boundaries is a six session, group based, dating violence prevention program that focuses on peer sexual harassment. The intervention consists of a classroom-based curricula and a building-level component designed to reduce the incidence and prevalence of dating violence and sexual harassment among middle school students.

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TAY DROP-IN CENTER TARGETED OUTREACH & ENGAGEMENT STRATEGIES

Age Group: TAY (16-25)

Peer Lead Support groups are held at the TAY MHSA Permanent Supportive Housing units to promote coping and life skills to minimize the need for emergency and/or ongoing intensive mental health services. The groups are efforts to build self-sufficiency, promote a sense of community and ultimately prevent TAY from losing their housing. The Painted Brain is a culturally relevant early intervention strategy for TAY transitioning out of justice or other institutional settings. The program increases social connectedness and engagement in mental health treatment through utilizing art, music, media and poetry.

TEACHING KIDS TO COPE

Age Group: Children (15), TAY (16-22)

This 10 session, group intervention is designed to reduce depression and stress by enhancing coping skills. Program components include: Group discussions, interactive scenes, videos, group projects, and homework assignments. Group discussions include a variety of topics, such as family life situations, typical teen stressors, self-perception issues, and interactions with others.

VETERANS COMMUNITY COLLEGES OUTREACH AND CASE MANAGEMENT SERVICES

Age Group: TAY (16-25), Adults (26-59)

Veterans attending Community Colleges in Los Angeles County and their families, an unserved or underserved population whose is at-risk for developing mental health which can cause complex issues related to the impact of military service experience and adjustment to civilian life. Veterans and their families in this target population have unique mental health needs requiring highly specialized mental health services to help them cope with complex issues related to the impact of military service. Veterans on the community college will be interviewed and assessed for mental illness or seeking information to assist with referrals and resources. For Veterans in the program, they will have access to services of housing, unemployment, linkage to mental health services that best address their mental illness.

VETERANS MENTAL HEALTH SERVICES

Age Group: TAY (16-25), Adults (26-59), Older Adults (60+)

A range of services to Veterans countywide will be expanded and initiated, including services emphasizing peer support, female veteran's services, and suicide prevention, and retreats. Collaboration with and coordination of services public and private existing veterans service organizations both in the development and implementation of services will occur, with grants community-based and faith-based organizations working with veterans. Supportive housing services for Veterans and their families.

VETERANS SERVICE NAVIGATORS

Age Group: TAY (16-25), Adults (26-59), Older Adults (60+)

This Veterans Mental Health Services program will utilize military veterans to engage veterans and their families in order to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff follow with the veterans and their families to ensure that they have successfully linked and received the help they need. The Navigators engage in joint planning efforts with community partners, including veteran's groups, veteran's administration, community-based organizations, other County Departments, intradepartmental staff, schools, health service programs, faith based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.

WHY TRY PROGRAM

Age Group: Children (7-15), TAY (16-18)

Why Try Program is a resilience education curriculum designed for dropout prevention, violence prevention, truancy reduction, and increased academic success. It is intended to serve low income, minority students at risk of school failure, dropping out of school, substance use/abuse, and/or juvenile justice involvement. Why Try includes solution-focused brief therapy, social and emotional intelligence, and multisensory learning. It utilizes a series of ten visual analogies that teach important life skills (e.g., decisions have consequences; dealing with peer pressure; obeying laws and rules; plugging in to support systems).

YOUTH DIVERSION AND DEVELOPMENT (YDD)

The collateral consequences of arrest and incarceration for youth who have justice system involvement remains significant, including an increased risk of dropping out of high school, trauma, substance abuse, and other negative outcomes. The YDD program can improve outcomes for youth by redirecting law enforcement contact and addressing underlying needs through systems of care that prioritize equity, advance wellbeing, support accountability, and promote public safety. Law enforcement will determine whether a youth is eligible for diversion services. The screening tool is being developed.

The YDD Program is comprised of three components:

1. Annual YDD Summit: One-day conference designed to provide law enforcement, community-based agencies, other youth-serving agencies, and key stakeholders with training and capacity building.
2. Youth Intensive Case Management Services (Y-ICMS): Intensive case management provided to youth identified and referred through law enforcement through contracted community-based partners.
3. YDD Training and Technical Assistance: Education, training and technical assistance necessary to provide Y-ICMS services and ensure the success of the YDD Program.

Suicide Prevention

Latina Youth Program

The primary goals of Pacific Clinics' School Based Services for the Latina Special Program are: to promote prevention and early intervention for youth to decrease substance use and depressive symptoms, which are major risk factors for suicide; increase youth awareness of high-risk behaviors and provide immediate assessment and treatment services; increase access to services while decreasing barriers and stigma among youth in accepting mental health services; increase family awareness about high-risk behaviors and empower families through education about the benefits of prevention and early intervention and health promotion; and enhance awareness and education among school staff and community members regarding substance abuse and depression.

The agency's coordination of collaborative relationships with schools, private and public agencies, as well as other community-based organizations continue to allow it to successfully leverage many services and resources for the benefit of program participants. One of the most important aspects of the collaborative effort is the reduction of barriers and increase in access to mental health services by the community in general and children and adolescents in particular. One way in which this has been achieved is by locating the program at school sites and providing services at locations and times convenient to the program participants and their families. The services are provided at no cost to the participants and that they are provided by staff that is both culturally and linguistically competent further enhances the participants' accessibility to treatment.

For FY 17-18, the program provided services to 100 individuals, who ranged in age from four (4) to thirty (30) years. An equal number of females (N=50) and males (N=50) participated in the program. With regard to ethnicity, the majority of program participants were Latino (77%); fifteen percent of participants did not specify their race or ethnicity; Caucasians comprised 5%, followed by Asian/Pacific Islander individuals (2%) and Native Americans (1%).

Consumers Served for FY 17-18 by Latina Youth Program

Program /Project/ Activity	Number of Consumers Served by Ethnicity and Gender (Total 100 participants)								
	White	African American	Latino	API	American Indian	Multiple	Male	Female	Unknown
Latina Youth Program	5	0	77	2	1	0	50	50	0
	Other Ethnicities: 0								
	Not Specified: 15								
	Participants' Age Range								
	4 - 30								

24/7 Crisis Hotline

In FY 17-18, the 24/7 Suicide Prevention Crisis Line responded to a total of 99,574 calls, chats, and texts originating from L.A. County, including Spanish-language crisis hotline services to 10,418 callers. Korean and Vietnamese language services are also available on the Crisis Hotline. Additionally, various outreach events were conducted in LA and Orange County. Types of outreach events include Adolescent, Adult, Adult Clinical, ASIST, Clinical College, College Clinical, First Responders, and lecture, medical, and safe TALK presentations.

Partners in Suicide (PSP) Team for Children, TAY, Adults, and Older Adults for FY 17-18

The Partners in Suicide Prevention (PSP) Team for Children, TAY, Adults, and Older Adults (OA) is an innovative program offered by LACDMH is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The PSP Team offers community education and provides best-practice training models in suicide prevention, and provides linkage and referrals to age appropriate services.

PSP is designed to increase public awareness of suicide and reduce stigma associated with seeking mental health and substance abuse services. The team is comprised of eight staff representing each of the four age groups, and includes six (6) Spanish-speaking members. The team offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age appropriate services.

PSP Team members participated in a total of 133 suicide prevention events during FY 17-18, outreaching to more than 2,051 L.A. County residents. These events included countywide educational trainings, participation in suicide prevention community events, the 7th Annual Suicide Prevention Summit, and collaboration with various agencies and partners. PSP's accomplishments included:

- The PSP team provided three ASIST (Applied Suicide Intervention Skills Training) trainings throughout the County to 63 participants and continued its collaboration with adjunct ASIST trainers from outside of LACDMH, which increased its training capacity countywide, particularly in service areas further from metro Los Angeles.
- Provided 39 QPR (Question, Persuade and Refer) gatekeeper trainings throughout the County, totaling 1,116 community members trained in QPR by the PSP team during FY 17-18.
- Provided 28 MHFA (Mental Health First Aid) trainings, which is designed to teach members of the community to recognize the symptoms of mental health concerns, offer and provide initial help, and guide the individual to professional help if appropriate. Additionally, three (3) Youth Mental Health First Aid (YMHFA) trainings were held, with 65 community members trained to recognize symptoms of mental health concerns in youth ages 12-18.
- Four (4) AMSR (Assessing & Managing Suicide Risk) trainings were

completed this fiscal year, with a total of 114 clinicians, case managers, and nurses in both Directly Operated programs and contracted providers being trained. AMSR trains on the 24 core competencies related to suicide risk assessment and reviews safety planning.

- Provided one (1) Recognizing and Responding to Suicide Risk (RRSR) trainings to 25 participants. RRSR trains on the 24 core competencies as well as safety planning, and provides time for highly interactive discussions and role-play for attendees.
- Participated in the Inter-Agency Council on Child Abuse and Neglect (ICAN)/ DCFS Child Suicide Review Team at the L.A. County Coroner's Office.
- Coordinated and hosted the L.A. County Suicide Prevention Network (SPN), which has recruited over fifty members from a wide variety of organizations and conducts quarterly meetings to increase collaboration and coordination of suicide prevention activities. Quarterly Suicide Prevention Network meetings occurred on the following dates: 9/28/17, 12/7/17, 3/16/18, and 6/8/18.
- Partners in Suicide Prevention participated in Parks After Dark (PAD) for the 7th year in a row. PAD was launched in 2010, at three County Parks, as the prevention component of the County's Gang Violence Reduction Initiative. PAD has successfully expanded to 33 parks Countywide and evolved into a key prevention and intervention strategy that utilizes cross-sector collaborations to promote health, safety, family cohesion, community well-being and equity in our underserved communities. This year PSP participated in eight (8) Parks After Dark events.
- 7th Annual Suicide Prevention Summit "The Suicide Contagion Effect: Why Does it Happen, What We Know, & What We Can Do": held on Thursday, September 7, 2017 at the California Endowment and featured April C. Foreman, Ph.D. as a keynote speaker. The theme for this year's Summit stemmed from criticism around the program "13 Reasons Why" and its depiction of suicide among high school students. Topics addressed included suicide contagion in schools, the impact (positive and negative) of social media, school response in the event of a suicide, and a discussion of a model suicide prevention program in a local school district. Additionally, there was a 'special session' geared towards clinicians that addressed professional anxieties around the use of social media. Approximately 165 attendees from mental health, education, law enforcement, and community-based organizations took part in this event, which was organized and implemented by LACDMH and partners such as Teen Line, Didi Hirsch, and Santa Monica College.
- Throughout FY 16-17, the Older Adult System of Care outreached to community-based as well as faith-based organizations throughout the County to identify approximately 150 community members to be trained as QPR instructors in an effort to broaden the capacity of this suicide prevention gatekeeper model. The members were trained during the latter portion of FY 16-17 and began their trainings in the community during FY 17-18. Throughout this FY, 26 of these instructors remained active, training 817 of their fellow community members in this suicide prevention gatekeeper model.

To strengthen the reach of this project, QPR materials were translated into Chinese, Amharic, and Korean, along with the already-existing Spanish. Instructors who spoke these languages were specifically identified to provide QPR to their respective communities.

- In an effort to increase capacity to provide RRSR, eight (8) LACDMH staff, most from outside of PSP, were trained in February 2018 by the American Association of Suicidology to become RRSR trainers. A RRSR Training of Trainers has not been held at LACDMH since approximately 2012, so a new cohort of RRSR trainers has been essential to PSP and LACDMH's suicide prevention efforts.

LACDMH has chosen to implement a suicide prevention program in the form of training and education that has shown to be effective in changing attitudes, knowledge, and/or behavior regarding suicide. Participants in these trainings include but are not limited to first responders, teachers, community members, parents, students, and clinicians. For trainings conducted in FY 17-18, changes in knowledge about suicide were measured using the Suicide Prevention (SP) survey. Participants complete the "pre" survey, just prior to the training to assess their baseline level knowledge about suicide prevention and then complete the "post" survey shortly after completing the training. Increases in participants' survey scores from "pre" to "post" suggest knowledge about suicide prevention has been improved.

The number of surveys received in FY 17-18 decreased by 70% from the previous fiscal year (1,197). There are two (2) possible causes for the decrease: 1) decrease from last year to this year in survey collection rates and/or 2) decrease from last year to this year in the number of people receiving SDR programs.

Survey Outcomes for Partners in Suicide Prevention:

Total number of Partners in Suicide Prevention (PSP) Surveys: **363**

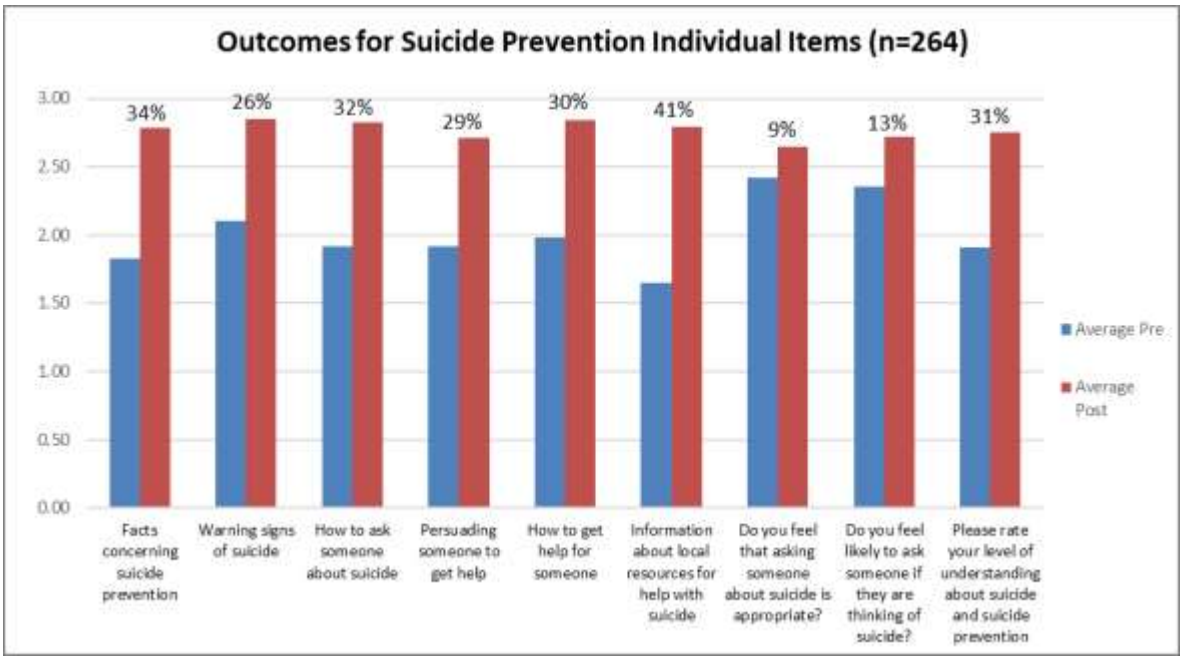
Demographics:

- Gender (n=276): 76% Female and 24% Male
- Ethnicity (n=263): White, 23%, Latino, 50%, African/African American, 16%, Asian/Pacific Islander, 7%, Other, 4% and Native American, .3%
- Age Group (n=219): up to 30, 54%, 31-40, 24%, 41-50, 14%, 51-60, 7%, and 61+, 1%
- Highest Level of Education: 2 Years of College, 8%, 4 Years of College, 25%, 5+ Years of College, 61%, High School, 5%, Trade/Vocational School, 1%

The SP survey has nine (9) items. Scores from the nine (9) items are added together to create a total Knowledge score. The total score can fall into one of three ranges: Low Knowledge, Medium Knowledge, or High Knowledge. An increase in the total scores from "pre" to "post" suggests having more information about suicide. Survey results for FY 17-18 suggest participants' knowledge about suicide and suicide prevention increased through training and education:

- The average score increased by 27% from “pre” to “post” (243)
- The average “pre” score fell in the Medium Knowledge range and the average “post” score fell in the High Knowledge range
- Prior to training, 21% of participants’ (52) scores fell in the High Knowledge range. Post training, 91% of participants’ (222) scores fell in the High Knowledge range, an increase of 80%
- Prior to training, 24% of participants’ (59) scores fell in the Low Knowledge Range. “Post” training, all of these 59 participants’ scores fell in the Moderate Knowledge Range (12%) or High Knowledge Range (84%)

Suicide prevention trainings have shown positive outcomes since inception in FY 13-14. Below, is chart showing the average percent change in score from “pre” to “post” training for each of the nine (9) suicide prevention survey items in FY 17-18, as well as few statements about the results.



- Items 1 and 6 showed the greatest improvement in score from “pre” to “post”, increasing by 34% and 41%, respectively.
- Items 7 and 8 showed the least improvement in score from “pre” to “post”, increasing by 9% and 13%, respectively. These items likely changed the less than the others’ because: 1) their average “pre”-scores were higher than the other items’, which created a “ceiling effect,” i.e. scores on items 7 and 8 could not improve from “pre” to “post” as much as scores on the other items because there was less room for improvement 2) items 1- 6 and 9 measure changes in knowledge while items 7 and 8 measure changes in behavior. Typically, for instructive interventions like Suicide Prevention, measures of knowledge show greater change from “pre” to “post” treatment than measures of behavior.

School Threat Assessment and Response Team (START)

The three (3) main objectives for START are the following: Prevention and Reduction of targeted school violence in L.A. County, Provision of on-going support and assistance to students at risk, their families/caregivers and schools through interventions, trainings, and consultations and establishment of partnerships with schools, law enforcement, and other involved community organizations.

The Early Start School Mental Health Initiative Program focuses on school mental health needs to reduce and eliminate stigma and discrimination. The program addresses the high need of students with developmental challenges, emotional stressors, and various mental health risks and reduces violence at educational institutions through collaborative efforts and partnerships with the community. This is a comprehensive prevention and early intervention program to prevent violence in schools and create a safe learning environment. Services include eliminating substance use and abuse; addressing any trauma experiences; development of school-based crisis management teams; and training. Early screening and assessment of students of concern are provided at the earliest onset of symptoms.

In FY 17-18, the School Threat Assessment Response Team (START) provided 1,820 services to 305 individuals at potential or real threat to harm self and/or others on campus: 86 open cases and 219 potential cases. The law enforcement and schools continued to be the two (2) main referral sources. After years of services delivered in the L.A. County, START has become one of the major violence crisis management resources in addition to the law enforcement.

START's challenge centered on a decline in the number of staff and increased in demand for services in FY 17-18. Nearly half the number of staff was to be filled. The number of referrals increased from 216 in FY 16-17 to 259 in FY 17-18. Note that it surged from six (6) cases in July, 2017 to 53 in February, 2018 following the school shooting in Parkland, Florida. In addition to MOSAIC and Columbia-Suicide Severity Rating Scale (C-SSRS), two (2) new violent threat assessments were being implemented: Structured Assessment of Violence Risk in Youth (SAVRY) and Workplace Assessment of Violence Risk-21 (WAVR-21). These two (2) tools were chosen by the START clinicians. They do not quantitatively calculate the total scores (the risk levels), but present the risk factors. The presence of same risk factors may be weighted differently by various users, and which results in different risk levels. Therefore, the reported outcomes for FY 17-18 will be based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources.

Of the 86 open cases, male and female were 74.42% and 25.58%. 39.54% aged between 0 and 15, while 46.51% aged between 16-25, and 13.95% older than 25 years. Note that the 0-15 age group declined from 51.18% in FY 16-17 to 39.54% in FY 17-18, while the 16-25 age group increased from 31.50% to 46.51%. English

continued to be the most spoken language: 87.21%. Latino made up of 48.84% of the 86 consumers. To meet the consumers' cultural need, three fourths of the START clinicians are Spanish speaking and proficient in the Latino culture.

SA 3 was the most served area (19.77%) replacing SA 2 in prior fiscal year, followed by SA 8 (16.28%), SA 2, 4, and 6 (15.12%), SA 7 (11.63%), SA 5 (4.65%), and SA 1 (2.31%). Of the 86 open cases, 38 (44.19%) consumers were admitted within the same day of the referrals received, 5 (5.81%) within two days, 8 (9.30%) within a week, and 35 (40.70%) exceeded one weeks partially due to difficulty in reaching the consumers. In FY 17-18, START admitted 45 (52.33%) cases and discharged 56 (65.12%) consumers of the 56, 20 (23.26%) were admitted and discharged in the same fiscal year.

In addition to the 86 active consumers, 219 refer-in cases were outreached to determine their eligibility for the START Program services. If follow-up was required to engage those potential cases, the clinicians extended their services beyond one visit. 1820 services were rendered: 757 (41.59%) to the 86 open cases, 825 (45.33%) to those 219 individuals whose cases were not activated because they were reluctant or ineligible for START Program services, and 238 (13.08%) to the community in general.

In FY 17-18, 56 consumers were closed with nine (9) dropped out early and 47 completed treatment cycles. 30 consumers posed low suicidal risk throughout the treatment cycles, ten (10) from moderate to low, and seven (7) from high to low. As for the violent risk levels, 29 cases improved from moderate to low violent risk levels, nine (9) remained low throughout the treatment cycles, seven (7) from high to low, one (1) from high to moderate, and one (1) remained moderate.

Consumers Served for FY 17-18 by START

Program/ Project/ Activity	Percentage of Consumers Served by START (Of the 86 Open Cases)
START	**Gender**
	• Male : 64 (74.42%) • Female: 22 (25.58 %), Unknown: 0%
	Primary Language of Staff
	• Spanish: 75%
	Primary Language of Participants
	• English: 87.21%
	Primary Ethnicity of Participants
	• Latino: 48.84%
	Age Range of Participants:
	• Age 0-15 : 39.54% • Age 16-25 : 46.51% • Age 26 and above: 13.95%
	The Most Served SA:

Program/ Project/ Activity	Percentage of Consumers Served by START (Of the 86 Open Cases)
	Gender
	• SA 3 : 19.77% • SA 8 : 16.28% • SA 2, 4, & 6 : 15.12% • SA 7 : 11.63% • SA 5 : 4.65% • SA 1 : 2.31%
	Of the 86 Open Cases, • 38 (44.19%) clients were admitted within the same day of the referrals received • 5 (5.81%) were admitted within two days • 8 (9.30%) were admitted within a week • 35 (40.70%) exceeded one weeks partially due to difficulty in reaching the clients

Early Intervention
Some 44,212 consumers received an Early Intervention direct mental health service: 89% were children and transitional age youth. These practices have resulted in the following reduction in symptoms and improvement in functioning.

- **Depression**
  After completing Depression Treatment Quality Improvement, Managing an Adaptive Practice, Mental Health Integration Program, Group and Individual cognitive behavioral therapy (CBT) for Depression, Interpersonal Psychotherapy for Depression, Problem Solving Therapy for older adults, or the Program to Encourage Active Rewarding Lives for Seniors (PEARLS), consumers achieved average reductions in depressive symptoms of at least 40% and/or average improvements in functioning of at least 45%.

- **Trauma**
  After completing Alternatives for Families-CBT, Managing and Adapting Practice (MAP), individual CBT, Child Parent Psychotherapy, or Trauma Focused CBT, consumers achieved average reductions in post-traumatic stress symptoms of at least 40% and/or average improvements in functioning of at least 45%.

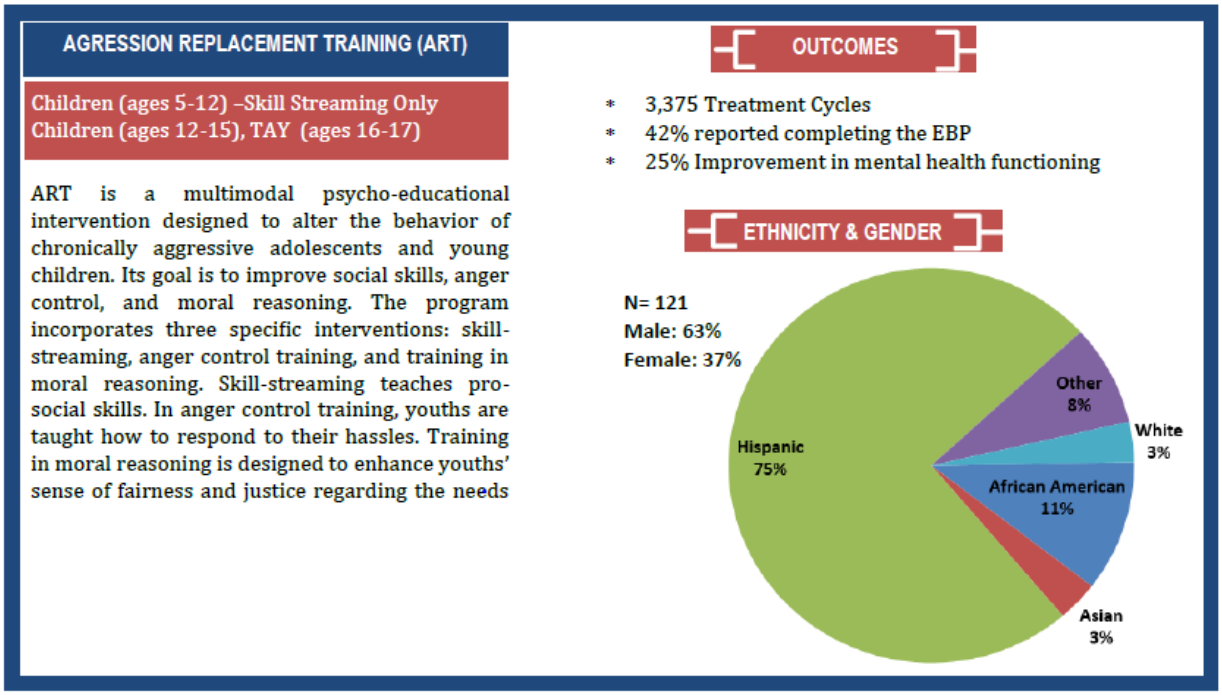
- **Improving Parenting Skills to Reduce Disruptive Behavior in Children**
  After completing Parent Child Interaction Therapy, Loving Intervention, Family Enrichment Program, Brief Strategic Family Therapy, Triple P Positive Parenting Program, MAP, or Families Overcoming Under Stress (FOCUS), consumers achieved average reductions in disruptive behaviors of at least 40% and/or average improvements in functioning of at least 45%.

- **Severe Behavioral Conduct**
  After completing Functional Family Therapy or Multi-systemic Therapy, consumers achieved at least a 30% improvement in functioning.

- **Anxiety**
  After completing MAP, individual CBT, or Mental Health Integration Program, on average, consumers achieved average reductions in anxiety symptoms of at least 40% and/or average improvements in functioning of at least 45%.

Early Intervention Outcomes of FY 17-18

(Source: MHSA Annual Update Report FY 19-20)



Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)

Children (ages 4-15), TAY (ages 16-17)

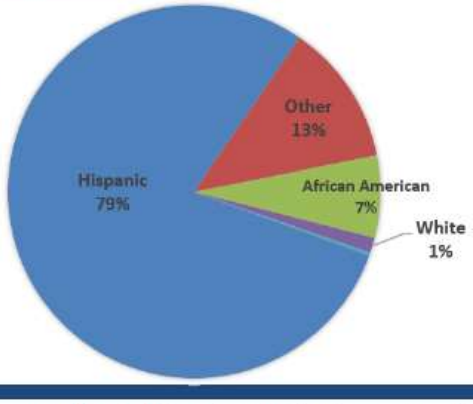
AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.

OUTCOMES

* 1,332 Treatment Cycles
* 49% reported completing the EBP
* 50% Improvement in mental health functioning
* 53% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=381
Male: 60%
Female: 40%



*Data as of 4/4/2018. Outcomes entered July 2011 through April 2018. Percentage of clients completing the EBP was determined by what was entered in the PEI

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Asian American Family Enrichment Network (AAFEN)

Children (ages 12-15), TAY (ages 16-18)

The AAFEN Program serves Asian immigrant parents and primary caregivers with inadequate parenting skills to effectively control and nurture their teenage children, who experience reduced family attachment, social functioning, as well as increased family conflict. The AAFEN Program aims at increasing the emotional and behavioral self-efficacy of the Asian parents/caregivers and enhancing the safety and healthy development of Asian immigrant youths. In particular, the AAFEN Program is designed to promote such protective factors as the stability of the Asian immigrant families, the confidence and competence of the Asian immigrant parents and/or primary caregivers in carrying out responsive and effective bicultural parenting and family management skills, and positive family bonding and relationship.

Brief Strategic Family Therapy (BSFT)

Children (ages 10-15), TAY (ages 16-18)

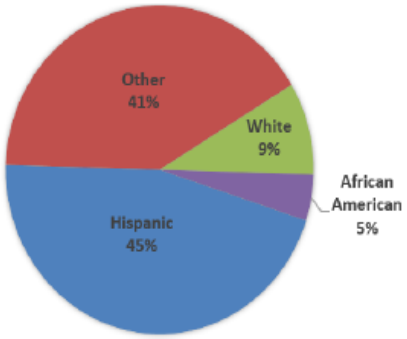
BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.

OUTCOMES

* 185 Treatment Cycles
* 66% reported completing the EBP
* 50% Improvement in mental health functioning
* 50% Reduction in behavioral problems

ETHNICITY & GENDER

N=22
Male: 50%
Female: 50%



(Source: MHSA Annual Update Report FY 19-20)

Caring for Our Families (CFOF)

Children (ages 5-11)

Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.

OUTCOMES

* 732 Treatment Cycles
* 68% reported completing the EBP
* 23% Improvement in mental health functioning
* 30% Reduction in disruptive behaviors

Center for the Assessment and Prevention of Prodromal States (CAPPS)

TAY

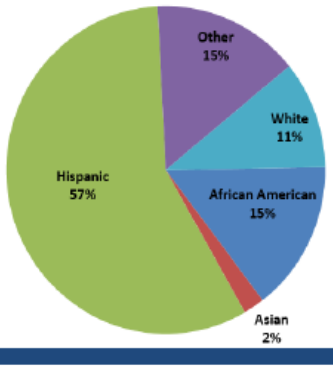
The focus of CAPPS is to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into mental health diagnoses, this project will also engage families and significant others of the youth as well as the youth themselves in PEI services.

OUTCOMES

* 189 Treatment Cycles
* 44% reported completing the EBP
* 31% Improvement in mental health functioning
* 60% Reduction in prodromal symptoms

ETHNICITY & GENDER

N=
Male: 60%
Female: 40%



(Source: MHSA Annual Update Report FY 19-20)

Child-Parent Psychotherapy (CPP)

Young Children (ages 0-6)

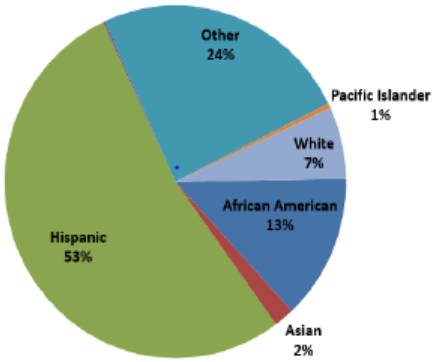
CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged by the experience of domestic violence. CPP is intended as an early intervention for young children that may be at risk for acting-out and experiencing symptoms of depression and trauma.

OUTCOMES

* 5,039 Treatment Cycles
* 48% Reported completing the EBP
* 55% Improvement in mental health functioning
* 19% Reduction in child's mental health functioning following a traumatic event

ETHNICITY & GENDER

N= 1,572
Male: 52%
Female: 48%



Cognitive Behavioral Intervention for Trauma in School (CBITS)

Children (ages 10-15), TAY

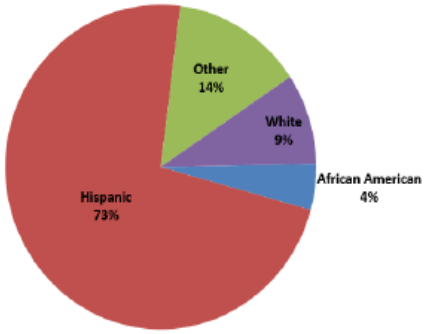
CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma -related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure .

OUTCOMES

* 121 Treatment Cycles
* 68% reported completing the EBP
* 31% Improvement in mental health functioning
* 28% Reduction in symptoms related to posttraumatic stress

ETHNICITY & GENDER

N=22
Male: 32%
Female: 68%



(Source: MHSA Annual Update Report FY 19-20)

Coordinated Specialty Care Model for Early Psychosis (CSC-EP)

Children (ages 12-15) & TAY (ages 16-25)

CSC-EP is a team-based, multi-element approach to treating early psychosis. CSC-EP serves youth experiencing the symptoms of early psychosis including: onset of psychotic symptoms in the past year, subthreshold symptoms of psychosis, and recent deterioration in youth with a parent/sibling with a psychotic disorder. This collaborative, recovery based treatment approach involves clients and treatment team members as active participants. The program includes various treatment components that focus on reducing and managing symptoms and distress and improving individuals' ability to achieve success in independent roles. Services include comprehensive clinical assessment, medication management, case management, individual and family psychoeducation and support groups including multifamily therapy, and peer and family advocate support. CSC-EP emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with early psychosis. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.

Crisis Oriented Recovery Services (CORS)

Children , TAY, Adults,, Older Adults

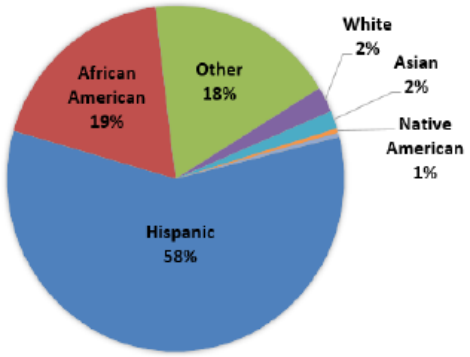
CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.

OUTCOMES

* 3,898 Treatment Cycles
* 59% reported completing the EBP
* 28% Improvement in mental health functioning

ETHNICITY & GENDER

N=716
Male: 50%
Female: 50%



(Source: MHSA Annual Update Report FY 19-20)

Depression Treatment Quality Improvement (DTQI)

Children , TAY , Adults , Older Adults

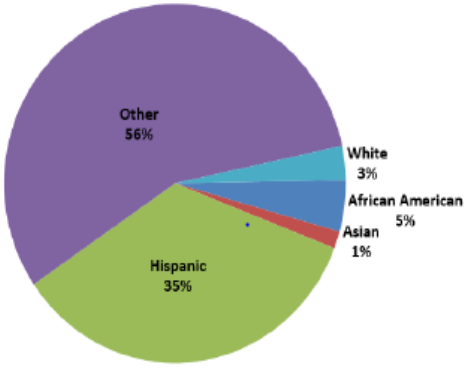
DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.

OUTCOMES

* 1,118 Treatment Cycles
* 62% reported completing the EBP
* 47% Improvement in mental health functioning
* 62% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=100
Male: 41%
Female: 59%



Dialectical Behavior Therapy (DBT)

Children (ages 12-15) TAY (ages 16-20)

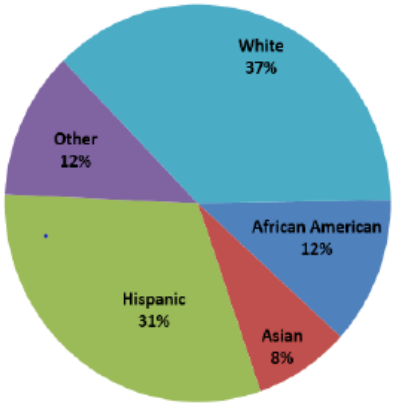
DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.

OUTCOMES

* 109 Treatment Cycles
* 47% reported completing the EBP

ETHNICITY & GENDER

N=100
Male: 29%
Female: 70%



(Source: MHSA Annual Update Report FY 19-20)

Families Over Coming Under Stress (FOCUS)

Children , TAY , Adults

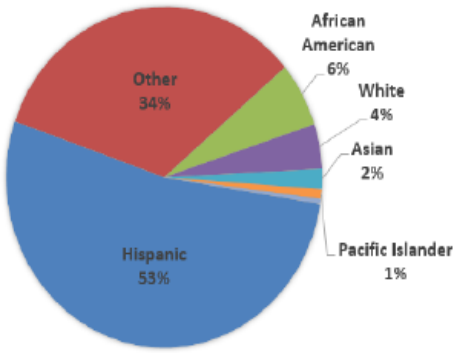
Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.

OUTCOMES

* 414 Treatment Cycles
* 71% reported completing the EBP
* 43% Improvement in mental health functioning
* 50% Improvement in family functioning

ETHNICITY & GENDER

N=212
Male: 53%
Female: 47%



Family Connections

Children (ages 0-17), TAY (ages 16-17)

The goal of FC is to help families meet the basic needs of their children and prevent child maltreatment. Nine practice principles guide FC interventions: community outreach individualized family assessment, tailored interventions, helping alliance; empowerment approaches, strengths perspective, cultural competence, developmental appropriateness, and outcome-driven service plans. Individualized family intervention is geared to increase protective factors, decrease risk factors, and target child safety, well-being, and permanency outcomes.

(Source: MHSA Annual Update Report FY 19-20)

Functional Family Therapy (FFT)

Children (ages 11-15) TAY (ages 16-18)

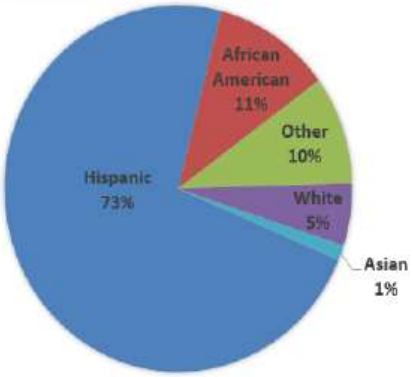
FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.

OUTCOMES

* 1,637 Treatment Cycles
* 65% reported completing the EBP
* 31% Improvement in mental health functioning

ETHNICITY & GENDER

N=73
Male: 55%
Female: 45%



Group Cognitive Behavioral Therapy for Major Depression (Group CBT)

TAY (ages 18-25), Adults, , Older Adults

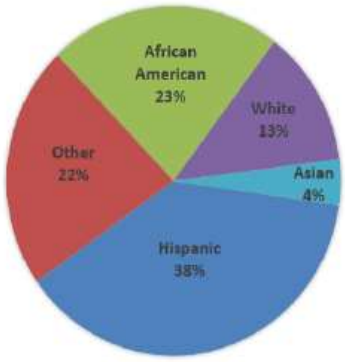
Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African-American adults.

OUTCOMES

* 1,086 Treatment Cycles
* 44% reported completing the EBP
* 21% Improvement in mental health functioning
* 42% Reduction in symptoms related to depression

ETHNICITY & GENDER

N=71
Male: 35%
Female: 65%



(Source: MHSA Annual Update Report FY 19-20)

Group Individual Psychotherapy (Group IPT)

Ages 15+

Group IPT is most effective when the group members all have a similar diagnosis or problem area, such as depression, cancer, or PTSD. Groups designed to prevent postpartum depression or depression during pregnancy, or groups for high-risk adolescents would also be highly suitable for treatment with IPT. The similarity in treatment focus fosters rapid development of group cohesion and support. Both are fostered within the group as quickly as possible; later sessions are designed to generalize these skills to the client's family and community, where they can apply them to interpersonal relationships to identify and develop the support they need during crises, and to resolve interpersonal conflicts or manage difficult transitions or losses.

Incredible Years (IY)

Young Children (ages 2-5)
Children (ages 6-12)

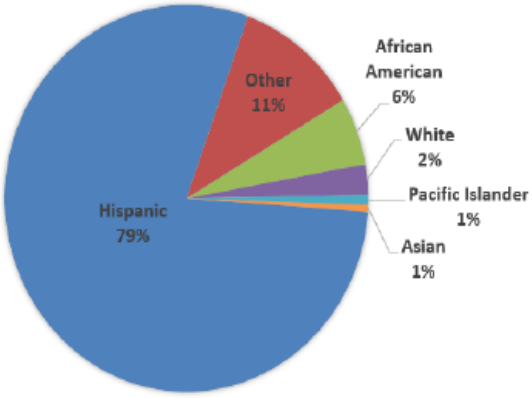
IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/ emotional competencies. Teacher training intervention focuses on teachers' classroom management strategies, promoting pro-social behaviors and school readiness.

OUTCOMES

* 2,477 Treatment Cycles
* 64% reported completing the EBP
* 27% Improvement in mental health functioning
* 35% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=354
Male: 68%



(Source: MHSA Annual Update Report FY 19-20)

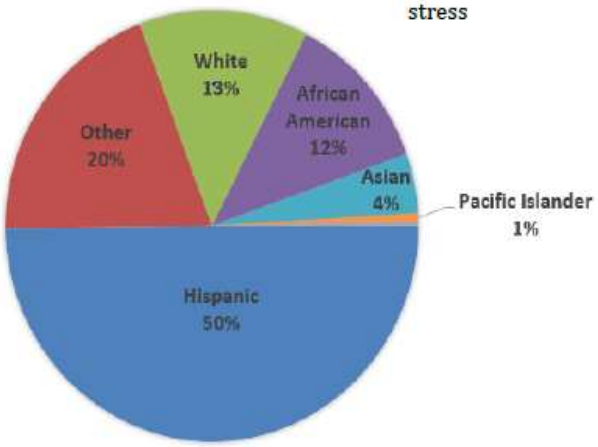
Individual Cognitive Behavioral Therapy (Ind. CBT)

TAY (ages 18-25) , Adults , Older Adults , Directly Operated Clinics only

CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.

ETHNICITY & GENDER

N=3,962
Male: 32%
Female:



OUTCOMES

Anxiety:
* 1,902 Treatment Cycles
* 43% reported completing the EBP
* 37% Improvement in mental health functioning
* 54% Reduction in symptoms related to anxiety

Depression:
* 4,687Treatment Cycles
* 42% reported completing the EBP
* 35% Improvement in mental health functioning
* 53% Reduction in symptoms related to depression

Trauma:
* 583Treatment Cycles
* 48% reported completing the EBP
* 42% Improvement in mental health functioning
* 59% Reduction in symptoms related to posttraumatic stress

(Source: MHSA Annual Update Report FY 19-20)

Interpersonal Psychotherapy for Depression (IPT)

Children (ages 9-15) TAY , Adults , Older Adults

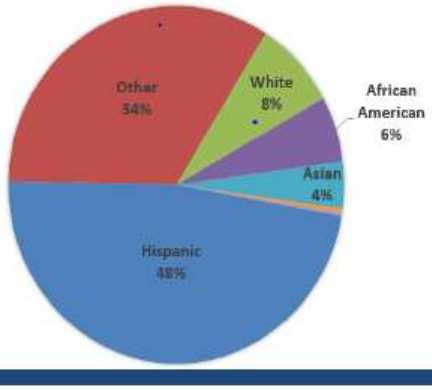
IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.

OUTCOMES

* 5,443 Treatment Cycles
* 52% reported completing the EBP
* 31% Improvement in mental health functioning
* 54% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 2,110
Male: 33%
Female:



Loving Intervention Family Enrichment Program (LIFE)

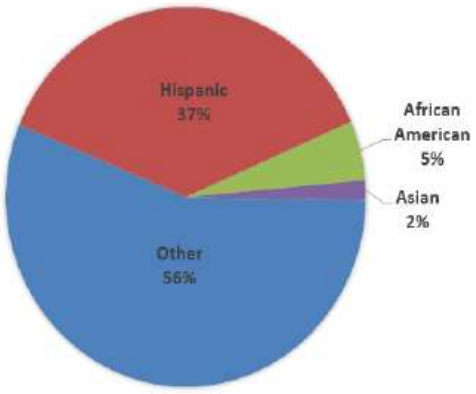
Children (ages 0-8)

An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program was designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/ or school failure.

OUTCOMES

* 402 Treatment Cycles
* 65% reported completing the EBP
* 33% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

N=59
Male: 61%
Female: 39%



(Source: MHSA Annual Update Report FY 19-20)

Managing and Adapting Practice (MAP)

Young Children , Children , TAY (ages 16-21)

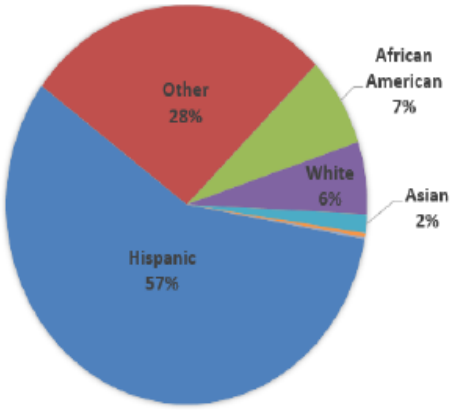
MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal evidence-based programs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP as implemented in L.A County has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.

OUTCOMES

* 42,654 Treatment Cycles
* 54% reported completing the EBP
* 43% Improvement in mental health functioning
* 43% Reduction in disruptive behaviors
* 55% Reduction in symptoms related to depression
* 41% Reduction in symptoms related to anxiety
* 53% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 19,129
Male: 54%
Female: 46%



(Source: MHSA Annual Update Report FY 19-20)

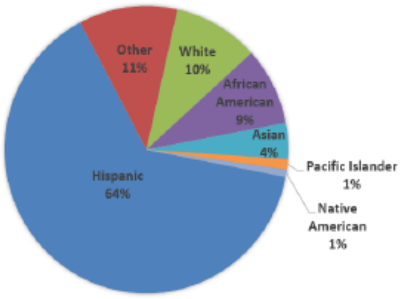
Mental Health Integration Program (MHIP) formerly known as IMPACT

Adults

MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider. MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.

ETHNICITY & GENDER

N= 595
Male: 28%
Female: 72%



OUTCOMES

MHIP-Anxiety
* 1,803 Treatment Cycles
* 39% reported completing the EBP
* 58% Reduction in symptoms related to anxiety

MHIP-Depression
* 5,275 Treatment Cycles
* 34% reported completing the EBP
* 53% Reduction in symptoms related to depression

MHIP-Trauma
* 297 Treatment Cycles
* 29% reported completing the EBP
* 24% Reduction in symptoms associated with exposure to trauma

Mindful Parenting Groups (MP)

Young Children (ages 0-3)

MP is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than 4-6 months difference in age for the children.

The Mothers and Babies Course, Mamas y Bebes

Ages 13+

Developed in both Spanish and English, prenatal intervention is designed to prevent the onset of major depressive episodes (MDEs) during pregnancy and postpartum. The explicit goal of the intervention is to help participants create a healthy physical, social, and psychological environment for themselves and their infants. The program consists of a 12-week mood management course and four booster sessions conducted at approximately 1, 2, 6, and 12 months postpartum. The program is specifically designed to be culturally sensitive and linguistically appropriate for immigrant, low-income Latinas.

(Source: MHSA Annual Update Report FY 19-20)

Multidimensional Family Therapy (MDFT)

Children (ages 12-15) TAY (ages 16-18)

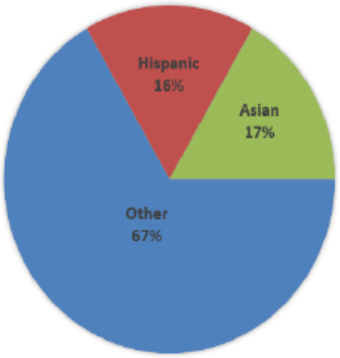
MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with pro-social influences such as schools, peer groups, and recreational and religious institutions.

OUTCOMES

* 74 Treatment Cycles
* 89% reported completing the EBP
* 25% Improvement in mental health functioning

ETHNICITY & GENDER

N= 6
Male: 67%
Female: 33%



Multisystemic Therapy (MST)

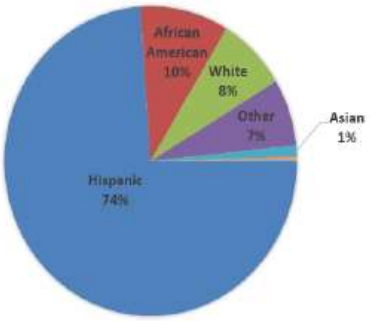
Children (ages 12-15) TAY (ages 16-17)

MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family, friends) and removing barriers (e.g. parental substance abuse, high stress).

OUTCOMES

* 1256 Treatment Cycles
* 72% reported completing the EBP
* 46% Improvement in mental health functioning

N= 1,513
Male: 67%
Female: 33%



(Source: MHSA Annual Update Report FY 19-20)

Problem Solving Therapy (PST)

Older Adults

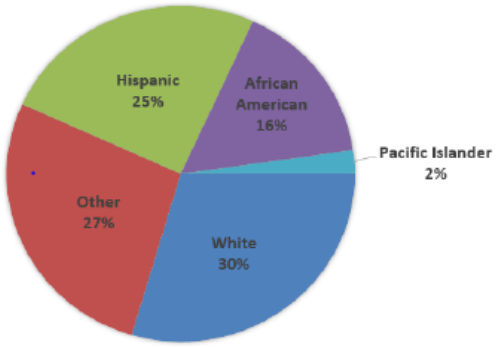
PST has been a primary strategy in IMPACT/ MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.

OUTCOMES

* 378 Treatment Cycles
* 61% reported completing the EBP
* 28% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 44
Male: 36%
Female: 64%



Parent-Child Interaction Therapy (PCIT)

Young Children (2-7)

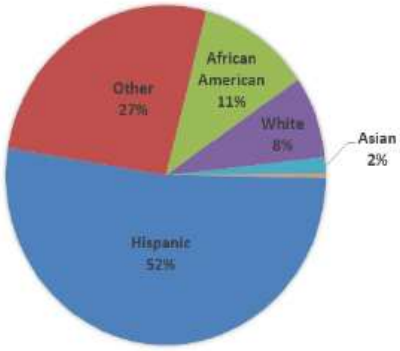
PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/ caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.

OUTCOMES

* 2,947 Treatment Cycles
* 41% reported completing the EBP
* 57% Improvement in mental health functioning
* 63% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=1,410
Male: 66%
Female: 34%



(Source: MHSA Annual Update Report FY 19-20)

Program to Encourage Active Rewarding Lives for Seniors (PEARLS)

Older Adults

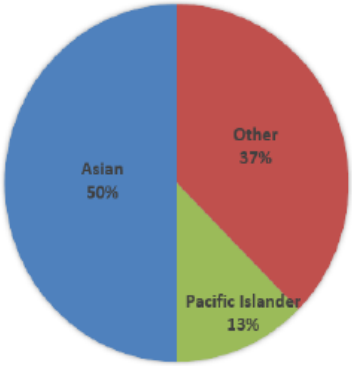
PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.

OUTCOMES

* 162 Treatment Cycles
* 50% reported completing the EBP
* 26% Improvement in mental health functioning
* 45% Reduction in symptoms related to depression

ETHNICITY & GENDER

N= 8
Male: 38%
Female: 63%



Prolonged Exposure – Post Traumatic Stress Disorder (PE-PTSD)

TAY (ages 18-25) Adults , Older Adults , Directly Operated Clinics Only

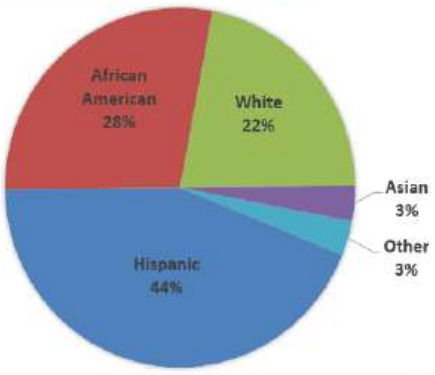
PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.

OUTCOMES

* 66 Treatment Cycles
* 52% reported completing the EBP

ETHNICITY & GENDER

N= 32
Male: 66%
Female: 34%



(Source: MHSA Annual Update Report FY 19-20)

Promoting Alternative Thinking Strategies (PATHS)

Children (5-12)

PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.

OUTCOMES

* 745 Treatment Cycles
* 34% reported completing the EBP
* 37% Improvement in mental health functioning
* 33% Reduction in disruptive behaviors

Reflective Parenting Program (RPP)

Young Children (ages 2-5)
Children (ages 6-12)

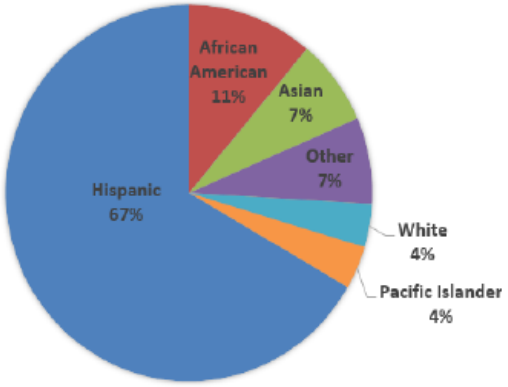
RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents / caregivers enhance their reflective functioning and build strong, healthy bonds with their children.

OUTCOMES

* 222 Treatment Cycles
* 74% reported completing the EBP
* 11% Improvement in mental health functioning
* 15% Reduction in disruptive behaviors

ETHNICITY & GENDER

N=27
Male: 56%
Female: 44%



(Source: MHSA Annual Update Report FY 19-20)

Seeking Safety (SS)

Children (13-15) TAY , Adults, Older Adults

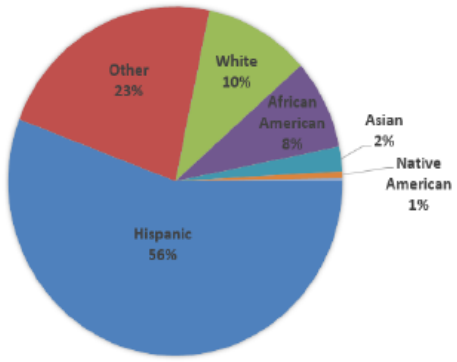
SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.

OUTCOMES

- 18,075 Treatment Cycles
- 40% reported completing the EBP
- 36% Improvement in mental health functioning
- 31% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 3,290
Male: 39%
Female: 61%



Strengthening Families (SF)

Children (ages 3-15) TAY (ages 16-18)

SF is a family-skills training intervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle

Children (ages 3-8)

This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. The EBP includes traditional aspects of healing with American Indians and Alaskan Natives from their world view.

(Source: MHSA Annual Update Report FY 19-20)

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Young Children , Children , TAY (ages 16-18)

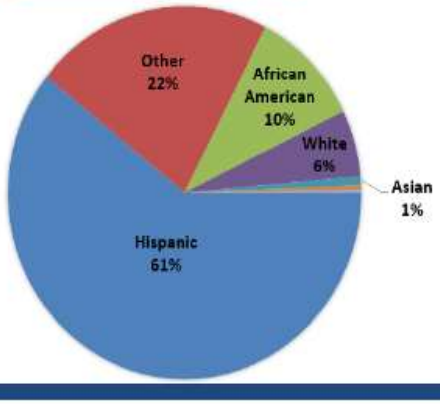
An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, traumatic loss, etc.), for children and TAY receiving these services.

OUTCOMES

* 18,440 Treatment Cycles
* 55% reported completing the EBP
* 47% Improvement in mental health functioning
* 51% Reducing symptoms related to posttraumatic stress

ETHNICITY & GENDER

N= 5,781
Male: 44%
Female: 56%



Triple P Positive Parenting Program (Triple P)

Young Children (ages 0-5)
Children (ages 6-15) TAY (age 16)

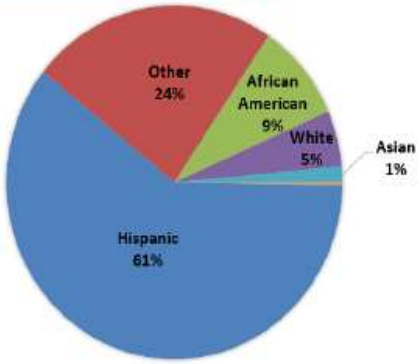
Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by DMH directly operated and contract agencies.

OUTCOMES

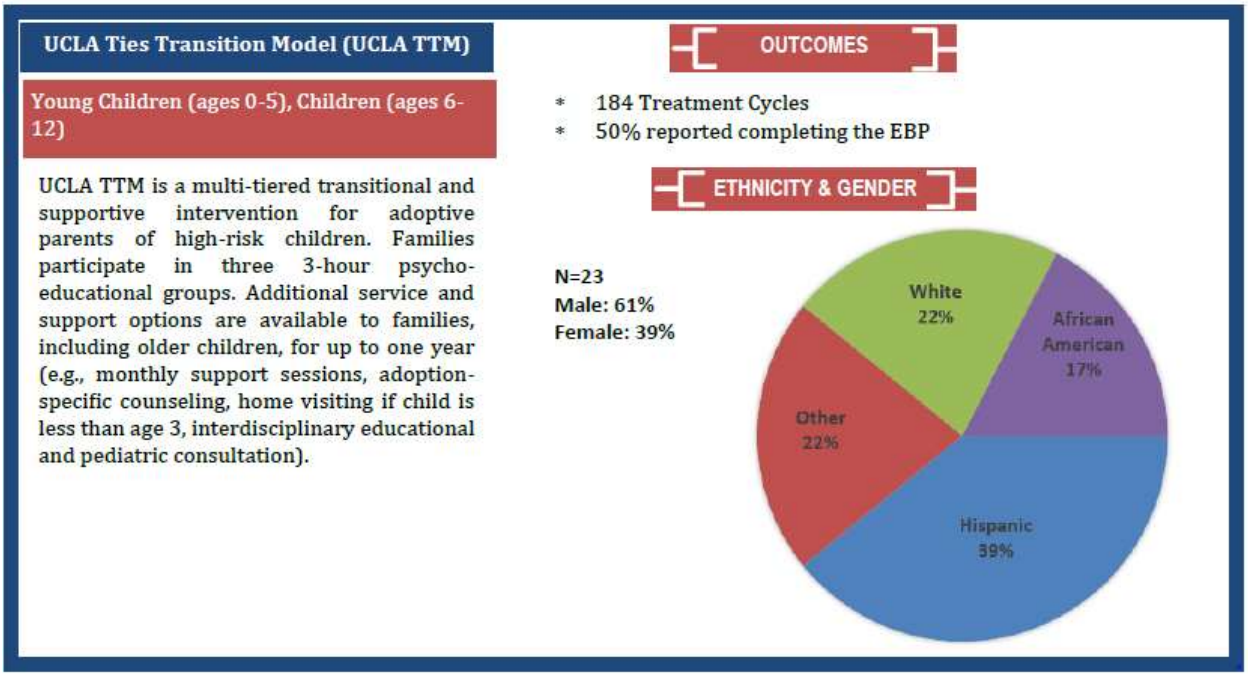
* 5,410 Treatment Cycles
* 59% reported completing the EBP
* 41% Improvement in mental health functioning
* 50% Reduction in disruptive behaviors

ETHNICITY & GENDER

N= 1,270
Male: 68%
Female: 32%



(Source: MHSA Annual Update Report FY 19-20)



(Source: MHSA Annual Update Report FY 19-20)

PEI projects and activities contribute to LACDMH's provision of culturally and linguistically competent services. Evidence Based Practices (EBP) implemented under PEI address cultural and linguistic needs of the communities. The Department and providers have worked with program developers on accommodations or adaptations when needed to meet the needs of the consumers served. Supporting materials including videos, workbooks, and other handouts have been translated into threshold languages. Additionally, the EBP Symposium- Outreach to Outcome that was held in April, 2017 was the first for LACDMH Prevention and Early Intervention. The conference consisted of high quality presentations relating to strategies that promoted cultural competency with many workshops focusing on the unique needs of the Prevention and Early Intervention (PEI) population. The EBP Symposium was intended to provide a Range of information dissemination, skills training, and data informed research enhanced outreach to vulnerable communities and address disparities. Furthermore, PEI has provided EBP training target the Native American/Alaska Native Population in Los Angeles be adding Mending the Circle Adaptation to Trauma Focused Cognitive Behavior Therapy (TF-CBT) PEI has also added the American Indian Life Skills Program that focuses school-based, culturally grounded, life-skills training program that aims to reduce high rates of AI/AN) adolescent suicidal behaviors by reducing suicide risk and improving protective factors.

The following table is a list of EBPs and the age groups served:

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
Aggression Replacement Training (ART)	ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning in youth. The program incorporates three specific interventions: Skill-streaming, anger control training, and training in moral reasoning. Skill-streaming teaches prosocial skills. In anger control training, youths are taught how to respond to their annoyances. Training in moral reasoning is designed to enhance youths' sense of fairness and justice regarding the needs and rights of others.	Children (ages 5-12) – Skill streaming Only Children (ages 12-15) TAY (ages16-17)
Alternatives for Families – Cognitive Behavioral Therapy (AF-CBT)	AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills to enhance self-control, strengthen positive parenting practices, improve family cohesion/communication, enhance child coping skills and social skills, and prevent further instances of coercion and aggression. Primary techniques include affect regulation, behavior management, social skills training, cognitive restructuring, problem solving, and communication.	Children (ages 4-15) TAY (ages 16-17)
Brief Strategic Family Therapy (BSFT)	BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed to be directly related to the child's symptoms, thus reducing risk factors and strengthening protective factors for adolescent drug abuse and other conduct problems.	Children (ages 10-15) TAY (ages 16-18)
Caring for Our Families (CFOF)	Adapted from the "Family Connections" Model, CFOF includes community outreach, family assessment, and individually tailored treatment programs. The goal is to help families meet the basic needs of their children and reduce the risk of child neglect. The core components include emergency assistance/concrete services; home-based family intervention (e.g., outcome-driven service plans, individual and family counseling); service coordination with referrals targeted toward risk and protective factors; and multi-family supportive recreational activities.	Children (ages 5-11)
Center for the Assessment and	The focus of this CAPPS PEI Demonstration Pilot will be to conduct outreach and engagement specifically to	TAY

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
Prevention of Prodromal States (CAPPS)	youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and progression of these challenges into mental health diagnoses, this project engages families and significant others of the youth as well as the youth themselves in PEI services.	
Child-Parent Psychotherapy (CPP)	CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been injured by the experience of domestic violence. CPP is intended as an early intervention for young children who may be at risk for acting-out and experiencing symptoms of depression and trauma.	Young Children (ages 0-6)
Cognitive Behavioral Intervention for Trauma in School (CBITS)	CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school setting by clinical staff as part of multi-disciplinary treatment teams. CBITS intends to reduce the impact of trauma-related symptoms, build resilience, and increase peer and parental support for students at-risk of school failure.	Children (ages 10-15) TAY
Crisis Oriented Recovery Services (CORS)	CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assures linkage to ongoing services. Its primary objective is to assist individuals resolve and/or cope with psychosocial crises by mitigating additional stress or psychological harm. It promotes the development of coping strategies that individuals can utilize to help restore them to their previous level of functioning prior to the crisis event.	Children TAY Adults Older Adults
Depression Treatment Quality Improvement (DTQI)	DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed in the future. The psychotherapy component assists individuals who are currently depressed to gain understanding of factors that have contributed to the onset and maintenance of their depression and learn ways to treat their disorder.	Children (ages 12-15) TAY (ages16-20)

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
Dialectical Behavioral Therapy (DBT)	DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, dialectical strategies, mindfulness, contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.	TAY (18-25) Adults Older Adults Directly Operated Clinics only
Families Overcoming Under Stress (FOCUS)	Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. Treatment is delivered to couples and/or the family as a whole by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.	Children TAY Adults
Functional Family Therapy (FFT)	FFT is a family-based, short-term prevention and intervention program for acting out youth. It focuses on risk and protective factors that impact the adolescent, specifically intra-familial and extra-familial factors, and how they present and influence the therapeutic process. Major goals are to improve family communication and supportiveness while decreasing intense negativity these families experience.	Children (ages 11-15) TAY (ages16-18)
Group Cognitive Behavioral Therapy for Major Depression (Group CBT)	Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is particularly helpful in challenging distorted perceptions and bringing thoughts more in-line with reality. Cultural tailoring of treatment and case management shows increased effectiveness for low-income Latino and African American adults.	TAY (ages 18-25) Adults Older Adults
Incredible Years (IY)	IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child training curriculum strengthens children's social/emotional competencies. Teacher training intervention focuses on	Young Children (ages 2-5) Children (ages 6-12)

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
	teachers' classroom management strategies, promoting prosocial behaviors and school readiness.	
Individual Cognitive Behavioral Therapy (CBT)	CBT is intended as an early intervention for individuals who either have or may be at risk for symptoms related to the early onset of anxiety, depression, and the effects of trauma that impact various domains of daily living. CBT incorporates a wide variety of treatment strategies including psychoeducation, skills acquisition, contingency management, Socratic questioning, behavioral activation, exposure, cognitive modification, acceptance and mindfulness strategies, and behavioral rehearsal.	TAY (18-25) Adults Older Adults Directly Operated Clinics only
Interpersonal Psychotherapy for Depression (IPT)	IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It not only targets symptom reduction, but also improvement in interpersonal functioning, relationships, and social support. Therapy focuses on one or more interpersonal problem areas, including interpersonal disputes, role transitions, and grief and loss issues.	Children (ages 9-15) TAY Adults Older Adults
Loving Intervention Family Enrichment Program (LIFE)	An adaptation of Parent Project, LIFE is a 22-week skills-based curriculum implemented with parenting classes/support groups, youth mental health groups, and multi-family groups for parents with children at risk of or involved with the juvenile justice system. The program is designed for low-income Latino families with monolingual (Spanish) parents of children at high-risk of delinquency and/or school failure.	Children (ages 10-18)
Managing and Adapting Practice (MAP)	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioner's easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the system can suggest formal EBPs or can provide detailed recommendations about discrete components of evidence-based treatments relevant to a specific youth's characteristics. MAP has four foci of treatment, namely, anxiety, depression, disruptive behavior, and trauma.	Young Children TAY (ages 16-21)
Mental Health Integration Program (MHIP) formerly known as IMPACT	MHIP delivers specialty mental health services to Tier 2 PEI and Low-Income Health Plan (LIHP)/Healthy Way LA enrollees with less intense mental health needs who are appropriately served through focused, time-limited early intervention strategies. An integrated behavioral health intervention program is provided within a primary care facility or in collaboration with a medical provider.	Adults

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
	MHIP is used to treat depressive disorders, anxiety disorders or PTSD, and to prevent a relapse in symptoms.	
Mindful Parenting Groups (MPG)	MPG is a 12-week parenting program for parents and caregivers of infant, toddler and preschool children at risk for mental health problems and disrupted adoptions. Parents/caregivers and children are grouped in tight developmental cohorts with no more than four to six months difference in age for the children.	Young Children (ages 0-3)
Multidimensional Family Therapy (MDFT)	MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are also two intermediate intervention goals for every family: 1) Helping the adolescent achieve an interdependent attachment/bond to parents/family; and 2) helping the adolescent forge durable connections with prosocial influences such as schools, peer groups, and recreational and religious institutions.	Children (ages 12-15) TAY (ages 16-18)
Multisystemic Therapy (MST)	MST targets youth with criminal behavior, substance abuse and emotional disturbance, as well as juvenile probation youth. MST typically uses a home-based approach to reduce barriers that keep families from accessing services. Therapists concentrate on empowering parents and improving their effectiveness by identifying strengths and developing natural support systems (e.g. extended family and friends) and removing barriers (e.g. parental substance abuse and high stress).	Children (ages 12-15) TAY (ages 16-17)
Nurse Family Partnership (NFP)	Registered nurses conduct home visits to first-time, low-income mothers, beginning during pregnancy and continuing through the child's second birthday. Nurses begin 60-90 minute visits with pregnant mothers early in their pregnancy (about 16 weeks gestation). Registered nurses visit weekly for the first month after enrollment and then every other week until the baby is born. Visits may continue until the baby is two years old. Provided in conjunction with the Los Angeles County Department of Public Health.	Young Children (ages 0-2)
Parent-Child Interaction Therapy (PCIT)	PCIT provides highly specified, step-by-step, live coaching sessions with both the parent/caregiver and the child. Parents/caregivers learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific skills	Young Children (ages 2-7)

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
	as he or she interacts in specific play with the child. The emphasis is on changing negative parent/caregiver-child patterns.	
Problem Solving Therapy (PST)	PST has been the primary strategy in MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those consumers who are experiencing short-term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for older adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.	Older Adults
Program to Encourage Active Rewarding Lives for Seniors (PEARLS)	PEARLS is a community-based treatment program using methods of PST, social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.	Older Adults
Prolonged Exposure Therapy for– Posttraumatic Stress Disorder (PE-PTSD)	PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help consumers process traumatic events and reduce their PTSD symptoms as well as depression, anger, and general anxiety.	TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only
Promoting Alternative Thinking Strategies (PATHS)	PATHS is a school-based preventive intervention for children in elementary school. The intervention is designed to enhance areas of social-emotional development such as self-control, self-esteem, emotional awareness, social skills, friendships, and interpersonal problem-solving skills while reducing aggression and other behavior problems. Skills concepts are presented through direct instruction, discussion, modeling, storytelling, role-playing activities, and video presentations.	Children (ages 5-12)
Reflective Parenting Program (RPP)	RPP consists of a 10-week workshop that includes instruction, discussions, and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents /caregivers enhance their reflective functioning and build strong, healthy bonds with their children.	Young Children (ages 2-5) Children (ages 6-12)

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
Seeking Safety (SS)	SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual format, in a variety of settings, and for culturally diverse populations.	Children (ages 13-15) TAY Adults Older Adults
Strengthening Families (SF)	SF is a family skills trainingintervention designed to enhance school success and reduce substance use and aggression among youth. Sessions provide instruction for parents on understanding the risk factors for substance use, enhancing parent-child bonding, monitoring compliance with parental guidelines, and imposing appropriate consequences, managing anger and family conflict, and fostering positive child involvement in family tasks. Children receive instruction on resisting peer influences.	Children (ages 3-15) TAY (ages 16-18)
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered by clinical staff, as part of multi-disciplinary treatment teams. Program is intended to reduce symptoms of depression and psychological trauma, which may be the result of any number of traumatic experiences (e.g., child sexual abuse, domestic violence, and traumatic loss), for children and TAY receiving these services.	Young Children TAY (ages16-18)
Trauma Focused CBT (TF-CBT): "Honoring Children, Mending the Circle"	This practice for Native American child trauma victims is based on TF-CBT. Treatment goals are to improve spiritual, mental, physical, emotional, and relational wellbeing. AI/AN healing traditions and world view are included.	Children
Triple P Positive Parenting Program (Triple P)	Triple P is intended for the prevention and early intervention of social, emotional, and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community-based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by LACDMH Directly Operated and Contracted agencies.	Young Children (ages 0-5) Children (ages 6-15) TAY (age 16)
University of California Los	UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children.	Young Children (0-5)

EBP	DESCRIPTION	AGE GROUPS SERVED (AGE LIMITS)
Angeles (UCLA) Ties Transition Model (TTM)	Families participate in three three-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age three, interdisciplinary educational, and pediatric consultation).	Children (ages 6-12)

Utilization of Evidence Based Practices by Race/Ethnicity and Gender

Evidence Based Practice	Race/Ethnicity							Gender		
	African American	Asian	Latino	Native American	Other	Pacific Islander	White	Male	Female	Total
Aggression Replacement Training (ART)	13	4	90		10		4	76	45	121
Alternatives for Families-Cognitive Behavioral Therapy (AF-CBT)	27	1	301		47		5	228	153	381
Assertive Community Treatment	6	2	11		19	1	14	20	33	53
Brief Strategic Family Therapy (BSFT)	1		10		9		2	11	11	22
Center for the Assessment and Prevention of Prodromal States (CAPPS)	7	1	27		7		5	28	19	47
Child Parent Psychotherapy (CPP)	210	30	834	3	384	7	104	827	744	1572
Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	1		16		3		2	7	15	22
Crisis Oriented Recovery Services (CORS)	133	12	418	3	130	3	17	355	361	716
Depression Treatment Quality Improvement (DTQI)	6	2	45		73		4	53	77	130

Evidence Based Practice	Race/Ethnicity							Gender		
	African American	Asian	Latino	Native American	Other	Pacific Islander	White	Male	Female	Total
Dialectical Behavioral Therapy (DBT)	12	8	31		12		37	76	45	100
Early Screening, Identification and Mental Health Consultation			2				1		3	3
Families OverComing Under Stress (FOCUS)	13	4	112	1	71	2	9	112	100	212
Family Connections (FC)	3	2	24		14		2	23	22	45
Functional Family Therapy (FFT)	8	1	53		7		4	40	33	73
GLBT Champs	3	1	4		6	1	4	8	11	19
Group Cognitive Behavioral Therapy for Major Depression (Group CBT for Major Depression)	16	3	27		16		9	25	46	71
Incredible Years (IY)	20	2	281		39	3	9	239	115	354
Individual Cognitive Behavioral Therapy	477	176	1974	10	771	28	526	1260	2697	3962
Interpersonal Psychotherapy for Depression (IPT)	125	89	1004	9	708	5	170	695	1412	2110
Loving Intervention Family Enrichment (LIFE)	3	1	22		33			36	23	59
Managing and Adapting Practice (MAP)	1392	292	10971	30	5265	62	1117	10342	8779	19129
Mental Health Integration Program (MHIP)	52	24	382	5	67	7	58	166	428	595
Multidimensional Family Therapy (MDFT)		1	1		4			4	2	6
Multisystemic Therapy (MST)	148	18	1118	3	105	4	117	653	860	1513
No Evidence-Based	341	36	1000	3	714	10	148	1145	1104	2252

Evidence Based Practice	Race/Ethnicity							Gender		
	African American	Asian	Latino	Native American	Other	Pacific Islander	White	Male	Female	Total
Practice/Service Strategy										
Pacific Clinic's Latina Youth Program		1	47		43			45	46	91
Parent – Child Interaction Therapy (PCIT)	161	22	737	2	374	4	110	930	480	1410
Positive Parenting Program (Triple-P)	114	18	768	1	301	3	65	867	403	1270
Problem Solving Therapy (PST)	7		11		12	1	13	16	28	44
Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)		4			3	1		3	5	8
Prolonged Exposure for PTSD (PE)	9	1	14		1		7	11	21	32
Promoting Alternative Thinking Strategies (PATHS)	1		1		2			3	1	4
Reflective Parenting Program (RPP)	3	2	18		2	1	1	15	12	27
School Threat Assessment Response Team (START)	68	16	135	2	58	2	43	185	139	324
School-based Targeted MH Prevention and Early Intervention– Outreach & Engagement		2		1			1	1	3	4
Seeking Safety (SS)	274	75	1835	21	740	9	336	1284	1999	3290
Service Strategy	40	12	100		56	2	57	140	127	267
Stepped Care (SC)	64	14	257		60		31	200	226	426
Strengthening Families Program (SFP)			1					1		1
Suicide Prevention Specialist Team	3	1	12		9		3	9	19	28

Evidence Based Practice	Race/Ethnicity							Gender		
	African American	Asian	Latino	Native American	Other	Pacific Islander	White	Male	Female	Total
Support Group for Survivors and Bereaved							1		1	1
Training Community Partners	1	1	6		1		1	3	7	10
Trauma Focused - Cognitive Behavioral Therapy (TF-CBT)	591	45	3511	23	1262	15	334	2537	3243	5781
UCLA Ties Transition Model (UCLA Ties Transition Model)	4		9		5		5	14	9	23

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Promotores de Salud Mental (Mental Health Promoters) Program
Promotores de Salud Mental is a program composed of lay workers trained to enhance a community's understanding of mental health symptoms, syndromes, and available treatments. Promotores de Salud decrease the stigma associated with mental illness and provides targeted outreach to ethnic communities that do not traditionally seek mental health services due to linguistic isolation; cultural beliefs and stigma around mental health/illness; and financial barriers.

The Promotores de Salud Mental projects and activities contribute to LACDMH's provision of culturally and linguistically competent services by addressing the barriers to accessing mental health services. Barriers such as lack of resources due to poverty, limited knowledge of the English Language, immigration issues, transportation problems, and stigma create major challenges for the community to learn about mental illness and treatment resources.

Promotores are trusted leaders who are embedded in their community and serve as a powerful tool to improve access to care. Promotores' ability to enhance language capacity and cultural relevance by speaking the same language and often sharing similar cultural and spiritual beliefs with the Latino community helps to lessen these disparities. Through the use of mental health presentations, Promotores serve as connectors between the monolingual community to health services and community resources. Promotores can be trained consumers, family members, and local community leaders, who bring their unique skills in reaching Latinos. They are perceived as peers with similar life experiences providing credible information and linkage to resources.

The Promotores program demonstrates the effectiveness of collaboration between non-profit and community-based partnerships in terms of developing awareness about mental health. The Promoters are effective in reaching residents of their community because they are part of that community, raised in the culture and fluent in the local language.

Promotores have established connections with schools and other community organizations and they are invited to return year after year. Promotores establish new routes to preventative mental health care for underserved communities and help them to take collective action in promoting mental health in their homes and families. Promoters also assist the Department address the issues of disparate access to mental health services for Latino communities. The tables below summarize the number of Community Events by SA and presentations sites.

During FY 17-18, the Promotores de Salud Mental Program continued to improve access to mental health services and eliminate disparities by increasing the number of Promotores outreaching into the community, and by collaborating with Los Angeles County Department of Public Health (DPH) to educate the community on public a health concern that also affected their mental wellbeing.

Number Outreached by Promotores
FY 17-18

Service Area	Presentations Conducted	Approximate # of Persons Served
2	17	120
3	7	40
4	1,006	9,711
6	698	6,788
7	1,368	11,791
8	1,191	9,105

Presentations by Site Type and Service Area
FY 17-18

Service Area	Schools	Churches	MH Clinics/ Wellness Centers	Private Homes	Social Service Organizations	Senior Centers	Housing Complex	Community Centers	County Facilities/ Libraries & Parks	Other
2	2	4	0	3	0	0	0	5	3	0
3	0	0	0	0	0	0	0	0	0	7
4	215	1	21	1	10	43	99	20	25	0
6	52	5	6	13	0	2	8	5	5	5
7	77	9	15	26	8	8	5	28	6	10
8	148	32	29	92	33	1	2	38	10	10

Presentations by Content Area
FY 17-18

Service Area	Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide	Childhood Disorders
2	4	5	0	2	0	2	0	0	4
3	2	1	1	1	1	1	0	0	0
4	119	114	119	85	95	85	79	80	230
6	82	72	71	67	65	69	51	56	165
7	174	149	129	128	120	129	109	97	333
8	116	123	109	94	98	104	91	107	281

Outreach Event Locations

- Cabrillo High School
- Trinity Church
- Volunteers of America
- Inglewood School District
- St. Gertrude's Health Fair
- Core Centro Estrella Children's Resource Fair
- Maywood City Hall Health Fair
- Lanternman Regional Center
- Carecen
- Iglesia Universal del Reino de Dios
- Dolores Huerta School
- Club Nutrition
- All People's Community Center
- TELACU Housing Corp
- Cerritos Park
- Pico Housing Corporation
- Cesar Chavez Community Center
- Weekly Resource and Information tables at the following consulates
  - Mexican, Guatemala
- Providence Little Company of Mary Fair – Wilmington
- Torrance School Fair
- Charles R. Drew University of Medicine and Science Conference
- Parks after Dark- Parks throughout all Service Areas
- Providence Little Company of Mary Fair – Wilmington
- Torrance School Fair
- Charles R. Drew University of Medicine and Science Conference
- Parks after Dark- Parks throughout all Service Areas

Promotores de Salud/Health Promoters		
Projects/Activities/ Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Expansion of the Promoters Program	Ongoing	This expansion was designed to promote mental health and wellbeing, support and help to strengthen families by providing educational mental health workshops, resources, and linkage to mental health and other needed services. Collectively, the Promoters conducted 4,287 mental health presentations throughout their Service Areas and reached approximately 35,138 residents. In addition, they participated in 197 community events, which included health and resource fairs, and had resource tables twice a week at both the Mexican and Salvadorian Consulates. Total Number of Promoters per Service Area for FY 17-18: • SA 2 - 20 • SA 3 - 20 • SA 4 - 18 • SA 6 - 17 • SA 7 - 29 • SA 8 – 20
Promoters' Collaboration with Department of Public Health (DPH)	A. A total of 13 Promoters collaborated with DPH B. A total of 14 Promoters were selected to participate	For FY 17-18, DPH requested the continued assistance of the Mental Health Promoters to outreach the Latino communities affected by the Exide Battery Plant located in the City of Vernon. A. The Promoters collaboration with the DPH led to 469 hours of community outreach in affected communities. These activities included participating in community meetings, assisting the DPH to register residents for lead level blood testing in community resource fairs, and registering homes for soil clean-up and door-to-door outreach. In addition, 88 Exide Lead Contamination presentations were conducted at various schools, churches, and other community organizations. Presentations were 1.5 hours long. B. Promoters received a four hour training about the Zika Virus and other mosquito borne diseases. They participated in field exercises and worked in crews with the Mosquito and Vector Control Departments, going door-to-door distributing Zika literature and talking to residents of the intended communities about prevention. **EXIDE Community Project FY 17-18**

<table>
<tr><th colspan="3">Promotores de Salud/Health Promoters</th></tr>
<tr><th>Projects/Activities/ Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><th>Activity</th><th>Quantity</th><th>Hours Completed</th></tr>
<tr><td>EXIDE Community Outreach</td><td>Average number of Promoters: 3 per event</td><td>496 hours</td></tr>
<tr><td>EXIDE Community Presentations</td><td>88 Exide Community presentations</td><td>Approximately 1.5 hours per presentation</td></tr>
</table>

ZIKA Virus Community Project, FY 17-18
<table>
<tr><th>ZIKA</th><th>Date</th><th># of Promoters</th><th># of hours</th></tr>
<tr><td>All SAs – Resource Tables and Street Outreach</td><td>September 2017 to November 2018</td><td>Ave. # of Promoters per event: 22</td><td>689 hours</td></tr>
<tr><td>All SAs – ZIKA Refresher Training</td><td>December 29, 2017</td><td>28 Promoters x 3 hours each</td><td>84 hours</td></tr>
<tr><td>All SAs – Power Point training on Mosquito Borne Diseases</td><td>April 11, 2018</td><td>14 Promoters x 3 hours each</td><td>42 hours</td></tr>
<tr><td>Community Mosquito Borne Disease Presentations</td><td>May and June 2018</td><td></td><td>78 Presentations</td></tr>
<tr><td>Community Mosquito Borne Disease Information Tabling</td><td>Various dates</td><td></td><td>23 hours</td></tr>
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Promotores de Salud/Health Promoters		
Projects/Activities/ Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Promoters' Outreach	Community Event Participation	Promotores engaged with the community in SAs 2,4,6,7 and 8. The number of outreach events is indicated below: • SA 2 – 3 • SA 4 – 130 • SA 6 – 18 • SA 7 – 13 • SA 8 – 36

Additional Highlights of the Promoters Program, FY 17-18

- Thanksgiving Celebration - Promoters from all SAs collaborated and coordinated a celebratory event with food, music, and entertainment
- Promoters facilitated Mental Health 101 training for SB82 Staff
- 21st Annual Parent Academy – Promoters facilitated workshops on Symptoms and Treatment of Anxiety, Grief and Loss, and Domestic Violence
- LACDMH Promoters entered into a Memorandum of Understanding (MOU) with the Gloria Molina Greater Los Angeles YWCA Center in the incorporated area of Walnut Park and TELACU Housing Corporation to conduct Mental Health presentations
- First Annual Resource Fair held on May 18, 2018 – The fair was coordinated and executed solely by the Promoters with 24 vendors. Approximately 70 community members attended this event.
- Promoters shared a resource table with the DPH providing mental health and mosquito borne disease information. At the annual Visión y Compromiso Conference, an organization committed to community wellbeing by supporting Promotoras and Community Health Workers through self-empowerment, educational programs, health advocacy outreach, specifically aimed at Latinos and their families.

Recovery, Resilience, and Reintegration (RRR)

Recovery, Resilience, and Reintegration (RRR) services provide a continuum of care so that consumers can receive the care they need, when they need it and in the most appropriate setting to meet their needs. RRR services are designed to meet the mental health needs of individuals in different stages of recovery.

There are three (3) Core Service Components: Community-Based Services, Clinic-Based Services and Well-being Services. These programs provide consumers with a combination of one or more of the core components to meet these individual needs. RRR contributes to the Department's provision of culturally and linguistically appropriate services. RRR works closely with the consumers and specialized community organizations to receive

feedback and direction and continues to focus on expanding and delivering effective services to the communities and citizens of Los Angeles County.

Individuals referred for services can come from many sources. Referrals can be made by individuals, the community, family members, institutional settings such as jails, hospitals and schools, and other organizations including homeless shelters and health care facilities.

All consumers have the right to services that are delivered in a timely and sensitive manner. RRR programs are dedicated to providing culturally and linguistically appropriate services by ensuring these are provided in the consumer's preferred language and that providers employ a cultural humility approach. Program administration also has constant communication with mental health providers and together determine the need for additional training that will ensure staff is able to work with different ethnically diverse, multi-lingual, and special populations.

RRR provides an array of services designed for mental health consumers who have less needs for ongoing engagement and crisis-focused care as provided through Full Service Partnership (FSP), but are committed to their recovery and following their mutually developed treatment plan. RRR services meet the needs of all age ranges from child to transitional age youth (TAY) to adults and older adults. While there may be some minor differences in the specific services provided to each population, there is more commonality across age groups than differences. All age groups will have access to assessments, traditional mental health services, crisis intervention, case management and medication support. The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each consumer and will likely change over time. While the hope is that most consumers will move from more intensive to less intensive services, some of them may need more intensive services for periods of time due to a variety of factors, which include, but are not limited to, the emergence or exacerbation of a severe mental illness, non-adherence to treatment recommendations, a substance use disorder, exposure to trauma or violence or external psychosocial stressors, such as housing, employment, relationship or legal problems.

The goal of RRR is to build the capacity of LACDMH to serve the significantly underserved population with specifically trained professional and paraprofessional staff working together as part of a multi-disciplinary team.

The following mental health and support services are examples of potential services that consumers might receive if participating in RRR:

- Bio-psychosocial assessment
- Self-help groups
- Peer support services
- Mental Health Services
- Case management
- Relapse prevention services and other services for clients with a history of or active co-occurring substance use and mental health conditions
- Health management activities

- Medication support
- Assistance with employment and education
- Assistance with housing
- Family support and education
- Community integration support
- Culturally and linguistically appropriate services

Consumers Served by RRR
(Age Group, Ethnicity, and Language)
FY 17-18

Age Group	Ethnicity						
	African American	Asian	Hispanic	Native American	Other	Pacific Islander	White
Child	2921	430	13500	80	5129	66	1413
TAY	2753	643	8253	85	1948	57	1463
Adult	14999	3498	18988	601	4766	241	11625
Older Adult	3327	1327	3746	96	1174	67	3505
Languages Spoken by Staff							
Armenian	Amharic	English	Mandarin	Farsi	Hebrew	Russian	Spanish
Cambodian	Arabic	Ibo	Tagalog	Vietnamese	Japanese	Cantonese	Korean
Edo							

Consumers Served by RRR
(Age Groups and Gender)
FY 17-18

Age Group	Gender				
	Female	Male	Transgender (F to M)	Transgender (M to F)	Unknown
Child	9734	13793	3	0	9
TAY	7734	7435	17	7	9
Adult	29172	25459	32	37	18
Older Adult	8251	4984	5	2	0

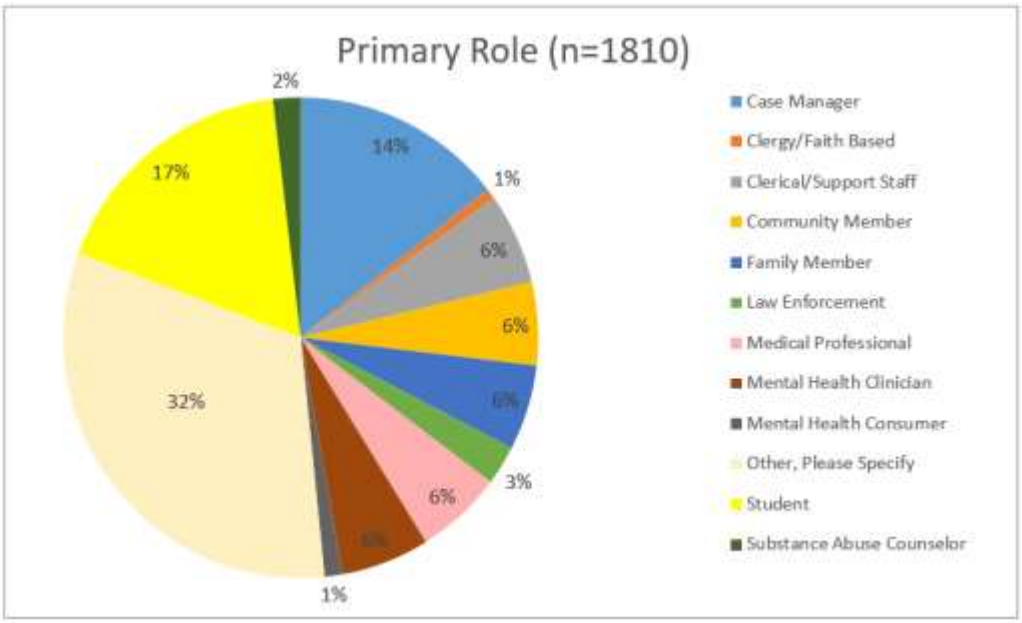
Stigma and Discrimination Reduction (SDR)

The purpose of the Early Start Stigma and Discrimination Project is to reduce and eliminate barriers that prevent people from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through consumer-focused, family support and education and community advocacy strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. Services include: anti-stigma education specifically targeting underrepresented communities through outreach utilizing culturally sensitive and effective tools; educating and supporting mental health providers; connecting and linking resources to schools, families, and community agencies; and consumer and family education and empowerment. The number of participants outreached during FY 17-18 was 72,753

Mental Health First Aid

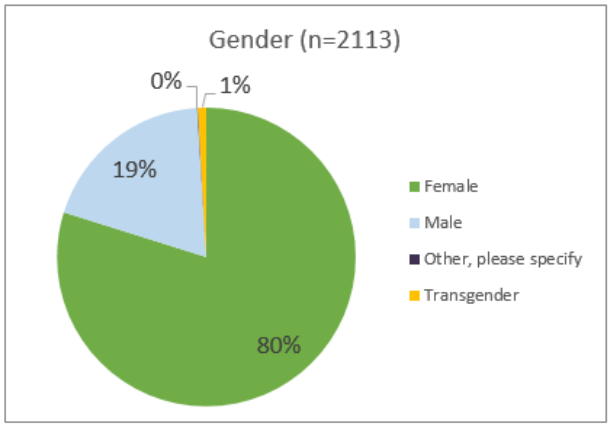
Mental Health First Aid (MHFA) is an interactive 8-hour evidence based training that provides knowledge about the signs and symptoms of mental illness, safe de-escalation of crisis situations and timely referral to mental health services. The use of role-playing and other interactive activities enhance the participants' understanding and skill set to assess, intervene and provide initial help pending referral/linkage to a mental health professional. Participants are also provided information about local mental health resources that include treatment, self-help and other important social supports.

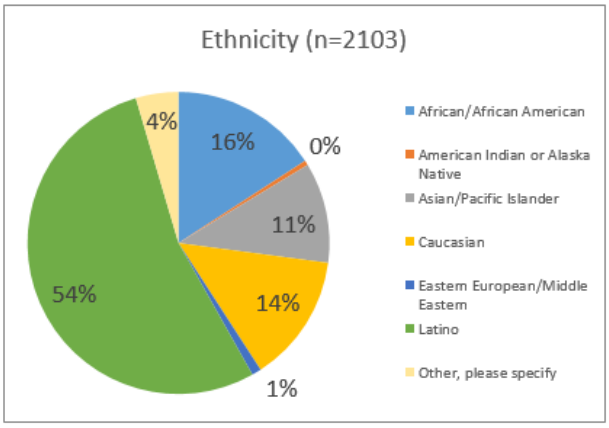
The following are results from the 2,268 surveys received for FY 17-18:

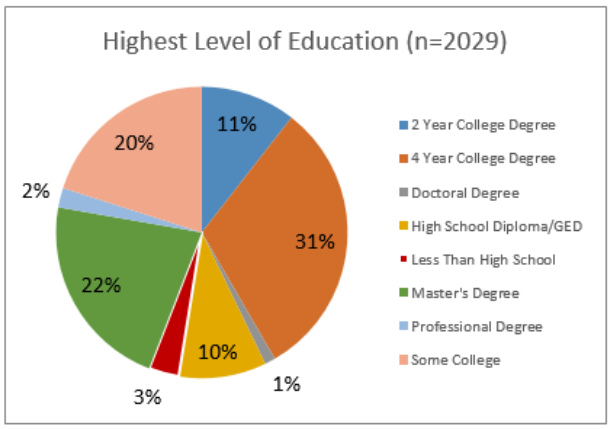


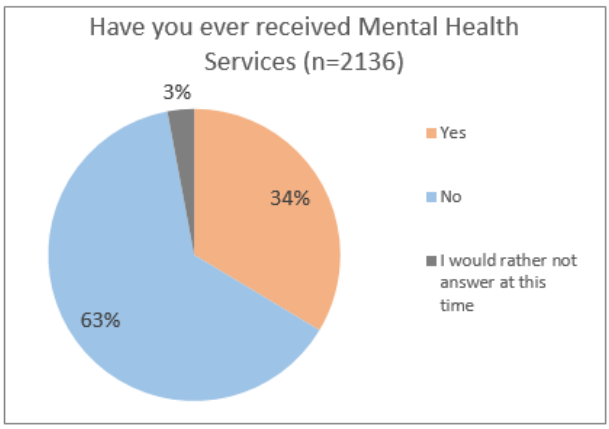
The number of surveys received in FY 17-18 increased by 31% from the previous fiscal year (1,729) and by 51% from FY 15-16 (1,502). There are two (2) possible causes for the increase: 1) increase in survey collection rates from year-to-year and/or 2) increase in the number of people receiving SDR programs from year-to year.

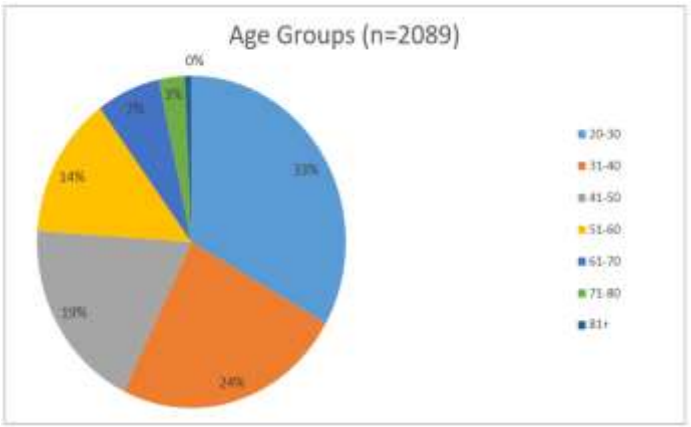
The graphs below summarize participant demographic information.



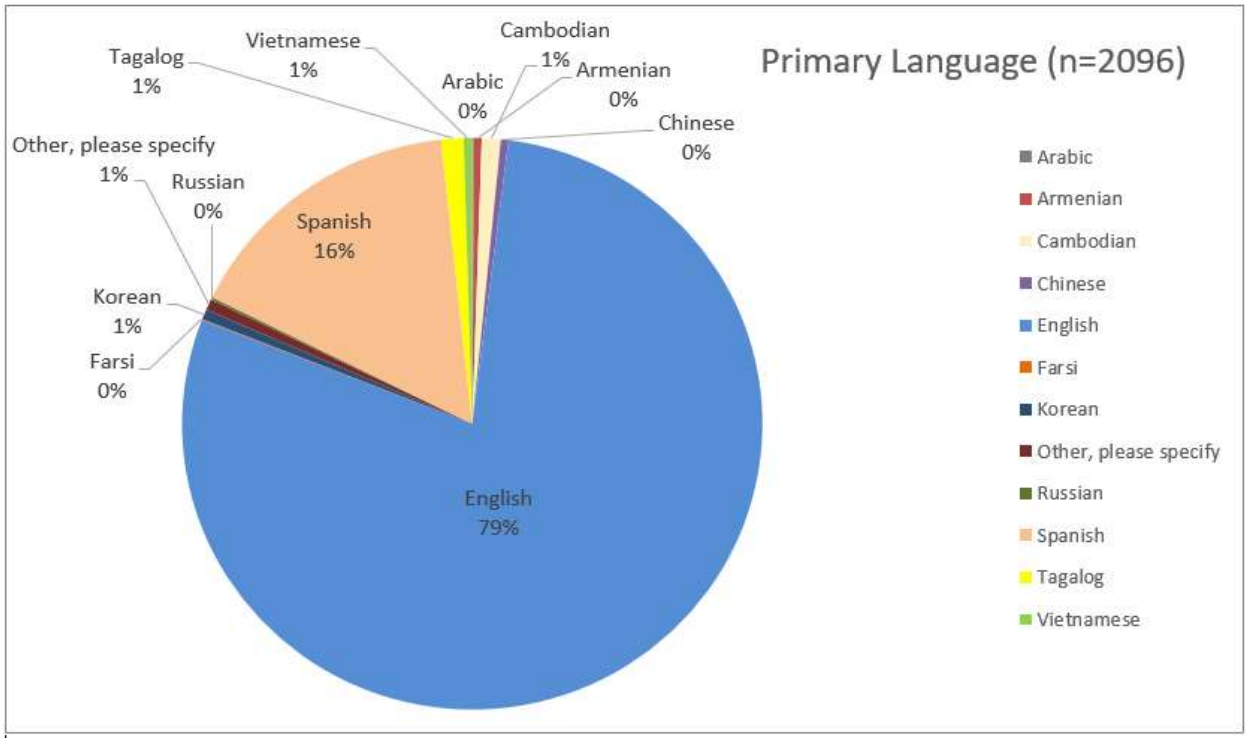








Note: The mean age of trainees who submitted a survey was 40 (age range 18-99).



(Source: Mental Health Services Act Annual Update FY 19-20)

Demographic comparison charts are included when the average percent change in score from “pre” to “post”, for at least one group within the category is at least double the percent change of another group. For example, in the Primary Role category, the average percent change in Perception/Attitudes score for the groups, Clerical/Support Staff (4.3%), Law Enforcement (3.3%), and Medical Professional (3.5%) are more than twice as large as the of the average percent change for the group, Case Manager (1.5%). Two sets of results met the percent change condition: 1) Primary Role: Changes in Attitudes/Perceptions about People with Mental Illness; 2) Highest Level of Education: Changes in Attitudes/Perceptions about People with Mental Illness.

The SDR-MHFA survey has six (6) items that assess attitudes toward persons with mental illness. Scores from the six (6) items are added together to provide a total score, which gives some indication of whether the person completing it tends to have negative or positive perceptions of persons with mental illness. The Attitudes total score can fall into one of four (4) ranges: Very Negative, Negative, Positive, and Very Positive. An increase in the total scores from “pre” to “post” suggests having more positive perceptions about persons with mental illness, following the training:

- The mean average Attitudes score improved by (3%) from “pre” to “post”
- Prior to the training, the average total score was in the Very Positive range; at “post” training, the average total score was still in the Very Positive range.
- Prior to the training, 99% of participants’ total scores were in either the Positive

range (609) or Very Positive range (937). At "post" training, 99% of participants were still in either the Positive range (454) or Very Positive range (1095). These results are identical to the results from FY 16-17. In that year, 99% of participants had "pre" scores in either the Positive or Very Positive range and 99% had "post" scores in either the Positive or Very Positive range.

- Prior to training, 60% of participants' (937) scored in the Very Positive range. At "post", 70% of participants' scored in the Very Positive (1095), an increase of 10%.
- Prior to the training, 12 participants scores were in either the Negative or Very Negative Attitudes Range. Seventy-five percent (75%) of those participants' scores fell in either the Positive (8) or Very Positive (1) range at "post" training.

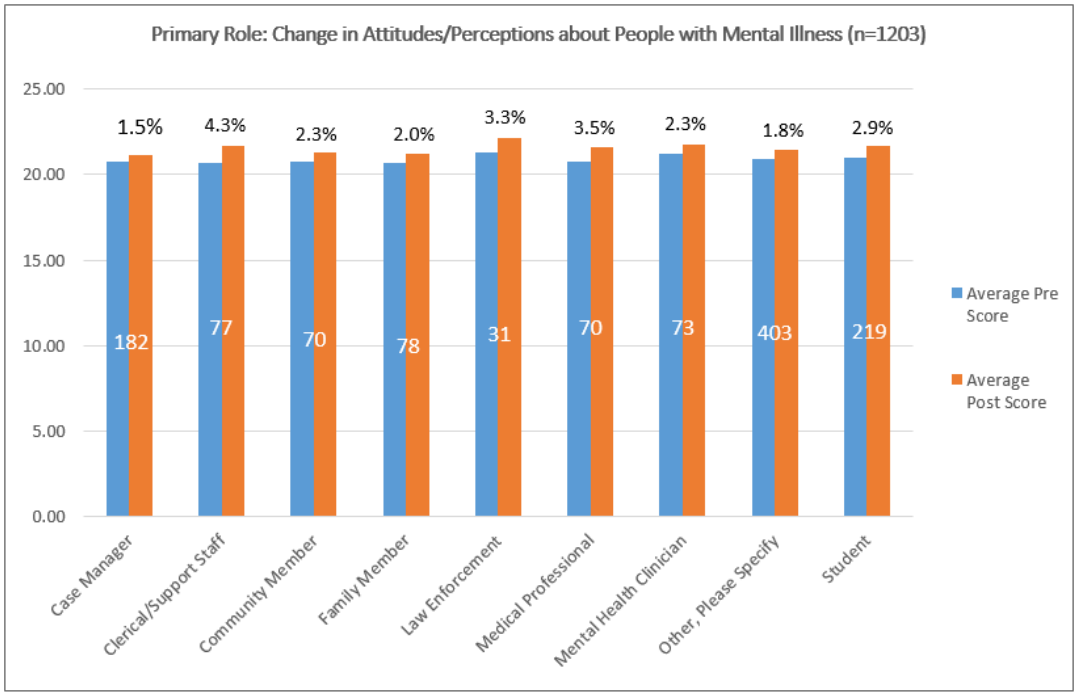
These results suggest: 1) the great majority of participants had positive perceptions about people with mental illness prior to attending the training and their positive perceptions were either maintained or increased following training; 2) training helped many participants increase their knowledge about mental health, even among participants who had a moderate level of knowledge prior to attending the training.

The SDR-MHFA Survey includes a seventh item, "Please rate your current level of knowledge about mental health," which has five (5) possible responses: Not at all Knowledgeable, Somewhat Knowledgeable, Moderately Knowledgeable, Very Knowledgeable, and Extremely Knowledgeable. An increase in the Knowledge from "pre" to "post" suggests a participant has gained knowledge about mental illness:

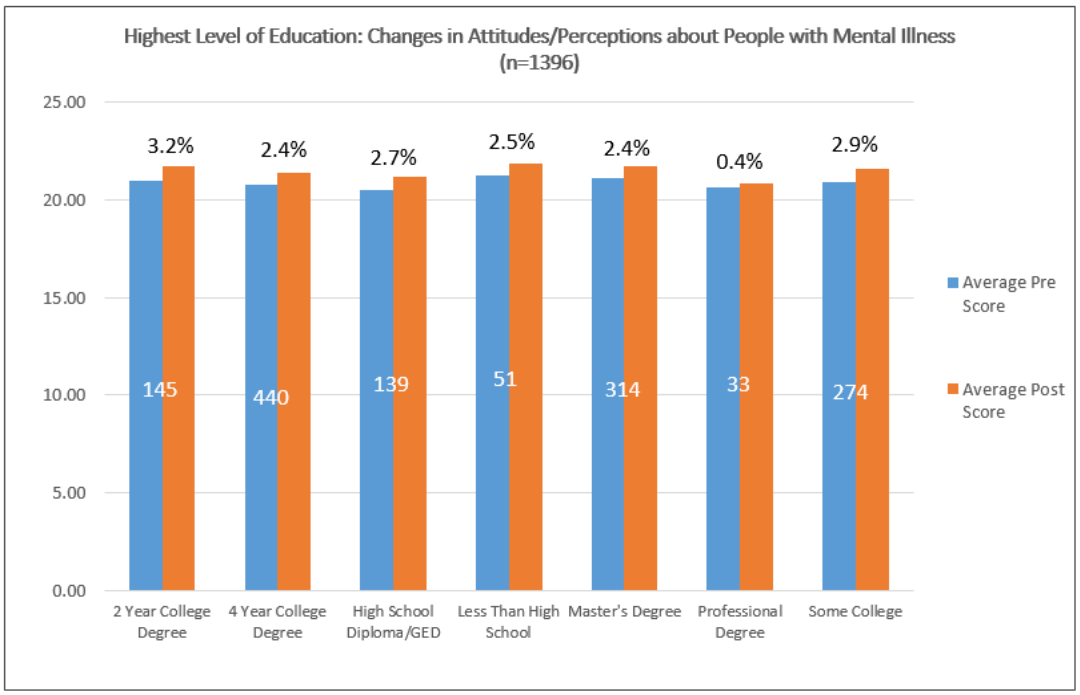
- The mean average knowledge score improved by (27%) from "pre" to "post"
- Ninety-eight percent (98%) of participants (1526) either increased their knowledge about mental illness or showed no change because they were already knowledgeable on the subject matter.
- Prior to the training, 67% of participants selected Moderately, Very, or Extremely Knowledgeable. "Post" training, 95% of participants selected Moderately, Very, or Extremely Knowledgeable, an increase of 28%.
- Prior to the training, 697 participants selected the response, Moderately Knowledgeable. Fifty-seven percent (57%) of these participants selected either Very Knowledgeable (349) or Extremely Knowledgeable (50), at "post" training.
- Prior to the training, 513 participants selected either the response, not at all Knowledgeable or Somewhat Knowledgeable. Eighty-seven percent (87%) of these participants selected either Moderately Knowledgeable (277), Very Knowledgeable (141) or Extremely Knowledgeable (26), at "post" training.

Attitudes/perceptions of people who have mental illness, Primary role

- Participants who selected the primary role, Case Manager, had the lowest average percent change (1.5%), from "pre" to "post"; participants who selected Clerical/Support Staff had the highest (4.3%).
- Participants who selected the primary role, Law Enforcement, had the highest average "pre" (21.3) and "post" (22.2) scores; participants who selected Clerical/Support Staff had the lowest average "pre" (20.7) score and participants who selected Case Manager had the lowest average "post" (21.2) score



Note: Results for primary roles that had fewer than 30 matched "pre" and "post" SDR surveys (Clergy/Faith based, Mental Health Consumer) are not included in the chart. (Source: MHSA Annual Update Report FY 19-20)



Note: Results for highest level of education that had fewer than 30 matched "pre" and "post" SDR surveys (Doctoral Degree) is not included in the chart.

Attitudes/Perceptions of people who have mental illness, Highest level of education

- Participants who selected the highest level of education, Professional Degree, had the lowest average percent change (0.4%), from “pre” to “post”; participants who selected 2-year College Degree had the highest (3.2%).
- Participants who selected the highest level of education, Less than High School, had the highest average “pre” (21.3) and “post” (21.9) scores; participants who selected High School Diploma/GED had the lowest average “pre” (20.5) score and participants who selected Professional Degree had the lowest average “post” (20.9) score.
- The low average change in score among participants in the category, Professional Degree, compared with other groups, may be an anomaly resulting from having a small n (33) and/or some characteristic of the group’s participants. Deeper review of results for this group showed that 52% of the participants (17) attended the same training and 76% of those at the same training (13) reported working in the legal field, either as an attorney, supervisor, or paralegal. Among those 17 participants, the average “pre” score was (20.8), average “post” was (20.4), and average percent change was (-2.5%).

Older Adults Mental Wellness

For the majority of FY 17-18, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of a Community Services Counselor, a Community Worker, and a Service Extender. Other Outpatient Services staff routinely provide assistance, particularly if there is more than one presentation on a given day or if there is a need for a specific language. The OA ASD Team participated in a total of 272 events during the FY 17-18, outreaching to 3,792 L.A. County residents. These events include countywide educational presentations, community events such as Resource fairs, community meetings and collaboration with various agencies.

Highlights of OA ASD’s accomplishments include:

- Outreached to 3,792 individuals in L.A. County
- Provided 264 presentations for seniors throughout the county
- Participated in 8 Resource Health Fairs throughout the county
- Increased the number of workshops in Service Areas 1, 2, 5 and 8
- Developed a new presentation “Elder Financial Exploitation: Impact on Emotional Wellbeing” for addition to the menu of topics for our Mental Wellness Series.

OA ASD provides prevention services primarily by increasing awareness of Mental Wellness for older adults throughout L.A. County, particularly among underserved and under-represented communities. We continue to develop new presentation topics for seniors. OA ASD Team collaborates and coordinates with LACDMH contracted agencies to provide clinical back-up and coordination of translation services as needed.

Presentations by Service Area

Service Area Number	Area	Number of Presentations
1	Antelope Valley	7
2	San Fernando Valley	80
3	San Gabriel Valley	26
4	LA Metro Area	48
5	West LA Area	21
6	South LA Area	16
7	East LA Area	43
8	South Bay Area	31
Total		**272**

The table above demonstrates the distribution of presentations offered throughout L.A. County. In comparison to when ASD initially began providing presentations for older adults, which required intensive outreach efforts to housing managers in senior housing and staff in senior centers, the ASD team is now contacted directly to request presentations daily.

Number of People Who Attended

Facility	Number of Attendants
Community Center	340
Senior Centers	1427
Senior Housing	1909
Other (Library, Church, City Hall)	116
Total	**3792**

Displays the number in attendance at the various facilities. It is noteworthy that 25% of the team's visits were to Senior Centers where they presented to 38% of the total attendants. This compares to 72% of the team's visits being to Senior Housing sites, where they presented to 50% of the total attendants. This illustrates that for FY 17-18, the team's efforts in outreaching in senior centers was a very productive use of their time.

Type of Facility

Facility	Number of Attendants
Community Center	14
Senior Centers	69
Senior Housing	178
Other (Library, Church, City Hall)	11

Illustrates the type of facilities where presentations were provided. In the past, most of our efforts focused on settings where large audiences of older adults congregate, such as senior centers. Due to an increase in awareness of our presentations, the number of senior housing complexes increased to 178 from last year's 165.

Presentations provided by Language

Language	Number of Attendants
English	205
Spanish	79
Korean	15
Farsi	5
Chinese	4
Russian	3

Details presentations provided in the following languages: English, Spanish, Korean, Farsi, Russian and Chinese. Request for Spanish has increased during the FY 17-18 due to senior housing complexes sharing information on the Wellness series.

SB 82 Mobile Triage Teams (MTTs)

MTTs are designed to increase access to mental health services for individuals/families who are homeless and highly vulnerable. MTT services are provided in the field by teams comprised of mental health clinicians, community workers and volunteers, with one dedicated team in each of the County's eight (8) Service Areas. The MTTs use EBPs including harm reduction, motivational interviewing and trauma informed care.

Consumers served

Program/Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
	White	African American	Latino	API	American Indian	Multiple	Male	Female	Unknown
MTT	991	622	645	43	18	17	1339	1009	31
	Other Ethnicities: 462								
	Not Specified:								
	Language of Staff:								
	English		Spanish				Mandarin		

The MTTs contribute to LACDMH's provision of culturally and linguistically competent services for individuals/families that are homeless. Persons who are homeless are considered experiencing a unique culture. Each MTT, to the extent possible, hires staff that reflect the demographics of the homeless population, who have lived experience with homelessness and/or mental illness.

The MTTs increase access to mental health services by providing field-based triage and outreach and engagement to individuals/families to determine their eligibility for LACDMH services. Short-term interventions, including linkage to interim housing, are provided until consumers are linked to long-term mental health services. The services are brought to homeless persons where they are at, thereby removing many barriers that they would experience in accessing clinic-based services.

Mobile Triage Team		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1. Provide field-based short-term interventions, linkage and co-occurring mental health services to individuals/families who are homeless.	The MTT model has been successful.	LACDMH uses an internal database to monitor the MTT outcomes. The MTT consumers had the following outcomes: • 59% linked to mental health services

Spirituality

LACDMH understands that many people living with mental illness find strength, purpose, and a sense of belonging through their spiritual beliefs and practices. LACDMH collaborates with diverse stakeholders, including clergy, lay leaders, and congregants, to share information on mental health resources and build community capacity for hope and recovery.

Mental Health Academy (MHA)

The MHA trains clergy and faith community members in their local service areas. Attendees are informed of the 24/7 ACCESS number and other multilingual LACDMH resources.

SPIRITUALITY: MHA		
Projects/Activities/Strategies: **5 Service Areas were engaged**	**Status/ Progress:** **11 Training sessions were conducted**	**Monitoring/ Outcomes/Findings:** **222 participants completed training**
1. Mental Health Academy (MHA) trainings for SA 2	Conducted two trainings; one in August 2017 and one in September 2017	Training totals: • 10 staff and volunteers trained on Domestic Violence • 89 volunteers trained in Spanish on Mental Health 101
2. MHA training for SA 3	Conducted two trainings; one in September 2017 and one in October 2017	Training totals: 22 staff and clergy trained on Self-Care

SPIRITUALITY: MHA		
Projects/Activities/Strategies: **5 Service Areas were engaged**	**Status/ Progress:** **11 Training sessions were conducted**	**Monitoring/ Outcomes/Findings:** **222 participants completed training**
3. MHA training for SA 4	Conducted one training in October 2017	Training totals: • 25 clergy and volunteers on Parenting
4. MHA training for SA 7	Conducted one training in July 2017	Training totals: • 16 volunteers on Suicide Prevention
5. MHA training for SA 8	Conducted five trainings; in July, August, September, October, and November 2017	Training totals: 10 volunteers on Bullying , 10 staff on Psychological First Aid, 15 volunteers on Effective Communication, 15 volunteers on Mindfulness, 10 volunteers on Caring Congregations

Faith-Based Advocacy Council (FBAC)

LACDMH convenes monthly meetings of the Faith-Based Advocacy Council (formerly named the Clergy Advisory Council). This group serves as a volunteer consulting body in the preparation of LACDMH provider training parameters on the integration of spiritual interests of clients in the provision of mental health services and supports. FBAC also engages Outreach and Engagement staff from the eight SAs. FBAC meetings focus on pressing mental health issues in the County. Topics covered this year included: healing through arts programs, effective homeless outreach, pending legislation on mental health priorities, foster family needs, and fostering LGBTQIA-friendly congregations.

SPIRITUALITY: FBAC		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1. Monthly meetings of and average of 46 clergy and congregants from diverse faiths and cultures of Los Angeles County	Continuing uninterrupted for eleven years.	The outcome is a diverse cultural and inter-faith group that has formed lasting connections with LACDMH
2. Executive Board meetings with a culturally diverse	The Executive Board has been meeting for over	Each Board member promotes access to LACDMH and as a group

SPIRITUALITY: FBAC		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
group providing leadership for FBAC	three years and currently meets every month	advocates for diverse representation
3. Resource tables at conferences and workshop development.	These activities are ongoing throughout the year in preparation for the annual conference	Outcomes include the trainings at conferences on mental health issues pertinent to particular cultures and gender

Mental Health/Interfaith Clergy Roundtable Program

The purpose of the Roundtable Program is to expand partnerships between clergy and the mental health staff of the local community to increase knowledge of LACDMH and faith community resources.

SPIRITUALITY: MENTAL HEALTH – INTERFAITH CLERGY ROUNDTABLE		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1. Monthly Mental Health/Interfaith Clergy Roundtables in diverse communities throughout Los Angeles County	A total of 5 Mental Health/Interfaith Clergy Roundtables were conducted each month for two hours in: • Antelope Valley • El Monte • Northeast San Fernando Valley • Southeast Los Angeles County • Central Long Beach	Mental Health and Interfaith Clergy members take the information, skills, techniques, and resources back to their mental health consumers and their congregations.
2. Mental Health/Interfaith Clergy Roundtable Facilitators Training/meetings	Every other month all Mental Health/ Interfaith Clergy Roundtable Facilitators meet for training, technical assistance, and networking.	Mental Health/Interfaith Clergy Roundtable Facilitators take the information, skills, techniques, and resources back to their monthly Roundtables, clinics, and programs.

Mental Health and Spirituality Conference

This conference is an annual event hosted for the clergy, members of religious organizations, and human services providers addressing integration of mental health and spirituality in the system of care. The Mental Health and Spirituality Conference was held on May 3, 2018 at the Center at Cathedral Plaza in downtown Los Angeles.

Clergy are often the first responders within their communities. Thus, the overarching goal for the conference is for the Clergy to gain knowledge and skills in identifying when their congregants need mental health services, thereby preventing the exacerbation of symptoms that could lead to serious mental illness. Consumers and family members also attend the conference.

SPIRITUALITY: MENTAL HEALTH AND SPIRITUALITY CONFERENCE		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1. 17th Annual Conference on Mental Health and Spirituality: Connected: You Are Not Alone	This year's conference included: • 2 Keynote speakers • 6 workshops • 20 Resource tables Conference topics: • Moral Injury and healing psychic wounds • Faith-led efforts to address homelessness • LGBTQ Inclusion • Mental health crisis resolution • Mindfulness Work in Prisons • The Blessing of Mental Health Support in a Faith Community	435 individuals attended the conference; 116 were affiliated clergy/other congregational. Simultaneous translation in Spanish, Korean, and Tagalog engaged a number of consumers, family members, and clergy.

Underserved Cultural Communities (UsCC) subcommittees
LACDMH has implemented UsCC subcommittees dedicated to working with the various underserved populations in order to address their mental health needs. These subcommittees are: African/African American (AAA); American Indian/Alaska Native (AI/AN); Asian Pacific Islander (API); Deaf, Hard of Hearing, Blind, and Disabilities; Eastern European/Middle Eastern (EE/ME); Latino; and Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex/Two-Spirit (LGBTQI2-S). Every Fiscal Year (FY), each of the UsCC subcommittees identifies Community Services and Supports (CSS) based capacity-building projects that will increase outreach and engagement, service accessibility, and penetration rates for UsCC communities. The following are projects implemented during FY 17-18:

AAA
African American Mental Health Radio Campaign
African American Mental Health Radio Campaign was launched on October 16, 2017 and was completed on January 7, 2018. A local radio station was contracted to produce and broadcast five (5) 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community. The PSA

successfully helped to reduce stigma, increase mental health awareness and access among African American community members.

Life Links: Resource Mapping Project
This project has been implemented for fifth consecutive years. Funds were allocated to develop a community resource directory called "Life Links." Community resources, service providers, and agencies were identified in South L.A. County, where there is a large AAA population. This directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers. This community resource directory has been updated four (4) times and the fifth reprint is scheduled for June 2018.

AI/AN
AI/AN Bus Advertising Campaign
The bus advertising campaign took place in SA 1 for 12 weeks from January to April, 2018. It included the following: 15 taillight bus displays, 12 king-size bus posters, 5 queen-size bus poster, and 80 interior bus cards. It also included an additional 80 interior bus cards for 12 weeks from April to June, 2018 at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in L.A. County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members.

AI/AN Mental Health Conference
The 2017 American Indian / Alaska Native Mental Health Conference: "Bridging the Gaps – Systems, Cultures, and Generations" took place on November 14, 2017. The purpose of the conference included the following: to inform participants of mental health issues unique to the AI/AN community; to improve participants' ability to recognize when to refer an AI/AN community member for mental health services; to provide participants with useful information on available mental health resources for AI/AN community members; and to improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. The voluntary and anonymous survey was handed out to all participants at the conference.

API
The Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities
This project was implemented on September 1, 2016 and completed on September 30, 2017. The Multimedia Mental Health Awareness Campaigns included linguistically and culturally appropriate mental health education and engagement workshops and an ethnic media campaign, including mental health awareness Advertisements (Ads) on Television and Radio and Newspaper Articles, that targeted the Cambodian and Vietnamese communities in Los Angeles County. The purpose of this project was to increase awareness and knowledge of the signs and symptoms of mental illness, and for improved

access to mental health services for the Cambodian and Vietnamese communities in L.A. County.

API Youth Video Contest: “Go Beyond Stigma!”
This project was implemented on January 1, 2018 and is scheduled to be completed on March 30, 2019. The API Youth Video Contest project included the recruitment and training of API Youth on mental health issues and resources as well as technical assistance to support the development of video (maximum of 3 minutes) on how mental health issues impact his/her life. The videos were submitted as part of a Video Contest and were showcased at an Awards Ceremony, which was part of a community event. The purpose of this project is to provide API youth (ages 16-25) an opportunity to share how mental health issues influence their life, family, and community, in order to increase awareness and knowledge of signs and symptoms of mental illness and improve access to mental health services for API Youth in L.A. County.

Samoan Outreach and Engagement Program
LACDMH utilized CSS funds to continue the Samoan Outreach and Engagement Program in order to improve awareness and knowledge of mental health issues and resources, and increase referrals and enrollment into mental health services by the Samoan community. LACDMH contracted with Special Services for Groups (SSG) who partners with two (2) Samoan community-based agencies to conduct individual and group outreach, engagement, and referral activities with the Samoan community in SA 8, which has the largest concentration of Samoans within the County of Los Angeles. This program completed its third year of implementation on June 30, 2018 during which community outreach was conducted at some colleges, churches, IMDs, hospitals, jail and other community gathering sites. Starting July 1, 2017, the program started emphasizing more on referrals and enrolments.

API Mental Health Awareness Media Campaigns
This project includes seven (7) separate campaigns that were implemented on in May 2018 and are scheduled to be completed in April 2019. The goals of this project were to target various API communities in L.A. County and educate them about signs and symptoms of mental illness, mental health resources, reduce mental illness related stigma, and reduce gaps in mental health service delivery in the various API communities by using media to help link the API communities to the public mental health system.

LACDMH targeted the following API communities: Cambodian (Khmer), Chinese (Mandarin and Cantonese), Indian (Hindi and English), Filipino (Tagalog and English), Japanese, and Korean. Each Media company developed and aired at least one (1) PSA for the respective target community. LACDMH banners were developed and posted in their station website, with a link to the LACDMH website. Some media companies also provided interview segments, outreach events and community mental health surveys. Social media was utilized where possible. All PSAs, segments, etc. were posted onto the LACDMH website and used for future outreach purposes.

The Deaf, Hard of Hearing, Blind, and Physical Disabilities
This subcommittee was established on January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018.

The goals of this subcommittee are to reduce disparities and increase mental health access for the deaf, hard of hearing, blind, and physically disabled community. This group works closely with community partners and consumers in order to increase the capacity of the public mental health system, to develop culturally relevant recovery oriented services specific to the targeted communities, and to develop capacity building projects.

As of June 30, 2018, this subcommittee has identified four (4) capacity building projects for the next Fiscal Year, has a membership roster of over 50 individuals, and is actively recruiting new members.

EE/ME
Armenian Talk Show Project Part II
The Armenian Talk Show Project Part II was aired to inform the Armenian community about common mental health issues and how to access services in the County of Los Angeles. The show included mental health topics such as eating disorders, terminal illness and mental health, intergenerational conflict, mental illness and family support and caregiver stress. The most popular 44 episodes of the Armenian Mental Health Show from two seasons were re-aired from April 15, 2017 to September 9, 2017.

Mental Health Farsi Language Radio Media Campaign
This project consisted of producing and airing three (3) different PSAs in the Farsi language. The PSAs aired on a Farsi radio station 5-8 times daily, from May 4, 2017 to July 30, 2017. The PSAs targeted Iranian/Persian communities of Los Angeles County. Each PSA provided culturally sensitive information, education, and resources about a specific mental health topic. The topics included mental health awareness and domestic violence.

Mental Health Russian Language Television Media Campaign
This project consisted of four (4) different PSAs in the Russian language. The PSAs helped educate the Russian community and increase awareness of the signs and symptoms of mental illness, as well as reduce the stigma associated with mental health conditions with this underserved subgroup. The PSA's aired in a rotation and one (1) PSA aired at least six (6) times a day for three (3) months, from April 25, 2017 to July 29, 2017. The PSAs included mental health education and information on topics such as general mental health information, depression, and anxiety. The PSAs informed consumers of existent mental health issues in the Russian community and resources available within the LACDMH.

Latino

Latino Media Campaign

The Latino media campaign was launched on May 1, 2017 and was completed on July 16, 2017. The PSAs were aired on KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran a total of 138 television PSAs, a 2-day Homepage takeovers and Univision.com geo-LA/Local Los Angeles Rotation – in banner, video, and Social Media. KLVE, KRCD, and KTNQ radio stations ran 501 PSAs, and a 2-day Homepage takeovers and social media. In addition, 3-minute interviews on different mental health topics with the LACDMH Ethnic Services Manager were aired weekly on Dr. Navarro's program at KTNQ – 1020 Radio Station for nine (9) weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview for PSA was aired on four (4) radio stations on June 12, 2017 and June 25, 2017.

Latino Bus Advertising Campaign

A Bus Advertising Campaign was implemented to promote mental health services, increase the capacity of the public mental health system, and reduce mental health stigma within the Latino community. The campaign began on February 27, 2017 and ended on October 8, 2017. It included the following: 172 taillight bus displays, 56 king-size bus posters, and 4,000 interior bus cards for a total of 32 weeks (that includes an additional 2,000 interior bus cards for 12 weeks at no additional cost). The campaign delivered a total of 21,919,004 impressions.

LGBTQI2-S

LGBTQI Iranian Outreach and Engagement Project

The objective of the LGBTQI Iranian Outreach and Engagement Project was to engage, empower, enlist, and enlighten the LGBTQI and non-LGBTQI Iranian community, as well as to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County. This would enable the underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services as well. The project involved two phases: Phase 1 included eight (8) health and wellness workshops, which provided outreach to Iranian LGBTQI community members and their families, as well as Iranian Student Clubs at local high schools and colleges; and Phase 2 included a media campaign targeting Iranian LGBTQI and non-LGBTQI community members through local Iranian talk shows, magazines, newspapers, and radio programs.

LGBTQI2-S Mental Health Conference

One of the recommendations of the LGBTQI2-S UsCC subcommittee was to plan and coordinate the 2018 LGBTQI2-S Mental Health Conference, "Unraveling the Rainbow– Embracing Our Diversity." The conference took place on June 6, 2018. The purpose of the conference included the following: to inform participants of mental health issues unique to the LGBTQI2-S community; to improve participants' ability to recognize when to refer an LGBTQI2-S community member for mental health services; to provide participants with useful information on available mental health resources for LGBTQI2-S community members; and to improve participants' ability to provide culturally appropriate mental health treatment to LGBTQI2-S consumers. A survey was handed out to all

participants at the start of the conference, which was anonymous and voluntary. In total, 303 individuals attended the conference and of those, 168 completed surveys.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
AAA 1. African American Mental Health Radio Campaign	Completion Date: 1/7/2018	A local radio station was contracted to produce and broadcast five (5) 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community. The PSA successfully helped to reduce stigma, increase mental health awareness and access among African American community members. • In total, 124 PSAs were aired and a total of 342,000 radio impressions were delivered. • The digital display banners on the radio station's website delivered approximately 332,934 impressions. • A total of 883,000 impressions and audio streaming were delivered under contract. • Additional impressions were delivered as bonuses, with a grand total of 2,650,800 impressions. • The e-blast total was 116,121 impressions.
2. Life Links: Resource Mapping Project		Community resources, service providers, and agencies were identified in South L.A. County, where there is a large AAA population. This directory, of approximately 300 services and listings of unique interest to specific cultural groups, includes names, addresses, contact information, hotlines and toll-free numbers.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
		• For the fifth reprint, 15,000 booklets were ordered as of December 2018. • There have been over 20,000 Life Links booklets distributed in Los Angeles County.
AI/AN 1. AI/AN Bus Advertising Campaign	From January to April 2018 for 12 weeks	The bus advertising campaign took place in SA 1 for 12 weeks from January to April, 2018. It included the following: 15 taillight bus displays, 12 king-size bus posters, 5 queen-size bus poster, and 80 interior bus cards. It also included an additional 80 interior bus cards for 12 weeks from April to June, 2018 at no additional cost. The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in L.A. County, increase awareness of the signs and symptoms of mental illness, and reduce the stigma associated with mental health conditions for the AI/AN community. • This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members. A total of 12,346,100 impressions were delivered.
2. AI/An Mental Health Conference	Completion Date: 11/14/2017	2017 American Indian / Alaska Native Mental Health Conference: "Bridging the Gaps – Systems, Cultures, and Generations." The conference took place on November 14, 2017. The purpose of the conference included the following: to inform participants of mental health issues unique to the AI/AN community; to improve participants' ability to recognize when to refer an AI/AN community member for mental health services; to provide participants with useful information on available mental health

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
		resources for AI/AN community members; and to improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers. The voluntary and anonymous survey was handed out to all participants at the start of the conference. In total, 119 out of 265 individuals attended the conference completed surveys. • 95% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community • 88% agreed or strongly agreed the conference improved their ability to recognize when to refer an AI/AN community member for mental health services • 95% agreed or strongly agreed they received useful information on mental health resources for AI/AN community members • 97% agreed or strongly agreed, as a result of the conference, they had a better understanding of where to refer AI/AN community members for mental health services • 95% agreed or strongly agreed that the conference improved their ability to provide culturally-appropriate mental health treatment to AI/AN consumers
API 1. The Multimedia Mental Health Awareness Campaign for the Cambodian and Vietnamese Communities	Completion Date: 9/30/2017	This project was implemented on September 1, 2016 and completed on September 30, 2017. The Multimedia Mental Health Awareness Campaigns included linguistically and culturally appropriate mental health education and engagement workshops and an ethnic media

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**

		campaign, including mental health awareness Advertisements (Ads) on Television and Radio and Newspaper Articles, that targeted the Cambodian and Vietnamese communities in Los Angeles County.
		• 22 mental health education workshops were held, 11 in Khmer for the Cambodian community and 11 in Vietnamese for the Vietnamese community.
		  ○ Of the 238 participants surveyed, 58% were female and 42% were male
		  ○ Of the 238 participants surveyed, 55% were older adults, 37% were adults, and 8% were TAY (16-25)
		  ○ Of the 238 participants surveyed, 45% were Cambodian, 29% were Vietnamese, and 26% were Chinese
		• 238 Pre-Test and 238 Post-Test surveys were collected by workshop participants to assess the impact on their knowledge about the risk factors related to mental illnesses and the importance of prevention.
		• Before the workshops, 42% of participants were aware of risk factors that can affect a person's mental health. After the workshops, 97% of participants were aware of the risk factors that can affect a person's mental health, which is an increase of 55%.
		• Before the workshops, 36% of participants were aware of how biological factors can affect a person's mental health. After the workshops, 98% of participants were aware of how biological factors can affect a person's mental health, which is an increase of 62%.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
		• Before the workshops, 39% of participants understood how a person's mood can affect their mental health. After the workshops, 98% of participants understood how a person's mood can affect their mental health, which is an increase of 59%. • Before the workshops, 38% of participants understood how a person's environment can affect their mental health. After the workshops, 95% of participants understood how a person's environment can affect their mental health, which is an increase of 57%. • Before the workshops, 35% of participants were aware of how they can help prevent mental health problems. After the workshops, 98% of participants were aware of how they can help prevent mental health problems, which is an increase of 63%. • A Cambodian Mental Health Radio Ad and a Vietnamese Mental Health TV Ad were developed. The Cambodian Ad was aired 257 times on FM 106.3, which airs a Khmer Radio program. The Vietnamese TV Ad was aired 5,320 times on Saigon TV, which targets the Vietnamese community. • Four (4) newspaper articles were published in local newspapers. Two articles were published to target the Cambodian community using the Khmer Post and Khmer Voice newspapers. The other two articles were published targeting the Vietnamese communities using the Viet Bao newspaper.

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 4

Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

August 2019

Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

The Cultural Competency Committee (CCC) serves as an advisory group for the infusion of cultural competency in all of Los Angeles County Department of Mental Health (LACDMH) operations. Administratively, the CCC is housed within the Office of Administrative Operations - Cultural Competency Unit (CCU). Comprised of 46 members, the CCC membership includes the cultural perspectives of consumers, family members, advocates, Directly Operated (DO) providers, Contracted providers, and community-based organizations. Additionally, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining the mission of the Committee.

CCC Mission Statement

"Increase cultural awareness, sensitivity, and responsiveness in the Los Angeles County Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, resilience, and recovery in our communities."

Leadership

The CCC is led by two Co-Chairs elected annually by members of the Committee. The roles and responsibilities of the Co-Chairs include:

- Facilitate all meetings
- Engage members in Committee discussions
- Collaborate with the CCU in the development of meeting agendas
- Appoint ad-hoc subcommittees as needed
- Communicate the focus of the CCC activities and recommendations made to diverse LACDMH entities
- Represent the CCC at the departmental System Leadership Team (SLT)
- Provide update regarding CCC projects and activities at various meetings such as the Departmental Countywide Quality Improvement Council (QIC)

The LACDMH Ethnic Services Manager (ESM) monitors all activities pertaining to the CCC and provides technical support. The ESM is also the supervisor for the CCU and is a member of QIC. This structure facilitates communication and collaboration for attaining the goals as set forth in the Departmental QI Work Plan and the Cultural Competence (CC) Plan to reduce disparities, increase capacity, and improve the quality and availability of services. Additionally, relevant CCC decisions and activities are reported to the membership at each Departmental QIC meeting.

For Calendar Year (CY) 2018, the CCC leadership was composed of:

- CCC Co-Chairs (LACDMH and Community representatives)
- LACDMH Ethnic Services Manager

The CCC Co-Chairs and the ESM meet on a monthly basis with the OAO Deputy Director to discuss CCC activities and projects. The CCC Co-Chairs are also members of the Underserved Cultural Communities (UsCC) Leadership Group.

Membership

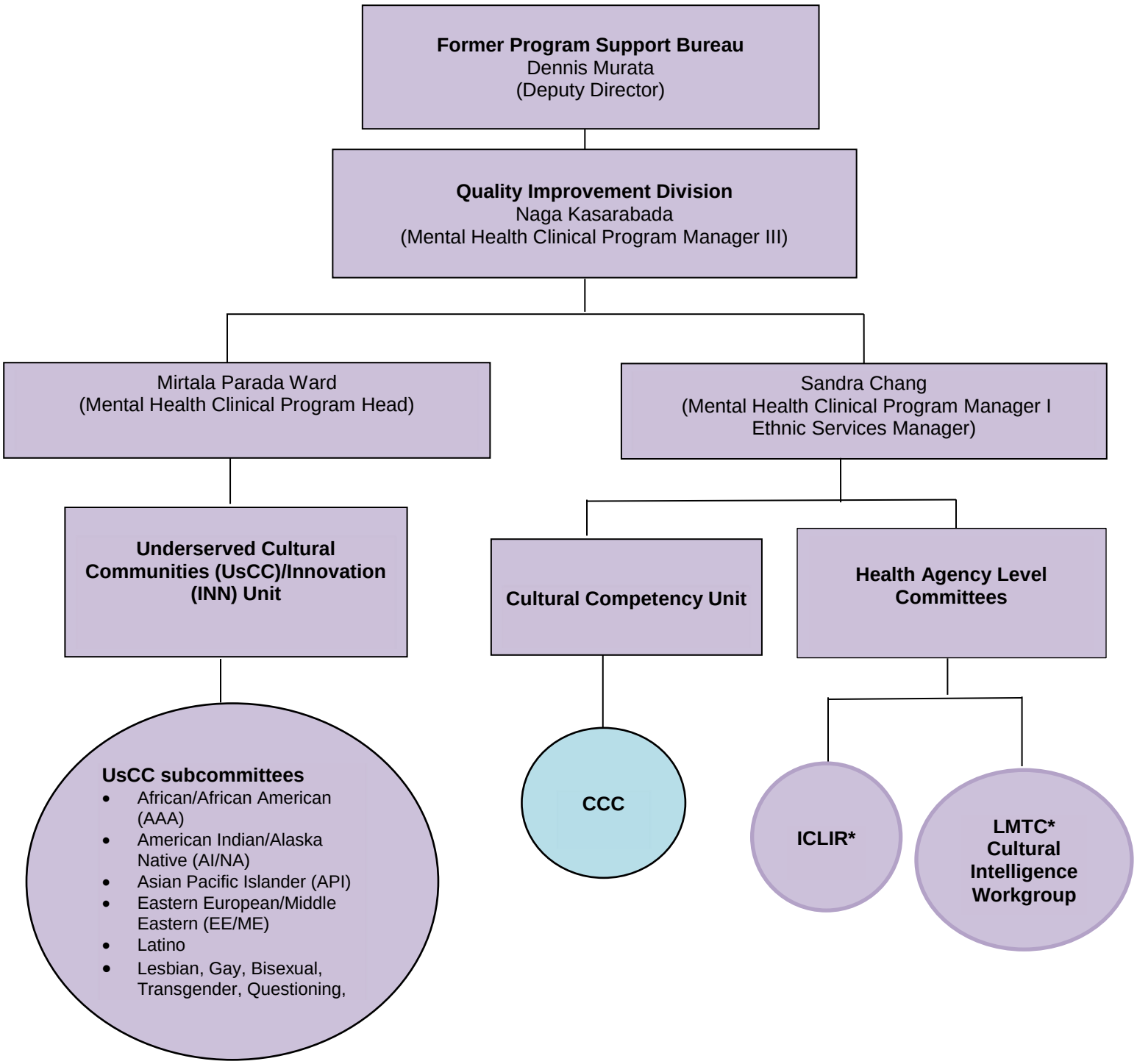
The membership of the CCC is culturally and linguistically diverse. For Calendar Year (CY) 2018, the CCC membership reached 46 members. Of this number, nine are males and 37 are females. The CCC members described their racial/ethnic identities as follows:

- African American
- Asian
- Black
- Black American
- Caucasian
- Filipino
- Hispanic
- Indigena Latina
- Irish and German
- Italian
- Japanese
- Jewish
- Latina
- Latino
- Chinese Latino
- Mexican
- Mexican American
- Native Indian
- Spaniard/Latino/American Indian
- Spanish
- White

Additionally, the following 10 threshold and non-threshold languages are represented in the CCC membership:

- American Sign Language
- English
- German
- Hebrew
- Japanese
- Korean
- Portuguese
- Spanish
- Swahili
- Tagalog

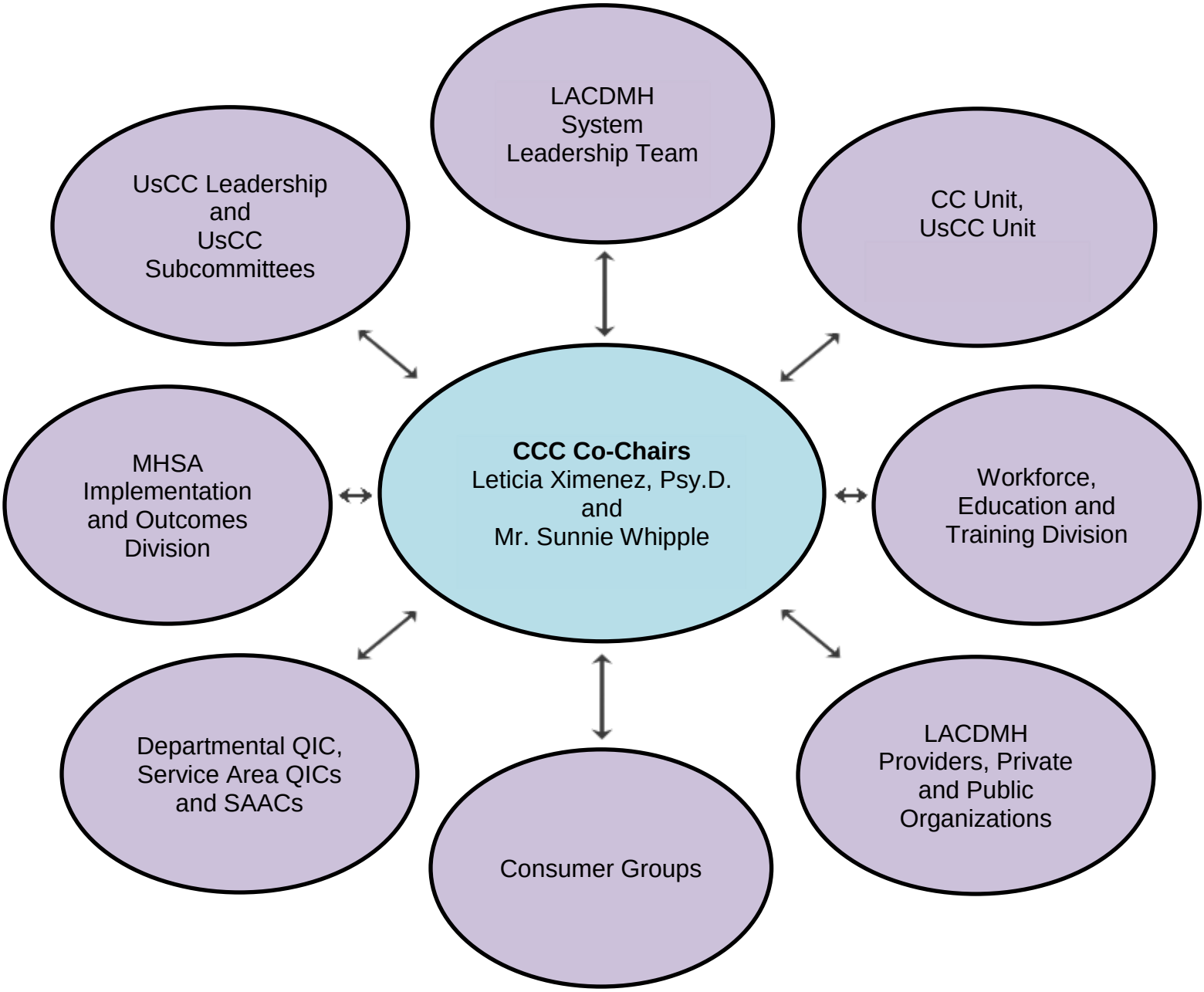
Organizational Chart of the CCC, FY 17-18



* ICLIR = Institute for Cultural and Linguistic Inclusion and Responsiveness

*LMTC = Labor Management Transformational Council

CCC Partnerships and Collaborations



CCC Goals and Objectives
At the end of each CY, the Committee holds an annual retreat to review its goals, activities and accomplishments; vote on cultural competency objectives to be undertaken for the next year; and reinforce the collaborative team atmosphere among Committee members. Once the CCC identifies areas of organizational cultural competency to be addressed, it proceeds to operationalize its goals and objectives in the form of workgroups. Each CCC workgroup identifies two co-leads and determines their goals, projects, and meeting frequency. Throughout the CY, the co-leads from each workgroup provide updates to the Committee at large during the monthly meetings for purposes of receiving feedback.

Review and Recommendations to County Programs and Services
As an advisory group to the Department, the CCC provides feedback and recommendations to various programs. The collective voice of the CCC is also represented at the SLT/"YourDMH" monthly meetings. This practice ensures that the voice and recommendations of the Committee are heard at these system wide decision-making meetings. The voice of the CCC is also strengthened by the Co-Chairs' participation in the UsCC Leadership Team. Together, the CCC and UsCC subcommittees advocate for the needs of underserved cultural groups and the elimination of mental health disparities.

The CCC also has an impact on the system of care by inviting and scheduling presentations from various LACDMH programs. These presentations take place during the monthly meetings. Feedback is either provided via the Committee at large or ad-hoc workgroups, when the Committee deems that an in-depth project review is necessary. The main goal of the CCC is to ensure that cultural competency and linguistic appropriateness are included in new projects and initiatives. During CY 2018, the CCC provided feedback for the departmental programs and projects listed below:

- The "Revised Grievance/Appeal/Expedited Appeal form" presentation provided by the PRO
- The "Prevention-Related Services Funded by the Mental Health Services Act (MHSA)" presentation provided by the Prevention Bureau
- The "MHSA Three-Year Program, Expenditure Plan, and Annual Update" presentation provided by the Program Development and Outcomes Bureau
- The "Los Angeles County Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR)" presentation provided by the Department's ESM
- The "Perspectives about the Deaf Community and its Culture" presentation provided by the Greater Los Angeles Agency on Deafness (GLAD), Inc.
- The "Disaster Preparedness Brochure" presentation provided by the EOTD – Disaster Services
- The "INN 6 Virtual Trainings for Staff Project" presentation provided by the Program Development and Outcomes Bureau
- The Department's "CCP for FY 15-16" presentation provided by the ESM
- The "Juvenile Justice Initiative: California's Continuum of Care Reform (CCR)" presentation provided by the Continuum of Care Reform Division

- The presentation on Policy and Procedure 200.02, “Hearing Impaired Mental Health Access provided by the Department’s ESM
- Special visit from the Orange County Cultural Competency Advisory Committee
- The “Spirituality in Mental Health Services” presentation provided by a CCC Co-Chair.
- The “YourDMH Vision and Guidelines Concept Paper” presentation provided by the Underserved Cultural Communities Unit
- The “Project About Building Connections (ABC)” presentation provided by the SA 6 Wraparound Program

Review and Recommendations to County Programs and Services

As an advisory group to the Department, the CCC provides feedback and recommendations to various programs. The collective voice of the CCC is also represented at the “Your DMH” meetings. This practice ensures that the voice and recommendations of the Committee are heard at these system wide decision-making meetings. The voice of the CCC is also strengthened by the Co-Chairs’ participation in the UsCC Leadership Team. Together, the CCC and UsCC subcommittees advocate for the needs of underserved cultural groups and the elimination of mental health disparities.

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1) <u>The Revised Grievance/Appeal/Expedited Appeal form</u>

   In January 2018, the PRO Director presented the revised “Grievance/Appeal/Expedited Appeal” form that incorporated the CCC’s content and formatting recommendations. The committee members reviewed the revised form and provided the following additional feedback:

   - Add that forms will be processed “without any retaliation” and assistance will be provided to complete the form
   - Make the form available in clinic lobbies
   - Provide information to consumers about their rights to file a grievance/appeal/expedited appeal, or State Fair Hearing when they are dissatisfied with mental health services
   - Make the PRO contact information visible in all forms, brochures, and documentation
   - Employ peers who are trained as advocates at the PRO. Peer advocates could educate and guide the individual filing the grievance

- Consideration should be given to use of “culture-specific advocates” who can guide those who may not trust the system to file grievances by providing reassurance
- Ensure that there is no retaliation towards staff who assist in providing the forms
- Train coalition groups on how to use the “Grievance/Appeal/Expedited Appeal” form

2) Prevention-related services funded by the Mental Health Services Act
In February 2018, a PowerPoint presentation was delivered to the CCC on countywide prevention-related services funded by the MHSA Prevention and Early Intervention (PEI). The presentation informed the Committee about Prevention Services taking a public health approach to address the needs of children, families, and communities LACDMH who have experienced trauma or are at risk of trauma. The CCC provided these recommendations:
    - Promote outreach and engagement to be inclusive of persons with disabilities
    - Provide a follow-up presentation on new programs
    - Re-examine existing Memorandum of Understanding (MOU) among authorized LACDMH programs providing services at public schools

3) The Mental Health Services Act Three-Year Program, Expenditure Plan, and Annual Update
In April 2018, the Program Development and Outcomes Bureau delivered a PowerPoint presentation to the CCC on the MHSA Annual Update Report for FY 18-19. The CCC reviewed detailed program information and data as follows:

    - Community Services and Supports (CSS) Client Counts by race/ethnicity, primary languages, and SA; Full Service Partnership (FSP) slot allocations for children, Transition Age Youth (TAY), adults and older adults and outcomes by FSP type
    - PEI programs such as Stigma and Discrimination Reduction, Suicide Prevention, Early Intervention, and Prevention; and PEI Client Counts by race/ethnicity and language and outcomes

4) Los Angeles County Health Agency’s Institute for Cultural and Linguistic Inclusion and Responsiveness
In April 2018, the ESM introduced the Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) to the CCC as a Health Agency initiative for cultural and linguistic competence under the Center for Health Equity. The CCC was informed that this Institute was implemented in early April 2018 with representatives from the Department of Health Services (DHS), Department of Mental Health (DMH), and Department of Public Health (DPH). The ICLIR will focus on creating an infrastructure centered on cultural and linguistic responsiveness, training/staff development, communication and stakeholder involvement, and resources for cultural competency, health equity, and disparities. The CCC engaged in a discussion and will provide recommendations to ICLIR as projects and activities are planned and implemented.

5) Perspectives about the Deaf Community and its Culture

In May 2018, the Greater Los Angeles Agency on Deafness, Inc. delivered a PowerPoint presentation to the CCC regarding the deaf culture and perspectives of the deaf community. The CCC members learned about key definitions related to deaf culture, effective communication strategies, assistive technologies, and community resources for deaf and hard-of-hearing communities. The CCC received this presentation with great interest and as a whole concluded the need for access to mental health services for deaf and hard-of-hearing communities. This presentation was coordinated by the CCU to provide background knowledge to guide the review of the Department's Policy and Procedure 200.02, "Hearing Impaired Mental Health Access."

6) The Disaster Preparedness Brochure

In May and June 2018, the EOTD, Disaster Services Unit solicited feedback and recommendations from the CCC on the "Coping with Disaster for People with Chronic Mental Illness" draft brochure. The CCC engaged in a discussion regarding the content of the brochure and provided these recommendations:

- Include information for the deaf and hard of hearing community
- Translate the brochure in all threshold languages
- Provide the address and telephone number of the Emergency Outreach and Triage Division on the front page of the brochure
- List hotline numbers on the front page of the brochure
- Specify what a Two Week Emergency Kit contains and ways to prepare for an emergency
- Provide a Family Disaster Plan as an additional handout that can be distributed along with the brochure

7) Mental Health Services Act Innovations 6 Virtual Trainings for Staff Project

In June 2018, a PowerPoint presentation was delivered to the CCC regarding INN 6 Staff Training project which involved the production of on-line trainings that introduced direct service staff and peer support specialists to various cultural competence scenarios. The CCC membership engaged in a discussion regarding the benefits of these trainings and provided these recommendations:

- Develop avatars that will speak in threshold languages
- Develop trainings that are Applied Behavior Analysis (ABA) compliant
- Consider utilizing human actors instead of the virtual characters

8) Los Angeles County Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness Update

In June 2018, the ESM distributed a handout that explained the adopted model for ICLIR under the Center for Health Equity. The CCC was informed that the mission of the institute is "to create culturally and linguistically appropriate pathways that address

gaps in service delivery and advance the Health Agency's ability to meet the needs of Los Angeles County communities." The CCC engaged in a discussion regarding ICLIR's Work Plan for FY 18-19 and the CCC was asked to identify areas where the CCC and ICLIR can work collaboratively in advocating for more appropriate service delivery. The CCC provided the following feedback:

- Consider implementing a staff training on micro-aggressions
- Provide cultural competency trainings to new hires across the three Departments to ensure consumers are being treated with dignity and respect
- Increase the number of approved languages for bilingual bonus

9) Cultural Competence Plan (CCP) for Fiscal Year

In July 2018, the ESM delivered a PowerPoint presentation to the CCC on the eight criteria composing the Department's CCP developed in accordance with the Title IX CCP Requirements from the Department of Health Care Services. The specific topics of the presentation included:

- Criterion 1: Commitment to Cultural Competence
  - The Department's mission and vision statements
  - Policies and procedures related to cultural competence
  - Budget for cultural competence initiatives and activities

- Criterion 2: Updated Assessment of Service Needs
  - Demographic data for Los Angeles County General Population (race/ethnicity, age group, and gender)
  - Data on identified unserved/underserved target populations with disparities for Medi-Cal, CSS, WET, and PEI populations
  - Departmental strategies to reduce disparities
  - MHSA-funded strategies to reduce disparities

- Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
  - Program reports on consumers served, strategies/objectives, status of implementation/progress, monitoring and outcomes
  - Departmental strategies to reduce mental health disparities

- Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
  - The Department's CCC mission, membership, structure, and racial/ethnic and linguistic diversity

- Criterion 5: Culturally Competent Training Activities
  - Foundational cultural competence trainings
  - Cultural competence trainings for Specialty Mental Health Services (SMHS) providers

- Language interpreters training and monitoring
- Requirement for 100% of the Department's workforce to receive annual cultural competence training inclusive of clerical/support, financial, clinical/direct service, and administration/management at DO and LE/Contracted programs

- Criterion 6: County's commitment to growing a multicultural workforce
  - Hiring and retaining culturally and linguistically competent staff

- Criterion 7: Language Capacity
  - Profile of threshold languages by SA
  - Departmental policies and procedures related to language assistance services
  - Departmental protocols to assist persons who have Limited English Proficiency

- Criterion 8: Adaptation of Services
  - Consumer-driven/operated recovery and wellbeing programs such as Wellness Centers, Drop-in Centers and Client-Run Centers
  - The Department's Contractual Agreements
  - Consumer Perception Survey outcomes
  - Performance Improvement Projects (PIPs)
  - ACCESS Center calls
  - Grievances and complaints data

10) Juvenile Justice Initiative - California's Continuum of Care Reform

In August 2018, a PowerPoint presentation was delivered to the CCC on Juvenile Justice Initiatives – California's CCR and its framework to ensure access to mental health services and supports to children and youth in the foster care system. The CCC was informed about CCR goals, principles, and programs. The CCC membership engaged in discussion regarding medications given to children and youth. The committee advocated for the following:

- Provide education about CCR services at all schools, including private schools especially when children are enrolled at new schools
- Include the voice and perspective of children in staff trainings
- Create a report addressing how CCR services improve the lives of children and families, and disseminate it to the community

11) Policy and Procedure 200.02, "Hearing Impaired Mental Health Access"

In August 2018, the ESM presented the CCC with Policy and Procedure 200.02, "Hearing Impaired Mental Health Access" for review. The CCC recommendations for the revision of this policy included:

- Change the title of this policy to Mental Health Access for the Deaf and Hard of Hearing Community and avoid using the term “hearing impaired”
- Specify that the Department will be providing access to mental health services for the Deaf and Hard of Hearing community
- Delete wording “hearing impairment” and replace with “consumers who are deaf and hard of hearing with mental health needs”
- Identify the contracted agencies that are providing sign language interpretation services for the ACCESS Center
- Update Teletype/Telecommunications Devices to include: Video Phone Technology
- Provide a description of California Relay Service (CRS) or Video Phone for consumers who are deaf and hard of hearing

12) Special Visit From the Orange County Cultural Competency Advisory Committee

In September 2018, the CCC welcomed a visit from the Orange County ESM and members of Cultural Competency Advisory Committee who were interested in learning about the Department’s CCC structure, activities, meeting format, and impact on the system of care. The Orange County visitors shared information on their advisory committee demographics, history, leadership, objectives, and projects. The CCC members expressed satisfaction in being held as an example for other Counties.

13) Spirituality in Mental Health Services

In September 2018, the CCC benefited from a brief presentation on Spirituality in Mental Health by one of its co-chairs. The presentation featured spirituality as an element of culture and a healing strategy for several cultural communities.

14) “YourDMH” Vision and Guidelines Concept Paper

In September and October 2018, the CCC learned of the Department’s executive management efforts to reinvigorate the System Leadership Team (SLT) under a new name and structure called “YourDMH.” Examples of the feedback provided by the committee members by document section:

General

- Simplify the language used throughout the document
- Post the “YourDMH” Vision and Guidelines on the Department’s website and translate it the threshold languages
- Continue gathering input on the name

Vision

- Define “Stakeholder groups”
- Specify the mechanism to be used for LACDMH follow-up on stakeholder recommendations
- Ensure that culturally competent and linguistically appropriate services are part of the vision
- Define what is meant by “services” by including cultural competence, accessibility, ADA compliance, trauma-informed, and CODs as qualifiers

Purpose

- Define what is meant by stakeholder priorities
- Provide a copy of the departmental action plan along with this document

Values

- Add cultural competence and "acknowledgement and honoring of consumers' ideas" as core values

Overall Structure

- Open meetings to the community and make everyone feel welcome
- Hold "YourDMH" full group meetings on a monthly basis
- Ensure that the meeting location is accessible by public transportation and ADA compliant
- Provide monetary support/assistance to community members for transportation expenses
- Inform the community about the date/time/location of meetings well in advance, including changes in meeting scheduling
- Develop a communication system to provide meeting information and updates
- Ensure that meetings uphold the Consumers' Bill of Rights
- Inform the community about budget allocations for various programs and projects

Membership Composition

- Ensure that the "YourDMH" membership is inclusive of all cultural groups, individuals with lived and shared experience, and youth
- Allow the SAs to decide the number of members and to not place any caps on the membership
- Include consumer protections, advocacy, and investigation of issues that may arise during meetings

Membership Eligibility

- Remove quorum specifications and simplify membership eligibility by using a baseline of 50% meeting attendance
- Gather information from prospective members on how they plan to represent the interests of specific stakeholder groups
- Enforce regular attendance of members to the public meetings
- Ensure that voting members miss no more than two consecutive public meetings

Membership Voting

- Simplify the language in this section
- Enforce the requirement for voting privileges to be 50% attendance/participation in meetings

- Allow each SA “YourDMH” committee to make decisions regarding co-chairs

Membership Leadership

- Keep the current leadership roles to one chair position held by a LACDMH staff and one co-chair held by a community member
- Include the voice of the community and their recommendations in decision-making and shaping of the SA-based “YourDMH” committees

Meetings

- Provide Full group and SA-based “YourDMH” meeting schedule information well in advance via several venues and on the LACDMH website
- Rotate the meeting location
- Ensure that the meeting location is easily accessible via public transportation
- Provide meeting coordinators to answer questions in a timely manner
- Include an item for “stakeholder priorities” in each meeting agenda
- Exercise an open door policy for meetings to ensure participation from the community
- Track meeting attendance for purposes of establishing voting privileges
- Develop a mechanism to respond to stakeholder priorities and ensure that recommendations presented are taken seriously
- Provide language accessibility in the 13 threshold languages as well as ASL

LACDMH Responsibilities

- Provide language interpretation and translation services for all meetings
- Translate meeting information in the threshold languages and ASL and meet the needs of persons who are blind or have vision conditions
- Translate website into the threshold languages and ASL
- Allocate LACDMH support staff to help with meetings and activities at SA-based meetings
- Provide compensation such as gift cards, transportation vouchers, and bus tokens to members attending meetings
- Disseminate “YourDMH” meeting minutes one week prior to the next meeting

“YourDMH” Cultural Communities

- Base all programming and activities on the “Culturally and Linguistically Appropriate Standards” to ensure that services are “effective, equitable, understandable, respectful, and responsive to the diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs of the communities served.”
- Establish close partnerships with the following groups besides the Underserved Cultural Communities subcommittees:
    - CCC

- Faith-based organizations
- Age groups
- Other culture-related groups

15) Project About Building Connections

In November 2018, a PowerPoint presentation was delivered to the CCC on the Project about Building Connections (Project ABC); a federally funded project aimed to assist Los Angeles County in providing an integrated childhood system of care network that responds to family needs and includes families in planning and service delivery. The CCC learned that the goal of the project is to ensure that children living in Los Angeles County from birth to five years of age have access to a variety of mental health services that are family-driven, strength-based, and culturally competent. The CCC engaged in a dialogue relating to the impacts of early childhood trauma. The CCC was appreciative of this presentation and advocated for prevention and early trauma intervention for children**.**

Human Resources Report

In January 2019, the Cultural Competency Unit presented to the CCC information on bilingual certified staff receiving bilingual across the Health Agency, inclusive of the LACDMH), DHS, and DPH. Data source: ICLIR, July 2018.

- LACDMH – out of 4,600 employees, a total of 1,600 receive the bilingual bonus in 39 different languages as follows:
  - Armenian – 69
  - Cambodian – 23
  - Cantonese – 22
  - Other Chinese – 6
  - Farsi – 31
  - French – 1
  - German – 1
  - Hindi – 9
  - Japanese – 7
  - Korean – 38
  - Laotian – 1
  - Mandarin – 52
  - Portuguese – 2
  - Russian – 27
  - Spanish – 1,200
  - Tagalog – 50
  - Vietnamese – 18
  - Yiddish/Hebrew – 1

- DPH – out of 4,000 employees, 633 receive bilingual bonus as follows: Spanish – 500, Armenian – 29, Arabic – 1, Cantonese – 18, Mandarin – 18, Other Chinese – 13, Farsi – 3, Korean – 13, Russian – 3, Swahili – 1, Tagalog – 10, and Vietnamese – 18.

- DHS – out of 22,719 employees, 3,500 receive bilingual bonus as follows: Arabic – 3, Armenian – 31, Cantonese and Mandarin combined – 59, Cambodian – 1, Farsi – 1, Japanese – 1, Hindi – 2, Korean – 38, Russian – 5, Spanish – 3,113, Tagalog – 14, and Vietnamese – 11

(See Attachment I: Health Agency Bilingual Capacity for a comparative table across the three Departments)

2018 LACDMH Cultural Competence Organizational Assessment

As a system wide effort, this assessment focused on surveying staff perceptions regarding the Department's responsiveness to the cultural and linguistic needs of the Los Angeles County diverse communities. As the lead for this project, the CCU worked closely with the hired consultant throughout CY 2018 on the difference phases of the project, inclusive of:

- The conduction of focus groups with consumers, and LACDMH staff representing clerical support, direct, clinical, and management administration staff functions
- Review of the focus group qualitative data to be utilized in the development of the cultural competence organizational assessment tool (CCOAT)
- Development and field testing of the CCOAT with various LACDMH programs and executive management
- Establishing the methodology for quantitative data collection and survey distribution within LACDMH
- Oversight of the CCOAT distribution, inclusive of regular reminders with deadlines to complete the survey
- The outcomes and recommendations from the Cultural Competence Organizational Assessment are expected by Spring 2019. This information will inform future cultural and linguistic competence strategies to reduce mental health disparities. The Department will utilize these recommendations to improve its system of care in the area of cultural and linguistic competency.

Meanwhile, the CCC utilized the strategic areas identified in the previous LACDMH Cultural Competence Organizational Assessment in activity planning. The strategic areas include:

- Cultural Competent System of Care
- Funding
- Human Resources
- Policy
- Structure
- Training
- Treatment Outcome Measurement
- MHSA

Different presentations are scheduled throughout each CY to provide information and updates on various initiatives that fall under the cultural competence organizational assessment strategic areas.

To address the strategic areas of *Culturally Competent System of Care, MHSA and Funding*, the CCC has delegate representation at the LACDMH System Leadership Team (SLT) meetings. This allows the CCC to vote on Departmental initiatives that are related to cultural competency. Some examples include: Expansion in services for the homeless and Wellness Centers, MHSA Three-Year Program and Expenditure Plan, MHSA CSS Plan consolidation, housing support services and jail diversion services.

To address the strategic areas of *Human Resources and Training*, the ESM briefed the CCC on the number and languages of bilingual certified staff within LACDMH and the Health Agency. Discussions were held in terms of languages represented across the three Health Agency Departments. The CCC was also informed about the LACDMH Cultural Competence Training Plan, in terms of new trainings and alternatives for staff to meet the requirement to receive annual training on cultural competence.

To address the strategic area of *Structure*, cultural competency updates continue to be provided in all the monthly Service Area QIC meetings. Examples of updates done by ESM and CCC Co-Chairs include the 2018 CCU projects and statewide initiatives regarding cultural competence.

Training Plans

Cultural Competence Trainings

The CCC continues to regularly provide information on LACDMH trainings and conferences related to cultural competency that are available to service providers and community members. The meeting agenda includes a permanent item specific to announcement regarding upcoming cultural competence training/conferences, community events that tap into cultural diversity, health equity, and opportunities for community feedback. This information is documented in the CCC minutes, which in turn are distributed to all the SA QICs.

Additionally, it is the practice of the Committee to brief the membership after culture-related conferences have taken place. This is done with the following purposes:

- Inform the membership about the overall quality of the conference in terms of keynote speakers, culture and cultural competency content, and general flow
- Share information about the main themes, learning, and conference takeaways to benefit members who were not able to attend
- Maintain a feedback loop between the community and the program/unit coordinating the conference.

Criterion 4 Appendix

Attachment I: Health Agency Bilingual Capacity

1.

Bilingual Bonus Total Count.pdf

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 5

Culturally Competent Training Activities

August 2019

Criterion 5: Culturally Competent Training Activities

I. LACDMH Cultural Competence Training Plan

The LACDMH Cultural Competence Training Plan aims to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge and cross-cultural competencies, all of which are essential to effectively serve our culturally and linguistically diverse communities. It is based on the Cultural Competence Plan Requirement, which affirms that 100% of employees must receive annual cultural competence training, inclusive of clerical/support, financial, clinical/direct service, and administration/management at Directly Operated, Legal Entities/Contracted, and Administrative programs whether directly employed, contracted, subcontracted, or affiliated.

The three-year training plan presents employees with options to fulfill the annual cultural competence training requirement. It also avails staff the opportunity to engage in a personal evaluation of training needs. The goals of providing a customizable cultural competence training plan include:

- Engage the workforce in individualized cross-cultural skill set development
- Discover and nurture their professional areas of interest
- Join the departmental pursuit of quality service standards and consumer satisfaction with services received
- Expand staff's insights regarding the vital role of cultural competency in decreasing disparities and promoting health equity
- Deepen employees' cross-cultural compassion, humility, and empathy in working with consumers and co-workers

Additionally, the training plan includes blended learning opportunities that offer a combination of online and instructor-led trainings. By strategic design, it includes a broad spectrum of trainings that focus on specific elements of culture and cultural groups.

In accordance to DMH Policy No 614.02, in-service Training, LACDMH is committed to provide training activities with the express purpose of preparing staff to perform specific functions, tasks and procedures necessary for the operation of their programs or units. All department employees are eligible for in-service training according to the needs of their specific assignments.

3.1 This policy enhances staff capabilities to carry out mandated requirements associated with their positions.

3.2 Supervisors are expected to 1) work with employees in identifying training needs and 2) to notify the Office of Administrative Operations Workforce Education and Training (OAO – WET) regarding new training needs. Supervisors may authorize or require an employee's attendance at any approved in-service training conducted within DMH.

Table 1: LACDMH Training Plan, FY 17-18 through FY 19-20

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 17-18		
<u>Innovative training feature</u> • Implicit Bias/Cultural Competence Summit (IB/CC) in January 2018 • Cultural Competence 101 online training which can be downloaded from the Quality Improvement Division (QID) intranet page	• Office of Administrative Operations (OAO) – Cultural Competency Unit (CCU) Annual Cultural Competence Training Attestation (Administrative Programs) • LACDMH app for Network Adequacy (Practitioners)	• Available to executive staff, managers and program leads • Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing Specialty Mental Health Services (SMHS)
<u>Training alternative 1</u> • Foundational cultural competence trainings ○ Diversity Skills for the 21st Century Workforce ○ Integration of Cultural Competency in the Mental Health System of Care [designed for newly hired staff and offered during New Employee Orientation]	• Same as above	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS

• **TRAINING OPTIONS**	**TRACKING MECHANISM**	**TARGET STAFF**
Training alternative 2 • Cultural Competence related – SMHS offered by the OAO-WET Division. Training bulletins available via the intranet	• Same as above	• Same as above
Training alternative 3 • Annual cultural competence related conferences	• Same as above	• Same as above

Training alternative 4
• Language Interpreters Series
  ○ Introduction to interpretation in mental health settings
  ○ Advanced mental health interpreter's training
  ○ Use of interpreter services in mental health settings
	• Same as above	• Language interpreter trainings are available to bilingual certified staff
		• Use of interpreter services training is available to all English monolingual staff

FY 18-19		

Innovative training feature 1
• IB/CC (Los Angeles County Board of Supervisors mandated training)
	• LACDMH – Human Resources Bureau (HRB) and Learning Net	• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 2 • Gender Bias Training Series (See Section F. below)	• LACDMH Learning Net	• Same as above
Innovative training feature 3 • LACDMH Multicultural Mental Health Conference: Health Integration through a "WHO-LISTIC" Approach	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
Innovative training feature 4 • Los Angeles County Equity Summit	• LACDMH app for Network Adequacy (Practitioners)	• Available to Administrative/Management
Training alternative 1 • Cultural competence related SMHS offered by the OAO-WET Division. Training bulletins available via the intranet	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Foundational Cultural Competence Training (as specified above for FY 17-18)	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Available to all staff including: IB/CC on-line trainings and other training alternatives: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training alternative 3 • Cultural competence related SMHS offered by the OAO-WET Division. Training bulletins available via the intranet	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
Training alternative 4 • Language interpreters series o Introduction to interpretation in mental health settings o Advanced mental health interpreter's training o Use of interpreter services in mental health settings	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Language interpreter trainings available to bilingual certified staff • Use of interpreter services training is available to all English monolingual staff

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 19-20		
<u>Training alternative 1</u> • Foundational Cultural Competence Training (as specified above for FY 17-18)	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
<u>Training alternative 2</u> • Cultural Competence related – SMHS offered by the OAO-WET Division. Training bulletins available via the intranet	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 3 • Annual cultural competence related conferences	• LACDMH app for Network Adequacy (Practitioners) • OAO – CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above

Training alternative 4
• Language interpreters series
  ○ Introduction to interpretation in mental health settings
  ○ Advanced mental health interpreter's training
  ○ Use of interpreter services in mental health settings
	• Same as above	• Language interpreter trainings available to bilingual certified staff
		• Use of interpreter services training is available to all English monolingual staff

Training Plan Specifications
LACDMH can choose a training option described as an "Innovative training feature" or other training alternatives.

A. Innovative training features

Starting in 2016, the Department adopted the practice of implementing a new training feature as an option for staff to complete the annual cultural competence training requirement. For example:

- "Cultural Competency (CC) 101 Training"
  The OAO-CCU developed a basic cultural competency training in response to the External Quality Review Organization (EQRO) recommendation that system-wide training in cultural humility and cultural sensitivity be provided. The training, titled "Cultural Competency 101," was originally designed as a train-the-trainer tool for the Service Area Quality Improvement Committee (SA QIC) members. This on-line learning also serves as one of the foundational cultural competence trainings.

  Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data [Duration: 37 minutes]
  http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6638
  Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources [Duration: 30 minutes]
  http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6640
  Part 3: Cultural competency scenarios and group discussion [Duration: 18.5 minutes]
  http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6639

- "Implicit Bias/Cultural Competence Training"
  This online training introduces the basic concepts of cultural competence and implicit bias while providing general examples of how these two processes interplay in daily life.

B. Foundational Cultural Competence Trainings

The following are examples of foundational cultural competence trainings made available to the workforce:

- "Diversity Skills for the 21st Century Workforce"

  This four-hour class is geared toward assisting all employees to broaden and deepen their understanding, experience and critical thinking skills with regard to cultural and personal differences, and effective interpersonal communication in the workplace. The course content is highly interactive and emphasizes introspection about one's own identity and how that identity facilitates and/or hinders workplace interactions. Through group discussions and facilitated activities participants will start to cultivate various tools to help them positively utilize the similarities and differences of diverse groups and individuals in the workplace. Included in the course is also a brief review of the County Policy of Equity (CPOE) and related

policies and laws that aim to ensure an environment in which every individual's contributions are valued and their rights protected.

- "Integration of Cultural Competency in the Mental Health System of Care"
  This training is provided by the OAO-CCU to all LACDMH new employees during the New Employee Orientation. This training provides information on the CLAS definition of culture, the County of Los Angeles demographics, federal state and county regulations governing cultural competency, the Cultural Competence Plan Requirements, mental health disparities and departmental strategies to reduce disparities.

- "Cultural Competency (CC) 101" Training (described above)

C. Specialty Mental Health Services

The cultural competence-related trainings offered by the OAO-WET Division incorporate a multiplicity of cultural elements as listed below:

- Ethnicity
- Age
- Gender
- Sexual orientation
- Forensic population
- Homeless population
- Hearing impaired population
- Spirituality
- Client culture
- Veterans

Some of the trainings are offered in a second language such as Spanish, Farsi, Chinese and Khmer. Cultural competency is also a specific topic for clinical supervision trainings. Culture-specific conferences also provide an opportunity for the workforce and consumers to benefit from topics relevant to mental health disparities and culturally appropriate services for underserved/unserved communities, such as Latinos and Asian Pacific Islanders. Please see section II below for specific details.

D. Language Interpreters Series

The following language interpretation trainings are available for bilingual-certified staff:

- Introduction to Interpreting in Mental Health Settings
  This three-day language interpreter training series is designed for bilingual staff that who are proficient in English and another language. The main purpose of the training is to train the bilingual workforce to accurately interpret and meet the requirements of Federal and State laws pertinent to language interpretation services. The introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter.

The course provides the interpreters with knowledge and skills related to models of interpreting, mental health terms, standards of practice, cultural interpreting, and skills to address challenges when interpreting. Development and maintenance of specialized mental health glossaries based on the interpreter's level of proficiency in both languages is included in the training. Role-playing, memory exercises, videos, and interactive exercises offer an opportunity to practice the learned skills.

Learning objectives:

- Describe the fundamental principles of interpreting in mental health settings
- Review of Federal and State laws and regulations for Limited English Proficiency
- Examine examples of compliance with the interpreter standards of practice of ethics
- Practice the roles of a language interpreter with an emphasis on the cultural clarifier role
- Interpret the impact of culture and mental health terms
- Identify the fundamental components of recovery
- Identify consumers' rights related to language assistance services

The language interpretation training series is available to all LACDMH workforce, inclusive of administrative/management, clinical, and support/clerical staff. The Department recognizes that even though administrative/management staff do not routinely perform language interpretation services, their positions may involve significant public contact, which requires use of their bilingual skills. Additionally, the trainings are strategically planned and include a series of threshold language specific Mental Health Terminology trainings along with trainings targeted at personnel who utilize interpreters. Examples include:

- Increasing Spanish Mental Health Clinical Terminology
  This training is intended to increase cross-cultural knowledge and skills with Spanish-speaking populations, specifically to improve clinicians' and bilingual staff's vocabulary and the use of terms related to the provision of mental health services inclusive of assessment, diagnosis, treatment, and crisis intervention. Additionally, topics cover challenges that present interpreting in and providing services in Spanish. For example, the use of incorrect or misleading terminology, misunderstanding of information, misdiagnosis, inappropriate, diagnosis, and other unintended consequences. This training is designed for participants of varying levels of Spanish language proficiency.

- Increasing Mandarin Mental Health Clinical Terminology
  This training is intended to increase cross-cultural knowledge and skills with Chinese-speaking populations, specifically to increase clinicians' and bilingual staff's vocabulary and use of terms related to the provision of mental health services inclusive of assessment, diagnosis, treatment and crisis intervention. Training content covers the challenges that present when interpreting and providing services in Chinese. For example: the use of incorrect or misleading terminology, misunderstanding of information, misdiagnosis, inappropriate

diagnosis, and other unintended consequences. Exercises are will conducted in Mandarin. The training is designed for participants of varying levels of old Chinese language.

Furthermore, LACDMH conducts bilingual proficiency examinations and certifications for its bilingual employees. In accordance to LACDMH Policy No. 602.01, Bilingual Bonus, a certified bilingual employee possesses "a valid Language Proficiency Certificate issued as a result of the County's Bilingual Proficiency Examination, which tests for proficiency to speak, read, and/or write the language.

4.1.1 Candidates tested for bilingual proficiency as part of the examination process, if successful, are issued a Language Proficiency Certificate.

4.1.2 Successful candidate names are placed on the eligible lists. LACDMH may select candidates from the eligible lists when the foreign language skills are needed, including translation of materials and/or interpretation services by diverse LACDMH Programs/Units.

4.1.3 Candidates who are selected from the eligible lists are employed on the condition that they use their bilingual skills while holding the position and may participate in translation of materials or interpretation services upon solicitation by various LACDMH Programs/Units."
(See Attachment 1: Interpreter Trainings, FY 17-18)

E. Training Alternatives for Managers and Supervisors

In addition to the Cultural Competence-related trainings for staff providing Specialty Mental Health Services, learning opportunities are available specifically to managers and supervisors through the OAO-WET. Examples include:

- Preparing The Next Generation for The 'Other Real World': A Culturally-Celebratory, Competency-Based Approach to Clinical Supervision
- Cultural Humility and Competency in Clinical Supervision: Contemporary Clinical Theory and Practice
- Creating Occupational Resiliency for Supervisors: Implementing Self-care Strategies to Prevent Secondary Traumatization While Working in the Behavioral Health Field
- Transgender Awareness for Managers and Supervisors
- Mental Health Strategies for Children and Youth with Co-occurring Intellectual Disabilities and/or Autism (MH4CID/ASD) - Clinical Supervisor
- Supporting Clinicians Working with Commercial Sexual Exploitation of Children and Youth (CSECY)
- Creating Occupational Resiliency for Supervisors: Implementing Self-care Strategies to Prevent Secondary Traumatization while Working in the Behavioral Health Field
- Advanced Clinical Supervision: Group Supervision

F. Gender Bias Training Series
Developed by the County of Los Angeles Department of Human Resources (DHR) in partnership with the Women's and Girls Initiative

- Understanding and Tackling Gender Bias in the Workplace
- Diversity Makes Simple Series for Line Staff and Supervisors
- Employee Essentials

G. Tracking and Reporting Mechanisms
Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs are regularly reminded that 100% of their employees must receive annual cultural competence training. The following guidelines are provided for the tracking and reporting of this requirement:

- Completion of the cultural competence training shall be monitored and tracked at all staff levels (e.g. clerical/support, administrative/management, clinical, subcontractors, and independent contractors)
- Program managers/directors shall monitor, track, document (e.g. training bulletins/flyers, sign-in sheets specifying name and function of staff, and/or individual certificates of completion, etc.)
- Program managers/directors make available upon request by the Federal, State and/or County the annual cultural competence training provided to staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors
- Program Directors/Managers of Directly Operated Programs may attest to the completion of annual cultural competence training by 100% of their staff in the Fourth Quarterly Monitoring Report for every Calendar Year (CY)
- Program Directors/Managers of Legal Entity/Contracted Providers may attest to the completion of annual cultural competence training by 100% of their staff in the Annual Quality Assurance Monitoring Report for every CY
- Before the implementation of the Network Adequacy app, the OAO-CCU Annual Cultural Competence Training Attestation form was required from Program Managers/Directors as evidence of annual completion of cultural competence training at the program level. The completed and signed attestation form was submitted to the Cultural Competency Unit's mailbox at psbcc@dmh.lacounty.gov. When Program Managers/Directors reported less than 100% of staff completion of annual cultural competence training, a revised form was required to be resubmitted once the goal of 100% completion was reached. The CCU entered the attestation forms received into a database which allowed for reports to be generated by SA, provider number, and percentage of training completed by staff. The goal of these reports is to inform the SA QIC chairs regarding the cultural competence training completion by their providers, to increase accountability, and compliance with this requirement.
  (See Attachment 2: OAO-CCU Annual Cultural Competence Training Attestation form and Comprehensive Attestation Report)
- Network Adequacy Compliance Tool
  The NACT app was developed in response to Network Adequacy standards as required by Medicaid. It captures the number of cultural competence training hours

over the past twelve (12) months for each Mode 15 practitioner. In addition, it tracks the percentage of all workforce members who received trained in cultural competence over the past twelve (12) months. The NACT app is divided into three levels:

- Organizational level (provider's legal entity)
- Site level (service location, physical location, or site)
- Practitioner level (individual rendering practitioner, acting within his or her scope of practice, who is rendering mental health services)

Additionally, the percentage of workforce members trained in cultural competence is entered at the site level

- Providers (practitioner and administrative staff from clinical programs) report completion of cultural competence trainings.
- Administrative staff from centralized headquarters programs continue to utilize the cultural competency unit's attestation forms.

(See Attachment 3: Frequently Asked Questions Regarding Annual Cultural Competence Training Completion per the Network Adequacy and CCPR, PowerPoint explaining the NACT elements and utilization to track trainings)

Information regarding the LACDMH training plan has made available via the following means:

- Memo regarding cultural competence training requirement (March 2018)
- Departmental Quality Improvement Council meetings
- Service Area-based Quality Improvement Committees
- Departmental Cultural Competency Unit webpage
- Frequently Asked Questions handout
- New Employee Orientation PowerPoint

(See Attachment 4: Examples of materials used to inform programs of the annual cultural competence training requirement)

Additionally, for new Contractors, Section 8.15.3 of the LACDMH Legal Entity Contract instructs prospective Contractors to provide services that are consistent with the Department's Cultural Competence Plan and all applicable Federal, State, and local regulations, manuals, guidelines, and directives. Specifically,

- Contractors shall ensure that 100% of staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors receive annual cultural competence training
- Contractors shall monitor, track, document and make available upon request, by Federal, State or County government entities, the annual cultural competence training completed by their staff
- Contractors shall complete and submit an attestation of annual cultural competence training completed by 100% of staff to the Ethnic Services Manager (psbcc@dmh.lacounty.gov) by March 23rd of every Calendar Year

(See Attachment 5: LACDMH Legal Entity contract)

II. Annual Cultural Competence Trainings

Over 300 trainings during each Fiscal Year (FY), with topics covering a wide spectrum of culturally relevant issues: age groups, ethnic underserved/unserved populations, lived experience concerns, language interpreter trainings, and culture-specific conferences, sponsored or supported by LACDMH which also expand the Department's partnerships in the community. While SMHS trainings target clinical skill acquisition, licensed administrative and management staff also attend these trainings to benefit from clinical service delivery updates and their application to clinical supervision. Additionally, at the beginning of each FY, the OAO-WET Division contacts the administrators for the Cultural Competency Committee (CCC) and Underserved Cultural Communities (UsCC) subcommittees to solicit stakeholder input into new cultural competence-related trainings that could be implemented.

The OAO-WET Division enforces guidelines for the inclusion of cultural responsiveness in all trainings. These guidelines specify the following:

- Trainers are expected to incorporate cultural references to trainings being delivered and monitored by training coordinators
- Training bulletin notices include learning objectives referencing cultural issues/concerns relevant to the topic. On January 7, 2017, a checkbox was added to the bulletins to inform the participants when the training content meets the cultural competence training requirements
- Training evaluations collected from participants are reviewed to ensure the training met the cultural inclusion objectives. When the evaluations indicate that the cultural inclusion objectives were not followed or important cultural issues were not covered, training coordinators follow up by reviewing the evaluation results with the trainer to ensure similar issues are considered in future training offerings
  (See Attachment 6: Inclusion of Cultural Responsiveness in Trainings)

Since January 2017, the OAO-WET Division has been tracking training attendance by staff function via the training evaluation form at the request of the Cultural Competency Unit. Training participants self-report their staff function by choosing among the following options:

- Direct Service, County
- Direct Service, Contractor
- Support Services
- Administration/Management
- Religious/Spiritual Population
- Community Organization
- Community Member
- Mental Health Board
- Interpreter
- Other staff function not specified above

(See Attachment 7: LACDMH Training Evaluation Form).

Trainings offered by the OAO-WET Division in accordance to areas of cultural competency content specified in the Cultural Competence Plan Requirement. The areas of classification include:

- Cultural formulation
- Multicultural knowledge
- Cultural sensitivity
- Cultural awareness
- Client culture/Family inclusion
- Social/cultural diversity
- Service integration and outcomes
- Co-occurring disorders
- Mental health interpreter training
- Training in the use of interpreters
- Non-clinical training
- Clinical training
- Justice-involved population
- Age-based population
- Homelessness

(See Attachment 8: Cultural Competence Trainings by Content Category)

Table 2: Examples of cultural competence-related specialty mental health trainings offered by the OAO-WET Division, FY 17-18

Title of Trainings
Adult
Sex Offender Assessment, Treatment and Management
Intimate Partner Violence 101 (non-clinical)
Intimate Partner Violence: Treatment with an Emphasis on Motivational Interviewing
Intimate Partner Violence – Assessment Intervention
Asian Pacific Islander (API)
Increasing Mandarin Mental Health Clinical Terminology
Children
Clinical Approaches to Working with Commercial Sexual Exploitation of Children and Youth (CSECY)
The Commercial Sexual Exploitation of Children (CSEC) 101, Community Agencies
The Commercial Sexual Exploitation of Children (CSEC) 101
Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population
The Mental Health Impact of Political Trauma on U.S. Immigrant Children and Families
Children and Adolescent Gender Variant Behavior Training

Title of Trainings
Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population
Developing Partnerships and a Shared Vision the Other Child and Family Team Process
Child and Family Teaming: Enhancing Outcomes for Youth Involved in the Child Welfare System
Telling Family Team Facilitator Training
Clinical Approaches to Working with Commercial Sexual Exploitation of Children and Youth
Keeping Children and Families at the Center-an Integrated Approach to Breaching Engagement Teaming and Assessment
Child and Family Team Facilitator Training
Impact of Violence at Home on Children Pre to Adolescence – An Ecological Perspective
Intimate Partner Violence and its Impact on Children from Childhood to Adolescence
Conferences
American Indian-Alaska Native Mental Health Conference
Asian American Mental Health Conference
Mental Health and Spirituality Conference
Latino Mental Health Conference
Foster Care
Fostering Resilience in Foster Youth and Families
Gender and Sexuality
Helping Women Recover and Beyond Trauma and Substance Abuse
Exploring Trauma – A Brief Intervention for Men
Integrating Incarcerated Women into Society
General Cultural Competency
Shared Core Practice Model (SCPM) – Emphasis on Underlying Needs
Crisis Oriented Recovery Service(CORS) Initial Training
Culture, Communication and Self Reflection
Cultural Humility: Integration of Shared Core Practice Concepts
All Public Health is Local: Global Mental Health in Los Angeles
The Role of Culture in Recovery
Homelessness
Permanent Supportive Housing – An Evidence Based Model
Fair Housing
Annual Housing Summit 2018
Co-Morbidity of Personality Disorders, Homelessness, and Substance Abuse
Justice System
An Overview of Correctional Mental Health Care and Malingering Assessments in a Correctional Setting

Title of Trainings
Seeking Safety Initial Training for Juvenile Justice Mental Health
Trauma in the Forensic Population
Using Culture As a Primary Intervention in Justice Involved Mental Health Services
The Invisible Wounds-Promoting Healing Via Trauma Informed Care Consciousness
Applying the Risk-Need-Responsibility Principles in Your Practice
Adapted Dialectical Behavior Therapy (DBT) for Juvenile Hall Staff (Part I)
Adapted Dialectical Behavior Therapy (DBT) for Juvenile Hall Staff (Part II)
Adapted Dialectical Behavior Therapy (DBT) for Juvenile Hall Staff (Part III)
Criminal Justice 101-Overview of the System and Jail Culture Norms
Assessment and Best Practice Treatment of Forensic Justice-Involved Consumers
Safely and Crisis Prevention – Interventions When Working with Forensic Justice Involved Consumers
Forensic-Justice Involved Advanced LPS Training
Dialectical Behavior Therapy for Justice Involved Consumers
Forensic Issues in Mental Health Treatment
Law and Ethics Navigating the Criminal Justice System with Forensic-Justice Involved Consumers
Latino
Increasing Spanish Mental Health Clinical Terminology
Curanderismo and Other Culture Specific Treatment Approaches
eCPR - Spanish
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Two Spirit (LGBTQI2-S)
Core Practice Concepts in Working with LGBTQ Youth
Multicultural Issues in the Mental Health Treatment of LGBTQI2S
Embracing Identities: Supporting LGBTQ+ Youth in the Mental Health and Child Welfare Systems
LGBTQI Conference
Mental Health Interpreter Training
Cross Cultural Communication and the Therapeutic Use of Interpreters
Older Adults
Gero-Psychiatric Breakfast
Screening Brief Intervention and Referral to Treatment (SBIRT) for Older Adult Clients
Milestones of Recovery Scale (MORS) – Older Adult Version/Determinants of Care
Spirituality
Faith and Spirituality Integrated SBIRT Training
Annual Conference on Mental Health and Spirituality
Seeking Safety – An Evidence-Based Practice for Trauma and/or Substance Abuse

Title of Trainings
Harm Reduction in the Three Es
Supervisors/Management
Preparing the Next Generation for the Other Real World: a Culturally Celebratory, Competency-Based Approach to Clinical Supervision
Advanced clinical supervision: improving outcomes for diverse clients
TAY
Substance Abuse Intervention Training: Transition Age Youth

* Total number of unique trainings = 65

In addition to WET Division learning opportunities, cultural competence-related trainings may be recommended and coordinated by program managers based on the collective training needs of their staff.

Table 3: Examples of trainings offered at the program level for FY 17-18

Program Name	Title of Trainings
SB 82 Mobile Triage	• Implicit Bias & Cultural Competence: Introduction to the fundamental concepts of implicit bias and cultural competency • Basics of Just Culture: Provide workforce members with basic knowledge on Just Culture and its principles • Just Culture for Supervisors: Introduces supervisors to the concept of the of the labor management partnership, discusses and reviews the Just Culture principles, impact of system contributors and human conditions to service delivery, workplace cultures, event analysis, roles and responsibilities in the implementation of the initiative.
DMH/DHS Collaboration	• Understanding Clients with Substance Use Disorders (SUD): Director of LA Centers for Alcohol and Drug Abuse addresses the complex etiology of SUD and clarifies needs and treatment options. • A Discussion of Race and Ethnicity: With changes in IBHIS coding of race and ethnicity, we took the opportunity to discuss why we pay attention to this data and how we relate and respond to race and ethnicity. • Understanding the needs of Victims of Crime: Shari Farmer from Victims of Crime educated and led a discussion about the complex picture of the “victim” populations and how to be sensitive to and address their needs.

Program Name	Title of Trainings
FSP, IFCCS, Wraparound, SFC, and MAT	• Exposure to Alcohol in Utero: FASD in Young Children Ages 0-5: This training addresses alcohol in-utero exposure and its effects on brain development & developmental impairments as the child ages. As a result of attending this training, participants enhance their knowledge of infant and early childhood development and more competently service children afflicted with FASD and their caregivers. • RISE Train the Trainers: Working Effectively with LGBTQ+ Youth: This Train the Trainers Program curriculum provided knowledge about sexual orientation, gender identity and gender expression. The curriculum familiarized the attendees with coaching strategies around best practices for ensuring the safety and well-being of LGBTQ children and youth. Attendees learned methods to assess their agency's organizational culture and environmental cues with a goal of reducing stigma and identifying and eliminating barriers to permanency for LGBTQ children and youth. Discussed were key principles around supervising the collection of sensitive information related to sexual orientation, gender identity and gender expression. The training also updated the attendees about California laws and federal and state policy regulations that protect LGBTQ children and youth in foster care. ○ This training was provided on several dates: 1/11/18, 2/22/18, 3/13/18, 5/17/18 and 6/14/18. • Integrating Nonviolent Education and Child-Raising into Clinical Practice: Eight 2-hour sessions took place at Roybal Family MHC for the Roybal staff. These sessions focused on integrating nonviolent education and child raising into clinical practice. During these sessions, the attendees learned about children's rights, such as emotional and physical safety. The sessions focused on working with the Roybal staff so that when they work with parents, teachers and others they can integrate current research in human development and trauma-informed care with the practice of nonviolence. ○ This training was provided on several dates: 03/10/17, 03/24/17, 04/28/17, 05/19/17, 06/09/17, 06/23/17, 07/13/17, and 08/10/17.

Program Name	Title of Trainings
Veteran FSP	• Diverse LGBTQ+ Coming Out Issues: This training will help MH Staff build further on their cultural competence in working with individuals struggling with difficult coming out issues • Diversity Made Simple for Line Staff: Embracing workplace Diversity • Employee Essentials: Diversity and Inclusion: Touches on dimensions of diversity and biases • Cultural Humility & Competency In Clinical Supervision
Katie A.	• Implementation of California's Cross System Integrated Core Practice Model • Everything You Wanted to Know about Psycho-Pharmacology: Medication Side Effects • Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare – Children, Youth and Families • Self-Care: Promoting Wellness and Resiliency • Module 1a Overview: Preparing for Child and Family Teaming • Cuidado Informado por Trauma: Promoviendo Seguridad y Desarrollando Resiliencia con Jóvenes en el Sistema de Crianza • Infant and Toddler Development within a Relational Context

III. Monitoring of staff's skills/post skills learned in trainings

The OAO-WET Division collects targeted training outcomes throughout the year. Trainings selected for assessment of staff's skill acquisition/post training skills learned are identified through staff and management collaboration. Specifically, based on program needs, the effectiveness of a particular training may necessitate such assessment to determine outcomes related to:

- Training cost
- Additional training needs
- Adequacy of content
- Clinical impact
- Knowledge/skill transfer

The outcomes are utilized by OAO-WET Division for refinement of ongoing trainings, justification for renewing training contracts, and planning for future trainings.
(See Attachment 9: Examples of trainings with one-month follow-up conducted by WET)

Criterion 5 Appendix

Attachment 1: Interpreter Trainings, FY 17-18

WET interpreter trainings FY 17-18.d

Attachment 2: OAO-CCU Annual Cultural Competence Training Attestation form and Comprehensive Attestation Report

CC training attestation 9-12-18.

Comprehensive attestation report -

Attachment 3: Frequently Asked Questions Regarding Annual Cultural Competence Training Completion per the Network Adequacy and CCPR

Final Cultural Competency Trainin

NACT - Cultural Competency v3.pptx

Attachment 4: Examples of materials used to inform programs of the annual cultural competence training requirement)

CC Plan 2017 PPT final 11.17.17.pdf

Annual Cultural Competence Training.

Attachment 5: LACDMH Legal Entity Contract

LACDMH Legal Entity Contractual Agreemer

Attachment 6: Inclusion of Cultural Responsiveness in Trainings

Inclusion of Cultural Responsiveness Trair

Attachment 7: LACDMH Training Evaluation Form).

DMH_Training_Evaluation_Form_2017.pdf

Attachment 8: Cultural Competence Trainings by State content category and sample training bulletins, FY 17-18

Cultural Trainings Listing 17-18 State I

CC Trainings FY July 17 through Jun

Attachment 9: Examples of trainings with one-month follow-up conducted by WET

4-13-18 Seeking Safety 1 Month Foll

3-14-18 Seeking Safety 1 Month Foll

11-29-17 Motivational Intervi

6-7-18 COS Documentation Trai

6-7&8-2018 Intimate Partner Vio

5-22-18 Occupational Resilie

5-17-18 IPV 1 Month Follow Up St

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

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OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 6

County's Commitment to Growing a Multicultural Workforce

August 2019

Criterion 6: County's Commitment to Growing a Multicultural Workforce

I. Recruitment, Hiring, and Retention

The Los Angeles County Department of Mental Health (LACDMH) is committed to growing a culturally and linguistically competent workforce to serve our communities with quality services. Despite the myriad of challenges resulting from the large size and the cultural diversity of the County, the Department continues efforts to recruit, hire, train, and retain culturally and linguistically competent staff through these strategies:

- Equip monolingual English-monolingual clinical staff with culturally responsive and linguistically competent language interpreters
- Integrate consumers, family members, and parent advocates/parent partners into the public mental health workforce at the peer, para-professional, and professional levels
- Retain current skilled workforce that represent a cultural or linguistic unserved or underserved population via tuition reimbursement and loan forgiveness programs
- Build collaborations with higher education institutions to promote mental health careers
- Provide the mental health workforce with a myriad of quality cultural competence trainings to enhance the service delivery at all points of contact
- Build the linguistic capability of the system of care by paying bilingual bonus to staff from Directly Operated programs
- Offer interpreter training to bilingual certified employees who are interested in language interpretation services
- Provide training for monolingual English-speaking staff on how to use language interpreters effectively

Below are examples of LACDMH's workforce development efforts for FY 17-18:

1) **Recovery Oriented Practices**
   This training program offers public mental health staff (i.e., clerical/support, direct clinical services and program administrators) a two-day immersion program on the tenets of the Mental Health Services Act (MHSA). The training incorporates the MHSA experience including consumers sharing their recovery journey. Upon training completion, staff is expected to acquire an understanding of the recovery-oriented approach and to incorporate these concepts into practice in their work. The delivered curriculum also addresses the integration of mental health, health and co-occurring disorders.

2) **Licensure Preparation Program (LPP)**
   This program funds licensure preparation study materials and workshops for unlicensed social workers, marriage and family therapy interns, and psychologists. All participants must be employed in the public mental health system and eligible to take the mandatory Part I, and thereafter Part II of the respective licensure board examinations.

3) Mental Health Promoters

This program trains Spanish-speaking community members as mental health promoters. With continued training and support, these individuals become community champions and liaisons educating their respective communities on available mental health services and promoting anti-stigma campaigns. This program continued with no changes during FY 17-18.

4) Health Navigator Skill Development Program (Adult and Family)

This program trains peer advocates, community workers, and medical case workers on knowledge and skills needed to assist adult consumers and family members to navigate and advocate for themselves in both the public health and mental health systems. This 52-hour course uniquely incorporates a seven-hour orientation for supervisors in support of staff who provide health navigation services. This program continued with no significant changes during FY 17-18.

5) Transitional Age Youth (TAY) Peer Support Specialist Training

This program prepares young adults to work with TAY in achieving life goals for independence and self-sufficiency. The TAY Peer Support Specialist training prepares participants to utilize their talents to assist TAY in creating meaningful daily activities, engaging in their communities, building positive alliances, and empowering themselves to move towards mental wellness. During FY 17-18, 51 participants completed this training.

6) Online Licensure/Pre-Licensure Training

The Department purchased online registration slots for pre-licensure and post licensure trainings that are available to clinical staff of the Los Angeles County public mental health system. The purpose of these online trainings is to provide clinical staff an opportunity to comply with State of California Board of Psychology (BOP) and Board of Behavioral Sciences (BBA) pre-licensure and continuing education mandates required for unlicensed (waivered) and licensed psychologists, social workers, marriage and family therapists, and professional clinical counselors.

7) Social Rehabilitation Curriculum Building

The Workforce Education and Training Division collaborated with industry subject matter experts to develop and implement trainings addressing the duties and responsibilities of social rehabilitation specialists (SRS), which are defined as public mental health staff working in positions such as community worker, employment specialist, substance abuse counselor and medical caseworker.

8) Interpreter Training Program (ITP)

The ITP offers trainings for bilingual staff who currently perform or are interested in performing interpreter services for English-speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. This training opportunity consists of the following options: “Introduction to

Interpreting in Mental Health Settings", "Increasing Spanish Mental Health Clinical Terminology", and "Increasing Mandarin Mental Health Clinical Terminology."

9) Intensive Mental Health Recovery Specialist Training Program

The Intensive Mental Health Recovery Specialist Training Program prepares consumers and family members, with a minimum of 2 years of college credit, to work in the mental health field as psychosocial rehabilitation specialists. This program is delivered in partnership with a mental health contractor and a local community college. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system.

10) Macro Peer Advocacy Program

This program prepares peers, family advocates and members to effectively promote and empower the consumer voice and advocate for continued support of MHSA tenets of recovery, resilience, and wellness. Components include the legislative process, communication strategies for both written and oral presentations with county and state constituents, and development of successful political collaborative/relationship approaches.

11) Individual Placement and Support (IPS)

IPS is an evidence-based approach to supported employment for persons who have a mental illness. IPS supports their efforts to achieve steady and meaningful employment in mainstream competitive jobs, either part-time or full-time. A key feature of IPS is integrating employment services with mental health services. IPS is based on eight principles. Mental health agencies that implement IPS aim to follow these eight principles in delivering vocational services:

- Every person with severe mental illness who wants to work is eligible for IPS supported employment
- Employment services are integrated with mental health treatment services
- Competitive employment is the goal
- Personalized benefits counseling is provided
- The job search starts soon after a person expresses interest in working
- Employment specialists systematically develop relationships with employers based upon their client's preferences
- Job supports are continuous
- Consumer preferences are honored

12) Peer Housing Specialist Training

This program trains individuals employed as community workers, medical case workers, substance abuse counselors, and peer specialists on knowledge and skills needed to assist consumers navigate and advocate for themselves in the mental health system and to address their housing circumstances.

13) Homeless Outreach Peer Enhancement Specialists (HOPES) Program

This program trains mental health peer and family peers who volunteer in a shelter setting. Participants are trained to provide supportive outreach in shelter environments, specifically to assist consumers in identifying early recovery goals related to mental health, physical health, substance use, and stability. The training consists of didactic and experiential experiences that incorporate informative learning, role-playing activities, group dynamics, shadowing, coaching, and onsite internship activities.

14) Independent Consumer Training Program

Peer Actions 4 Change (PA4C) group was developed through the Independent Consumer Association Development Training Program (ICADTP). The following activities were completed by PA4C with the support of the SHARE contractor lead: (1) Monthly contract consultations between LACDMH Program Director, SHARE, and PA4C; (2) Toastmasters meetings hosted by SHARE to support the Speakers Bureau component of the group; (3) Job Fair Conference Committee implementation which met monthly and coordinated a successful conference held on September 9, 2018 which raised $3,430, (4) Members also participated in the NAMI Walk and trained on Legislative Advocacy.

15) Parent Partners Training Program

This training program is designed to increase knowledge and technical skills to Parent Advocates/Parent Partners who are committed to provide support for family members; employment of parents and caregivers of children and youth consumers; and promote resilience and sustained wellness through personal self-help techniques that are grounded in parent advocate/parent partner empowerment.

16) Parent Partner Training Symposium

The 3-day symposium was held twice during FY 17-18 and was attended by approximately 200 parent partners. These training opportunities covered a wide range of topics including: integration of services for persons who have co-occurring disorders and criminal justice issues; crisis intervention and support strategies; education; employment; homelessness; housing; inpatient/hospitalizations; LGBTQ issues; older adults; residential and group homes; and suicide prevention among others.

17) Certification Exam Creation for the Parent Partner/Parent Advocate (PPTA) Training Program Evaluation and Outcomes Report and Presentation

During FY 17-18, a vendor developed program evaluation tools and provided outcome data reports. This vendor also developed a certification examination for PPTAs, which included minimum competency standards for the County of Los Angeles.

18) **Expanded Employment and Professional Advancement Opportunities for Family Members in The Public Mental Health System**
These trainings prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership, and to decrease barriers to employment. Topics covered in these trainings included: public speaking, navigating systems, and resource supports for consumers and families. This program is funded with the intent to target/outreach family members regarding mental health services in the community, thereby meeting the objectives of the program outlined in the MHSA-WET Plan.

19) **Mental Health Psychiatrist Student Loan Repayment Incentive**
This financial incentive program was implemented late FY 17-18 to recruit/retain mental health psychiatrists. Given the competitive job market for mental health psychiatrists and the severe shortage of these crucial positions, Psychiatrists employed by the LACDMH are eligible for outstanding student loan repayment awards of $50,000 annually. This incentive is contingent on continued employment in the Department and is not to exceed the awardees' outstanding educational loan balance.

20) **Stipend Program for Psychologists, Marriage and Family Therapists (MFT), Master of Social Work (MSW), and Psychiatric Nurses**
LACDMH provides 2nd year students with education stipends in the amount of $18,500 in exchange for a contractual obligation to secure employment in a hard-to-fill area of the county for a minimum of 1 year. This program targets students who are linguistically and/or culturally able to work effectively with the unserved and underserved populations of the County.

21) **Underserved Cultural Communities (UsCC) Recruitment Program**
During FY 17-18, a total of 14 students from underserved communities were awarded 2-year stipends to complete a Master's Degree in a Social Work or Marriage and Family Therapy in exchange for a commitment to work at LACDMH.

See Criterion 3 for additional information on program-specific accomplishments.

Collectively, these 21 activities increase the cultural and linguistic competency of the LACDMH workforce via the following strategies:

- Provision of culturally responsive and linguistic enhancement of interpreters and the clinicians that utilize them
- Integration of consumers, family members, and parent advocates/parent partners into the public mental health workforce at the peer, paraprofessional and professional levels
- Retention of current skilled workforce and recruitment of future workforce, with priority afforded to individuals that represent an unserved or underserved population and/or speak a needed language
- Outreach to community partners, such as community colleges and faith based leaders/organizations, to build collaborations and address stigma often associated with mental illness, while creating partnerships with community based organizations

that may create an additional way for consumers to enter the public mental health system
- Training the mental health workforce regarding the culture of lived experience and the promotion of hope, wellness and recovery

In addition to the 21 workforce development programs mentioned above and consistent with the CLAS standards, LACDMH builds its culturally and linguistically competent workforce by creating culture-specific job vacancies across a variety of positions. Examples include:

Psychiatric Social Worker II or Mental Health Clinician II for Transition Age Youth (TAY) Navigator position
Juvenile Justice Mental Health Programs is recruiting a licensed Psychiatric Social Worker or Mental Health Clinician for a TAY Navigator position at Camp Afflerbaugh, a locked juvenile detention center operated by Probation Department.

Essential job functions:
- Assess the needs, strengths and risk factors of camp youth and develop an individualized, post-release plan with each youth and his family in collaboration with the youth's camp clinician, camp probation officer, field probation officer, Los Angeles County Office of Education (LACOE) transitional counselor and, when applicable, Juvenile Justice Transition Aftercare Services (JJTAS) staff
- Explore community resources available near youth's release address and determine which resources will best serve the youth's needs
- Provide supportive documentation to Probation officer for WRAP-around referrals
- Generate and track Transition Age Youth Full Service Partnership (TAY FSP) referrals for severely emotionally disturbed or persistently mentally ill camp youth
- Advocate for acceptance into specialized programs such as Independent Living Program (ILP), TAY FSP and Systems of Care by communicating and collaborating with agency leads
- Make aftercare telephone contact with families following youth's release from camp to ensure youth is receiving appropriate services and assists with linkage
- Identify and compile information about community resources specific to the needs of youth transitioning out of Probation camps, thereby establishing a resource directory for Program use
- May facilitate transitional/discharge groups for youth
- May carry a small clinical caseload and provide training to unlicensed clinical staff

Clinical Psychologist I/II – Spanish Speaking
The Vermont Corridor Specialized Foster Care Program is looking for an energetic, positive and enthusiastic clinician to join our team. Ability to work in a fast paced environment, astute clinical assessment and diagnostic skills, as well as strong interpersonal and organizational skills are highly desired. Spanish speaking is a must.

Essential job functions:

- Complete initial diagnostic assessments, determine medical necessity, and develop treatment plans
- Provide crisis intervention services, both in the Department of Children and Family Services (DCFS) office and in the field
- Provide direct therapeutic intervention and treatment to children and youth monitored by DCFS
- Participate in multi-disciplinary team meetings with children and families and partner agencies to address the family's goals while involved with the Department of Children and Family Services
- When appropriate, link children and their caregivers to appropriate mental health and community-based services to best meet their underlying needs
- Actively participate in various case conferences and team meetings regarding social and mental health issues of high-risk families, and provide consultation regarding the best resources to address the mental health needs of children both prior to and following separation from their parents
- Complete all documentation using Integrated Behavioral Health Information System (IBHIS) and abide by all LACDMH documentation requirements

Psychiatric Social Worker II

The Adult Systems of Care Bureau – SA 7 Program Administration is recruiting a Psychiatric Social Worker II (PSW II) for the Latina Promotores de Salud Mental position. This Psychiatric Social Worker II will ensure appropriate guidance, coordination, administrative, and clinical oversite is in place as it relates to Promotores of Community Health Workers groups under the MHSA Prevention and Early Intervention plan.

Essential job functions:

- Provide leadership and clinical expertise to 40 para-professional Community Health Workers in SA's 7 and 8, who are faced with mental health crisis in the communities in which they are presenting on mental health topics
- Follow up with residents in need of mental health services as a result of these outreach and education sessions, to assure they are evaluated and linked to appropriate services
- Provide immediate clinical interventions in crisis situations related to the Community Health Workers' outreach to community residents, including involvement of the Psychiatric Mobile Response Team as needed.
- Assist CHW's with their own mental health crises that are sometimes triggered by the presentations and the over identification with the community residents to whom they are presenting
- Provide bi-monthly support group for the Promotores to share their concerns and challenges
- Provide direct support, consultation, and mentorship to these trained community presenters, through observation, evaluation, and feedback regarding the effectiveness of their presentations and areas of needed growth.
- Assist the presenters as needed with any clinical questions arising that they cannot address due to lack of sufficient clinical expertise.

- Support the Parent Partners who also guide the Promotores in their work when the needs of the Promotores are outside of their scope of practice
- Oversee the delivery of clinical training on a variety of mental health topics to assist the Community Health Workers in developing knowledge and skills related to a wide range of mental health topics, on which they will later present to the community. Provide direct training as needed
- Collect and gather data for outcomes analyses, including demographic statistics. Prepare outcome reports yearly

Community Worker
Arcadia Full Service Partnership (FSP) is a field-based adult outpatient program offering intensive service delivery for consumers experiencing and/or at-risk for institutionalization, incarceration, homelessness, or in-patient psychiatric services. Arcadia FSP is located in San Gabriel Valley and has an opening for a Community Worker. The Community Worker participates on a multi-disciplinary team to engage prospective FSP consumers, provides case management and supportive services to consumers once they are enrolled in FSP, and assists in the development of community resources for consumers with severe mental illness in order to support their recovery.

Essential job functions:
- Participate in the Outreach and Engagement of new referrals to the FSP program, meeting consumers in the field to help prospective consumers understand how FSP might benefit them
- Work in collaboration with other members of the treatment team to support the consumer's treatment and progress toward recovery
- Meet with consumer's in the field and in the clinic to determine possible case management needs and assists in developing a treatment plan objective for those needs
- Assist consumers in establishing benefits
- Assist consumers in the completion of necessary forms such as Bus Pass Applications, etc.
- Document all consumer contracts in the consumer record in Progress Notes in accordance with Medi-Cal requirements or in a Community Outreach Services (COS) note as required by LACDMH

Veterans Claim Assistant II
Provides advice and assistance to veterans and their dependents in securing rights and benefits under Federal, State, or local legislation and assists in the preparation of claims for benefits. Positions in this class perform the full scope of activities tasks necessary in assisting veterans and families. Incumbents are assigned full responsibility for processing applications and claims. They must exercise a knowledge of and apply Federal, State, and local legislation and regulations relating to veterans. These positions must also have knowledge of the organization and procedures of the Veterans' Administration and the State Department of Veterans' Affairs; terminology used in legislation, regulations and claims presentation; community resources available to

veterans and the principal sources of information important in completing veterans' claims.

Essential job functions:

- Interview veterans and their dependents, advise and assist them in establishing their rights to and filing claims for benefits, such as pensions, compensation, insurance, rehabilitation, education, hospitalization, medical care, and burial
- Explain applicable laws and regulations, and assist in drawing up the necessary application forms or correspondence
- Assist veterans in presenting evidence to prove veterans' disability or preference rating
- Secure documentary evidence of births, marriages, and divorces of veterans and their dependents
- Act as a liaison with other government or private agencies concerned with the welfare of veterans and their dependents; refer veterans and their dependents to other agencies for this information or services
- Make field calls to persons unable to come into the office
- Maintain records and prepare reports

Men's Community Reintegration Program – Substance Abuse Counselor

The Men's Community Reintegration Program is seeking a substance abuse counselor for its program located in the heart of downtown Los Angeles. This position will focus on providing intensive substance abuse services to justice-involved adults who have histories of co-occurring mental health and substance use disorders.

Essential job functions:

- Identify and conduct outreach to consumers both in and out of jail custody in need of substance abuse counseling and mental health care, and conduct interviews to obtain personal and family histories, particularly as they relate to substance abuse issues
- Work as part of a multi-disciplinary team to provide input regarding consumer's substance abuse issues as they pertain to services and supports planning, and to contribute to the development, implementation and evaluation of treatment and/or other therapeutic approaches
- Provide information to consumers on substance abuse or dependence
- Counsel consumers individually or in group settings, utilizing motivational interviewing and stages or change interventions, assisting them in recognizing casual factors of abuse and developing appropriate coping behaviors and stress reduction techniques to prevent relapse
- Provide linkage and referrals to substance abuse and other ancillary services in the community
- Engage consumers in peer support activities, including those specifically designed for persons with co-occurring mental illness and substance.
- Facilitate consumers access to community resources for social, recreational, and educational activities, and public transportation to support their recovery

- Participate in educational activities to improve knowledge of integrated treatment of mental health, medical and substance abuse disorders. May provide educational groups on substance use disorders

Mental Health Advocate
Provides a variety of peer support, advocacy, and other recovery services to consumers transitioning to community living.

Essential job functions:
- Act as an interpreter for consumer population
- Within the context of the program population served, communicates, represents, and promotes the mental health services consumer's perspective within the continuum of care
- Orient consumers' family members, significant others, and caregivers of mental health consumers to the mental health system I order to assist these parties to navigate the system and receive necessary services
- Facilitate consumer, family member, and caregiver access to departmental and community resources and services provided by other community and public agencies by assisting with scheduling appointments and transportation; or by accompanying the consumer to meetings that affect their receipt of services in order to provide advocacy and support in meeting consumers' needs
- Assist consumers in developing independent living skills related to housekeeping, cooking, shopping, budgeting, personal hygiene, and use of public transportation through demonstration and coaching
- Assist consumers with housing by facilitating access to residential care or permanent housing
- Facilitate consumers' participation with multi-disciplinary teams by assisting in formulating service goals and plans for achieving such goals
- Assist consumers with obtaining and completing appropriate application forms for various benefits and services
- Lead discussions with consumers regarding recovery, wellbeing and quality of life
- Recruit and train volunteer mentors for consumers transitioning into community living settings
- Accompany consumers to appointments and self-help activities

Intermediate Typist Clerk – Spanish Speaking
Valley Coordinated Children's Services in Reseda is seeking a highly qualified Bilingual Spanish-speaking individual for our reception area. This individual must possess the ability to function fluidly in a fast-paced working environment.

Essential job functions:
- Manage the busy phones in this child crisis clinic and keep track of staff in order to effectively transfer calls
- Learn and follow the clinic's policies and procedures with respect and courtesy
- Confirm doctor's appointments

- Receive and log payments from consumers. Make deposits as appropriate.
- Fax, file, and organize projects
- Apply knowledge of computer programs: Word, Excel, Outlook, PowerPoint, Integrated System (IS) to daily work operations
- Data entry of staff's Units of Service
- Keep the waiting and play room neat and orderly

II. New Workforce Enhancement Strategy: **Office of Discipline Chiefs**

The implementation of the LACDMH Office of Discipline Chiefs was a transformative initiative spearheaded by the Director during CY 2018. Structurally, it is composed of five discipline-specific executive leaders representing the fields of Nursing, Peer Services, Psychiatry, Psychology, and Social Services. The Office of Discipline Chiefs establishes an unprecedented platform to address the cultural and linguistic diversity within the workforce and the communities served by the Department. Collectively, the five Discipline Chiefs provide centralized leadership, promote the highest quality in clinical care, pursue optimal professional working conditions in the workplace, and fortify the departmental infrastructure for the delivery of culturally and linguistically inclusive services.

The Director's vision for the Office of Discipline Chiefs is that it accomplishes an integrated and profession-specific organizational structure based on the following functions and duties:

- Clinical staff advocacy and empowerment: Serve as chief advocates for each discipline, working to empower front line clinicians from the bottom up and each profession from the inside out.
- Discipline-specific training and professional development: Collaborate with the Workforce Development office to deploy a tailored and robust inventory of discipline-specific trainings, and establish and convene all relevant stakeholders to foster a healthy and professional work environment for delivering the best clinical care.
- Clinical practice standards and policies: Work in collaboration with the Policy Management division, Unions and Department leadership to develop discipline-specific practice standards, policies and staffing patterns that optimize the quality of clinical care.
- Clinical quality monitoring and system improvement: Collaborate with CIOB, Quality Assurance/Quality Improvement and other departmental offices to promote a Just Culture that embraces holistic, system improvement at the forefront, reviews quality issues related to clinical programs and develops informed standards for clinical quality monitoring and credentialing.
- Interdisciplinary collaboration and coordination: Develop models and guidelines for interdisciplinary teamwork.
- Clinical program: Work in collaboration to design program configurations and inform outcome measures for specific populations based on clinical input throughout the organization, from front-line to management.

- Clinical staff recruitment and retention: Work with Human Resources, Office of Strategic Communications and key administrative offices to build a workforce pipeline to recruit and onboard clinical staff through campaigns, outreach to trainees, and facilitation of application and interview processes.
- Liaison with professional organizations and labor unions: Establish and maintain relationships with discipline-specific professional organizations, labor unions and myriad training programs in fulfillment of the above functions and serve as executive sponsor for discipline-specific professional committees and associations.
- External relations: Collaborate with public relations programs and community organizations to promote discipline-specific education, programs and initiatives, and represent professional interests to external organizations and governmental bodies.
- Reporting relationships: Discipline Chiefs rotate equally on behalf of the Office as the designated direct report to the Director. Additionally, clinical staff throughout the Department, from front-line to management, have a dotted-line reporting relationship with their respective Discipline Chief.

LACDMH Discipline Chiefs' Background Information

- **Nursing** – Lu Ann Sanderson DNP, PMHCNS-BC, effective February 2018
  Dr. Sanderson is an Advanced Practice Registered Nurse (APRN) and translational researcher who brings over twenty years of clinical experience serving veterans and vulnerable community populations. Her clinical work history includes service as an Aging Specialist provider within a community mental health center, private practice provider in the community serving adults of all ages, and individual veteran care. For over ten years, she served as Chief Nurse-Mental Health in the Greater Los Angeles Veterans Affairs (VA) Healthcare System where she served as leader and role model for a nursing team of more than two hundred culturally diverse mental health nursing staff. Her commitment to life-long learning is evidenced by her advancement through nursing roles and professional nursing degrees.

- **Peer Services** – Keris Myrick, M.B.A., M.S., effective July 2018
  Ms. Myrick is a leading mental health advocate and executive, known for her innovative and inclusive approach to mental health reform and the public disclosure of her personal story. Ms. Myrick has over 15 years of experience in mental health services innovations, transformation, and peer workforce development. Ms. Myrick served as Director of the Office of Consumer Affairs for the Center for Mental Health Services (CMHS) of the United States Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA). Previously, she was also the President and CEO of Project Return Peer Support Network, a Los Angeles-based, peer-run nonprofit, the President of National Alliance on Mental Illness (NAMI), and served as a consultant to the American Psychiatric Association (APA) Office of Minority and National Affairs (OMNA).

- **Psychiatry** – David Ruskin, M.D., effective June 2018
  Dr. Ruskin served as the Associate Chief of Staff for Mental Health Services, VA Puget Sound Health Care System. His past executive experience includes serving as the Director of Emergency Psychiatric Services - UCLA Neuropsychiatric Institute & Hospital; Chief Psychiatric Liaison to both Liver and Lung Transplant Programs - UCLA Medical Center; Director of Psychiatric Emergency Services - Harbor-UCLA Medical Center; Director of Psychiatric Consultation and Liaison Services and Director of Psychiatric Emergency Services - LAC+USC Medical Center; Site Director, VA/USC Psychosomatic Medicine Fellowship, Department of Psychiatry and Behavioral Sciences - Keck School of Medicine at USC; and Chief of Psychiatry - VA Puget Sound Health Care System.

- **Psychology** – Jorge Partida Del Toro, Psy.D., effective September 2018
  Dr. Partida Del Toro is a clinical and research psychologist, specializing in addiction and trauma. He is an author, consultant, and national speaker integrating Native Ancestral Teachings with traditional Western psychotherapy. Dr. Partida Del Toro has been a consultant on many national and international projects designing and implementing clinical programs to address addiction, education, health, community building, diversity, and spirituality. He has worked with local and national governments to coordinate services for communities impacted by poverty, war and displacement. He has worked in Liberia and Africa in the repatriation of boy soldiers, forming "intentional communities" in war, and poverty-impacted countries such as Colombia, Peru, and Mexico. Furthermore, Dr. Partida Del Toro has served in several executive leadership positions such as Director of Substance Abuse and Deputy Director of Behavioral Health for San Francisco's Department of Public Health, Director of the Psy.D. Program at John F. Kennedy University now in Pleasant Hill, CA, and Clinical Director as well as Director of Family Treatment for Alo Recovery Centers in Malibu, CA.

- **Social Services** – Yvette Willock, L.C.S.W., effective June 2018

  Ms**.** Willock is an accomplished social worker with over 20 years of clinical and leadership experience in a variety of mental health settings. She joined LACDMH's Managed Care Division - Treatment Authorization Requests Unit in 2013. In 2015, she oversaw development and implementation of workflow processes used by the Integrated Care Unit's Care Coordination Team when interfacing with LACDMH care providers and health partners. Prior to LACDMH, she was with Pacific Clinics, where she was the Quality Improvement and Compliance Director of Training Education. In this role, she was responsible for creating and evaluating in-person and web-based trainings to address the education and regulatory needs of the organization. Ms. Willock's professional experience also includes implementing a quality assurance program at Sharper Future, a Los Angeles subsidiary of the Pacific Forensic Psychology Associates program, working as a Care Manager in the Managed Health Network and as a psychiatric social worker in the Kedren Community Mental Health Center.

  (See Attachment I: Discipline Chiefs Biographical Statements)

Each Discipline Chief exercises latitude in designing profession-specific frameworks for specialized clinical and peer services, facilitating conduits to amplify the voice of their constituents, establishing methods to identify and address constituents' professional functioning needs, and removing service delivery barriers for the culturally and linguistically diverse communities served by the Department.

Toward the end of their first year of service, the Ethnic Services Manager (ESM) asked the Discipline Chiefs how their goals and strategies contribute to the Department's commitment to build a culturally and linguistically responsive workforce. The Discipline Chiefs' responses echoed thoughtful and consistent themes:

- "My role is to serve the nurses and psychiatric technicians as an advocate for their workforce and educational needs, and to support and recognize their successes as they fulfill the LACDMH mission to deliver evidence-based professional nursing care that brings client-centered and recovery-oriented quality outcomes…. All efforts are central to the overall goal of ensuring a well-prepared group of nurses who deliver evidence-based care that meets the needs of their clients in a culturally sensitive manner. " ***– Lu Ann Sanderson, Discipline Chief of Nursing***
- "Having a dedicated expert and executive to support the advancement of a peer workforce addresses diversity by ensuring that those with lived experience have meaningful roles, whether employed or volunteer, within the larger LACDMH workforce… Further efforts need to increase the workforce knowledge, practices, and approaches to continue to develop a culturally responsive workforce and work place." ***– Keris Myrick, Discipline Chief of Peer Services***
- "The focus on the core competencies of psychologists assures that they understand the importance of aspiring to embody them, which places a strong emphasis on culture and diversity for both LACDMH and the American Psychological Association… Focus groups and individual consultation with psychologists provide feedback and clinical support for their work with diverse communities, while assuring professional and career development so that they can continue to deliver services in the most culturally sensitive and relevant manner." ***– Jorge Partida Del Toro, Discipline Chief of Psychology***
- "It is important to complete ongoing assessments of recruitment efforts, especially those that focus on including Social Workers and Marriage and Family Therapists who can provide culturally competent and sensitive services as well as services in the preferred language(s) of the diverse cultural populations that LACDMH serves… Best practices include outreach efforts, via collaborative efforts with community organizations, in the environments where the community members live. Members of certain cultural communities may be hesitant to come to a "brick and mortar" building identified with "mental health"; however they may feel comfortable going to places within their communities (e.g. places of worship) to receive help. Diffusion across the LACDMH System of Care is key to provide support and access points to needed services for our diverse cultural communities." ***– Yvette Willock, Discipline Chief of Social Services***

The following section presents each Discipline Chief's role conceptualization and a brief summary of goals and strategies pursued during CY 2018.

1. Discipline Chief of Nursing

- Serve as subject matter expert on the Scope & Standards of professional nursing practice and ensuring awareness of clinical competencies requirement for nurses
- Serve as the voice of LACDMH nursing
- Provide professional and effective leadership to LACDMH nurses
- Provide regularly scheduled meetings with LACDMH nurses and psychiatric technicians to ensure bidirectional communications with front line staff
- Serve as liaison with SEIU and professional organizations on matters pertaining to professional nursing at LACDMH
- Collaborate with Human Resources to update language used in Class Specifications, encourage standardization of duty statements that align with professional practice
- Identify psychiatric-mental health nursing education gaps and identify the quality resources available to meet the educational needs of the Registered Nurses and Psychiatric Technicians
- Support the education and development of psychiatric-mental health nurses
- Develop the pipeline of qualified applicants to fill vacant Psychiatric Mental Health-Registered Nurse (PMH-RN) and Psychiatric Mental Health Nurse Practitioner (PMH-NP) items
- Build healthy relationships and collaborate with affiliated college or university nursing programs to ensure quality learning opportunities for psychiatric-mental health nursing students
- Provide nursing perspective for the multidisciplinary treatment team
- Role-model nursing on the multidisciplinary team of Discipline Chiefs
- Ensure that evidence-based practice is incorporated into client care (direct care and indirect care)
- Review the current placement of nurses across the county and identify the roles of the nurses as they are placed across LACDMH services
- Collaborate with Pharmacy services on policy and nursing practices around medication storage, dispensing, administration, and waste
- Collaborate with the Workforce Education & Training (WET) Division to coordinate student nurse placements
- Promote stipend opportunities to graduating PMH-NP students
- Provide guidance and support to ensure a healthy environment of care to clients and nursing staff

Goals	Strategies	Status/Contributions/Accomplishments
1. Serve as the voice of LACDMH nursing	• Provide professional and effective leadership to LACDMH nurses across Los Angeles County • Provide regularly scheduled meetings with LACDMH nurses and psychiatric technicians to ensure bidirectional communications with front line staff	• Strategies in place. Outcomes being collected.
2. Support the education and development of psychiatric-mental health nurses	• Identify psychiatric-mental health nursing education gaps and identify the quality resources available to meet the educational needs of the Registered Nurses and Psychiatric Technicians	• Strategy in place. Outcomes being collected.
3. Develop the pipeline of culturally and linguistically diverse qualified applicants to fill vacant PMH-RN and PMH-NP items	• Review the current placement of nurses across LACDMH; identify which nurses are where; identify the roles of the nurses as they are placed across the LACDMH services to maximize culture/linguistic expertise in the specialty practice field • Collaborate with the WET Division to coordinate student nurse placements • Promote stipend opportunities to graduating Psychiatric-Mental Health Nurse Practitioner students	• Strategies in place. Outcomes being collected.
4. Develop the supportive relationships that encourage and support others to grow and develop to their highest potential	• Approaches vary from serving as an advocate to serving the foods we share in celebration of the professional accomplishments	• Strategies in place. Outcomes being collected.

Goals	Strategies	Status/Contributions/Accomplishments
	• Prompt the thinking of nurses who are working to advance their professional nursing degrees • Provide clarity to link the Scope and Standards of Practice to every day work competencies. Offer guidance to support and modify areas of practice as needed	
5. Ensure a well-prepared group of nurses who deliver evidence-based care that meets the needs of their clients in a culturally sensitive manner	• Deliver evidence-based professional nursing care that brings client-centered recovery-oriented quality outcomes • Identify environmental issues • Identify gaps in foundational nursing practices • Assist individuals to develop personal development goals • Recruit individuals and organizations to bring high quality educational offerings to the nurses and psychiatric technicians	• Strategies in place. Outcomes being collected.
6. Collaborate with the LACDMH Cultural Competency Unit (CCU) projects (i.e. diffusion of information related to departmental cultural competence initiatives, constituents' participation in cultural competence organizational	• Establish collaborations with the ESM and CCU to determine areas of participatory involvement and support to further the development of culturally competent and sensitive practices	• Promoted participation of the nursing profession in the CCU's 2018 Cultural Competence Organizational Assessment Project

Goals	Strategies	Status/Contributions/Accomplishments
assessments, development of policies and procedures concerning cultural and linguistic responsiveness, and support for Health Agency level cultural competence-related committees.)		

2. Discipline Chief of Peer Services

- Serve as the primary subject matter expert on Peer Workforce for the Department
- Provide advocacy around issue that affect the Peer Workforce
- Ensure that Peers are operating within and at the height of their scope of practice by aligning training and development for the staff and supervisors
- Work toward developing and supporting adherence to practice standards and policies; monitoring clinical (practice) and systems improvement and ensure collaboration and integration of the workforce on clinical teams
- Assist with staff recruitment and retention, program development (Peer Resource Center, Peer Full Service Partnerships, and Technology Suite Peer Roles, etc.)
- Serve as a liaison with the labor union and professional organizations and myriad of external partners

Goals for 2018	Strategies	Status/Contributions/Accomplishments
1. Determine current status of peer workforce in LACDMH in order to develop goals for staff development,	**Environmental Scan, CYs 2018 and 2019:** • Conduct Peer Grand Rounds as a means of learning from clinical operations managers and staff their understanding and current	**<u>Environmental Scan Findings:</u>** • Inconsistent understanding of Peer Services and role of Peer Staff throughout the Department. Those who are reportedly working as Peer Staff are doing

Goals for 2018	Strategies	Status/Contributions/Accomplishments
supervision support, training, and recruitment/ retention needs	use of Peer Services and Peer Staff – CY 2018 • Assess existing slew of peer-focused trainings for relevance to national standards in Peer Service competencies – CY 2018 • Interface with SEIU Labor Union representatives to understand the labor perspective on County classes and staff who are on items eligible for placing Peer Staff – ongoing strategy since CY 2018 • Participate in meetings with Wellness Outreach Worker (WOW) volunteers, supervisors, and program coordinators to understand their peer support roles within directly operated programs and to provide guidance on improving their effectiveness – ongoing strategy since CY 2018	a variety of tasks including atypical duties such as case management – CYs 2018 and 2019 • Supervision of Peer Staff has been challenging both from the Peer Staff's as well as the supervisors' perspective – CY 2018 • Class specifications for Community Health Worker item comingled Peer Service duties and other duties since it is a general Health Agency item. The interview questions used to ascertain Peer Staff designation were not in alignment with expected duties and competencies – CY 2018 <u>Activities programmed for CY 2019</u>: • Presentations at quarterly psychiatrist meeting, R.O.A.R. meetings, and meetings with staff at Coastal API Family Mental Health Center and E.D.E. Westside Mental Health Center • Based on item control provided by HR, survey Service Area and countywide program managers to identify who among current Community Health Workers and Mental Health Advocates are performing as Peer Staff (as per the essential job function of a peer worker, disclosure of

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		lived experience as a consumer, parent or family member is necessary) • Review existing class specifications of items currently used for employing Peer Staff to determine gaps in exam and hiring processes • SEIU has a high-level of interest in clarifying responsibilities, providing relevant trainings, and ensuring proper supervision of represented staff in general but whose who are working in a Peer capacity in particular
2. Design a supervisor and peer learning community	• Launch a learning collaborative on SharePoint to share learning, information, opportunities and discussions regarding role of Peer Support Staff and Supervisors of Peer Support Staff, and bring awareness of national standards and California's legislative efforts. Sixty-five Peer Staff, Supervisors and associates receive e-mail alerts to new postings – CY 2018. Research Peer Support Service oriented training programs – CY 2018	Strategies in place <u>Activities programmed for CY 2019:</u> • The learning collaborative on SharePoint and online discussion using the chat feature (SuPeers Learning Community at https://lacounty.sharepoint.com/sites/DMH/splc) • Support Promotores/mental health promoters work with Technical Assistance to create a Mental Health Promoters online virtual learning community of practice similar to SuPeers

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		• Collaborate with Health Agency workgroup and LACDMH HR to develop a strategy to delineate class specifications that align with national and California's planned standards for Peer Support Specialist functions
3. Peer Trainings	• Research existing trainings for peer support services oriented training programs – CY 2019. • Engage with Labor Union SEIU to provide hands-on training for Peer Staff and consumers in legislative advocacy.	Strategies in place <u>Activities programmed for CY 2019:</u> • Research established Peer Support Service oriented training programs • Secure approximately $900,000 for FY 19-20 to develop and implement Peer Support Specialist trainings o One of the seven, the Honest, Open, Proud (HOP) Peer-provider Training and Technical Support to be launched in June 2019. Twenty-two Peer Staff attended the first HOP training. The remaining six programs will be launched in FY 19-20 to deliver a combined number of 48 classes with a total capacity of 990 trainees o Trainings to include those specifically for unserved/ underserved cultural communities (Latino and African American) – Peer Health Navigator for people with Severe Mental Illness affected by homelessness (one is

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		Spanish and one for the African American community). This is an NIH PICORI evidence-based approach for Peer Specialists ○ Latino Peer Training OSHPD to be delivered in CY 2019
4. Hiring of Peers	• Develop interview questions and test exam process to hire a Peer Staff for the Peer Resource Center (PRC) – CY 2018. • Develop a strategy for establishing a shared vision, mission and guiding principles as the foundation for implementing Peer Support Services throughout the County – CY 2019. • Engage with Labor Union SEIU to provide hands-on training for Peer Staff and consumers in legislative advocacy	• Interview questions were developed and exam process to hire a Peer Staff for the PRC was successfully tested – CY 2018 • Implemented the Volunteer Alignment Workgroup to address the disparate volunteer programs that often serve as the "first rung" on the career ladder for peers seeking employment in the mental health field and a source for peer voices within various community meetings. The goal of the workgroup is to develop a single volunteer system that provides various levels of participation for peer and non-peer volunteers with standardized training, roles, and reimbursements – CY 2018 <u>Activities programmed for CY 2019:</u> • In collaboration with LACDMH-UCLA Mental Health Partnership, develop a draft strategy for establishing a shared vision, mission and guiding principles for Peer Support Services throughout the County

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		• Join SEIU sponsored bus trip to Sacramento to provide hands-on experience making statements of support for SB 10 before the Senate Health Committee in February 2019 This will provide hands-on experience at a Senate meeting and making statements of support
5. Explore Peer Workforce Policies to align with industry best practices	**Environmental Scan, CYs 2018 and 2019:** • Examine State and county status on establishing policies for Peer Support Specialist competencies, service standards, training and certification – CY 2018 • Examine LACDMH policies and processes on documenting and claiming for Peer Services – CY 2018 • Support the Director of Mental Health in advocating for the Senate Bill 10 on peer certification as it came before various California legislative bodies – CY 2018	**<u>Environmental Scan Findings:</u>** • California is one of two states nationwide without an established Peer Support Specialist certification program that allows for Medicaid reimbursement of specific Peer Support Services – CY 2018 • Existing LACDMH policies for documentation and claiming provide practical but complex guidelines. Despite available COS documentation trainings, the practice of documentation and training vary from program to program – CY 2018 <u>Activities programmed for CY 2019:</u> • Provide testimony at the Senate Health Committee hearing in February 2019 • Provide testimony at the Assembly Health Committee Hearing in June 2019

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		• Continue serving as subject matter expert for Steinberg Institute and Senator Jim Beall on multiple calls and in-person meetings • Canvass interest and recruited members for a Peer Services Documentation workgroup slated to begin on July 17, 2019. The goal is ascertain and spread current best practices while gathering information for future implementation of SB10 standards
6. Development of Peer Workforce Service Design	**Environmental Scan, CYs 2018 and 2019:** • Interact closely with staff and management at PRC to explore functionality of staff, space and programming – CY 2018 • Interact with departmental, regional and other subject matter experts on the Mental Health Services Act (MHSA) Innovation 10 Project (Suite of On-Demand Services) to assess overall consumer-friendliness and usefulness – CY 2018	**<u>Environmental Scan Findings:</u>** While functionality of staff, space and programming at PRC were not optimal, the potential for growth is high • PRC functioning is being impacted by demands placed on space and staff to host meetings and events unrelated to PRC • MHSA Innovation 10 Project is an exciting opportunity to bring Peer Support into the digital realm for Los Angeles County. However, it requires thoughtful fine-tuning to ensure its usefulness and friendliness for use by consumers of LACDMH services • Lack of expert assistance in helping consumers understand, learn and use

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		digital services to maximize their wellness and access to services • Just4Me portal is a step in the right direction, and will need several features added to it for its widespread adoption and usage by consumers **Strategy-Related Actions:** • Served as a subject matter expert for the MHSA Innovation 10 Project, working with LACDMH, regional and vendor teams to ensure appropriate standards, features and application in the deployment of digital services Activities programmed for CY 2019: • Explore the potential of the Department's effort to improve its consumer web portal, Just4Me • Assess interest for PRC expansion at other LACDMH locations and launch a PRC Expansion Workgroup to start in July 2019 ○ The workgroup will not only provide an assessment of local needs for PRC like services, but also explore various space, staffing and service configurations. The information will be used not only to support PRC like services in other locations but also to

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		improve functioning of the PRC at LACDMH Headquarters • Work on transitioning PRC management to an optimally dedicated structure and reporting up to Chief of Peer Services Specific staff assignments are expected to be completed in July 2019 • Plan and deliver a panel presentation on how to develop a PRC at the African American Mental Health Conference in February 2019 • Collaborate with the LACDMH Quality Improvement Division to launch a Non-Clinical Performance Improvement Project (PIP) focused on PRC ○ Not only will it help grow the potential for PRC, but also inform PRC like expansion as well as Peer Services in general countywide • Bring in nationally-recognized experts to assist with the 2019 non-clinical PIP and Technology Suite (Innovation 3 Project) • Introduce the idea of Tech Peer and brought in Painted Brain, a peer-run organization on board to assist with: ○ Development a digital health literacy curriculum

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		○ Deployment of Peers who can teach and support consumers in the use of digital services • Provide consultation and key recommendations to develop the Statement of Work and Request for Services for Innovation 5: Peer Support Specialist Field-based Intensive Recovery Service Teams (PSS FIRST)
7. Collaborate with the LACDMH CCU projects such as diffusion of information related to departmental cultural competence initiatives, constituents' participation in cultural competence organizational assessments, development of policies and procedures concerning cultural and linguistic responsiveness, and support for Health Agency level cultural competence-related committees	• Establish collaborations with the ESM and CCU to determine areas of participatory involvement and support to further the development of culturally competent and sensitive practices	• Provided recommendations to the ESM regarding the Cultural Competence Organizational Assessment Tool development • Collaborated with the Office of Consumer Affairs and CCU to create a process to track and complete requested translations of recovery-related materials • Reviewed and provided recommendations on the ESM's translation field testing plan
8. Program development and oversight	• Lead team members in direct oversight and/or management of several new and ongoing peer-based programs to obtain	<u>Activities programmed for CY 2019:</u> • Oversight of two (2) contracted Peer Respite homes

Goals for 2018	Strategies	Status/Contributions/Accomplishments
	firsthand information regarding program operations – CY 2019	• Implementation and management of Innovation 5: PSS FIRST • Coordination and oversight of the WOW Volunteer program

2. Discipline Chief of Psychology

- Responsible for ongoing strategic development, oversight and evaluation of personnel under the discipline of psychology, as well as services provided by the Department. All psychologist personnel in the Department maintain a dotted-line reporting relationship to this position.
- Ensure consistent standards, policies, and performance across the Department and, to the extent possible, with non-LACDMH entities, which interface with clients.
- Function as subject matter expert on all operations relating to the practice of psychology including strategic direction and governance for services, development of specialized services, planning and performance, quality systems, and workforce safety.
- Report directly to the LACDMH Director. May serve as lead, "Service Chief" for purposes of cross-discipline participation in specific executive projects or meetings, as assigned by the Director.
- Responsible for and reports on the ongoing development, review, evaluation of standards of psychological care, and all related policies, procedures, and practices to ensure compliance with State and Federal laws and regulations as well as best practices, i.e. Evidence-Based Practices (EBPs) in the field. Responsible for credentialing and monitoring adherence to existing parameters and guidelines.
- Actively cultivate a "Pipeline" of psychologists' talent to fill vacancies in this discipline across the entire County. Coordinate with all relevant entities within the Department to optimize psychologists' recruitment, hiring, deployment, initial and ongoing training, retention and support. Oversee, in collaboration with Human Resources, performance management of all applicable personnel. Coordinate training functions with the Workforce, Education and Training (WET) Division.

- Work collaboratively with executive management, mid-level management, other Clinical/Discipline Chiefs, line staff, labor unions, and administration in the pursuit, development, and maintenance of Departmental programs and priorities.
- Act as a consultant and liaison to other departments, agencies, organizations, groups and individuals inside and outside the county in order to promote mental health programs. Help implement new and effective assessment instruments, technologies, and/or treatments for psychological disorders or symptoms as they become available.

Goals for 2018	Strategies	Status/Contributions/Accomplishments
1. Collaborate with LACDMH Human Resources (HR) to review, revise, and update Psychology related Class Specifications	• Through directing meetings with HR and affiliated supervising psychologist, revise Class Specifications to add greater clarification regarding scope of practice for psychologists at LACDMH. This strategy will ultimately lead to specialty service delivery, and specific services to diverse and underserved communities	• Drafted revisions for all Class Specifications under discipline of psychology • Assisted in drafting new Class Specifications for Psychology Interns and Fellows
2. Build capacity for Psychological Testing and Assessment to improve services to diverse and under-represented communities	• Create a workgroup committee to design, assess, and implement all aspects related to psychological testing, training, and service implementation	• Implemented workgroup committee • Workgroup has been meeting monthly • Drafted departmental psychological testing policy <u>Activities programmed for CY 2019</u>: • Design a four-course training curriculum • Work with billing and procurement for service implementation • Creation of a referral form and process for psychological testing services

Goals for 2018	Strategies	Status/Contributions/Accomplishments
3. Review of EBPs to evaluate effectiveness with diverse and under-represented communities	• Identify practices and strategies to have greater impact on treatment outcomes particularly for diverse and underserved communities	• The Department is reviewing practice and implementation of EBPs to ensure these demonstrate greater outcomes for diverse and underserved communities
4. Promote core competencies of psychologists working in Public Mental Health Cont.	• Research and prepare a 6-hour training with Continuing Education Units outlining core competencies for public mental health psychologists	• Developed the 6-hour training to provide clarity on the role of psychologists, with a clinical focus on effective delivery of culturally competent services <u>Activities programmed for CY 2019</u>: • Delivery of the training anticipated for June 2019
5. Increase collaboration with Public Defender's and District Attorney's Offices to facilitate Justice Involved Diversion Curriculum	• Develop curriculum with particular focus on educating court officers, judges and attorneys regarding culture, diversity, the impact of mental illness on re-entry, and service delivery for diverse communities	• Completed first draft of the curriculum • Curriculum turned over to the District Attorney and Public Defender partners for review <u>Activities programmed for CY 2019</u>: • Follow-up meeting to collect feedback and comments scheduled for August 2019
6. Design outreach strategy to connect with faith-based communities and under-represented diverse communities to include and inform regarding multidisciplinary, multicultural, and integrated health departmental focus.	• Provide outreach and presentations to community to educate and inform regarding aspects of mental illness and culture-specific concerns	• Delivered keynote address and presentation at the 2018 "Promotoras de Salud"/Health Promoters End-of-Year Summit and the Interfaith Trauma and Spirituality Summit <u>Keynote addresses and presentations programmed for CY 2019</u>: • Armenian Genocide Commemoration

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		• Filipino Conference • Latinos Unidos Conference • Mental Health and Immigration Conference • Multicultural Mental Health Conference • NAMI of Southern California Conference
7. Obtain input from psychologists regarding professional development, work satisfaction, and clinical work with underserved communities	• Facilitate focus groups and individual consultation meetings with Department psychologists	• Facilitated seven (7) focus groups with LACDMH psychologists to ascertain job duties and responsibilities, strategic yearly planning, and specialty service design and delivery for underserved communities <u>Activities programmed for CY 2019</u>: • Conduction of an additional focus group to complete the round of eight (8)
8. Improve Training and Professional Development opportunities of future psychologists and assure collaboration with academic institutions to inform culturally competent training environment.	• Form workgroup committee that collaborates with academic institutions and LACDMH to assure curriculum and training experiences meet demands for culturally competency and diversity of future psychologists	• Training and Professional Development workgroup committee was formed at the end of CY 2018 • Workgroup committee has been meeting once per month
9. Help design and implement service programs that create a more welcoming	• Coordinate with existing subject matter experts and contracts to create proposal for a more sensitive and inclusive LGBTQ service environment	• Drafted initial innovation proposal • Meeting scheduled with Chief Medical Officer for implementation strategies

Goals for 2018	Strategies	Status/Contributions/Accomplishments
environment for LGBTQ clients and family members		
10. Design training to support clinicians affected by vicarious trauma as they provide outreach to diverse patient population	• Design and deliver training to Psychiatric Emergency Team and outreach and triage workers exposed to violence and trauma as a result of work functions	• Delivered three separate four-hour training on "Vicarious Trauma" to Emergency Outreach Division clinicians and staff
11. Collaborate with the LACDMH CCU projects (i.e. diffusion of information related to departmental cultural competence initiatives, constituents' participation in cultural competence organizational assessments, development of policies and procedures concerning cultural and linguistic responsiveness, and support for Health Agency level cultural competence-related committees.)	• Establish collaborations with the ESM and CCU to determine areas of participatory involvement and support to further the development of culturally competent and sensitive practices.	• Provided recommendations to the ESM regarding the LACDMH Cultural Competence Organizational Assessment Tool development <u>Activities programmed for CY 2019</u>: • Presentation for the Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) Action Plan Launch • Keynote address for the Labor Management Transformation Council's Cultural Intelligence Workgroup

3. Discipline Chief of Social Services

- Educate the L.A. County Department of Mental Health on the breadth and scope of practice of the Social Work Practitioner and Marriage and Family Therapist Practitioner.
- Identify gaps in work processes/program development that result in Social Work Practitioners and Marriage and Family Therapist Practitioners not functioning consistently at the height/top of their respective Scope of Practice.
- Advocate for Social Work and Marriage and Family Therapist Practitioners “on the line” (e.g. directly providing services at the micro, mezzo, and macro levels; and supervising the work of the Practitioners “on the line”).
- Identify gaps in our LACDMH Systems that impact Social Work and Marriage and Family Therapist Practitioners’ adherence to the Core Values of their respective Disciplines.
- Identify opportunities and actions to ameliorate the gaps that impact consistent adherence to the Core Values of Social Work Practice and Marriage and Family Therapy Practice.
- Evaluate to determine contributing factors to recruitment and retention of Social Work and Marriage and Family Therapist Practitioners.
- Develop relationships with Academic Institutions that confer Master’s degrees in the Disciplines of Social Work and Marriage and Family Therapy.
- Participate as an active member of the California Social Work Education Center (CalSWEC) Advisory Board to inform workforce development of Social Workers.

Goals for 2018	Strategies	Status/Contributions/Accomplishments
1. Begin Needs Assessment of LACDMH Social Work (SW), and Marriage and Family Therapy (MFT) staff to determine the Practice Needs of the respective disciplines, identify	• Hold in-person convening meetings, effective July 26, 2018.	• Completed in-person visits with **327** LACDMH *line* SW and MFT staff, and **42** LACDMH Mental Health Clinical Supervisors (staff in this classification are either SW or MFT Practitioners).

Goals for 2018	Strategies	Status/Contributions/Accomplishments
opportunities for improvement, and empower staff to advocate for program specific needs.		**Findings:** • LACDMH SW staff engage in outreach efforts with various community partners/community access platforms. One such outreach and collaborative effort occurs in Service Area 6 on a weekly basis with Mount Tabor Missionary Baptist Church where community members, primarily African American and Latino/Latina heritage receive services associated with basic needs (e.g. showers, food/meal, and clothing). LACDMH is present with bilingual and bicultural staff who provide basic information on mental health/access paths for mental health services, etc. **Next step:** Determine opportunities for diffusion of this needed outreach opportunity for members of communities *in their* communities (i.e. where they live). • Various "System" opportunities for improvement" and Program Specific Needs were identified during in-person visits. 1) **"System" Opportunity for Improvement:** One system improvement identified was gaining efficiencies with receipt of the Integrated Behavioral Health Information System (IBHIS) Clinical Practice Training. Elements of this training include informing our LACDMH SW and MFT Practitioners of documentation standards that include

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		how/where to note the self-reported ethnic identity/preferred language spoken/self-reported spiritual identity/needs, etc. of the individual receiving services at LACDMH Directly Operated Clinics/Programs. **Gap:** Some SW/MFT Staff reported receiving IBHIS Clinical Practice Training four months after commencement of employment at LACDMH. **Accomplishment:** • Collaborated with LACDMH Quality Assurance (QA) Division and Human Resources to develop a workflow that results in new LACDMH staff receiving needed IBHIS Training within four weeks of employment – October 2018. 2) **Program Specific Need with System-wide implications:** Provision of non-traditional interventions (e.g. drumming, storytelling via poetry/lyrical poetry, etc.) that honor various cultural populations (e.g. African American; Transitional Age Youth, etc.) **Findings:** • Based on the current understanding of LACDMH SW and MFT staff, some of these

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		non-traditional/non-Western oriented interventions are not reimbursable by Medicaid claiming rules). As a result, this can contribute to interventions not consistently being utilized that honor the culture of the individual receiving services. 3) **Program Specific Need:** SW and MFT *line* staff at a Program identified the need to install Diaper Changing Stations in the bathroom so parents of infants can have a safe and secure place to change them. **<u>Accomplishment:</u>** • Discussed Program Need with Administrative Services Manager and Diaper Changing Stations were installed in both women's and men's restrooms.
2. Collaborate with the LACDMH WET Division staff to evaluate the existing recruitment efforts for students graduating from Social Work and Marriage and Family Therapy graduate Programs.	• Participate in several meetings with the Program Manager III and Program Manager II of the WET Division regarding the existing "general" Intern Training Program for SW and MFT students and the "Stipend" Intern Training Program.	**<u>Findings:</u>** • There is a robust "general" and "stipend" Intern Training Program. The LACDMH Stipend Intern Program seeks to recruit graduate students who have: **1)** language capability to provide services in one of the 12 threshold languages in LA County; and **2)** the ability to provide culturally competent, appropriate and sensitive services to individuals in areas of high need. These graduate students have to commit to working

Goals for 2018	Strategies	Status/Contributions/Accomplishments
		full-time for one (1) year, post-graduation, in areas within LA County designated as a priority – Fall 2018. • Apart from the structure associated with the Intern Training Program and an annual visit by Human Resources to inform graduating students on the employment application process, there are no ongoing engagement efforts with Academic Institutions to inform students of the realities of providing services in the public mental health arena (e.g. regulatory standards associated with service delivery; providing services to an ever growing homeless population with significant mental health needs; etc.). Students who do not have an intern experience in the LACDMH System of Care might not be as equipped for the realities of providing services in the public mental health arena –Fall 2018.
3. Collaborate with LACDMH CCU projects (i.e. diffusion of information related to departmental cultural competence initiatives, constituents' participation in cultural competence organizational assessments, development of policies and procedures concerning	• Focus of collaborations with LACDMH ESM and CCU to determine/ identify areas of contribution from the respective perspectives of the Social Work and Marriage and Family Therapy Disciplines to further the development of culturally	• Provided input for the LACDMH commitments on Implicit Bias and Cultural Competence Worksheet • Provided recommendations to the Ethnic Services Manager regarding the LACDMH Cultural Competence Organizational Assessment Tool

Goals for 2018	Strategies	Status/Contributions/Accomplishments
cultural and linguistic responsiveness, and support for Health Agency level cultural competence-related committees.)	competent and sensitive practices.	• Promoted participation of SWs and MFTs in the CCU's 2018 Cultural Competence Organizational Assessment Project

Criterion 6 Appendix

Attachment I: Discipline Chiefs Biographical Statements


David Ruskin_bio.pdf


Keris Myrick bio.pdf


Jorge Partida Bio.pdf


Lu Ann Sanderson bio.pdf


Yvette Willock_Bio.pdf

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 7

Language Capacity

August 2019

Criterion 7: Language Capacity

The Los Angeles County Department of Mental Health (LACDMH) strives to meet the linguistic needs of its diverse communities by growing a multicultural and multilingual workforce, providing training opportunities for bilingual certified staff to become language interpreters, and funding culturally and linguistically competent programs. The County of Los Angeles has thirteen threshold languages, which include:

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Korean
- Mandarin
- Other Chinese
- Russian
- Spanish
- Tagalog
- Vietnamese

Due to the size and diversity of Los Angeles County, LACDMH has determined threshold language profiles for each of our eight Service Areas (SAs) as follows:

TABLE 1: SERVICE AREA THRESHOLD LANGUAGES

Service Area	Threshold Languages
1	English and Spanish
2	Arabic, Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog
3	Cantonese, English, Korean, Mandarin, Other Chinese, Spanish, Tagalog, and Vietnamese
4	Armenian, English, Korean, Other Chinese, Russian, Spanish, and Tagalog
5	English, Farsi, and Spanish
6	English, Other Chinese, and Spanish
7	English and Spanish
8	Cambodian, English, Korean, Other Chinese, Spanish, and Tagalog

Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018. Data reported only for LACDMH threshold languages. “Threshold Language” means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Arabic is a Countywide threshold language.

I. Increase bilingual workforce capacity

Bilingual Certified Employees

LACDMH's workforce is composed of over 6,000 employees from Directly Operated (DO) and Contracted programs, with bilingual capacity in 60 languages, the majority being proficient in Spanish (over 4,500). Other languages well represented in the workforce are Korean, Mandarin, Armenian, Tagalog, Farsi, and Cantonese (between 100 and 200).

According to information provided by the LACDMH Human Resources Bureau (HRB) regarding DO Programs, the Department pays bilingual bonus for the following 39 languages, inclusive of threshold and non-threshold languages: American Sign Language (ASL), Arabic, Armenian, Bulgarian, Cambodian, Cantonese, Catalan, Chinese, Flemish, French, German, Greek, Hakka, Hebrew, Hindi, Ilocano, Italian, Japanese, Korean, Laotian, Mandarin, Nahuatl, Pangasinan, Portuguese, Russian, Samoan, Spanish, Swedish, Tagalog, Taiwanese, Thai, Toi Shan, Turkish, Urdu, Vietnamese, Visuyan, and Yiddish. The departmental practice of hiring employees with various bilingual capabilities and providing bilingual bonus compensation demonstrates the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards Nos. 3, 5, 7, and 8.

Per LACDMH Policy No. 602.01, Bilingual Bonus, LACDMH bilingual certified employees possess a valid Language Proficiency Certificate issued as a result of the County's Bilingual Proficiency Examination, which tests for proficiency to either speak, read, and/or write the language. Bilingual compensation is paid to certified bilingual employees whose assignments require dual fluency in English and at least one foreign language, as well as knowledge of, and sensitivity toward, the culture and needs of the linguistic communities served by the Department. ASL is considered a foreign language for purposes of this bonus. All LACDMH bilingual certified employees are placed on the eligible lists and are contacted when their foreign language skills are needed for translation of materials and/or language interpretation services by diverse LACDMH Programs/Units.
(See Attachment 1: LACDMH Policy on Bilingual Bonus).

The LACDMH Human Resources Bureau (HRB) is responsible for maintaining a current list of employees receiving bilingual bonus. The list is categorized by employee name, payroll title, pay location, language, and language proficiency level (e.g. speaking, reading and writing.) The can be requested by LACDMH managers directly from the HRB
(See Attachment 2: List of LACDMH Bilingual Certified Staff).

Linguistic Competence Trainings

The Department allocates approximately $1.6 Million each Fiscal Year (FY) for staff training including conferences. A major portion of this expenditure is related to cultural competence trainings. For FY 17-18, the Department dedicated approximately $900,000 for cultural competence trainings including $72,851 for language interpreter and medical terminology trainings in threshold languages through the Workforce, Education and Training (WET) Division.

Examples of trainings offered to increase the linguistic competence of staff:

Introduction to Interpreting in Mental Health Settings
This three-day language interpreter training series is designed for bilingual staff who are proficient in English and in a second language. This introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter. The purpose is to assist the Mental Health and Wellness programs by training the bilingual workforce to accurately interpret and meet the requirements of Federal and State law. This course provides the participants with the knowledge and skills around the role of interpreters, models of interpreting, mental health terminology, standards of practice, cultural interpreting, and skills to face challenges arising in the mental health field. Introduction to glossary development and maintenance of specialized mental health glossaries based on the interpreters' level of proficiency in both languages are also included in the training.

Advanced Interpreter's Training: The Fine Art of Interpreting
This workshop is designed for bilingual clerical and clinical staff who serve as interpreters in mental health settings. This training provides participants with the knowledge and skills necessary to effectively facilitate communication between mental health providers and Limited English Proficient (LEP) consumers. The ethical principles and the decision-making process are addressed. This interactive class includes role-playing, group activities, and videos. Resources to access mental health terminology in multiple languages are also provided during this training.

Increasing Spanish Mental Health Clinical Terminology
This training is intended to increase cross-cultural knowledge and skills with Spanish-speaking populations, specifically to increase clinician and bilingual staff's vocabulary and use of terms related to the provision of mental health services such as assessment, diagnosis, treatment and crisis intervention. Additionally, the training addresses challenges that may arise when performing services in Spanish. For example: Using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis, inappropriate diagnosis, and other unintended consequences. Participants become familiarized with the challenges that may interfere with establishing rapport, and treatment adherence.

Culturally and Linguistically Competent Programs
LACDMH also builds the linguistic capacity of the system of care by dedicating funding for culture-specific programs that increase service accessibility for underrepresented populations. For example, $15 Million were allocated over a period of three FYs to the Recovery, Resilience and Reintegration Community-Designed Integrated Services Management Model (RRR-ISM). This Program was designed to incorporate the components of healthcare as defined by specific ethnic communities while promoting collaboration and community-based partnerships to integrate health, mental health, and substance use services utilizing non-traditional strategies to support recovery. The RRR-ISM model was implemented for five Underserved Cultural Communities (UsCC):

African/African American (AAA), American Indian/Alaska Native (AI/AN), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME), and Latino. Fourteen of the RRR-ISM providers with cultural and linguistic expertise received ongoing funding to provide the integrated services to these ethnic groups.

Additionally, LACDMH allocates Community Services and Supports (CSS) Planning Outreach and Engagement (POE) funding for the seven UsCC subcommittees' capacity building projects. Each UsCC subcommittee receives $100,000 per FY to implement culturally and linguistically competent projects, totaling $700,000. Please refer to Criterion (CR) 1 and CR 3 for additional details.

Another example is the Countywide Community Mental Health Promoters Program, which is an adaptation of the Promotores Model originally implemented for the Latino community. Currently, LACDMH is expanding the project countywide to four additional Mental Health Promoter groups and languages: AI/AN – English, AAA – Ethiopian, API – Tagalog, and EE/ME –Armenian. This countywide program will build system capacity and access to integrated services by utilizing Community Mental Health Promoters to increase the community's knowledge about mental health through outreach, engagement, community education, social support, linkage, and advocacy activities. The Department has allocated $860,000 per FY for this project. Additionally, the Latino Mental Health Promoters Program has been expanded countywide.
Please refer to CR 3 for additional details.

Language Translation and Interpretation Services
LACDMH currently allocates funding for language translation and interpretation services for meetings and conferences. For FY 17-18, a total of $53,300 was spent on language interpretation services, which allowed consumers, family members, and community members to participate in various departmental meetings and conferences. Language translation expenses totaled $79,500. Further, telephonic interpretation services are provided via the ACCESS Center and DO programs at an approximate cost of $200,000 annually. The cost of American Sign Language services offered to consumers from both DO and contracted clinics was $165,000.

II. Services to persons who have Limited English Proficiency (LEP)

24/7 Toll-Free Access Phone Line
LACDMH's ACCESS Center provides emergency and non-emergency services. The ACCESS Center strives to meet the cultural and linguistic needs of our communities by providing language assistance services in threshold and non-threshold languages, at the time of first contact. When callers request information related to mental health services and other social needs, the ACCESS Center provides referrals to culture-specific providers and services that are appropriate and conveniently located. The ACCESS Center tracks the number of calls received in non-English languages.

Additionally, the ACCESS Center also provides equitable language assistance services to deaf and hard of hearing consumers and providers requesting ASL interpretation services for their consumers.

TABLE 2: SUMMARY OF TRENDING DATA FOR DEAF AND HARD OF HEARING COMMUNITY APPOINTMENTS
FY 13-14 TO FY 17-18

Fiscal Year (FY)	Number of Assigned Appointments
FY 13-14	937
FY 14-15	1,137
FY 15-16	1,058
FY 16-17	1,242
FY 17-18	1,140
TOTAL	6,362

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: LACDMH ACCESS Center, FY 13-14 to FY 17-18

Table 2 presents the summary of appointments for deaf and hard of hearing consumers at the ACCESS Center for the last five years.

DMH Policy and Procedure 200.02, "Hearing Impaired Mental Health Access"
In August 2018, the ESM presented this policy to the departmental Cultural Competency Committee for review and recommendations for content updates. The CCC requested that the following revision be incorporated:

- Change the title of this policy to Mental Health Access for the Deaf and Hard of Hearing Community and avoid using the term "hearing impaired"
- Specify that the Department will be providing access to mental health services for the Deaf and Hard of Hearing community
- Delete wording "hearing impairment" and replace with "consumers who are deaf and hard of hearing with mental health needs"
- Identify the contracted agencies that are providing sign language interpretation services for the ACCESS Center
- Update Teletype/Telecommunications Devices to include: Video Phone Technology
- Provide a description of California Relay Service (CRS) or Video Phone for consumers who are deaf and hard of hearing

Subsequently, the title and content of this policy has been revised. It is now titled "Interpreter Services for the Deaf and Hard of Hearing Community."

TABLE 3: NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER FIVE YEAR TREND CY 2013 – 2018

*Language	CY				
	2014	2015	2016	2017	2018
Amharic	1	0	0	1	0
*Arabic	24	6	16	8	18
*Armenian	225	80	130	128	65
Bahasa	0	0	1	0	0
Bengali	0	0	1	0	2
Bosnian	1	0	0	0	0
Bulgarian	0	0	0	0	0
Burmese	0	0	0	0	2
Cambodian	0	0	7	10	26
*Cantonese	60	46	40	46	73
Cebuano	1	0	0	0	0
*Farsi	81	58	56	178	59
French	2	2	2	1	1
German	0	1	0	0	0
Greek	0	1	0	0	0
Hebrew	2	1	0	0	0
Hindi	1	0	0	0	1
Hungarian	0	3	0	0	0
Italian	0	0	0	0	0
Japanese	2	2	4	2	6
Khmer	5	3	1	0	0
*Korean	132	108	116	140	224
Kurdish-Behdini	1	0	0	0	0
Laotian	2	0	0	0	0
Luganda	0	0	0	0	1
*Mandarin	30	62	86	82	166
Mongolian	0	0	0	0	0
Nepali	2	0	0	0	0
Pashto	0	0	0	0	0
Persian	0	0	1	5	4
Polish	0	0	1	0	1
Portuguese	1	0	1	1	1
Punjabi	0	1	0	2	1
Romanian	0	0	1	0	0
*Russian	11	12	16	37	13
Samoan	0	0	0	0	0
Serbian	0	0	2	0	0

*Language	CY				
	2014	2015	2016	2017	2018
Slovak	0	0	1	0	0
[1]Spanish (LISMA)	1,402	1,089	1,474	2,303	1,370
[2]Spanish ACCESS Center	6,135	6,159	6,040	6,150	6,612
Spanish Subtotal	7,537	7,248	7,514	8,453	7,982
***Tagalog**	18	7	10	9	16
Thai	2	1	0	7	0
Turkish	0	0	0	0	0
Urdu	1	0	0	0	1
***Vietnamese**	24	**17**	**28**	195	34
Total	**8,169**	**7,659**	**8,035**	**9,305**	**8,697**

Note: *DMH Threshold Languages excludes Other Chinese in CY 2016 and CY 2017. [1]LISMA or Language Interpretation Services Master Agreement. [2]Telephone Interpreter Line Calls. Data Source: DMH ACCESS Center, CY 2014 to CY 2018.

Table 3 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2014 through CY 2018. Over the past five years, the majority of the requests for non-English language calls were for Spanish, followed Armenian and Korean.

In CY 2018, the ACCESS Center staff provided language interpreter services, in the Spanish language, for 6,612 calls. An additional 1,370 Spanish language calls were interpreted through a language interpreter service vendor. Approximately, 92% of the non-English calls received by ACCESS Center staff were in Spanish (N=7,982), followed by Korean (N=224) at 2.5% and Mandarin (N=166) at 2.0%. The remaining languages received less than 100 calls in CY 2018 and accounted for 3.5% of all non-English calls.

The SA Provider Directory

The Provider Directory is a primary tool developed by LACDMH to search for service providers in geographic locations that would be most convenient and accessible to consumers. The Provider Directory contains information Specialty Mental Health Services provided at each service location, languages in which services are offered, age groups served, provider contact information, and hours of operation. Hard copies of the Provider Directory are disseminated annually to SA providers for distribution and use by consumers, family members, staff, and other stakeholders. Furthermore, the directory can be accessed by the public via Internet at https://dmh.lacounty.gov/. LACDMH staff can also access this tool using the Provider Locator feature in the Intranet at https://lacounty.sharepoint.com/sites/DMH/SitePages/Default.aspx?wa=wsignin1.0
During FY 17-18, trainings were conducted throughout the SAs to inform stakeholders and providers of updates to information contained in the Provider Directory.

Language Interpretation Services

Language interpretation services are offered and provided to LEP consumers free of charge. LACDMH Policy No. 200.03, Language Translation and Interpretation Services,

specifies the procedures to be followed by DO programs when language interpretation and translation services are needed
(See Attachment 3: LACDMH Policy on Language Translation and Interpretation Services).

Additionally, the procedure for language interpretation services for meetings and conferences is outlined in this policy. The language assistance services addressed in this policy include: Face-to-face, telephonic, and interpretation services for the deaf and hard of hearing as well as translation services. LACDMH also has Policy No. 200.02, Hearing Impaired Mental Health Access, which includes procedures to request emergency and non-emergency sign language interpreter appointments.
(See Attachment 4: LACDMH Policy on Hearing Impaired Mental Health Access).

Furthermore, the clinical documentation guidelines, as outlined in the "LACDMH Organizational Provider's Manual for Specialty Mental Health Services", indicate how linguistic needs of consumers are to be documented ***(See Attachment 5: Organizational Provider's Manual for Specialty Mental Health Services).*** General documentation rules state: "Special client needs as well as associated interventions directed toward meeting those needs must be documented…Consumers whose primary language is not English, should not be expected to provide interpretive services through friends or family members [Please refer to LACDMH Policy No. 200.03, "Language Translation and Interpretation Services" for further details]. Oral interpretation and sign language services must be available free of charge… Documentation regarding cultural considerations must show that services took into account the client's culture…" (p.10). The Manual also states that clinical assessments should indicate "the role of culture and ethnicity in the client's life" (p.14), as well as record ethnicity and preferred language. Treatment Plans must record the "Linguistic and Interpretive needs" of consumers (p.21).

Change of Provider (COP) Forms
To monitor that beneficiaries are receiving mental health services in their preferred languages, LACDMH tracks the incidence of language as a reason for change of provider requests generated by consumers. The Patients' Rights Office (PRO) works closely with service providers from the eight SAs and collects requests received for changes of providers. This information is recorded, analyzed, and tracked to monitor the number of system-wide requests for COPs, reasons for the requested changes, and the rates of approved requests. Examples of culture-related reasons for consumers to request a change of provider include:

- Age
- Gender
- Language
- Does not understand me
- Insensitive/unsympathetic

TABLE 4: REQUEST FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 15-16 TO FY 17-18

[1]Reason	FY 15-16		FY 16-17		FY 17-18	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A – Time/Schedule	160	93.8%	148	90.8%	235	87.2%
B – Language	116	93.1%	128	96.2%	144	88.9%
C – Age	58	91.4%	76	87.4%	85	89.4%
D – Gender	188	95.7%	172	91.5%	246	94.3%
E – Treating Family Member	33	93.9%	25	92.6%	32	93.8%
F – Treatment Concerns	361	91.7%	330	92.7%	430	89.8%
G – Medication Concerns	230	90.9%	222	91.0%	276	87.0%
H – Lack of Assistance	331	91.5%	332	91.2%	427	85.9%
I – Want Previous Provider	94	95.7%	84	92.3%	89	83.1%
J – Want 2nd Option	116	89.7%	98	89.9%	155	89.0%
K – Uncomfortable	529	92.4%	553	92.0%	613	89.6%
L – Insensitive/Unsympathetic	347	90.5%	330	92.2%	398	89.7%
M – Not Professional	246	91.9%	240	91.6%	309	90.9%
N – Does Not Understand Me	382	92.4%	424	91.2%	509	88.8%
O – Not a Good Match	658	92.9%	555	91.7%	693	90.3%
P – Other	349	94.8%	373	92.6%	509	87.2%
R – No Reason Given	107	93.3%	102	86.4%	109	91.7%
Total	4,305	92.7%	4,192	91.7%	5,259	89.1%

Note: [1]Multiple reasons may be given by a consumer. Data Source: DMH, PRO, October 2018

Table 4 shows the number of request for COP by reasons and percent approved for FY 15-16, FY 16-17, and FY 17-18. Data on the requests for COP is based on monthly COP logs submitted to PRO. According to the FY 17-18 data, the most frequent reason for a COP request was "Not a Good Match (N=693)," and the least frequent reason for a COP request was "Treating a Family Member (N=32)."

Beneficiary Satisfaction Surveys

The effectiveness of linguistic and cultural services as perceived by consumers is assessed annually by the statewide-administered Beneficiary Satisfaction Surveys. One item on the Mental Health Statistical Improvement Program (MHSIP) survey addresses whether Staff was sensitive to the consumers' cultural background. Table 5 below summarizes three-year trending data of this specific item for youth, adults, older adults, and their families.

TABLE 5: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL/ETHNIC BACKGROUND" BY AGE GROUP
CY 2016 TO CY 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	94.9%	94.7%	95.4%	94.7%	94.9%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	81.5%	84.7%	86.0%	82.6%	82.4%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	86.0%	84.1%	84.5%	85.2%	86.1%
Older Adult					
Number	427	514	432	499	609
Percent	91.2%	92.0%	86.4%	91.0%	89.6%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	88.4%	88.9%	88.2%	88.3%	88.3%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 5 reports the percentage of consumers and families in families in CY 2016, CY 2017, and May 2018 that agreed to strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." Among YSS-F surveys, there was a 0.5 PP decrease from 95.4% in May 2017 to 94.9% in May 2018. Among YSS surveys, there was a 3.4 PP decrease from 86.0% in May 2017 to 82.4% in May 2018. Among Adult surveys, there was a 1.6 PP increase from 84.5% in May 2017 to 86.1% in May 2018. Among Older Adult surveys, there was a 3.2 PP decline from 86.4% in May 2017 to 89.6% in May 2018.

Translation of documents

In an effort to provide culturally and linguistically appropriate documents, various departmental forms and brochures have been translated into the threshold languages as listed in the table 6 below.

LACDMH's mechanism for ensuring accuracy of translated materials is field testing. Field Testing takes place via document reviews by bilingual certified staff, consumers, family members, or consumer caretakers who volunteer to read and comment on the linguistic and cultural meaningfulness of the translated documents. Edits gathered from the reviewers are then provided to the contracted vendor for the finalization of the translated documents.

LACDMH Policy No. 602.01, Bilingual Bonus, specifies that bilingual certified employees will be contacted when the Department needs language translation and interpretation services. It also directs Programs needing language translation and interpretation services complete a Request for Interpretation/Translation Services (RITS) form should be sent to a supervisor at the level of Program Manager or above. The RITS form must be signed by the Program Manager and submitted to the Ethnic Services Manager for the tracking of forms, brochures and other materials translated at the program level.
(See Attachment 6: Request for Interpretation and Translation Services Form).

TABLE 6: SAMPLE LACDMH FORMS AND BROCHURES TRANSLATED INTO THE THRESHOLD LANGUAGES

Forms and Brochures	THRESHOLD LANGUAGES												
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Korean	Mandarin*	Russian	Spanish	Tagalog	Vietnamese
ACCESS Brochure	X	X		X	X	X	X	X		X	X	X	X
ACCESS Center flyer "We are Here to Help"	X	X		X	X	X	X	X		X	X	X	X
Authorization for Request or Use/Disclosure of Protected Health Information (PHI)						X					X		
Be a Foster Parent brochure						X							
Beneficiary Problems Resolution Process	X	X		X	X	X	X	X		X	X	X	X
Beneficiary Satisfaction surveys (State)				X	X	X				X	X	X	X
CalWORKs brochure						X							
Caregiver's Authorization Affidavit	X	X		X	X	X	X	X		X	X	X	X
Child and Family Team Meetings Brochure						X					X		
Client Congress Flyer	X	X		X	X	X	X	X		X	X	X	X
Consent for Services	X	X		X	X	X	X	X		X	X	X	X
Consent for Staff/Volunteer/Intern Observation						X							
Consent for Telemental Health Services	X	X		X	X	X	X	X		X	X	X	X
Consent of Minor						X							
Consent to Photograph/Audio Record	X	X		X	X	X	X	X		X	X	X	X
Faith-Based Advocacy Council						X							
FCCS Brochure	X	X			X	X	X	X		X	X	X	X
FSP brochures	X	X		X	X	X	X	X		X	X	X	X
Adult FSP Client Satisfaction Survey	X	X		X	X	X	X	X		X	X	X	X
Grievance & Appeal Forms	X	X		X	X	X	X	X		X	X	X	X
Guide to Medi-Cal Mental Health Services	X	X		X	X	X	X	X		X	X	X	X
Hope, Wellness and Recovery	X	X		X	X	X	X	X		X	X	X	X

Forms and Brochures	THRESHOLD LANGUAGES												
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Korean	Mandarin*	Russian	Spanish	Tagalog	Vietnamese
LACDMH Advance Health Care Directive Acknowledgement Form	X	X		X	X	X	X	X		X	X	X	X
LACDMH Child Welfare Division Brochure						X							
LACDMH Notice of Privacy Practices	X	X		X	X	X	X	X		X	X	X	X
Multidisciplinary Assessment Teams Brochure						X					X		
Mental Health Academy Brochure						X							
Mental Health/Interfaith Clergy Roundtable Flyer						X							
Notice of Action A (State Form)						X					X		
Older Adult FSP Annual Client Satisfaction					X	X	X				X		
Outpatient Medication Review	X	X		X	X	X	X	X		X	X	X	X
Request for Change of Provider	X	X		X	X	X	X	X		X	X	X	X
Roybal Comprehensive Health Center Brochure					X								
SA Provider Directories	X	X	X	X	X	X	X	X	X	X	X	X	X
Spirituality Conference – 15th Anniversary Brochure						X							
Supportive Counseling Services						X					X		
Transitional Age Youth FSP Brochure	X	X			X	X	X	X			X	X	X
Tele-mental Health Services Brochure						X					X		
Treatment Foster Care Brochure						X							
Underserved Cultural Communities Flyer						X							
Veterans and Loved Ones Recovery Program Flyer						X							
Wellness Centers Brochure						X							

* Cantonese and Mandarin language translations are covered under Other Chinese; Data Source: CCU

Criterion 7 Appendix

Attachment 1: LACDMH Policy 602.01 – Bilingual Bonus

602_01.pdf

Attachment 2: List of LACDMH Bilingual Certified Staff

Employee List with Language and Skills 6-

Attachment 3: LACDMH Policy 200.03 – Language Translation and Interpretation Services

200_03.pdf

Attachment 4: LACDMH Policy 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community, previously titled Hearing Impaired Mental Health Access

200_02.pdf

Attachment 5: Organizational Provider's Manual for Specialty Mental Health Services

OrgManual 2017_04.pdf

Attachment 6: Request for Interpretation and Translation Services Form

CC P&P 602 01 Bilingual Bonus RITS.d

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

hope. recovery. wellbeing.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 17-18

Criterion 8

Adaptation of Services

August 2019

Criterion 8: Adaptation of Services

I. Consumer-driven/operated recovery and wellbeing programs

The Los Angeles County Department of Mental Health (LACDMH) is committed to support and enhance consumer-driven and wellbeing programs that are recovery-focused and rich in peer involvement. Examples:

Peer Run Centers: The LACDMH Peer Resource Walk-In Center

LACDMH celebrated the grand opening of its Peer Resource Walk-In Center on May 1, 2017. The Peer Resource Center (PRC) solidifies LACDMH's commitment to cultivate a space for consumers and community members to connect with each other. Resource center peer staff have lived experiences with mental illness, homelessness, or other issues. The goal of the PRC is for all visitors to have a positive experience, which led to the development of its motto: "Heart forward" and its service philosophy of "Everyone leaves with something." The center is located at 550 South Vermont Ave., Los Angeles, CA 90020 and it is open on weekdays from 9:00 a.m. to 6:00 p.m. Special attention is provided to Center visitors from underserved communities such as persons with limited English proficiency and persons experiencing homelessness.

The PRC functions as a centralized place where consumers and community members can engage in recovery oriented self-help, advocacy, education and socialization services free of charge. The PRC operates with peers as front-line staff who receive support from LACDMH clinical staff in the event of urgent situations and crisis interventions. Peer staff are actively involved in the provision and facilitation of peer-based counseling and support, advocacy, promoting engagement of consumers in various learning opportunities such as presentations, socialization activities such as arts and crafts, client coalition meetings, and guitar lesson

Below are the general categories for information sought out by PRC visitors

- Department of Motor Vehicles
- Employment Services
- Financial Assistance
- Family-Related
- Housing
- Legal Services
- Medical Services
- Mental Health Services
- Patients' Rights
- Police
- PRC Resources
- Referral Linkage
- Social Services
- Substance Use
- Transportation

Figure 1: Population Served by the PRC

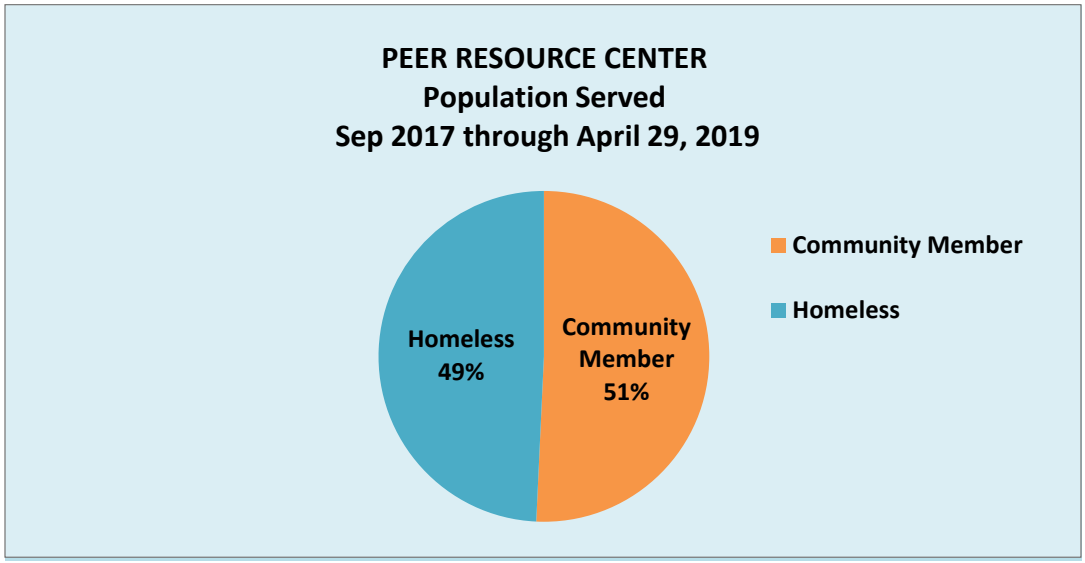
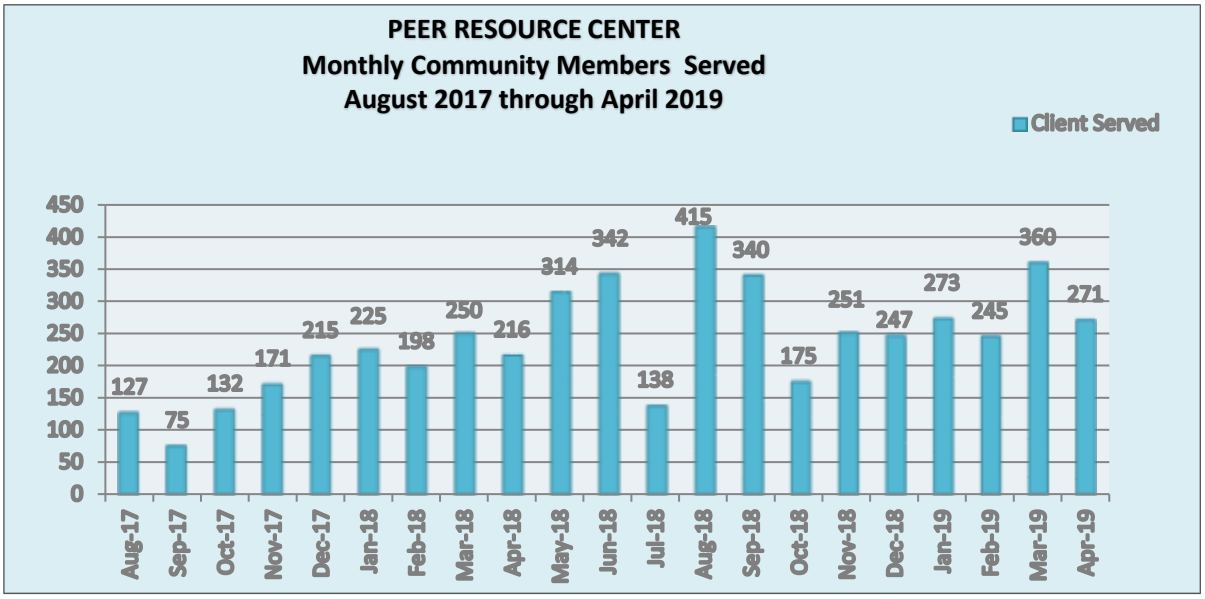


Figure 2: Number of Persons Served at the PRC



Peer-Run Respite Care Homes (PRRCH)

- PRRCH services are peer-operated and member driven community-based, the recovery-oriented, holistic alternatives to traditional mental health programs. The PRRCH program offers consumers a short voluntary stay in a warm, safe, and healing environment while engaging in recovery focused supportive services. Although PRRCH is not to be used as shelter, the PRRCH staff work diligently to help homeless persons get connected to housing services. All guests are provided referrals to resources at the time they depart PRRCH services.

PRRCH achievements and highlights, FY 17-18:

- 393 guests were served with an average length of stay of 10 days
- 133 of these guests were homeless when they were admitted. Of the 133, 63 remained homeless. This is due to some guests not disclosing their true housing situation until the day of departure. 78% of guests reported making progress towards a personal goal and working towards it during their stay
- 78% reported having a family member or friend involved in their mental health treatment; 16% reported that family involvement helped
- 88% of guests were involved in consumer-run services, peer support groups, Alcoholics Anonymous; drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs
- 49% of guests spent at least three-to-six hours per week in a meaningful role in their community (working, volunteering, or school); 13% spent at least 16-30 hours per week in meaningful activities.

Integrated Clinic Model (ICM)

This model integrates culturally and linguistically appropriate physical health, mental health, and substance use services at primary care and mental health sites for individuals who are:

- Homeless
- Uninsured and economically disadvantaged
- Members of underrepresented ethnic populations, i.e., (African/African American, Native American, Asian/Pacific Islander, Eastern European/Middle Eastern, and Latino.)

ICM consumers must have at least one health condition or vulnerability that requires on-going primary care AND must meet Medi-Cal medical necessity criteria for specialty mental health services.

ICM Services include:

- Primary Care and Medical Services
- Mental Health Services
- Co-occurring Mental Health and Substance Use Disorder Services
- Outreach and Engagement
- Peer Counseling and Self-help
- Client Supportive Services

TAY Drop-in Centers

TAY Drop-In Centers are entry points to the mental health system for homeless youth or youth experiencing unstable living situations. Drop-In Centers provide “low demand, high tolerance” environments in which youth can find temporary safety and opportunities to build trusting relationships with staff members who connect them to the services and supports they need. Drop-In Centers also assist in meeting the youths’ basic needs such as nutrition, hygiene facilities, clothing, mailing address, and a safe place to rest. Generally, these centers operate during regular business hours. MHSA funding allows for expanded hours of operation during evenings and weekends.

Table 1: Location of Drop-In Centers by Service Area

Service Area (SA)	Agency/ Drop-In Center Name	Address
1	Penny Lane Centers – Yellow Submarine	43520 Division Street Lancaster, CA 93535
2	The Village Family Services -TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd. North Hollywood, CA 91606
3	Pacific Clinics – Hope Drop-In Center	13001 Ramona Blvd. Irwindale, CA 91706
4	Los Angeles LGBT Center – Youth Center On Highland	1220 N. Highland Ave. Los Angeles, CA 90038
5	Daniel's Place - Step-Up on Second Street, Inc.	1619 Santa Monica Blvd Santa Monica, CA 90405
6	Good Seed Church of God in Christ, Inc.- Good Seed Youth Drop-in Center	2814 W. Martin Luther King Jr. Blvd. Los Angeles, CA 90008
7	Penny Lane Centers – With A Little Help From My Friends	5628 East Slauson Ave. Commerce, CA 90040
8	Good Seed Church of God In Christ, Inc. Good Seed on Pine Youth Drop-In Center	1230 Pine Avenue Long Beach, CA 90813

Service Extenders

Service Extenders are peer volunteers with lived experience, whose personal journeys inspire other consumers. They receive specialized training to serve as members of the team and are paid a stipend. They understand their communities, speak their language, and are culturally sensitive to consumers' needs. Service extenders provide supportive services, which help consumers comply with treatment and remain independently in the community. They also provide assistance in navigating the mental health system.

During FY 17-18, LACDMH had 29 Service Extenders representing multiple ethnic backgrounds, cultural groups, and language capabilities. Besides English, other languages spoken by Service Extenders included Armenian, Cantonese, Farsi, Khmer, Mandarin, Russian, Spanish, Tagalog, and Vietnamese. A database containing information on all trained Service Extenders was maintained and utilized to match the linguistic/cultural needs of Providers with Service Extenders who possess the areas of expertise needed.

Alternative Crisis Services (ACS)

ACS provide a comprehensive range of services and supports for persons experiencing mental illness. These services are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care; reduce homelessness; and

prevent incarceration. ACS programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs: e.g. Full Service Partnerships (FSP) and Assertive Community Treatment programs (ACT), housing services, and treatment for co-occurring substance use disorders. ACS targets individuals 18 years of age and older of all races/ethnicities, gender identities, and languages spoken.

Residential and Bridging Program

This program involves psychiatric social workers and peer advocates work collaboratively in the coordination of psychiatric services and supports for TAY, Adults, and Older Adults with complicated psychiatric and medical needs. The program ensures linkages to appropriate levels and types of mental health and supportive services through collaboration with Service Area Navigators, Full Service Partnerships, residential providers, self-help groups, and other community providers. Peer advocates provide support to individuals in Institutions for Mental Disease (IMD), step-down facilities, and intensive residential programs to successfully transition them to community living.

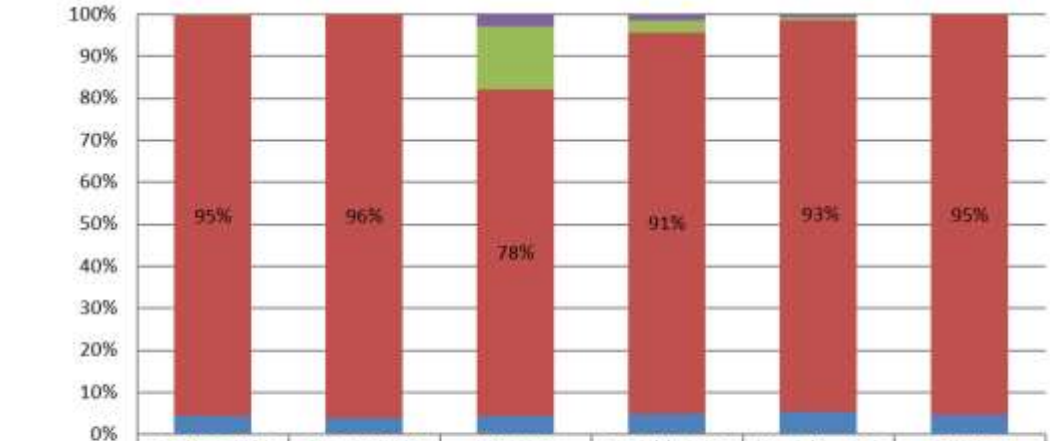
The County Hospital Adult Linkage Program is part of the Residential and Bridging program. Its mission is to coordinate of linkage services for consumers to ensure they are discharged with the appropriate level and type of mental health services, housing support, and substance use stabilization, among other needs. The County Hospital Adult Linkage Program is committed to assist individuals being discharged to successfully reintegrate into their communities.

Urgent Care Centers (UCCs)

Provide intensive and crisis intervention services to individuals who otherwise would be brought to emergency rooms for up to 23 hours of immediate care and linkage to community-based solutions. Integrated services are available for persons who have co-occurring substance use disorders. UCCs focus on recovery and linkage to ongoing community services and supports that are designed to reduce unnecessary and lengthy involuntary inpatient treatment.

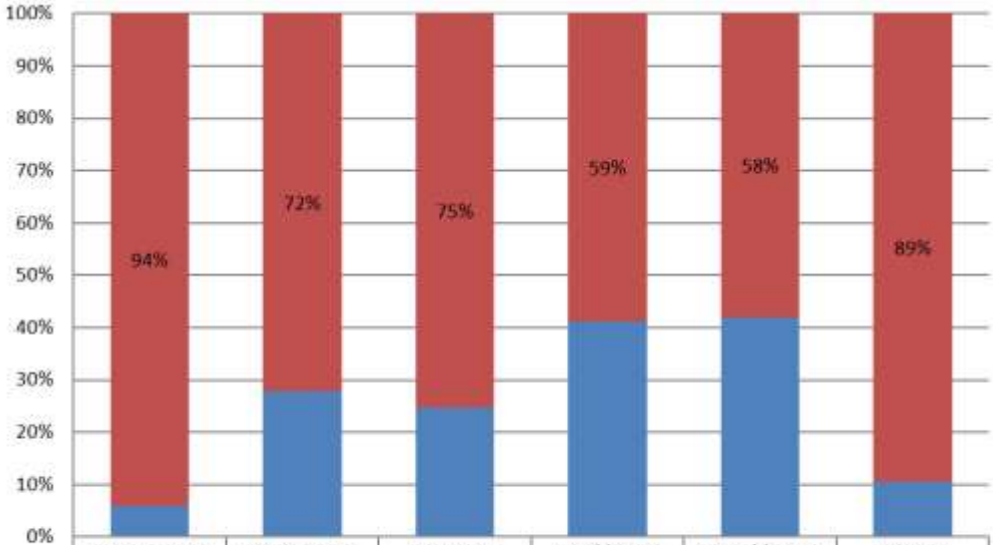
The Department tracks admissions to UCCs by age group: Child, Transition Age Youth, Adult and Older Adult countywide. The age group with the greatest rate of admissions is Adults. Additionally, data is also gathered on the new admission of persons who are experiencing homelessness. Figures 3 and 4 below summarize admissions on the basis of age group and homelessness status.

Figure 3: New Admissions at Urgent Care Centers (UCCs) By Age Category



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
Child	2	0	371	203	32	0
TAY	16	0	1863	445	35	0
Adult	4862	1479	9786	13629	4584	2173
Older Adult	224	61	541	739	269	109

Figure 4: New Admissions at UCCs Who Were Homeless upon Admission



	OV UCC 7591	OV UCC 7913	MLK UCC	Eastside UCC	Westside UCC	MHUCC
No	4802	1125	9447	8839	2853	2042
Yes	302	432	3087	6177	2067	240

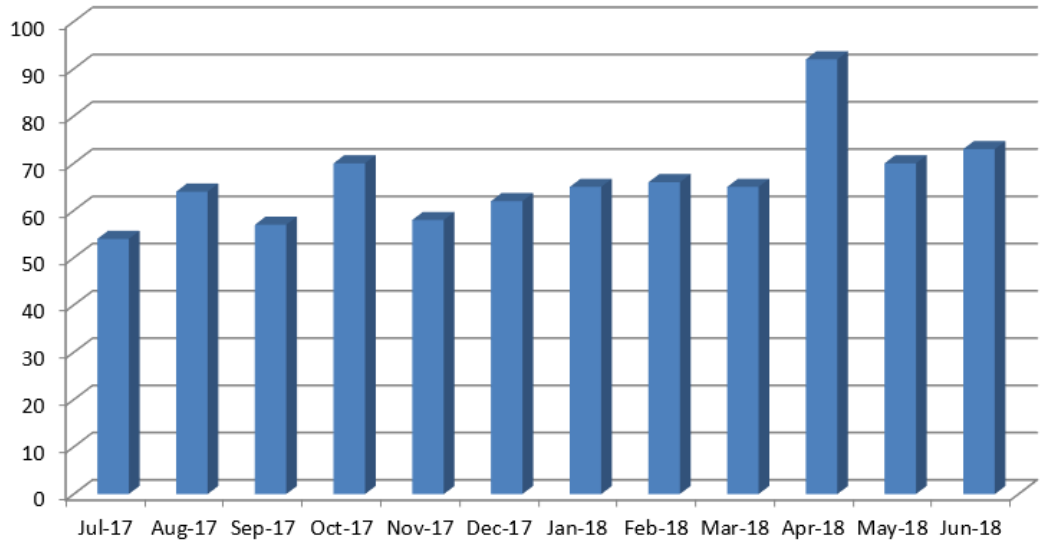
Enriched Residential Services

These services are designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities (ARF), in assisted living facilities, congregate housing or other independent living situations. Enriched Residential Service Providers assist consumers transitioning from acute inpatient and institutional settings to the community by providing intensive mental health, substance use treatment and supportive services. The majority of referrals for Enriched Residential Services are generated by IMDs, fee for service hospitals and community reintegration programs.

Table 2: Enriched Residential Services Admission Sources
FY 17-18

Source	# of Clients	%
State Hospital	9	1%
IMDs	222	26%
County Hospitals	106	13%
Fee for Service Hospitals	223	26%
Psychiatric Health Facilities/ Skilled Nursing Facilities	11	1%
LACDMH Jail/ Outpatient Programs	138	16%
Urgent Care Centers	20	2%
Mental Health Outpatient Providers	6	1%
Lateral Transfers/ Rollover/ Re-admits	80	10%
Emergency Outreach Bureau	16	2%
Crisis Residential Treatment Program	20	2%
Total	851	100%

Figure 5: Enriched Residential Services Discharge Sources
FY 17-18



II. Responsiveness of Mental Health Services

Recovery, Resilience and Reintegration-Community-Designed Integrated Service Management Model (RRR-ISM)

Starting July 1, 2017, this Model became the Recovery, Resilience and Reintegration (RRR)-ISM following the consolidation of the MHSA community services and support work plans. The RRR-ISM model provides a holistic model of care by incorporating components defined by the specific Underserved Cultural Communities (UsCC) subcommittees. The ISM promotes collaboration and community-based partnerships that integrate physical health, mental health, and substance use services with non-traditional practices to support recovery.

The model serves African/African-American (AAA), American Indian/Alaska Native (AI/AN), Asian Pacific Islander (API), Eastern European/Middle Eastern (EE/ME), and Latino communities. Additionally, the RRR-ISM promotes collaboration and community-based partnerships to integrate health, mental health, and substance use services together with non-traditional services to support recovery. A total of 10 RRR-ISMs have been implemented: One AAA, one AI/AN, three API, one EE/ME, and four Latino. The culturally-effective services are grounded in ethnic communities with a strong foundation on community-based services, non-traditional healing practices, and natural support systems such as faith-based organizations, homeopathic healers, voluntary associations, recreational providers, and any other community-defined approach for wellness and recovery (e.g., music studios and community club houses). RRR-ISM providers incorporate these non-traditional healing practices as part of the treatment in response to the cultural needs of the various underserved and underrepresented groups that they serve. Further, Outreach and Engagement (O&E) strategies are provided by community leaders and community peers as a way to promote mental health services in a culturally relevant manner.

The RRR-ISM providers implement non-traditional services creatively to engage underserved communities. The 35 different non-traditional activities utilized by the RRR-ISM providers to engage underserved communities include: Acupuncture/acupressure, art classes and presentations, art therapy, biofeedback sessions, coffee or tea clubs, chiropractic services, community social clubs, community walkathons, family picnics/concerts, cooking classes, dance, drumming classes, academic classes, faith-based activities, fitness activities, floral arrangement classes, gardening classes, grocery shopping, gym membership, healthy eating habits classes, jimjil-bang (Korean traditional spa), knitting support group, lesbian retreats, massage therapy, meditation classes, music classes, nutrition classes, poetry reading, spiritual blessings/healer sessions, spiritual retreats, sports activities, tai chi, writing classes, yoga, and Zumba.

RRR-ISM providers shall adhere to the following values and principles:

- Services are designed to assist individuals achieve their wellbeing and recovery/resiliency goals

- Services are voluntary and focus on helping individuals integrate into the community
- Services are provided in an individual's preferred language and in a culturally congruent manner
- Services support doing whatever it takes to improve mental and physical health and decrease substance use/abuse by including, non-traditional services, and culturally and linguistically appropriate outreach and engagement
- Programs work within and actively strengthen the natural support systems of specific underserved communities, so that these supports can be part of the consumer's recovery process
- Providers encourage consumers and their family members, parents, and caregivers to inform service providers on what is helpful and needed to assist him/her toward recovery
- Providers advocate for the consumer's needs and for changes in the system of care that will better support the integration of services and improved outcomes for the consumer
- Providers provide mental health, substance use and physical health promotion, and awareness through culturally competent outreach, education, and engagement strategies

(See Attachment 1: RRR-ISM Outreach and Engagement Calendars)

Promotores de Salud/Health Promoters

The LACDMH Promoters consist of individuals with lived experience, family members of consumers, or community leaders who live in and know well the geographic and cultural communities that they serve. They are mostly lay individuals with a wide range of educational levels and backgrounds. They are all Spanish speaking and bilingual, English and Spanish.

Once Promoters build connections in the community, they provide presentations on one of ten (10) possible mental health modules. The purpose of the modules is to educate the community on mental health issues, reduce stigma, prevent deterioration, and link to services when needed. The sites include schools, churches, senior citizen's centers, social service agencies such as YMCA, medical facilities, and even private residences.

The Health Promoters are hired to work by the hour or by the presentation. Some promoters work only a few hours a month while others may work up to 15-20 hours per week. Their work schedule is flexible and the number of hours worked varies based on their personal needs. For the most part, Health Promoters work part-time only as 1) they do not want to jeopardize their Supplemental Security Income (SSI) benefits, 2) they are parents with young children, 3) they may work as Promoters for other organizations and prefer to work independently. Most of the Promoters have limited income and receive Medi-Cal health insurance. When Promoters are interested in full time work, they receive assistance to become Community Health Workers within the Department. However, this job title and responsibilities change the scope of Promotor/Promoter work. In this regard, the Promoters program can be seen as an entry point for individuals wanting full-time employment at LACDMH.

Expansion of the Promotores de Salud Program

During FY 17-18, the Mental Health Promoters program was expanded to (SAs) 2, 3, 4, and 6. This expansion was designed to DPH's capacity to promote mental health and wellbeing, provide educational mental health workshops, resources, and linkage to mental health and other needed services to community members. Collectively, the Promoters conducted 4,287 mental health presentations throughout their service areas and reached approximately 35,138 residents. In addition, they participated in 197 community events, which included health and resource fairs, and had resource tables twice a week at both the Mexican and Salvadorian Consulates.

Furthermore during FY 17-18, Los Angeles County Department of Public Health (LACDPH) requested the continued assistance of the Mental Health Promoters to outreach the Latino communities affected by the Exide Battery Plant located in the City of Vernon. A total of 13 Promoters collaborated with the LACDPH providing 469 hours of community outreach in affected communities. These activities included participating in community meetings, assisting the LACDPH to register residents for lead level blood testing in community resource fairs, and registering homes for soil clean-up and door-to-door outreach. Promoters were also actively included in 88 Exide Lead Contamination presentations which were conducted at various schools, churches, and other community organizations.

Additionally, Promoters were asked to assist the LACDPH with a community education program to prepare county residents for the potential spread of the Zika Virus and other mosquito borne diseases. A total of 14 Promoters were selected based on their previous community outreach experiences and received a four (4) hour training on mosquito borne diseases. They were provided with presentation materials to demonstrate and deliver information on Zika Virus to the intended communities.

Transforming Clinical Practice Initiative (TCPI)

During FY 17-18, LACDMH continued efforts to apply the TCPI Model to 22 different initiatives. The TCPI model strategically engaged LACMDH programs to identify and test workflow approaches that would lead to improvements in procedural practices that best serve the community and commitment to meet quantifiable outcomes. Several Directly Operated clinics implemented the Transforming Clinical Practice Initiative (TCPI) and trained multi-disciplinary teams in Quality Improvement Process and Plan Do Study Act (PDSA) cycles to address and problem solve issues identified at their sites.

The LACDMH programs listed below worked directly with TCPI coaches to establish standard protocols for improved functioning:

- American Indian Counseling Center
- Antelope Valley Mental Health Center
- Arcadia Mental Health Center
- Augustus F. Hawkins Mental Health Center
- Coastal API Mental Health Center
- Compton Family Mental Health Center
- DMH/DHS collaboration

- East Gabriel Valley Mental Health Center
- Edelman Westside Mental Health Clinic
- Hollywood Mental Health Center
- Long Beach API Mental Health Center
- Northeast Mental Health Center
- Palmdale Mental Health Center
- Roybal Family Mental Health Center
- San Fernando Mental Health Center
- Telemental health program
- VALOR Program

Examples of TCPI projects/milestones:
- Meeting clinical quality metrics targets
- Improving follow-up after hospitalization
- Ensuring client engagement in individual goal setting
- Closing the for loop with community resources
- Enhancing coordination with primary care
- Consistently, using evidence-based protocol
- Demonstrating quality improvement culture
- Maximizing use of health information technology
- Supporting and maximizing joy in work
- Using methods to improve operational efficiency

TCPI coaches were assigned to specific Service Areas. Once established, they worked with each site individually to identify areas of performance improvement interest and implement a system that best serve the consumers, family members and communities. A central feature of site-specific TCPI work plans was establishing systems of accountability for each staff member's role and responsibilities. A quality improvement toolkit was developed by the coaches to assist clinics in TCPI goals. Site-level data collection has been planned for August and September 2018.
(See attachment 2: TCPI Quality Improvement Toolkit)

Performance Improvement Projects (PIPs)
As a part of the External Quality Review Organization (EQRO) requirements and mandated by the Code of Federal Regulations, Title 42, the Quality Improvement (QI) program is responsible for collaborating on SA QI projects and PIPs. Title 42 C.F.R. § 438.240(d) require LACDMH to conduct a clinical and non-clinical PIP, which must be validated and reviewed by an External Quality Review Organization (EQRO) annually.

The Office of Administrative Operations – Quality Improvement Division is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. Each year, the OAO-QID conducts a clinical and non-clinical PIP. The PIPs are conducted to ensure that selected administrative and clinical processes are reviewed to improve performance outcomes.

A Clinical Performance Improvement Project (Clinical PIP)

In July 2017, the External Quality Review Organization review team approved the clinical PIP project, "Post Discharge Outpatient Follow-up Appointment Scheduling for Hospital Discharges – Impact of Care Coordination and Continuous Quality Management (CQM) Protocols". The purpose of this clinical PIP was to reduce preventable hospital readmissions. The project's interventions were centered around increasing linkages to support LACDMH consumers approaching hospital discharge. According to the literature, interventions delivered pre- and post- hospital discharge have effectively targeted the clinical and demographic factors that contribute to multiple hospital readmissions. Examples of pre-discharge interventions and bridging strategies include discharge planning and continuity of care between inpatient and outpatient settings. Post-discharge interventions include services provided through integrated outpatient treatment, such as COD support. The project concluded in September 2018.

The following study questions formed the basis of the clinical PIP:

- Will prolonged stabilization of post hospital discharge impact hospital re-admission rates?
- Will Co-Occurring Disorders (COD) group participation contribute to positive perceptions regarding COD groups and self-reported reduction in substance use?
- Will implementing hospital discharge outpatient follow-up care coordination protocols reduce barriers to scheduling post-hospital discharge, urgent, outpatient appointments for Directly Operated (DO) and Legal Entity (LE)/Contracted programs?

The four interventions of this clinical PIP included:

- Availability of crisis residential treatment services upon discharge from a hospital and facilitated active communication between outpatient providers and hospitals
- Delivery of effective outpatient services focused on integrated COD treatment
- Implementation of the Hospital Discharge Outpatient Follow-up Care Coordination (HDOFCC) protocol, a system of addressing barriers that hospitals face when scheduling appointments at LACDMH clinics
- Introduction of the TCPI: CQM protocols for responding to appointment requests from hospitals at 15 DO clinics. In September 2017, the study's population was changed from exclusively Intensive Service Recipients (ISRs) to all adult consumers discharged from Fee-For-Service (FFS) hospitals and in need of immediate outpatient follow-up. The project expanded beyond ISRs due to several barriers with engagement. Hospital readmission, as a clinical problem, is complex with multiple contributing factors.

Results:

There was no notable improvement in the primary indicators and outcomes of this project, specifically: the seven (7)-day outpatient follow-up rates, the seven (7)-and 30-day readmission rates, and the average length of stay in hospitals. However, there was improvement in the consumers' perception of COD groups as well as evidence of increased participation in outpatient treatment services. Upon completion of the clinical PIP, LACDMH DO clinics and hospitals continued the new HDOFCC and TCPI

CQM protocols aimed at improving linkages and decreasing hospitalizations. The current PIP started in July 2017 and the projected completion date is July 2019.
(See attachment 3: 2018 Clinical PIP Summary Report)

Non-Clinical Performance Improvement Project (Non-Clinical PIP)
In July 2017, the EQRO team approved the Front Office Customer Services as the non-clinical PIP for FY 17-18. The purpose of this non-clinical PIP was to improve customer service of front office staff and thereby improve consumer satisfaction. The Department has administered a variety of consumer satisfaction surveys focusing on access to care and satisfaction with services. Survey data has reflected the feedback of consumers receiving services in general outpatient and specialized programs and across all age groups. Further, based on the feedback received from the consumer focus groups facilitated by the EQR team and Cultural Competency Committee members, LACDMH recognized the need to implement a consumer satisfaction survey to evaluate front office customer service at DO clinics. The front office experience and customer service was an under-evaluated area of the system; yet it played a role in beneficiary access to initial and ongoing care.

The question that formed the basis of the non-clinical PIP was:
"Will implementing front office customer service training and psycho-education on mental health educational materials improve the consumer satisfaction rates related to front office customer service?"

LACDMH implemented two interventions as a part of the non-clinical PIP:

- Front office staff was provided with customer service training on the consumer experience
- Psychoeducation on mental illness. The customer service training was applicable to front office staff at outpatient programs throughout the system of care, including DO and LE/Contracted programs.

The Department's Outpatient Services Bureau (OSB) developed the Front Office Customer Service (FOCS) satisfaction survey for this project. This brief satisfaction survey served as a self-report measure designed to assess five (5) aspects of customer service: helpfulness, flexibility, dignity and respect, feeling welcomed, and professionalism. The surveys were administered at 35 DO clinics. The FOCS satisfaction survey data was gathered prior to the customer service training, between February 12, 2018 and February 26, 2018, and following the training between June 5, 2018 and June 15, 2018.

Results:
With the exception of flexibility (i.e., with late arrivals and missed appointments), there was no additional improvement in consumer satisfaction. The question regarding flexibility was found to be the least answered. It is presumed that consumers were either unsure of how to interpret the question or were reluctant to provide a negative rating. While the training did not make an appreciable difference in LACDMH consumers' satisfaction, front office staff had positive ratings of the customer service training and presumably could use their improved knowledge and skills towards their interactions with

consumers. Given that satisfaction was already high, at upwards of 90%, it presented a challenge to further increase these ratings.

This non-clinical PIP provided LACDMH with confirmation that consumers are generally satisfied with their customer service experience and that "flexibility" warrants further investigation. The EQRO team encouraged LACDMH to identify and present a different project for the next non-clinical PIP.
(See attachment 4: 2018 Non-Clinical PIP Summary Report)

Pharmacy Services

Pharmacy Benefits Management Service

Since contracting with Magellan for Pharmacy Benefits Management (PBM) services, LACDMH has significantly expanded its pharmacy network to afford consumers access to over 1,700 retail pharmacies across Los Angeles County. The number of enrolled consumers has remained steady at approximately 33,000, with approximately 4,000 prescription claims adjudicated per month by Magellan. Other services delivered by Magellan include:

- Operating a 24/7 Call Center to answer questions/concerns from consumers, pharmacy providers, and prescribers regarding eligibility and prescription coverage (averaging 1,000 calls each month)
- Approving appropriate early refill requests from consumers and pharmacy providers in a timely manner
- Maintaining drug formulary to reflect LACDMH Pharmacy & Therapeutics (P&T) Committee decisions
- Providing data on prescribing patterns to guide quality improvement efforts
- Providing welcome letters and prescription plan identification cards to all LACDMH uninsured consumers
- Managing network pharmacies to ensure they meet expectations from LACDMH uninsured consumers

Clinical Pharmacy Service

In 2018, LACDMH received approval to expand pharmacy services and provide clinical pharmacist services at selected high-volume clinics. Clinical pharmacists provided comprehensive medication management services to:

- Ensure that medication choice is arrived based on a shared decision-making process between consumer and prescriber(s)
- Promote relationships between prescribers and consumers that are built on trust and collaboration
- Facilitate open and clear communication regarding treatment options, purpose of medication, and its side effects
- Ensure the consumers' and their families' wishes and values have been taken into consideration
- Identify and remove barriers to medication adherence

Innovation Projects

Innovation 2: Community Capacity Building to Prevent and Address Trauma

During FY 17-18, Los Angeles County Board of Supervisors (BOS) approved ten lead agencies, two in each Supervisorial District, to establish community partnerships in geographically-defined communities. The identified communities were those with a concentration of inequalities, including disproportionate levels of poverty, high concentrations of unserved and underserved individuals and poor health and well-being outcomes, including educational and unemployment inequities. Lead agencies were selected through a solicitation process. Each proposing organization and their community partners selected specific strategies based on their community's interests. Beyond the implementation of selected strategies, each community partnership was responsible for building the capacity of the specific communities to work collectively toward supporting community identification and reduction of trauma. The strategies include:

- Building Trauma-Resilient Families
- Targeting children ages birth to five (5) and their caregivers who have experienced trauma and/or are at risk for trauma. Activities involved assessing and educating families and young children for exposure to Adverse Childhood Experiences (ACES)
- Trauma-Informed Psycho-education and Support for School Communities
- Training/workshops on recognizing behaviors and symptoms of stress and trauma in children provided to early care/education (EC/E) and school personnel and community mentors who work with children ages 0-15. The workshops would teach simple trauma-informed coping techniques that can be implemented within EC/E and school settings to reduce stress experienced by children
- Outreach and Engagement to TAY and TAY Peer Support groups
- Outreach to TAY who are at risk of or experiencing trauma as a result of homelessness
- Coordinated Employment within a Community
- Through a standardized employment assessment tool, a network of businesses within a specific community was created and provided coordinated job opportunities to individuals who have a mental illness and who are homeless/formally homeless. Job opportunities were sought out in the competitive employment market and through the development of social enterprises within the neighborhood
- Community Integration for Individuals who have a mental illness with Recent Incarcerations or who were Diverted from the Criminal Justice System
- This was a community response involving the creation of a consortium of law enforcement, the courts, and community agencies to reduce re-incarcerations
- Geriatric Empowerment Model (GEM) Program
- It was designed to reach out, engage and house homeless older adults
- Culturally Competent Non-Traditional Self-Help Activities for Families with Multiple Generations Experiencing Trauma
- This included engagement, intergenerational story-telling and intergenerational mentorship programs

Innovation 3: Technology Suite

After receiving approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC) on October 26, 2017, for Kern and L.A. Counties initiated and formed the foundation for the statewide innovation collaborative, the "Technology Suite," which made steady progress toward launch of its first mobile-device based applications. The Department entered into an agreement with CalMHSA, a Point Powers Authority utilized by counties, to manage the administrative functions of this multi-county project. The participation agreement was approved by the L.A. County Board of Supervisors on February 20, 2018. The components of the Technology Suite include the following features, accessible from a computer, cell phone and tablet utilizing customized applications:

1. Digital detection of emotional, thought, and behavioral disturbances through passively collected data and sophisticated analyses that sense changes in the user interface known to correlate with social isolation, depression, mania, the early psychotic (prodromal) syndrome, and other indicators of either the onset of new mental illness or the recurrence of a chronic condition. As concerning signals are detected, communication to the user is generated through texts, emails, peer's or clinician's outreach for prompt care
2. A web-based network of trained and certified peers on call to chat 24/7 with individuals experiencing worsening symptoms of mental illness as well as family members and caregivers. A link to this network available through the reengineered LACDMH website and other forms of social media will be used to widely disseminate the service across L.A. County. It will be branded as both a support and a triage tool for anyone experiencing problems at any time, especially those unfamiliar with self-management techniques, confused or unclear about the resources available for help, or reluctant to walk into a mental health clinic
3. Virtual, evidence-based on-line treatment protocols that use avatars to deliver clinical care. By their nature as virtual tools, this client-provider interface is available 24/7 and can be accessed in the convenience of home environments, clinical settings, and even on smart phones

Los Angeles, Kern, and Mono Counties participated in vendor selection for each of these components on February 26 and 28, 2018 and selected 7 Cups for components 2 and 3, and Mindstrong for component 1. Orange and Modoc Counties were approved to join the Technology Suite on April 26, 2018, and ten additional counties were approved on September 27, 2018 for a total of 15.

During the early summer of 2018, RSE was selected as the outreach, engagement and marketing firm and the University of California, Irvine as the evaluator of the project. The Department has launched the digital phenotyping Mindstrong care application at Harbor-UCLA's outpatient Dialectical Behavioral Therapy (DBT) program as a strategy to promote early detection of emotional dysregulation. Elements of DBT, such as the Diary Card, have been incorporated into the Mindstrong application to create a more efficient way for consumers to complete diary cards and for clinicians to utilize the information in the treatment process.

Innovation 4: Transcranial Magnetic Stimulation (TMS)
The Department received approval from the MHSOAC on April 26, 2018 to implement TMS as a strategy to effectively treat depression in consumers that have tried two or more anti-depressants without relief and improvement. The Department will deliver TMS via an outfitted van that will travel to different outpatient mental health programs.

Innovation 5: Peer Support Specialist Full Service Partnership
The Department received approval from the MHSOAC on April 26, 2018 to implement two (2) teams comprised mostly of peer support specialists to provide FSP level services. The Department is in the process of identifying providers.
Source: The Innovation information listed above was extracted verbatim from the Mental Health Services Act-Three Year Program & Expenditure Plan Fiscal Years 2017-18 through 2019-20

MHSA Plan Consolidation
The original 24 Work Plans of the Community Service and Support (CSS) plan were consolidated into six (6) for purposes of improving service continuity, service capacity, and administrative oversight. The six (6) work plans under the new CSS Plan consolidation include: Planning, Outreach and Engagement (POE), Full Service Partnership, alternative crisis, non-FSP RRR services, linkage, and housing. The following table summarizes the types of services that will be provided under each Work Plan.

Table 3: CSS Consolidated Work Plans

POE	FSP	Alternative Crisis Services	Recovery, Resilience & Reintegration Services (Non-FSP)	Linkage	Housing
• POE Teams	• FSP • FCCS (part of) • Family Support Services (C) • Family Crisis/Respite Care (C) • Housing FSP	• Residential & Bridging • Urgent Care Centers • IMD Step Down/Enriched Residential Services (A) • Countywide Resource Management • Mental Health-Law Enforcement Partnerships (MHSA funded)	• FCCS (part of) • Wellness/Client Run Centers (A) • TAY Drop In Centers • Probation Camp Services (T) • TAY Supported Employment • Family Wellness Resource Centers (C) • Integrated Care Programs • Crisis Resolution Services • Service Extenders (OA)	• Jail Linkage & Transition (A) • Service Area Navigation	• Housing for TAY and Adult • Housing specialists • MHSA Housing Program/Special Needs Housing Program • Housing Trust Fund • Housing support team for No Place Like Home

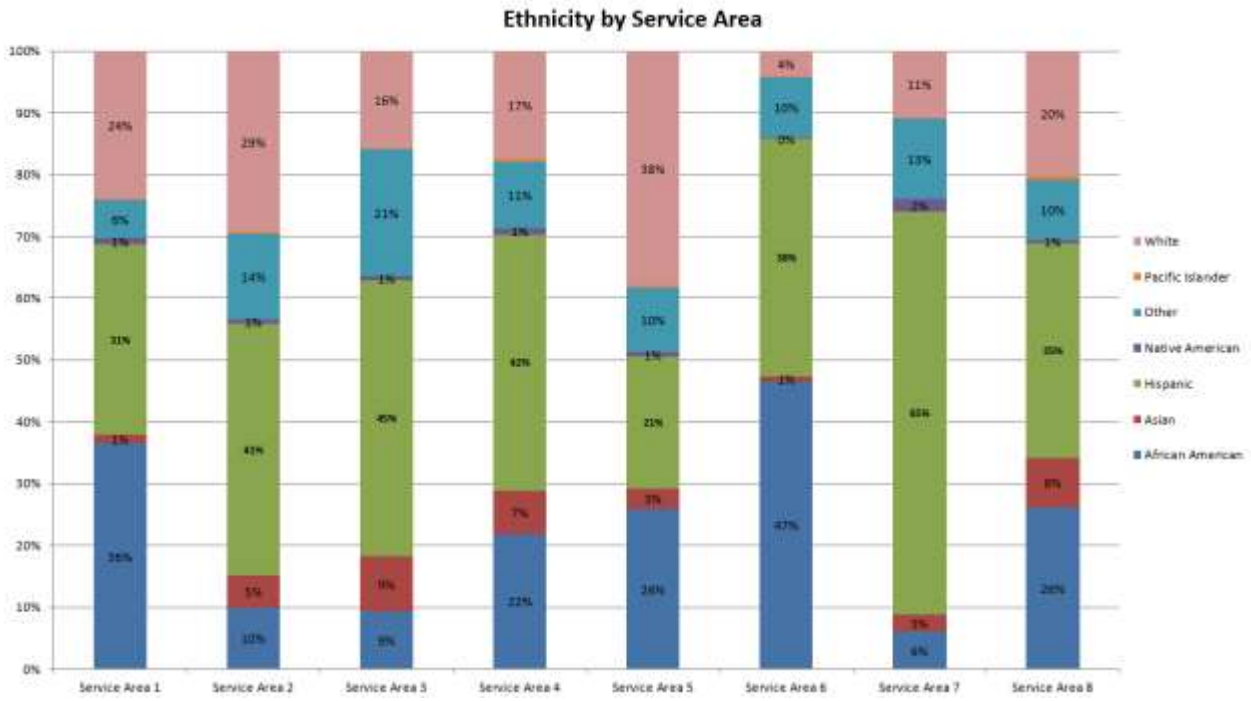
(A) - Adults (C) - Children (T) - Transition Age Youth (OA) - Older Adult

Table 4: L.A. County Clients Served Through CSS
FY 17-18

Clients	New Clients
• 132,397 clients received a direct mental health services • 40% of the clients were Latino • 23% of the clients were African American • 18% of the clients were White • 5% of the clients were Asian • 78% had a primary language of English • 15% had a primary language of Spanish	• 61,985 New clients received CSS services Countywide with no previous MHSA service • 39% of the new clients were Latino • 19% of the clients were African American • 18% of the clients were White • 75% had a primary language of English • 18% had a primary language of Spanish

Source: Outcomes during FY 17-18 from the MHSA Annual Update FY 19-20

Figure 6: L.A. County Clients Served Through CSS by Service Areas
FY 17-18



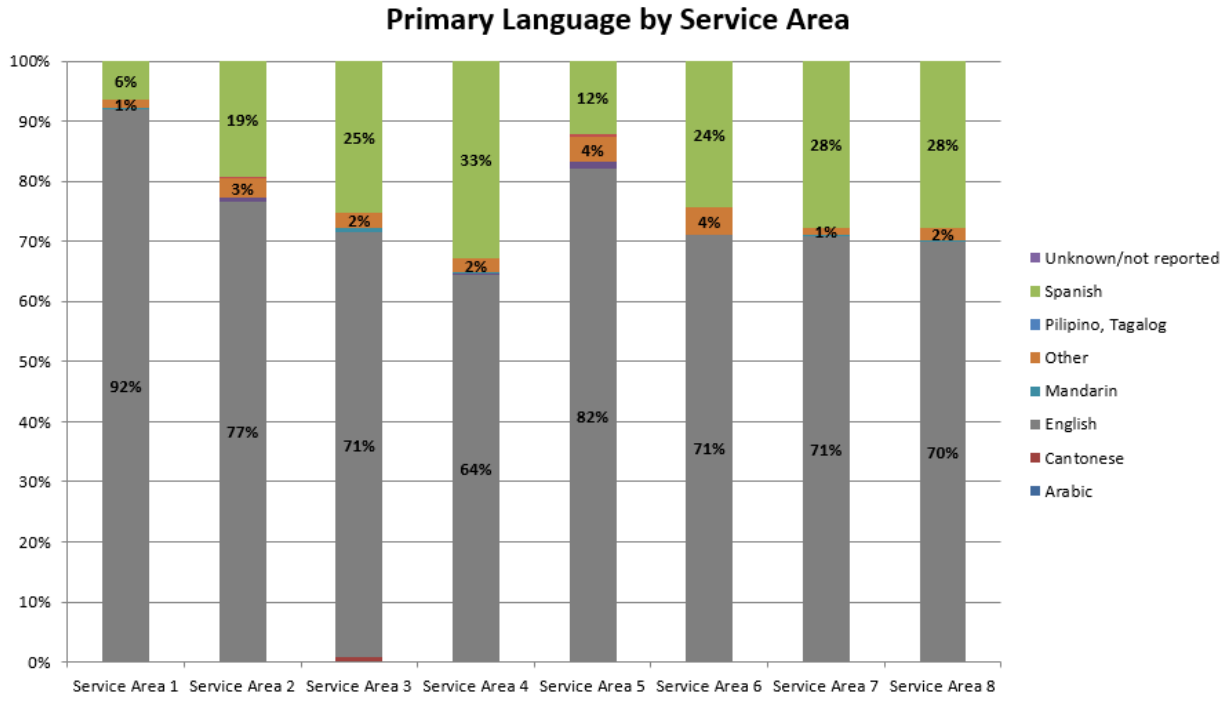
Source: Outcomes during FY 17-18 from the MHSA Annual Update FY 19-20

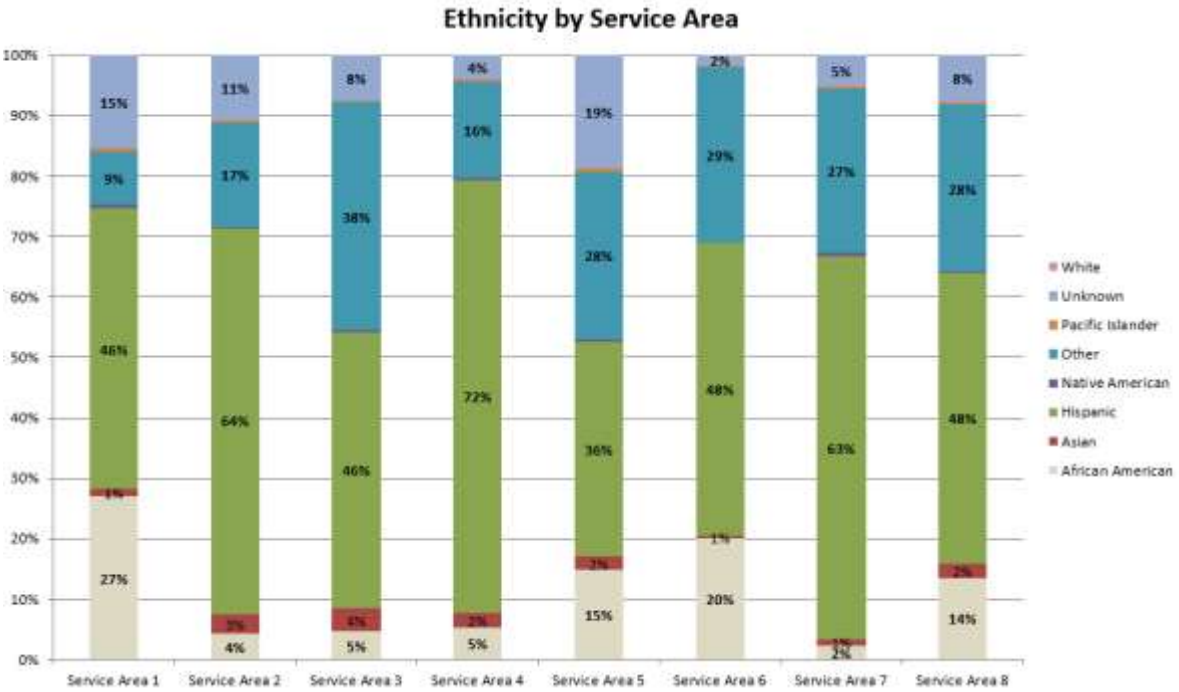
Table 5: L.A. County Clients Served Through PEI
FY 17-18

Clients	New Clients
• 44,212 clients received a direct mental health service • 55% were Latino • 73% had a primary language of English • 69% of the clients were children • 19% of the clients were TAY • 10% of the clients were Adult • 2% of the clients were Older Adult	• 27,341 new clients received PEI services Countywide with no previous MHSA service • 51% were Latino • 72% had a primary language of English

Source: Outcomes during FY 17-18 from the MHSA Annual Update FY 19-20

Figure 7: L.A. County Clients Served Through PEI by SAs FY 17-18





Source: Outcomes during FY 17-18 from the MHSA Annual Update FY 19-20

MHSA Information Technology (IT) Projects

1. *Access Call Center Recording System Upgrade*
   The Project objective was to replace aging on-premises video screen capture and audio call recording system with Cloud-based recording system to capture calls from any location. The project started on March 14, 2018 and the expected completion date is June 2019. The project included following activities:
   - Initial assessment of project scope and requirements
   - Identify key risks and issue
   - Identify core team members
   - Identify potential solution vendors

2. *Digital Workplace: Enterprise Mobility and Security*
   Migration of County-issued mobile devices (primarily Apple iPhone models) from the Mobile Device Management (MDM) solution, Research in Motion's BlackBerry Enterprise Server (BES), to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform to ensure compliance with federal regulations (i.e., HIPAA) regarding the protection of personal health information (PHI). This was to establish and apply conditional access policies that define how applications and services can be accessed both on and off the County network.

   The project started on June 15, 2017 and was completed on December 14, 2017 by migrating 1,294 devices to the cloud-based Microsoft Office365 Enterprise Mobility and Security (EM+S) device management module and platform. Enterprise Mobility Management (EMM) provided the capability to manage assigned mobile devices in protecting PHI and allowed use of only approved applications on the managed devices.

3. *Digital Workplace: WI-FI Access at LACDMH Clinics and Admin Sites*
   The project started in January 2018 and is expected to complete in December 2018. The project objective was to provide both employee and guest access wirelessly to County and Internet resources at LACDMH facilities. The employees who span multiple clinical environments can be more productive in whatever space they set up to work and they can serve the consumers more efficiently. The project for providing Wi-Fi access to the DO locations has been divided into three (3) phases. Phase 1 consists of 11 sites. Phase 2 consists of 21 sites. Phase 3 consists of 19 sites.

4. *Digital Workplace: Video Conferencing/Webcasting Expansion*
   The project objective was to expand webcasting to the Department by using Skype. Purchasing and deploying new equipment for continuation of video conferencing and webcasting as a mode of communication and collaboration save on travel time and increase productivity.

Phase 1 of the project initiated to roll out a set of Microsoft Surface HUBS to 20 locations. The subsequent phases will include the use of telepresence and Skype

capabilities throughout the department as a mode of collaboration and communication. The project started on December 15, 2017 and the projected completion date is June 30, 2019.

5. *Constituent Call Log - Consumer and Family Advocacy*

   The Office of Consumer Affairs logs complaints/issues from Constituents and resolves those concerns as a form of advocacy for LACDMH in all SAs. The BOS also submits issues/complaints and requests status updates. This project developed a solution using Microsoft Dynamics that allows multiple staff members and interns to simultaneously enter complaint/issue information real-time, track status of complaints, monitor trends/call patterns, and report information. The solution also provided a running history of transactions with constituents and accommodated the growing number of calls. The project was implemented on April 30, 2018 for the Office of Consumer Affairs.

Network Adequacy Certification Tool (NACT)

The NACT project complies with State Department of Health Care Services (DHCS) requirements pertaining to Network Adequacy and Certification. An on-line application was developed to collect and verify data regarding NACT. All LACDMH providers must review, update, and validate their information regarding organization, service location, and staff. The project was implemented on March 20, 2018. Microsoft CRM Solution was deployed for DO Providers and the Microsoft CRM Portal was deployed for LEs and Fee For Service (FFS) providers.

Network Adequacy Certification Tool (NACT) App

The objective of this project was to create an automated process to extract data from the NACT application and Integrated Behavioral Health Information System (IBHIS) to create submission files to be uploaded to the State of California Client and Service Information (CSI) website. This project intended to ensure LACDMH compliance with the DHCS network adequacy and certification requirements. The NACT application and NACT State Submission were created and developed in response to network adequacy standards as required by Medicaid. This application facilitated the process for providers to submit information regarding the NACT requirements on a quarterly basis as required by the State.

Specifically, the NACT application captures the number of cultural competence training hours over the past twelve (12) months for each Mode 15 practitioner. In addition, it tracks the percentage of all workforce members who have been trained in cultural competence over the past twelve (12) months. Providers are expected to keep the Network Adequacy app up-to-date on a monthly basis.

The NACT app is divided into three (3) levels:

1. Organizational level (provider's legal entity)
2. Site level (service location, physical location, or site)
3. Practitioner level (individual rendering practitioner, acting within his or her scope of practice, who is rendering services directly to the clients)

The percentage of workforce members trained in cultural competence is entered at the site level

- Providers (practitioner and administrative staff from clinical programs) report completion of cultural competence trainings
- Administrative staff from centralized headquarters programs continue to utilize the cultural competency unit's attestation forms

Patient's Rights Change of Provider App

The project objective was to computerize the process of consumers' requesting any change of provider that is part of the services they are receiving from LACDMH DO or LE/Contracted Providers. The Application will also track State mandated requirements that are related to any request for change of providers.

For DO users, the Microsoft CRM Dynamics Application is in the Execution Phase in the Sandbox Development environment. The primary users, patient's rights, are currently testing. The project started in December 2017.

Consumer/Family Access to Computing Resources Expansion

This project replaces aged equipment and expands resource as an extension of the original Consumer/Family Access to Computing Resources project, having the objective of empowering consumers and their families to use IT systems at LACDMH and County Library locations to allow them to enhance personal skills and support wellness. The Expansion project consists of additional sites including the LACDMH HQ-located PEER Center. The project start date was July 1, 2017 and the expected completion date is June 30, 2022.

Provider Directory

As a result of the Final Rule Mental Health Plans (MHPs), the Provider Directory should be available to beneficiaries in both electronic and print form (upon request). The directory includes information regarding Dos and LEs/Contracted providers such licensed, waivered, or registered status of practitioners in the LACDMH system of care.

The Provider Directory as tool can be accessed by the public and staff. Data for the Provider Directory is gathered from the NACT application. LACDMH submitted the Provider Directory to the State in its PDF version in compliance with the State requirements of the Final Rule on March 30, 2018.

LACDMH 2018 Cultural Competence Organizational Assessment

This ultimate goal of this project involves a system wide assessment of staff perceptions regarding the Department's responsiveness to the cultural and linguistic needs of the Los Angeles County diverse communities. During FY 17-18, the Ethnic Services Manager, worked closely with the hired consultant, Davis Ja & Associates to implement the first phase of the project, which involved the development of a focus group questionnaire to be utilized with consumers and various staff functions (e.g. clerical/support, direct clinical providers, and management).

The focus questionnaire was presented to the departmental Cultural Competency Committee in draft form for feedback and recommendations. Once finalized, the consultant utilized the questionnaire to conduct a total of nine focus groups. Five of the focus groups were run with total of 34 consumer participants and four focus groups with 27 staff. The Cultural Competency Unit collaborated with the Human Resources Bureau to acquire the support of Labor Unions and a random sampling of employees to participate in the focus groups. The consumer participants were recruited via the Cultural Competency Committee and the Underserved Cultural Communities subcommittees. The pool of focus group participants was racially/ethnically and linguistically diverse.

The focus group questionnaire was composed of 15 open-ended as summarized in the table below

TABLE 6: FOCUS GROUP QUESTIONNARIE

Areas identified by LACDMH for Questionnaire Items	Items Developed for Consumer Focus Groups	Items Developed for Staff Focus Groups
The culture of being a mental health consumer	1. What do consumers of MH services share in common?	1. How can providers, including office staff and receptionists develop more positive attitudes about consumer culture?
The consumer's personal experience in receiving mental health services	2. What has it been like for you to be a consumer of mental health services? 3. What, if any, are some examples of times when you felt that your cultural group was understood or welcomed, or that you did not feel understood or welcomed?	2. How can providers, including staff and front desk receptionists develop a better understanding of the personal and cultural experiences of consumers (e.g. intergeneration trauma, genocide, immigration stress)?
The consumer/ service provider relationship and its impact on the consumer's wellness and recovery	4. How comfortable do you feel about addressing issues related to cultural sensitivity (or lack thereof) with your provider? 5. What are ways to improve consumer/service provider relations?	3. What needs to be improved in terms of DMH provider relationships with consumers?
How service providers can demonstrate their cultural and linguistic	6. What has been your experience with interpreters? What are the benefits and disadvantages of having an interpreter present?	4. How can service providers (inclusive of therapists, psychiatrists, and front desk staff) show cultural sensitivity toward consumers?

Areas identified by LACDMH for Questionnaire Items	Items Developed for Consumer Focus Groups	Items Developed for Staff Focus Groups
responsiveness to consumers	7. How can service providers (inclusive of therapists, psychiatrists, and front desk staff) show cultural sensitivity toward consumers? 8. What role does spirituality play in providing culturally competent MH services?	5. What role does family play in mental health care? 6. What role does spirituality play in providing culturally competent MH care?
How service providers can promote a welcoming and respectful atmosphere for consumers and other staff	9. How can providers, including front desk staff, create more culturally welcoming facilities and office spaces?	7. How can providers, including front desk staff, create more culturally welcoming facilities and office spaces?
Effects of culturally and linguistically incompetent services on the consumer and the outcome of mental health services	10. In your experience, what are some of the negative things that can happen when service providers lack cultural or language sensitivity? 11. How can consumers let providers or staff know when their services are not culturally sensitive?	8. When services are not provided in either a cultural or linguistic appropriate way, what are the negative effects? 9. How can providers know when their services are not culturally appropriate?
Effects of diagnosis and labeling	12. For you or anyone you know who get services, how does learning that you or they have a diagnosis affect personal development or your relationships with friends and family?	10. For those that do counseling, how do you discuss diagnoses and treatment plans with a consumer in a culturally appropriate or sensitive way?
Service provider response to consumers' experience of societal, institutional, and	13. How does trauma that occurred to generations that came before you (sometimes called generational trauma) impact your mental health?	11. How does trauma/generational trauma relate to mental health treatment?

Areas identified by LACDMH for Questionnaire Items	Items Developed for Consumer Focus Groups	Items Developed for Staff Focus Groups
generational trauma	14. What should service providers know about societal or generational trauma that affects consumer MH (such as immigration related stress, discrimination stress, generational trauma)?	12. How can DMH providers be more aware of consumer trauma (such as immigration related stress, discrimination stress, generational trauma)?
Stigma reduction	15. In your opinion how do negative opinions about mental illness affect consumers?	13. How can providers help consumers cope with the negative impact of stigma?
Trainings to increase the cultural sensitivity of the workforce	N/A	14. What type of training should providers get to help build cultural sensitivity among staff? 15. How can DMH training help staff understand cultural similarities and differences among co-workers?
Recommendations for Developing a CC Assessment Survey	16. Do you have any recommendations for developing a Cultural Competence Assessment Survey that would be used to monitor LA County DMH's progress toward improving services?	16. Do you have any recommendations for developing a Cultural Competence Assessment Survey that would be used to monitor LA County DMH's progress toward improving services?

The outcomes of the focus groups will inform the development of the Cultural Competence Organizational Assessment Tool (CCOAT), which is scheduled for development and launch during FY 18-19.

Table 7: Results from Focus Group Conducted with Consumers and Staff

Consumer Themes	Staff Themes
Issues related to lack of general respect (e.g., no empathy and judgment)	Training needs and suggestions for training of non-clinical staff
Struggle with stigma and stigmatization	Cultural competence training recommendations

Consumer Themes	Staff Themes
Quality of service delivery	Staff efforts to be culturally competent in the workplace
Challenges navigating the system	Informal cultural competency training opportunities
Providers/staff demonstrate cultural sensitivity	Quality assurance needs related to cultural competence
Providers/staff demonstrate lack of cultural competency or sensitivity	Linguistic needs and issues, including interpretation and translation services
Suggestions for consumer involvement in the infrastructure	Bilingual staff
Experience with apathetic/desensitized providers	Effects of cultural competency or lack thereof in the provider-consumer relationship
Family involvement in mental health care	Suggestions on improving cultural competency and sensitivity in the workforce (besides through formal trainings)
Availability of services and information in non-English languages	Need for quality assessment
Family involvement in mental health care	Opportunities for consumer feedback
Training needs for interpreters	Issues with stigma and anti-stigma efforts
Cultural competency training needs for providers/staff	Hiring and appropriately staffing position
Importance of spirituality and its effects on mental health	Importance of Leadership – the trickle-down effect
Stories of intergenerational trauma	Focus on cultural humility
	Integrating spirituality in assessment and care
	Cultural competency in the physical environment/space
	Staff Morale and its effects on cultural competence

The consultant utilized the themes and specific recommendations gathered from the focus groups to inform the development of the CC Organizational Assessment Tool along with the following content identified by the ESM:

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
  - Principal Standard

  Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs

- Governance, Leadership and Workforce Standards. Examples:
  - ✓ Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources
  - ✓ Recruits, promotes, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area
- Communication and Language Assistance Standards. Examples include, but not limited to the following:
  - ✓ Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services
  - ✓ Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided
- Engagement, Continuous Improvement and Accountability Standards. Examples include, but not limited to the following:
  - ✓ Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations
  - ✓ Partner with the community to design, implement, and evaluation policies, practices and services to ensure cultural and linguistic appropriateness

- The CLAS definition of culture
- Cultural Competence Plan Requirements (CCPR)
- LACDMH data regarding mental health disparities
- County of Los Angeles ethnicity demographics and threshold languages
- LACDMH P&Ps that tap into cultural competency [e.g. hearing impaired mental health access, bilingual bonus, language interpreters, Clinical parameters for cultural competent service delivery, integration of spirituality, and family engagement, etc.]
- LACDMH Strategic Plan goals as related to cultural competency and reduction of disparities
- Cultural competency trainings available through the Department
- The concept of client culture, which refers to the clients' personal experience on topics such as wellness, recovery, stigma, discrimination, trauma, medication, hospitalization, etc.
- Mental Health Statistical Improvement Program (MHSIP) consumer satisfaction survey items related to cultural competency and reduction of disparities
- Mental Health Services Act (MHSA) Plans and programs that advance cultural competency and reduce mental health disparities within LACDMH
- Knowledge of Departmental committees, subcommittees, and taskforces that focus on the needs of underserved populations (i.e. Cultural Competence Committee and the Underserved Cultural Communities (UsCC) subcommittees)

- Information and recommendations gathered from interviews and focus groups conducted with key consumer/stakeholder groups and Departmental committees identified by LACDMH

III. Quality of Care: Contracted Providers

LACDMH Contractual Agreement

Section 8.15.3 of the LACDMH Legal Entity Contract instructs prospective Contractors to provide services that are consistent with the Department's Cultural Competence Plan and all applicable Federal, State, and local regulations, manuals, guidelines, and directives. Specifically,

- Contractors shall ensure that 100% of staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors receive annual cultural competence training
- Contractors shall monitor, track, document and make available upon request, by Federal, State or County government entities, the annual cultural competence training completed by their staff
- Contractors shall complete and submit an attestation of annual cultural competence training completed by 100% of staff to the Ethnic Services Manager (psbcc@dmh.lacounty.gov) by March 23rd of every Calendar Year

(See Attachment 5: LACDMH Legal Entity Contract)

In addition, per the Federal Managed Care Network Adequacy Final Rule requirements, 100% of direct service practitioners (psychotherapists, psychiatrists, case managers, etc.) must complete cultural competence training within the past 12 months to meet annual reporting requirements. This information needs to be entered and updated quarterly into the application (https://lacdmhnact.dynamics365portals.us/) based on each practitioner specifying the hours of cultural competence training completed. This information is due quarterly on the following dates of every Calendar Year.

An extensive list of regulatory legislations is cited in the contractual agreement. The most significant guidelines for culturally and linguistically competent service delivery include:

The California Welfare and Institutions Code, Section 5600

- Mental health services shall be based on person-centered approaches and the needs of priority target populations. Services shall also be integrated and inclusive of assertive outreach to homeless and hard-to-reach individuals and evaluated for effectiveness

Title IX

- Objectives and strategies need to be in place to improve the organization's cultural competency

- Population assessment needs and service provider/organization assessments are to be conducted in order to evaluate cultural and linguistic competence capabilities
- Specialty mental health services listings need to be made available to beneficiaries in their preferred language
- Cultural competence trainings need to be made available for all staff including administration and management

LACDMH Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services

- Program staff needs to reflect the culture, language, ethnicity, age, gender, sexual orientation, and other social characteristics of the community that the program serves
- Special consumer interventions employed to meet those needs must be documented. For example:
  - Visual and hearing accommodations
  - Language interpretation services
  - Cultural considerations
- Assessments need to identify the consumers' strengths, stages of recovery, and special service needs related to gender, ethnicity, preferred language, and other relevant information
- Documentation needs to include any relevant conditions and psychosocial factors affecting the consumer's physical health and mental health; including living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma
- Treatment Plans need to reflect individualized and strength-based services, address language interpretation needs, support family involvement, and encourage consumer input and participation

IV. Quality Assurance: Culturally Relevant Consumer Outcome Measures

The Consumer Perception Survey (CPS)

LACDMH's Office of Administrative Operations (OAO) – Quality Improvement Division (QID) shares responsibility with providers to maintain and improve the quality of services and delivery infrastructure. In addition to being required by State and Federal mandates, a regular assessment of our consumers' experience of services provided and their providers is essential to improvement and innovation within LACDMH.

The QID is responsible for the formal reporting on annual measurement of consumer perception of satisfaction in six areas, namely: General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcomes of Services, Perception of Functioning, and Perception of Social Connectedness. The Mental Health Consumer Perception Survey (CPS) forms were designed to assess each of these specific domains. CPS data is gathered twice a year in May and November.

CPS forms were developed for each age group. The Youth Services Survey (YSS) form is administered to consumers ages 13 to 17 years. The Youth Services Survey for Families (YSS-F) form is administered to family/caregivers of consumers aged 0 to 17 years. The Adult Mental Health Statistics Improvement Program (MHSIP) Consumer Survey form is administered to consumers aged 18 to 64 years and the Older Adult CPS is administered to consumers aged 65 years and older.

The survey items by age group are as follows:

YSS-F

- I felt my child had someone to talk to when he/she was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- My child gets along better with family members
- My child is doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

YSS

- I felt I had someone to talk to when I was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- I get along better with family members
- I am doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

Adult survey (ages 18-59 years)

- The location of services was convenient for me
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems
- I do better in school and/or work
- My symptoms are not bothering me as much

Older Adult survey (ages 60 years and over)

- The location of services was convenient
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems
- I do better in school and/or work
- My symptoms are not bothering me as much

LACDMH conducts consumer satisfaction surveys twice a year. The CPS Survey is utilized and administered to consumers served in randomly-selected Outpatient Clinics. The CPS were distributed at randomly selected Outpatient and Day Treatment programs in November 2017 and May 2018. Survey data was gathered from youth (ages 13-17) using the Youth Services Survey (YSS), from adults (ages 18–59) using the Adult Survey, and from older adults (ages 60 and older) using the Older Adult Survey. The families of Youth (ages 0-17) completed surveys for services received by their children using the Youth Services Survey for Families (YSS-F).

Results show on average, consumers agreed or strongly agreed that their services were sensitive to their cultural and linguistic needs, and that services were provided at convenient times and locations.

One of the survey goals was "Maintain the percentage of consumers/families reporting overall satisfaction with services provided between 89% and 90% for the May 2018 survey period and continue year to year trending of the data." During the May 2018 survey period, this goal was met for two (2) of the four (4) age groups/CPS forms. When comparing the overall satisfaction reported by consumers/families completing one of the four CPS forms, the goal was not met by ratings of overall satisfaction on the Adult survey (87.0%) or the YSS (86.7%). The goal was met and exceeded by families who completed the YSS-F (93.1%) and consumers who completed the Older Adult survey (90.3%).

Table 8: Three-Year Trend in Overall Satisfaction for May Survey Periods by Age Group CY 2016 – 2018

Age Group	May 2016	May 2017	May 2018
YSS-F			
Percent	88.5%	94.2%	93.1%
YSS			
Percent	93.3%	88.3%	86.7%
Adult			
Percent	86.5%	87.3%	87.0%
Older Adult			
Percent	92.0%	89.7%	90.3%

Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 8 presents the three-year trends in overall satisfaction for the May 2016, May 2017, and May 2018 survey periods by age group.

Table 9: Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Location of Services was Convenient" CY 16-18

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	92.4%	91.2%	92.8%	91.7%	92.8%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	80.8%	83.7%	84.3%	82.5%	84.3%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	84.2%	83.9%	83.7%	82.5%	83.7%
Older Adult					
Number	427	514	432	499	609
Percent	91.5%	88.7%	89.5%	88.4%	86.6%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	87.2%	86.9%	87.0%	86.0%	86.9%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 9 reports that approximately, 86.9% of the consumers/families who participated in the May 2018 survey period reported they agreed or strongly agreed with the statement, "Location of services was convenient." This represents a 0.1 PP decline from May 2017 and a 0.3 PP decrease from May 2016.

Overall, the percentage of consumers and families in CY 2016, CY 2017, and May 2018 that agreed or strongly agreed with the statement, "Location of services was convenient." There was no change i
n percentages for the YSS-F (92.8%), YSS (84.3%), and Adult (83.7%) from May 2017 to May 2018. Among Older Adult surveys, there was a 2.9 PP decline from 89.5% in May 2017 to 86.6% in May 2018.

Table 10: Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Services Were Available at Times That Were Convenient" CY 2016 - 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	94.0%	92.3%	93.4%	92.7%	93.5%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	82.3%	83.3%	86.3%	83.1%	84.5%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	90.6%	89.3%	90.3%	90.2%	90.5%
Older Adult					
Number	427	514	432	499	609
Percent	95.1%	93.3%	94.0%	95.2%	93.8%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	90.5%	89.6%	90.8%	90.0%	90.6%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses on the five point Likert scale. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 8 reports a total of 90.6% of the consumers and families that participated in the May 2018 survey period reported they agreed to strongly agreed with the statement, "Services were available at times that were convenient." There was a 0.2 percentage point (PP) decline from 90.8% in May 2017.

The percentage of consumers and families in families in CY 2016, CY 2017, and May 2018 agreed to strongly agreed with the statement, "Services were available at times that were convenient." Among YSS-F surveys, there was a 0.1 PP increase from 93.4% in May 2017 to 93.5% in May 2018. Among YSS surveys, there was a 1.8 PP decrease from 86.3% in May 2017 to 84.5% in May 2018. Among Adult surveys, there was a 0.2 PP increase from 90.3% in May 2017 to 90.5% in May 2018 in reported satisfaction. Among Older Adult surveys, there was a 0.2 PP decline from 94.0% in May 2017 to 93.8% in May 2018.

Table 11: Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Staff Were Sensitive to My Cultural/Ethnic Background" CY 2016 – 2018

Age Group	CY 2016		CY 2017		CY 2018
	May	November	May	November	May
YSS-F					
Number	2,622	2,684	2,209	4,158	4,213
Percent	94.9%	94.7%	95.4%	94.7%	94.9%
YSS					
Number	1,223	1,263	1,107	1,944	1,979
Percent	81.5%	84.7%	86.0%	82.6%	82.4%
Adult					
Number	3,346	3,620	3,299	5,119	5,422
Percent	86.0%	84.1%	84.5%	85.2%	86.1%
Older Adult					
Number	427	514	432	499	609
Percent	91.2%	92.0%	86.4%	91.0%	89.6%
Total					
Number	7,618	8,081	7,047	11,720	12,223
Percent	88.4%	88.9%	88.2%	88.3%	88.3%

Note: The "Number" represents the number of responses with a value of 3 or 4 (Agree or Strongly Agree) on a Likert scale from one to five. The denominator is the sum of all survey responses for that item. Data Source: CPS forms completed by consumers/families served in DMH outpatient programs between CY 2016 and May 2018.

Table 9 reports that a total of 88.3% of the consumers and families who participated in the May 2018 survey period reported they strongly agreed or agreed that staff were sensitive to their cultural/ethnic background. There was a 0.1 PP increase in reported satisfaction from May 2017 to May 2018.

The percentage of consumers and families in families in CY 2016, CY 2017, and May 2018 that agreed to strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." Among YSS-F surveys, there was a 0.5 PP decrease from 95.4% in May 2017 to 94.9% in May 2018. Among YSS surveys, there was a 3.6 PP decrease in May 2018. Among Adult surveys, there was a 1.6 PP increase from 84.5% in May 2017 to 86.1% in May 2018. Among Older Adult surveys, there was a 3.2 PP increase from 86.4 % in May 2017 to 89.6% in May 2018.

Consumer Perception Survey Open-Ended Comments (OEC)

In order to collect valuable feedback from consumers, the Quality Improvement Team requested that the Open-Ended Comments (OEC) Report forms be completed by each at each provider site being surveyed. The goal of the OEC form is to assess qualitative feedback collected from consumers in the form of positive and negative comments, general comments, and recommendations from consumers. A summary report is generated and shared with the SA QICs and further dissemination to providers across

the system of care. The selected timeframe for the Spring 2018 survey period was from Monday, May 14, 2018 to Friday, May 18, 2018. Surveys were collected and submitted by Service Area (SA) Quality Improvement Committee (QIC) liaisons and delivered to the LACDMH Chief Office of Information Bureau (CIOB) for submission to the CIBHS. All completed OEC forms were forwarded to QID. The report forms were reviewed by internal QI staff and the findings are summarized in the following.

Methodology

The May 2018 OEC Report form was three pages long (see Attachment 1). Providers were instructed to work collaboratively on their OEC Report with the QIC and Program Managers/Directors for their respective programs. The OEC Report form prompted providers to include the following information:

- Service Area
- Provider Number
- Whether or not consumers provided open-ended feedback on their May 2018 CPS forms
- Number of surveys reviewed
- Description of common positive themes reported by consumers
- Description of common negative themes reported by consumers
- Description of general comments or recommendations by consumers
- An action plan created by the provider to address consumer concerns
- Whether or not the provider has received provider–level results from their SA QIC Chair
- If past results were received, were the survey results shared during the provider's staff or internal QIC meetings

OEC Report forms were submitted to the QID on or around July 16, 2018. Providers were asked to submit copies of the comment sections they reviewed and organized into themes, or frequent similar comments. Protected Health Information (PHI) was removed/redacted.

Table 12: Number of Surveys Reviewed for Open-Ended Comments May 2018

SA	Number of Surveys Reviewed
SA 1	421
SA 2	1,927
SA 3	486
SA 4	786
SA 5	554
SA 6	0
SA 7	351
SA 8	884
Total	5,409

Data Source: Completed OEC Report Forms, May 2018

Table 12 presents the overall number of CPS forms reviewed for OEC by SA.

Open-ended Comments (OEC) Report Forms Received in May 2018
Providers were asked to review the OEC for their site and provide a summary of the common positive and negative themes and recommendations noted by consumers. The information summarized by the providers is described below according to their respective SA.

- Service Area 1
  SA 1 service providers reviewed open-ended comments for approximately 421 surveys.

  The positive themes identified by consumers were: having a reduction in symptoms, feeling staff were supportive and nonjudgmental, and being pleased with the services available to them.

  Negative themes included: feeling wait times for psychiatry were lengthy; negative interactions with staff, such as experiencing staff as “rude”, not listening, and being spoken to unprofessionally; and limited availability of clinicians who identify as African American.

  Recommendations made by consumers on how to improve services were: hiring a new psychiatrist and increasing the number of appointments.

- Service Area 2

  SA 2 service providers reviewed open-ended comments for approximately 1,927 surveys. Of all the SAs, SA 2 had the highest OEC response rate.

  Common positive themes noted by consumers were: feeling well supported by staff, satisfaction with services available to consumers, and feeling treatment was successful.

  Negative themes noted by consumers were: facility issues such as limited parking and difficulty accessing services. Consumers further reported limited availability of psychotherapy and psychiatry appointments, inconvenient hours of operation, and a limited number of staff due to turnover.

  The consumers' recommendations for improvement included: increasing appointment availability by extending hours of operation; providing services on Saturdays or opening additional sites; increasing the length and frequency of psychotherapy sessions; and offering academic support such as tutoring services, educational materials, and additional groups for children during school vacations.

- Service Area 3

  SA 3 service providers reviewed the open-ended comments for approximately 486 surveys.

  Common positive themes noted by consumers were: experiences with staff displays of kindness and flexibility, being appreciative of available services, and seeing positive effects from treatment.

  Negative themes noted in the open-ended comments included: concerns related to staff turnover, number of available SA 3 providers, and limited access to services in their preferred language, such as Spanish. Several consumers reported being offered appointment times that were not convenient or were frequently changed by staff.

  Recommendations for improvement from consumers included: increasing the number of Spanish-speaking staff, male psychotherapists, and psychologists; increasing communication with and in support of families; and increasing the number of appointments. A family-oriented approach involving additional groups, parenting classes, and family sessions was also encouraged by SA 3 consumers.

- Service Area 4

  SA 4 service providers reviewed open-ended comments for approximately 786 surveys.

  Positive themes identified by consumers included: being pleased with the number of services available, feeling supported by staff, and feeling treatment was effective.

Negative themes identified by consumers included: difficult-to-reach treatment teams, a history of not being notified of appointment cancellations, and difficulties related to transportation such as accessibility of clinics and limited parking.

The consumers' recommendations included: extending hours of operation to evenings and Saturdays, increasing resources for caregivers such as housing assistance and parenting groups, and improving access to parking.

- Service Area 5
  SA 5 service providers reviewed the open-ended comments for approximately 554 surveys.

  Positive themes reported by consumers were: feeling grateful for the support and safe environment provided by staff, feeling pleased with available services, and receiving services that were easily accessible.

  Negative themes included: facility issues like limited parking, inoperable elevators, and noise interrupting therapy sessions; wait times for psychiatry appointments are lengthy; and poor communication between treatment teams, caregivers, and schools.

  Recommendations for improvement from consumers were: having access to vending machines for food and drinks; increasing groups and activities; and extending hours of operation to include evenings and weekends.

- Service Area 6
  OEC Report forms were not received from SA 6 during the May 2018 survey period.

- Service Area 7
  SA 7 service providers reviewed open-ended comments for approximately 351 surveys.
  Consumers reported feeling staff were: supportive to both caregivers and children, feeling pleased with services, and experiencing positive treatment outcomes.

  Negative themes noted by consumers included: concerns about staff turnover disrupting services, limited appointment availability, and unpleasant interactions with front office staff. Reportedly, consumers have witnessed front office staff being unprofessional and speaking loudly about private information.

  Recommendations from consumers included: hiring additional staff in order to increase the availability of appointments, expanding hours of operation to include evenings and weekends, and expanding locations; facility improvements such increasing parking, access to snacks, having a television in the waiting room; and managing noise in the waiting area.

- Service Area 8
  SA 8 service providers reviewed open-ended comments for approximately 884 surveys. Positive themes noted by consumers were: feeling supported by staff and

treatment was helpful. According to consumers, their treatment team collaborated with schools and provided psychoeducation to caregivers.

Negative themes were: concerns related to poor communication between the treatment team and caregivers, feeling staff was unprofessional and inexperienced, and that parking was limited.

Consumer recommendations included: updating facilities with access to food, increased parking, comfortable seating in waiting rooms, having toys for infants, playing music, having Wi-Fi available, and offering areas designated for studying; increase access to services by expanding hours of operation to evenings and weekends, expanding locations, and hiring more staff including male, bilingual and Filipino-speaking psychotherapists, and giving weekly reports to caregivers.

Table 13: Themes by Service Area (SA)
May 2018

SA	Positive Themes			Negative Themes			Recommendations		
	Pleased with support	Pleased with services	Positive treatment outcomes	Limited availability of staff	Limited availability of appointments	Parking issues	Expanding hours	Facility improvements	Increase staff
SA 1	X	X	X	X	X				X
SA 2	X	X	X	X	X	X	X	X	
SA 3		X	X	X	X				X
SA 4	X	X	X	X	X	X	X	X	
SA 5	X	X	X		X	X	X	X	
SA 6	-	-	-	-	-	-	-	-	-
SA 7	X	X	X	X	X		X	X	X
SA 8	X		X			X	X	X	X

Data Source: Completed OEC Report Forms, May 2018

Countywide Themes
There were a number of reoccurring themes and recommendations observed in the OEC Report forms for all eight SAs. Table 9 provides a summary of the positive and negative themes and recommendations reported by consumers throughout Los Angeles County.

Consumers appeared pleased with the support they received from their providers. They felt they were cared for and well-respected. Consumers tended to report feeling pleased with the available services and were generally seeing positive outcomes as a result of their treatment.

Despite many positive experiences, consumers had concerns related to the general availability of staff, staff turnover, understaffing, and limited bilingual and male staff. They also reported experiencing difficulties making appointments due to limited scheduling availability and wait times. Consumers reported that parking was an issue at many facilities.

Consumers recommended increasing appointment availability by providing evening and weekend hours and increasing staff, particularly Spanish-speaking, bilingual, psychiatry providers, and male psychotherapists. A number of recommendations were related to the improvement of facilities: increase parking, spacing and seating, entertainment for children, accessibility of food, and creating an environment to promote learning and completion of homework.

Action Plans

Action plans were created by providers to address concerns, issues, and recommendations for improvement identified by consumers who completed the OEC portion of their CPS forms. The plans were individualized and site-specific. Examples of action plans included sharing consumer feedback with staff and management teams, plans to address the most urgent or significant concerns, and a deadline for meeting the plan.

Below are examples of action plans from four sites:

Site 1:

- Clinicians will review treatment options with all consumers, including frequency of services to ensure agreement about services.
- Supervisors will ensure consumers understand differences in intensity of services based on the level of care assignment/program to ensure agreement with program placement. Supervisors will continue to work with clinicians in regularly reviewing consumer participation in treatment to ensure that there is continuity of care. Supervisors will be responsible to reach out to caregivers when there are significant lapses in treatment.

Site 2:

- The agency is working to enhance the telepsychiatry program.
- The agency is continuing to encourage clinicians and emphasize the importance of regular discussions of needs, goals, and progress with families. Weekly supervisions are used to discuss appropriate level of treatment.
- The agency is working on retention of clinicians. Salary was adjusted and pay was enhanced for the performance program.
- The Outpatient program is working to expedite intakes and management will continue to work with the Referral Team to identify acuity and need in order to provide intakes as soon as possible. The Referral Team will continue to communicate with families and gain updates while they are waiting for services.

Site 3:

- “Incredible Years” parent groups are offered on site.
- The Outreach Specialist is creating more brochures in both English and Spanish and will have them available in our lobby.

- Clinicians have the ability to schedule clients at times - including the weekend - that meet family needs. Clinicians work with children at school sites with whom we have Memorandum of Understandings (MOUs) in SA 3; however, the provider does not.

Site 4:

- The agency has an entirely new staff operating the front desk. They have attended customer service training, Mental Health 101 training, and our Staff Assistant monitors and mentors their interactions with the clients at least two to three days a week.

Receipt and Sharing of Provider-Level Consumer Perception Survey (CPS) Results

The OEC Report form prompted providers to report on the receipt of provider-level CPS data. Table 10 presents the providers' responses to the question, "Have you received the Provider Level survey results from your SA QIC Chair for the past survey periods?"

Table 14: Provider Reported Receipt of Consumer Perception Survey (CPS) Data by Service Area
May 2018

SA	Number of Providers that reported "Yes"	Number of Providers that reported "No"	Total Responses
SA 1	5	4	9
SA 2	16	13	29
SA 3	5	6	11
SA 4	12	10	22
SA 5	14	0	14
SA 6	0	0	0
SA 7	6	4	10
SA 8	11	5	6
Total	**69**	**42**	**111**

Data Source: Completed OEC Report forms, May 2018

A total of 111 providers responded to the question of whether or not they had received CPS results from their SA QIC Chair. Approximately 62% (N=69) of the providers reported they had received past CPS data and the remaining 38% (N=42) of the providers had not received past data.

The OEC Report form prompted providers to report on the dissemination of provider-level CPS data within their agency. Table 14 presents the providers' responses to the question, "If yes, did you share the survey results during your program's staff meetings or QIC meetings?"

Table 15: Provider Reported Dissemination of Provider-Level Data by Service Area
May 2018

Service Area (SA)	Number of Providers who reported "Yes"	Number of Providers who reported "No"	Total Responses
SA 1	4	3	7
SA 2	15	2	17
SA 3	5	1	6
SA 4	13	3	16
SA 5	14	1	15
SA 6	0	0	0
SA 7	7	0	7
SA 8	12	0	12
Total	**70**	**10**	**80**

Data Source: Completed OEC Report forms, May 2018

A total of 80 providers responded to the question of whether or not they shared past survey data in staff or QIC meetings. Reportedly, 87.5% (N=70) of providers disseminated the data. Conversely, 12.5% (N=10) indicated they had not shared the data.

Fifty-percent of the participating providers reported they had received provider-level CPS data. Providers also shared the data with their staff or during internal QIC meetings (87.5%). Some providers indicated not having received past survey data, yet marked they had disseminated the information within their agency.

Recommendations

- Outcomes from the Summary OEC Report should be reviewed at the provider-level and with each site's QIC and leadership team.
- Outcomes should be reviewed with clinical and support staff for the purpose of staff education and collective involvement in improving service delivery for consumers.
- Action plans should be created by each site's QI, management team, and Program Managers to target individualized areas for improvement.
- Outcomes of the OEC Summary Report may be shared with State and/or national level QIC programs to better improve overall quality of care.

V. Grievances and Complaints

As mandated by the State Department of Health Care Services (DHCS) Program Oversight and Compliance, QID facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. Grievances and appeals are collected and reviewed by the Patients' Rights Office (PRO) and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required for Medi-Cal beneficiaries only.

LACDMH monitors grievances, appeals, and requests for State Fair Hearings and their resolution. The following tables summarize the number and percentage of inpatient and outpatient grievances and appeals by category and disposition.

During FY 17-18, the Department's PRO finalized a new and electronic process for filing grievances and appeals. Patient's Rights Office (PRO) proposed a "Grievance and Appeal Reporting" feature through "YourDMH" online patient portal. The implementation date will be announced in CY 2019.

Table 16: Inpatient and Outpatient Appeals' Disposition and Total Notice of Adverse Benefit Determination/Notice of Action Issued FY 17-18

Category	APPEAL DISPOSITION			EXPEDITED APPEAL DISPOSITION			NOABD/NOA
	Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Expedited Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Total Number of NOABD/NOAs Issued
[1]Appeals Resulting From NOABD NOA							
Denial Notice (Formerly NOA A)	0	0	0	0	0	0	2,440
Payment Denial Notice (Formerly NOA C)	0	0	0	0	0	0	1,784
Delivery System Notice	0	0	0	0	0	0	0
Modification Notice	0	0	0	0	0	0	0
Termination Notice	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice (Formerly NOA E)	0	0	0	0	0	0	5,935
Financial Liability Notice	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice (Formerly NOA D)	0	0	0	0	0	0	0
Notice of Action - B (NOA B)	0	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**	**10,162**

Note: [1]Prior to implementation of the Final Rule, (Title 42, Code of Federal Regulations, part 438, Subpart F), five types of Notice of Actions, referred to as NOA-A, NOA-B, NOA-C, NOA-D, and NOA-E, were the responsibility of the Network Providers to issue to beneficiaries. However, since the implementation of the Final Rule, these NOAs are obsolete and are replaced by Notices of Adverse Benefit Determination (NOABD) letters developed by the DHCS and under the authority of the MHP for determinations on SMHS. Data Source: DMH PRO – ABGAR Form FY 17-18, October 2018

Table 16 shows the total number of inpatient and outpatient beneficiary grievances and appeals by category for FY 17-18. A total of ninety-eight (98) grievances were received in FY 17-18. Of the beneficiary grievances received, 53% were related to Quality of Care and the remaining 47% were categorized as Other. There were no inpatient and outpatient grievances related to Access, Change of Provider, or Confidentiality Concern. There were 12 State Fair Hearings that were closed/dismissed or redirected.

Table 16 also reports the total number of Notice of Adverse Benefit Determination (NOABDs), formerly known as Notice of Action (NOAs), as well as the dispositions for appeals and expedited appeals. There were 10,162 NOABDs issued during FY 17-18, out of which 58% were determined to be Timely Access Notices (N=5,935), followed by Denial Notices (N=2,440) at 24%, and Payment Denial Notices (N=1,784) at 18%. There were no beneficiary appeals resulting from NOABD.

Table 17: Inpatient and Outpatient Grievance Disposition
FY 17-18

Category	Grievance Disposition		
	Grievances Pending as of June 30	Resolved	Referred
Access			
Service not Available	0	0	0
Service not Accessible	0	0	0
Timeliness of Services	0	0	0
24/7 Toll-Free Line	0	0	0
Linguistic Services	0	0	0
Other Access Issues	0	0	0
Access – Total by Category	0	0	0
Percent	**0%**	**0%**	**0%**
Quality Of Care			
Staff Behavior Concerns	0	12	12
Treatment Issues or Concerns	0	13	2
Medication Concern	0	3	2
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	7	1
Quality of Care – Total by Category	**0**	**35**	**17**
Percent	**0%**	**81.4%**	**31.0%**
Change of Provider – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Confidentiality Concern – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
Other			
Financial	0	0	0
Lost Property	0	0	0
Operational	0	0	3
Patients' Rights	0	6	12
Peer Behaviors	0	2	0
Physical Environment	0	0	0
Other Grievance not Listed Above	0	0	23
Other – Total by Category	**0**	**8**	**38**
Percent	**0%**	**18.6%**	**69.0%**
Grand Totals	**0**	**43**	**55**

Data Source: DMH PRO – ABGAR Form FY 17-18, October 2018

The table above shows the disposition of 98 grievances during FY 17-18. Out of the 43 grievances that were resolved, 81.4% pertained to Quality of Care (N=35) and the

remaining 18.6% were categorized as Other (N=8). Out of the 55 grievances that were referred, 69.0% were categorized as Other (N=38) and the remaining 31.0% pertained to Quality of Care (N=17). There were no grievances pending as of June 30, 2018.

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Criterion 8 Appendix

Attachment 1: ISM Outreach and Engagement Calendars


2019 AAA UsCC Projects OEE Summar


2018 Latino UsCC Projects OEE Summar


2018 EE-ME UsCC Projects OEE Summar


2018 API UsCC Projects OEE Summar


2018 LGBTQI2-S UsCC Projects OEE Su


2018 AI-AN UsCC Projects OEE Summar


2018 API UsCC Projects OEE Summar

Attachment 2: TCPI Quality Improvement Toolkit


LAPTN DMH QI Toolkit 01 08 2019.p

Attachment 3: 2018 Clinical PIP Summary Report


3D Clin PIP 8-27-18 Pre-Review.docx

Attachment 4: 2018 Non-clinical PIP Summary Report


3E Non-clin PIP Final Session Doc.docx

Attachment 5: LACDMH Legal Entity Contract


LACDMH Legal Entity Contractual Agreemer