LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS - CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – CY 2020

Criteria 1-8

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August 2020

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

2020 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 Unit 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 1: Commitment to Cultural Competence
- Criterion 2: Updated Assessment of Service Needs
- Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- Criterion 4: Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System
- Criterion 5: Culturally Competent Training Activities
- Criterion 6: County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
- Criterion 7: Language Capacity
- Criterion 8: Adaptation of Services

The 2020 Cultural Competence Plan Report is based on data and programmatic information for Fiscal Year 18-19.

TABLE OF CONTENTS

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 18-19

Criterion 1

Commitment to Cultural Competence

August 2020

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 optimal 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 directly 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 o 2.6 Special Considerations of Older Adults o 2.7 Assessment of Individuals with Co-Occurring Mental Health and Cognitive Impairment o 2.8 Treatment of Co-Occurring Mental Health and Cognitive Impairment • Parameters for Clinical Programs o 4.8 Delivery of Culturally Competent Clinical Services o 4.13 Parameters for DMH Peer Advocates o 4.15 Parameters for Spiritual Support o 4.16 Parameters for Family Inclusion o 4.18 Parameters for Assessment and Treatment of 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 Interpreter Services • Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Ensuring Access to Benefits and Care for Veterans and Their Families

Policies and Procedures and Other Documents	
	• Policy No. 200.09 – Culturally and Linguistically Inclusive Services • Policy No. 201.02 – Nondiscrimination of Beneficiaries • 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 Clients' Spiritual Interests in Mental Health Services • 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 • Gender Bias

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, 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 Office of Administrative Operations-Quality Improvement Division (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.

Additionally, 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

Consistent with the Cultural Competence Plan Requirements (CCPR) and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), 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

Stakeholder Engagement

LACDMH takes pride in its robust and ever growing stakeholder process. Starting in FY 17-18, LACDMH revamped 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 have focused on establishing active partnerships with stakeholder groups, consumers, families, and community members to impact departmental policy; budget allocations; program planning monitoring and evaluation; and quality improvement.

YourDMH

After extensive consultation with stakeholders, LACDMH decentralized its original stakeholder system and started to implement the new stakeholder engagement process named "YourDMH." The main goal of YourDMH is to engage communities in dialogue and decision-making pertinent to departmental priorities, service delivery models, funding allocations, target populations for various programs and projects, and outcomes. Additionally, this partnership with the community drives the planning, implementation and evaluation of system wide endeavors, among them the Mental Health Services Act (MHSA) Three-Year Plan. Stakeholder groups such as the Underserved Cultural Communities subcommittees, the Cultural Competency Committee, and the Service Area Advisory Teams (SALTs), formerly known as Service Area Advisory Committees (SAACs) developed their own charters under YourDMH, specifying their internal membership infrastructures and modes of operation. This process empowered them to define their own leadership, membership, goals and projects.

LACDMH sponsored a considerable number of community engagement events including conferences, local health fairs, policy forums and special events highlighting cultural diversity and the voice of consumers and family members. For example:

WERISE

The Department launched another 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 took place during May is Mental Health Month. 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 art exhibits, panel presentations, and spoken poetry. The campaign was also promoted through social media including Facebook, Instagram, and Twitter.

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 the system of care. The summary below briefly introduces these efforts:

Health Integration

The revamped structure for this interdepartmental initiative under the Los Angeles County Board of Supervisors involves three Health Departments (e.g. the Department of Health Services (DHS), Department of Mental Health (DMH), and Department of Public Health (DPH). It aims 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. These efforts operate under the

understanding that the implementation of a collaborative framework and partnerships with labor unions, community stakeholders, other County Departments are necessary for the implementation of cross-cutting initiatives and metrics that will move Los Angeles County toward ultimate health care integration. At the same time, the three Departments to maintain their individual missions and activities.

During CY 2018, the Board of Supervisors pursued the revision of the former Health Agency's priorities, currently the Alliance for Health Integration (AHI), with the goal of improving consumer outcomes through the collaboration and integration of services and operations across Health Departments. 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

The "Health Equity and Reduce Health Disparities among Vulnerable Populations" priority continued being addressed by the "Institute for Cultural and Linguistic Inclusion and Responsiveness" (ICLIR). The ultimate goal of the Institute is to create culturally and linguistically appropriate pathways that address gaps in service delivery and advance the three Departments' ability to meet the needs of Los Angeles County communities. Members from DHS, DMH, and DPH participated in the development of the institute's Action Plan draft, which was approved to the three Directors. Six specific strategies form the framework for the ICLIR Action Plan:

1) Data Standards
2) Consumer Satisfaction Outcome Data Collection and Reporting
3) Trainings Related to Cultural Competence and Implicit Bias
4) Language Assistance Services
5) Quality Improvement Projects
6) Technological Upgrades and Solutions

All strategies have been embodied by workgroups staffed by subject matter experts from the three Health Departments. *See ICLIR section on page 25 for further details.*

Women and Girls' Initiative

Established by the Board in December 2016, the Women and Girls' Initiative focuses on enhancing Los Angeles County's gender-responsive capabilities and advance the mission of improving the quality of life for women and girls. In commemoration of the 100th anniversary of the ratification of the Constitutional Amendment for women's right to vote, all County Departments sponsor, conduct, and support activities that raise awareness to women's rights.

The Faith-based Advocacy Council (FBAC)

This Council empowers the Department's collaboration 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 was originally implemented by the Latino UREP UsCC subcommittee in 2009 as a capacity-building project that awarded four community-based organization to recruit, train, monitor and support the activities of the very first cohort of LACDMH Promoters. A second wave of implementation took place in 2011, focusing specifically in Service Area 7. Since, the expansion of the Mental Health Promoters Program has reached the eight Service Areas. During FY 18-19, LACDMH had trained one hundred and fifty three (153) Spanish-speaking Community Mental Health Promoters representing all Service Areas.

This countywide expansion builds system capacity and promotes access to health services by increasing the community's knowledge about mental health through the outreach, engagement, community education, social support, and advocacy activities led by the 153 mental health promoters. These natural leaders 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.

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. The Community Mental Health Promoters effectively connect with underserved communities with high rates of mental health stigma and facilitate navigation of systemic cultural and linguistic barriers they often experience.

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 UsCC populations and languages, increase service accessibility, fight stigma, and increase UsCC penetration rates into the system of care.

Veterans Access Network (VPAN)

This initiative creates connections of hope, wellbeing, and recovery for Los Angeles County veterans and their families. Services to the Veterans community has been expanded through the development of a Veterans Access Network (VPAN) which coordinates resources and services for veterans and their families. It was developed as a part of the Prevention and Early Intervention (PEI) program. The VPAN implements strategies for improved data sharing and coordination of services and creates a more robust process for greater stakeholder involvement for veterans and their families.

Mental Health Court Linkage Program

The Mental Health Court Linkage Program has two (2) sub-programs funded by MHSA: Court Liaison Program and Community Reintegration 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.

Justice Reform

The goal of Justice Reform is to improve the Re-Entry Initiatives of the Department, which target individuals who are homeless, justice-involved, and/or previously institutionalized and assist them in the process of re-entering and re-integrating into their communities. By providing comprehensive services that include physical health, mental health, and substance use interventions, the system can prevent recurrent cycling in and out of jails, reduce homelessness, or shorten incarceration time. Los Angeles County is committed to divert as many individuals as possible. When safe diversion is not possible, holistic mental health and health services are provided to persons in custody to prepare them for their eventual re-entry into the community.

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 (8) 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) mitigate police use of force; 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. During FY 18-19, there were 20,995 calls, of which 66% reported being homeless. Of those calls, there were only 646 (3%) arrests.

Continuum of Care (CCR)

Assembly Bill (AB) 403, also known CCR, established a comprehensive transformation of the foster care system. 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 (4) 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 charged 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.

Immigration and Immigrant Protections

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.

Unaccompanied Immigrant Children

On September 12, 2017, the Board recognized "Immigration" as the sixth County Priority and directed all County departments to adopt and implement policies and strategies to protect the rights and support the success of all County immigrant residents and their families. The Office of Immigrant Affairs (OIA) in the Department of Consumer Affairs was identified as the lead for this effort. During FY 18-19, the OIA and the Immigrant Protection and Advancement Taskforce (IPAA) developed the immigrant Protection and Advancement Strategy Report which specifies more than 75 recommendations to support the success of all County immigrants and their families with justice equity, wrap-around support services, economic advancement, and outreach and education.

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 get 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. During FY 18-19, each HOME team established stakeholder partnerships with Coordinated Entry System leads, law enforcement, E6 teams, and community members to identify the most vulnerable and difficult to engage individuals in need of intensive outreach, engagement and treatment.

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 but are not limited to, trainings, screenings, assessment, psychoeducation, skill building, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources.

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.

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 in the 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.

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
- Deaf and hard of hearing 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 18-19.

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

LACDMH utilizes the MHSA Plans to advance cultural and linguistic competence within its system of care. The numerous initiatives funded under the MHSA Plans are making a difference in the lives of consumers, their families and communities. Some examples include:

Community Services and Supports (CSS) – Underserved Cultural Communities (UsCC) subcommittees

POE is a part of the Community Services and Supports (CSS) Plan of the MHSA. The UsCC Unit operates under the CSS Plan and has established subcommittees dedicated to working with the various underrepresented ethnic and cultural populations in order to address their individual needs. The seven UsCC subcommittees include:

- African/African American (AAA)
- American Indian/Alaska Native (AI/AN)
- Asian Pacific Islander (API)
- Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
- Eastern European/Middle Eastern (EE/ME)
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

Every Fiscal Year, each UsCC subcommittee is allotted one-time funding totaling $200,000 to focus on CSS-based capacity-building projects. The membership from each subcommittee generates conceptual ideas for capacity building projects, which are turned into proposals by the UsCC Unit, and presented for approval. The UsCC projects are voted via a participatory and consensus-based approach within each subcommittee.

UsCC projects implemented during FY 18-19 by subcommittee

AAA

1) Black Immigrant Youth Empowerment Project

The Black Immigrant Youth Empowerment Project was implemented on July 1, 2018 and was completed on June 30, 2019. This project was developed to engage, empower, and educate the black immigrant community to seek mental health services as well as reduce stigma and increase the capacity of the public mental health system.

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 Los Angeles 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.

Outcomes for CY 2018:

- For the fifth reprint, 15,000 booklets were ordered as of December 2018
- To date, there have been over 20,000 Life Links booklets distributed in the County

AI/AN

1) The AI/AN Bus Advertising Campaign

The goal of this advertising campaign was to promote mental health services, increase the capacity of the public mental health system in Los Angeles 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. The campaign took place in SA 1 for 12 weeks from January to April 2018 and included the following: 15 taillight bus displays, 12 king-size bus posters, five queen-size bus posters, 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. This 12-week advertising campaign educated and provided linkage and referrals to AI/AN community members.

Outcomes for CY 2018:

- A total of 12,346,100 impressions were delivered
- Advertising took place in Lancaster, Palmdale, Littlerock, Lake Los Angeles, and unincorporated areas of the County.

API

1) API Youth Video Contest: "Go Beyond Stigma!"

This project was implemented on January 1, 2018 and was 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 the County.

2) API Mental Health Awareness Media Campaigns
This project includes seven (7) separate campaigns that were completed in April 2019. The goal of the project was to target various API communities in Los Angeles 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

1) The Deaf, Hard of Hearing, Blind, and Physical Disabilities UsCC subcommittee
This 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. As of June 30, 2018, this subcommittee has identified four (4) capacity building projects for FY 18-19 with a membership roster of over 50 individuals and is actively recruiting new members.

EE/ME

1) Armenian Mental Health Show
A local Armenian television station, ARTN TV Station, was contracted to produce, direct, host, and broadcast a weekly mental health show in the Armenian language. The show consisted of 28 half-hour episodes, where various mental health topics were presented. The Armenian mental health show included episodes on the following topics: depression, anxiety, couple's therapy, trauma, and intergenerational

issues. The show provided an opportunity for the Armenian community to be educated and informed on the symptoms associated with a variety of different psychological disorders and the psychotherapeutic process. It included current psychological issues that are impacting the Armenian community in Los Angeles County.

2) The Arabic, Farsi, and Russian Public Service Announcement (PSA) Project

This project was implemented on July 1, 2018 and completed on August 31, 2019. The project sought to increase mental health awareness and education to the Arabic, Farsi, and Russian speaking communities in the County, which are significantly underserved by the public mental health system. A consultant produced, implemented, posted, and tracked 42, 90-second PSAs in the Arabic, Farsi and Russian languages. There were 14 PSAs in each language. The PSAs included celebrities and/or prominent community figures from the three-targeted communities.

Latino

1) Latino Media Campaign

The Latino media campaign was launched on May 1, 2017 and was completed on July 16, 2018. The commercials 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 takeover, 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, interviews on different mental health topics with Dr. Sandra Chang, 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.

2) Latino Mental Health Stigma Reduction Community Theater Project

The goal of this project was to outreach, educate, and increase knowledge pertaining to mental health services within the Latino community. By utilizing a non-stigmatizing method such as a theatrical play, Latino community members learned about the signs and symptoms associated with mental health and became familiar with the services that are available through LACDMH. The project is scheduled to be completed by May 30, 2020.

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.

Workforce Education and Training (WET)

Several WET Programs support the LACDMH commitment to strengthen partnerships with community organizations that build the capacity of the system through multiple strategies. Among them, efforts support the integration of peers and parent advocates into system of care and to build pipelines for future mental health professionals in Los Angeles County. Examples of WET projects and programs include the following:

1) Public Mental Health Partnership (PMHP)
   The mission of the University of California, Los Angeles (UCLA)-LACDMH PMHP is to implement a training and technical assistance focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across the County.

2) Navigator Skill Development Program
   - Health Navigation Certification Training
     This program trains individuals employed as community workers, medical case works, substance abuse counselors, peer specialists, and their supervisors on the knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems.
   - Family Health Navigation Certification Training
     This program trains staff working with family members of children served in the public mental health system to navigate and advocate medical concerns on behalf of their children's needs in both the public health and mental health systems.
   - Interpreter Training Program (ITP)
     ITP offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English speaking mental health providers.

3) Charles R. Drew Affiliation Agreement - Pathways to Health Academy Program
   This academic and internship program is for high school students in Service Area 6 interested in behavioral health careers including mental health.

4) Intensive Mental Health Recovery Specialist Training Program
   This program prepares individual, mental health consumers and family members, with a minimum of 2 years of college credit, to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This training is delivered in partnership with a mental health contractor and local community college.

5) Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

- Parent Partners Training Program

  This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children.

- Parent Partner Training Symposium

  These training opportunities covered a wide range of topics including 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.

6) Continuum of Care Reform (CCR)

CCR provides comprehensive transformation of foster care system with the intent of achieving permanency planning for foster youth and their families. LACDMH provided the following trainings:

- Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families
- Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth and Families
- Integrating a Peer Support Program into Children and Youth Serving Systems
- Being in the Child Welfare System: A Youth Perspective
- Child and Adolescent Needs and Strengths (CANS) Overview
- CANS – Training of Trainers
- CANS – Transformational Collaborative Outcomes Management (TCOM) for Thought Leaders
- Permanency Values and Skills for Child, Welfare, Probation and Mental Health Professionals

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

Early Intervention practices focus on individuals and families for whom a short duration and low intensity treatment interventions are required to measurably improve a mental health condition. While LACDMH continues to provide early intervention services, the focus of activities in the next Three-Year Plan will be on expanding prevention services.

LACDMH is committed to the expansion of prevention services through schools, public libraries, parks, and other community-based locations. Prevention promotes positive cognitive, social and emotional development needed to reduce or prevent mental illness

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

Sandra Chang, Ph.D. is the LACDMH Ethnic Services Manager (ESM). Dr. Chang is also the Program Manager for the departmental Cultural Competency Unit (CCU). 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 functions:

- 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 departmental leadership meetings

- Collaborating with LACDMH programs/Units to increase the accessibility of mental health services to underserved communities.
- Collaborating all other Southern Region ESMs in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee

The most salient CY 2019 activities of the CCU directly under the oversight of the ESM include:

1. Multicultural Mental Health Conference: Health Integration through a "WHOLISTIC" Approach

   The CCU spearheaded the planning and coordination of the Multicultural Mental Health Conference. The main goal of the conference was to highlight the benefits of integrated health care for persons receiving services, family members and communities. The conference addressed models of health integration for less-recognized yet well-established underserved populations such as 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. The conference was held at the Los Angeles Convention Center in June 18, 2019 and brought approximately 700 participants from several County of Los Angeles Departments and community members from all Service Areas. Participants were submerged into a learning environment that promoted cross-departmental collaborative partnerships, health care coordination, and inclusion of cultural and linguistic responsiveness.

   The conference program included three (3) stellar keynote speakers: Dr. Jorge Partida Del Toro, LACDMH Chief of Psychology; Dr. Bernardo Ng, President of the American Society of Hispanic Psychiatry; and Dr. Bryant Marks, Sr. Professor in the Department of Psychology at Morehouse College. Additionally, the conference offered nine (9) dynamic workshops on the following integrated health topics:

   - A Queer Peer Perspective: Providing Culturally Responsive Mental Health Services
   - Building Successful Collaboration through Integrated Programs
   - Culturally Responsive Integrated Mental Health Model for Children in Foster Care
   - Forming Inter-Agency Partnerships for Clients with Co-Occurring Intellectual/Developmental Disabilities and Mental Health Disorders
   - Health Promotion through Self-Management Education: Exploring the Availability and Utility of Community Programming in Integrated Health Care
   - Integrating Evidence-Based Treatments and Traditional Practices for American Indians/Alaska Native Receiving Mental Health Services in Los Angeles County
   - Merging Mental Health Services and Correctional Treatment

- NORMAL is Just a Setting on a Washing Machine-Strategies for Successful Disability Integrated Health Care
- Using Health Navigation and Family Health Navigation to Support Mental Health Integration

The feedback received from participants via conference evaluation forms was overwhelmingly positive. Sample comments include:

- "The best conference I have attended! Keep it going!"
- "Awesome conference"
- "Lovely event"
- "Very informative, capturing and engaging"
- "Well organized; very thoughtful"
- "The conference was run smoothly"
- "Great conference and keynote speakers!"
- "Very useful information. My knowledge was broadened"
- "Thank you to all who plan to volunteer to make this conference possible. It was very well executed"
- "The conference was a great way of learning"
- "Great workshop topics. Wish I could have attended three or four workshops"

2. <u>Development of the Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) Action Plan</u>

   The ICLIR membership developed a comprehensive list of proposed deliverables as potential activities for CY 2019. The deliverables were based on the four (4) domains of the Institute: infrastructure, training and staff development, communication and community involvement, and virtual repository of resources. Additionally, the Principles, Framework, and Guidelines Workgroup and the Webpage Resources and Technology Workgroup joined efforts to develop the ICLIR Action Plan. In September 2019, ICLIR held its Action Plan Launch Event, which brought subject matter experts from all three (3) Health Departments together to discuss goals and deliverables for CY 2020 and 2021 under six (6) areas of concentration. Workgroups were formed representing each focus area as follows:

   - Data Standards Workgroup

     Goal: to establish minimum standards for race, ethnicity, sexual orientation and gender identity, preferred language, and disability status data collection, analysis, and dissemination. These minimum data standards would allow for timely, reliable, consistent and continuous data collection, analysis, and comparison within and across Departments to monitor health disparities.
   - Consumer Satisfaction Outcome Data Collection and Reporting Workgroup

     Goal: to implement the practice of collecting consumer demographic information pertinent to race, ethnicity and preferred language by each Health Department to make the data gathered from Consumer Satisfaction Surveys more meaningful.

- Trainings Related to Cultural Competence and Implicit Bias Workgroup
  Goal: to develop at least one on-line training regarding cultural competency that can be made available to the DHS, DMH, and DPH workforce.
- Language Assistance Services Workgroup
  Goal: to develop mechanisms for a more robust, integrated and responsive way to provide language assistance services to the consumers served by the three Departments. The development of a model protocol for language assistance services would promote meaningful access and equal opportunity for persons who have Limited English Proficiency to participate in the services, programs, and activities.
- Quality Improvement Projects Workgroup
  Goal: to develop quality improvement projects across the Health Departments to address gaps in services.
- Technological Upgrades and Solutions Workgroup
  Goal: to develop technological solutions to improve delivery of culturally and linguistically appropriate services

3. Development and Implementation DMH's Policy and Procedure (P&P) 200.09: Culturally and Linguistically Inclusive Services
   This policy establishes guidelines for participation, implementation, and compliance with Federal and State regulations regarding cultural and linguistic competence. Effective September of 2019, P&P 200.09 informs the system of care that culturally and linguistics appropriate, effective, and equitable services are provided at all points of entry in the department. Further, it fosters a collective sense of shared responsibility for the implementation of culturally and linguistically responsive interventions that address health inequities among the staff from Directly Operated, Contracted, and Administrative programs.

   The policy framework is based on the Federal National Standards for Culturally and Linguistically Appropriate Services (CLAS) and the State's Cultural Competence Plan Requirements (CCPR). Additionally, it introduces key definitions that conducive to the application of Federal and State mandates in daily Departmental operations. These definitions include: culture, individual cultural competence, organizational cultural competence, cultural humility, cultural identity, health disparities, health inequities, implicit bias, social determinants of health, and underserved communities.

4. LACDMH Cultural Competence Organizational Assessment Tool (CCOAT)
   This project is a system wide assessment of staff perceptions regarding the Department's responsiveness to the cultural and linguistic competence 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. The CCOAT was distributed via emails sent by the CCU. Those emails invited all employees inclusive of Legal Entities/Contracted providers to complete the survey online from December 1, 2018 to January 15, 2019. Strategic survey completion reminders were sent to the entire LACDMH workforce to encourage participation. In total, 2,489 individuals started the survey and 1,673 (67.2%) completed the CCOAT.

Following data analysis, it was determined that item responses confirmed the five (5) subscales as follows:

- Services and Outreach
- Services Provided to Consumers
- Training and Staffing
- Programs and Committees
- Policies and Procedures

The findings from the CCOAT will inform future cultural and linguistic competence strategies to reduce mental health disparities. The CCU will share the survey outcomes and recommendations with the LACDMH workforce and stakeholder groups community via Webinars or live presentations during CY 2020. The CCU plans to utilize these recommendations to improve the Department's system of care in the area of cultural and linguistic competency.

5. Labor Management Transformation Council (LMTC)'s Cultural Intelligence (CQ) Workgroup

   The mission of the Cultural Intelligence Workgroup is to increase cultural sensitivity, understanding, and humility within three Health Departments in order to enhance the quality of interpersonal human relationships for all individuals connected to the County of Los Angeles. The CQ workgroup launched a pilot project of the Cultural Intelligence Education Campaign for DHS, DMH, and DPH employees at the Martin Luther King (MLK) campus (SPA 6) to introduce various themes selected for CY 2020. Those themes include:

   - Cultural Intelligence
   - Cultural Empathy
   - Cultural Sensitivity
   - Cultural Humility

   The CQ's Educational Campaign Component will include four (4) toolkits around each theme, four (4) CQ definition screensavers, universal poster featuring the four (4) themes, and campaign flyers.

6. Cultural Competency Trainings and Community Presentations

   1) New Employee Orientation (NEO)
      The CCU regularly continued training new employees on Cultural Competence and Cultural Humility during NEO. This training also served the purpose of introducing 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.

   2) Cultural Competence Plan (CCP) presentations at SA QICs
      The CCU developed and delivered PowerPoint presentations at all SA QICs to provide updates on the departmental CCP. The main goal of these presentations was to highlight how the collective commitment and dedication

of staff to honor the personhood of each consumer can positively effect their mental health outcomes.

Additionally, the presentations also served as a means to gather information on the strategies implemented by DO and LE/Contracted programs to reduce racial, ethnic, cultural and linguistic mental health disparities. The presentations were conducted from November 2019 to February 2020, and included information regarding the eight (8) criteria:

- Requirements and components of the CCP
- Departmental commitment to cultural competence
- Updated assessment of service needs
- Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
- Client/family member/community committee: Integration of the committee within the County mental health system
- Culturally competent training activities
  - The Annual Cultural Competence Training Requirement
- County's commitment to growing a multicultural workforce
- Language capacity
- Adaptation of services

3) Cultural Competence (CC) and Cultural Humility 101 Training Presentation
The CCU provided the Cultural Competence and Cultural Humility 101 training for clinical interns and other healthcare providers at the Comprehensive Community Health Centers (CCHC) on October 3, 2019. The evaluation forms gathered from participants reported high levels of satisfaction with the content relevance and applicability to cultural competency and humility in clinical settings. Training topics included:

- Introduction and definitions
- LACDMH strategies to reduce mental health disparities
- Cultural competence and cultural humility
- The client culture and stigma
- Elements of cultural competency in service delivery
- County of Los Angeles and LACDMH demographics
- Case discussions on how to apply cultural competence and cultural humility in clinical interventions

7. <u>External Quality Review Organization (EQRO) Review</u>
The CCU actively participated in the annual EQRO Review in September 2019. 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 2019 LACDMH CCP Update

and EQRO evidentiary documentation. Additionally, the ESM provided a presentation on the CCU's activities in the Cultural Competence, Disparities and Quality Improvement session.

8. 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. 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.

9. 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 Service Area. These reports are utilized to track the language requests from LEP consumers at the time they access mental health services.

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IV. Budgetary Allocations for Cultural Competent Activities, FY 18-19

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.

Cultural Competence-related trainings

- $600,500 was dedicated to cultural competence trainings, inclusive of conferences sponsored by the Department, delivered through the WET Division
- $50,000 for Human Resources trainings such as Diversity, Employee Discrimination Prevention, and Sexual Harassment Prevention
- $51,282 for the commercially sexually exploited youth trainings
- $142,082 for the LGBTQI2-S trainings
- $72,851 for language interpreter trainings

Language Translation and Interpretation Services

- $138,279 for language interpretation services, which allows consumers to participate in various departmental meetings and conferences
- $79,324 for language translation services
- $146,650 American Sign Language (ASL) services offered to consumers from both DO and contracted clinics
- Approximately 500 employees receive a monthly bilingual bonus between $85 and $100 for 39 different languages

MHSA Plan-Specific budget allocations

Furthermore, a sizable amount of funding is dedicated for cultural competence-related activities under the MHSA Plans. The following tables summarize the MHSA-specific budget allocations for FY 18-19:

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

CSS Plan Budget*

Programs	CSS Funding
FSP Programs	
1. Full Service Partnerships	114,100,761
2. Recovery, Resilience and Integration	86,666,046
3. Alternative Crisis Services	37,577,252
4. Planning Outreach & Engagement	7,188,520
5. Linkage Services	12,692,101
6. Housing	75,681,119
Non-FSP Programs	
1. Recovery, Resilience and Integration	124,714,553
2. Alternative Crisis Services	40,708,691
3. Planning Outreach & Engagement	8,785,969
4. Linkage Services	6,834,208
5. Housing	1,544,513
CSS Administration	41,111,675
Total CSS Program Expenditure	557,605,408

PEI Plan Budget*

Programs	PEI Funding
PEI Programs	
1. PEI-01 Suicide Prevention	9,826,570
2. PEI-02 Stigma Discrimination Reduction Program	7,558,900
	41,977,800
3. PEI-03 Prevention	100,647,186
4. PEI-04 Early Intervention	
PEI Administration	17,191,807
Total PEI Program Expenditures	177,202,263

INN Plan Budget*

Programs	INN Funding
INN Programs 1. INN #2 Community Capacity Building 2. INN #3 Technology Suite 3. INN #4 Transcranial Magnetic Stimulation Center 4. INN #5 Peer Full Services Partnership	 21,000,000 11,500,000 540,000 2,085,160
INN Administration	2,050,227
Total INN Program Expenditures	37,175,387

WET Plan Budget*

Programs	WET Funding
WET Programs 1. Training and Technical Assistance 2. Mental Health Career Pathway 3. Financial Incentive	 720,000 1,578,400 3,873,600
WET Administration	925,800
Total WET Program Expenditures	7,097,800

** Data Source: MHSA Three-Year Program and Expenditure Plan, FYs 20-21 through 22-23*

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	• Departmental mission and vision statements, strategic plan, policies, and procedures provider

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		manual and parameters that guide clinical care • Implementation of tri-departmental 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
2. Governance and leadership promote 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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• 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 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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• 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
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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
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 • 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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Monitoring the use of innovative programs by the community, such as tele psychiatry services • Monitoring the effectiveness of medication practices •
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 • 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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• 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

Criterion 2

Updated Assessment of Services Needs

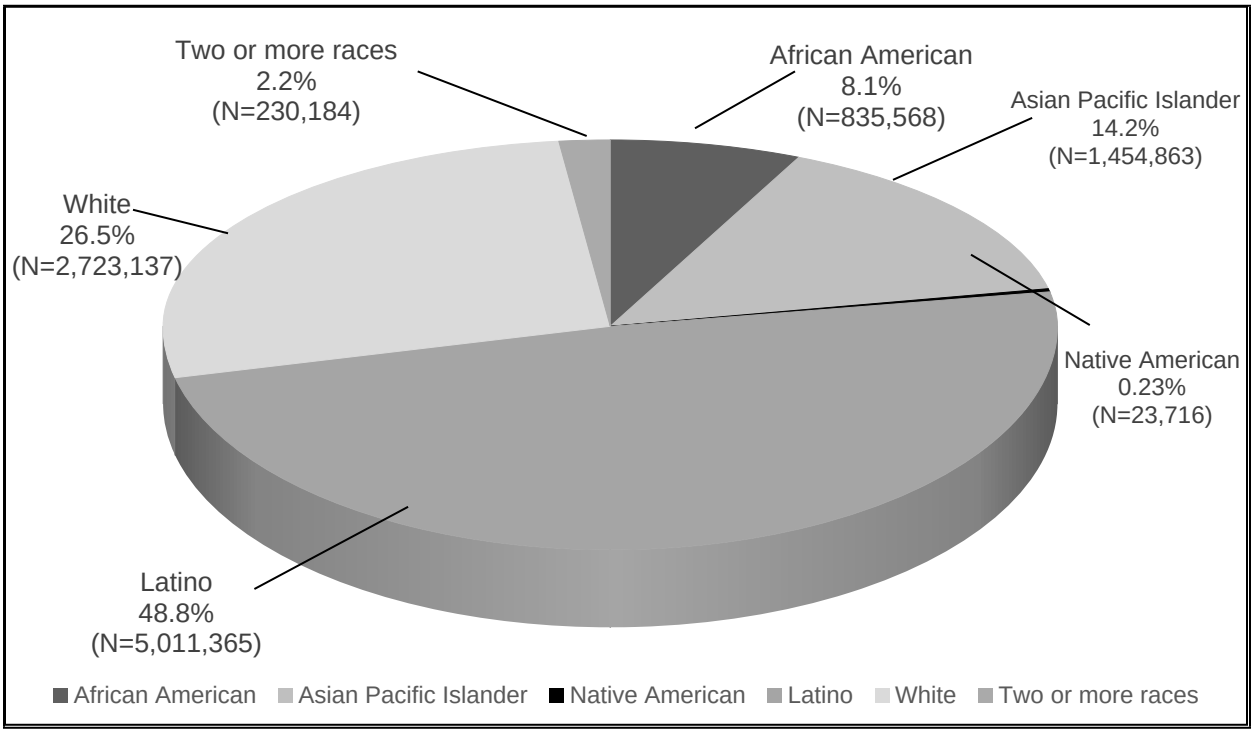
August 2020

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.

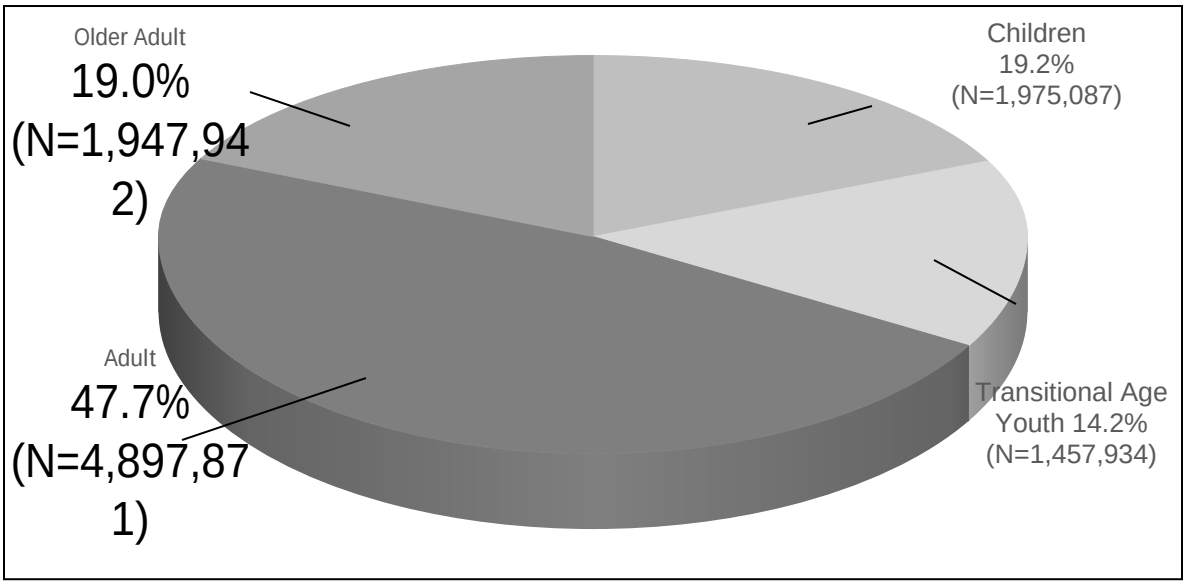
FIGURE 1: POPULATION BY RACE/ETHNICITY
CY 2018 (N = 10,278,834)



Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2019.

Figure 1 shows population by race/ethnicity. Latinos are the largest group at 48.8%, followed by Whites at 26.5%, Asian/Pacific Islanders (API) at 14.2%, African Americans at 8.1%, persons with Two or More Races at 2.2%, and Native Americans at 0.23%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2018 (N = 10,278,834)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

Figure 2 shows population by age group. Adults make up the largest group at 47.7%, followed by Children at 19.2%, Older Adults at 19.0%, and Transition Age Youth (TAY) at 14.2%.

TABLE 1: POPULATION BY RACE/ETHNICITY AND SERVICE AREA
CY 2018

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	60,592	15,412	182,426	1,912	125,919	11,322	397,583
Percent	15.2%	3.9%	45.9%	**0.48%**	31.7%	2.8%	100.0%
SA 2	76,738	255,524	916,400	4,751	949,722	59,141	2,262,277
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,526	505,293	843,458	3,716	357,632	34,638	1,808,263
Percent	3.5%	**27.9%**	46.6%	0.21%	19.8%	1.9%	100.0%
SA 4	58,698	204,655	617,033	2,599	281,580	21,229	1,185,794
Percent	5.0%	17.3%	52.0%	0.22%	23.7%	1.8%	100.0%
SA 5	37,280	91,290	110,426	1,198	399,221	28,448	667,863
Percent	5.6%	13.7%	**16.5%**	0.18%	**59.8%**	**4.3%**	100.0%
SA 6	276,877	19,331	722,715	1,812	25,529	11,431	1,057,694
Percent	**26.2%**	**1.8%**	68.3%	**0.17%**	**2.4%**	**1.1%**	100.0%
SA 7	38,961	118,547	975,913	3,329	169,183	15,372	1,321,304
Percent	**2.9%**	9.0%	**73.9%**	0.25%	12.8%	1.2%	100.0%
SA 8	222,896	244,810	642,994	4,401	414,351	48,604	1,578,056
Percent	14.1%	15.5%	40.7%	0.28%	26.3%	3.1%	100.0%
Total	835,568	1,454,863	5,011,365	23,716	2,723,137	230,184	10,278,834
Percent	8.1%	14.2%	48.8%	0.23%	26.5%	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, 2019.

Differences by Race/Ethnicity

The highest percentage of African Americans was in SA 6 (26.2%) compared to SA 7 (2.9%) with the lowest percentage.

The highest percentage of Asian/Pacific Islanders was in SA 3 (27.9%) compared to SA 6 (1.8%) with the lowest percentage.

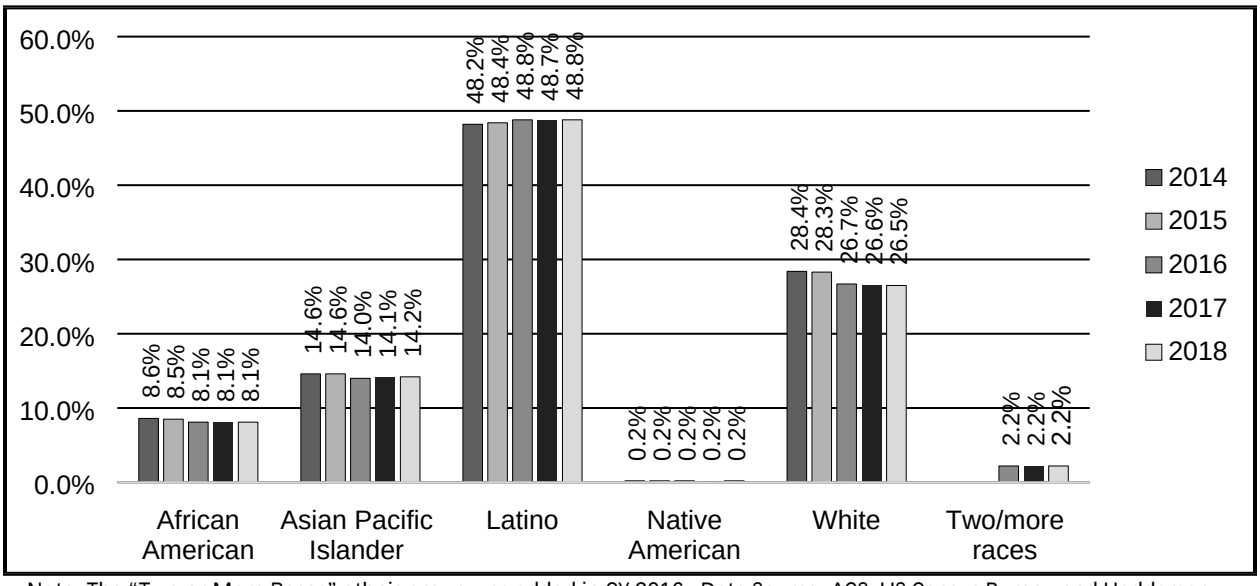
The highest percentage of Latinos was in SA 7 (73.9%) compared to SA 5 (16.5%) with the lowest percentage.

The highest percentage of Native Americans was in SA 1 (0.48%) compared to SA 6 (0.17%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (59.8%) compared to SA 6 (2.4%) with the lowest percentage.

The highest percentage of Two or More Races was in SA 5 (4.3%) compared to SAs 6 and 7 (1.1%) with the lowest percentage.

FIGURE 3: POPULATION PERCENT CHANGE BY RACE/ETHNICITY
CY 2014- 2018



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 2014 and 8.1% of the population in CY 2018.

The percentage of Asian Pacific Islanders (API) in Los Angeles County has decreased by 0.4 PP over the past five years. API represented 14.6% of the total population in CY 2014 and represented 14.2% in CY 2018.

The percentage of Latinos in Los Angeles County has increased by 0.6 PP over the past five years. Latinos represented 48.2% of the total population in CY 2013 and represented 48.8% in CY 2018.

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 2014 and in CY 2018.

The percentage of Whites in Los Angeles County has decreased by 1.9 PP over the past five years. Whites represented 28.4 of the total population in CY 2014 and represented 26.5% in CY 2018.

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 2018.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2018

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	106,815	13,746	35,085	175,578	23,206	43,153	397,583
Percent	26.8%	3.5%	8.8%	**44.2%**	5.8%	10.9%	100.0%
SA2	499,201	61,811	155,507	1,091,975	143,160	310,623	2,262,277
Percent	22.1%	2.7%	6.9%	48.3%	6.3%	13.7%	100.0%
SA3	397,955	54,967	133,761	831,319	116,518	273,743	1,808,263
Perce**nt**	22.0%	3.0%	7.4%	46.0%	**6.4%**	15.2%	100.0%
SA4	241,723	26,490	70,982	637,635	62,497	146,467	1,185,794
Percent	20.4%	**2.2%**	6.0%	**53.8%**	5.3%	12.3%	100.0%
SA5	119,703	23,198	41,669	335,949	40,961	106,383	667,863
Percent	**17.9%**	3.5%	**6.2%**	50.3%	6.2%	**15.9%**	100.0%
SA6	307,162	38,831	93,469	476,370	48,518	93,344	1,057,694
Percent	**29.0%**	**3.7%**	**8.8%**	45.0%	**4.7%**	**8.8%**	100.0%
SA7	337,324	41,472	105,306	605,575	70,813	160,814	1,321,304
Percent	25.5%	3.1%	8.0%	45.8%	5.4%	12.2%	100.0%
SA8	370,643	44,234	111,967	743,470	95,325	212,417	1,578,056
Percen**t**	23.5%	2.8%	7.1%	47.1%	6.0%	13.5%	100.0%
Total	2,380,526	304,749	747,746	4,897,871	600,998	1,346,944	10,278,834
Percent	23.2%	3.0%	7.3%	47.7%	5.7%	13.1%	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, 2019.

Difference by Age Group

The highest percentage of individuals between 0 and 18 years old was in SA 6 (29.0%) compared to SA 5 (17.9%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old was in SA 6 (3.7%) compared to SA 4 (2.2%) with the lowest percentage.

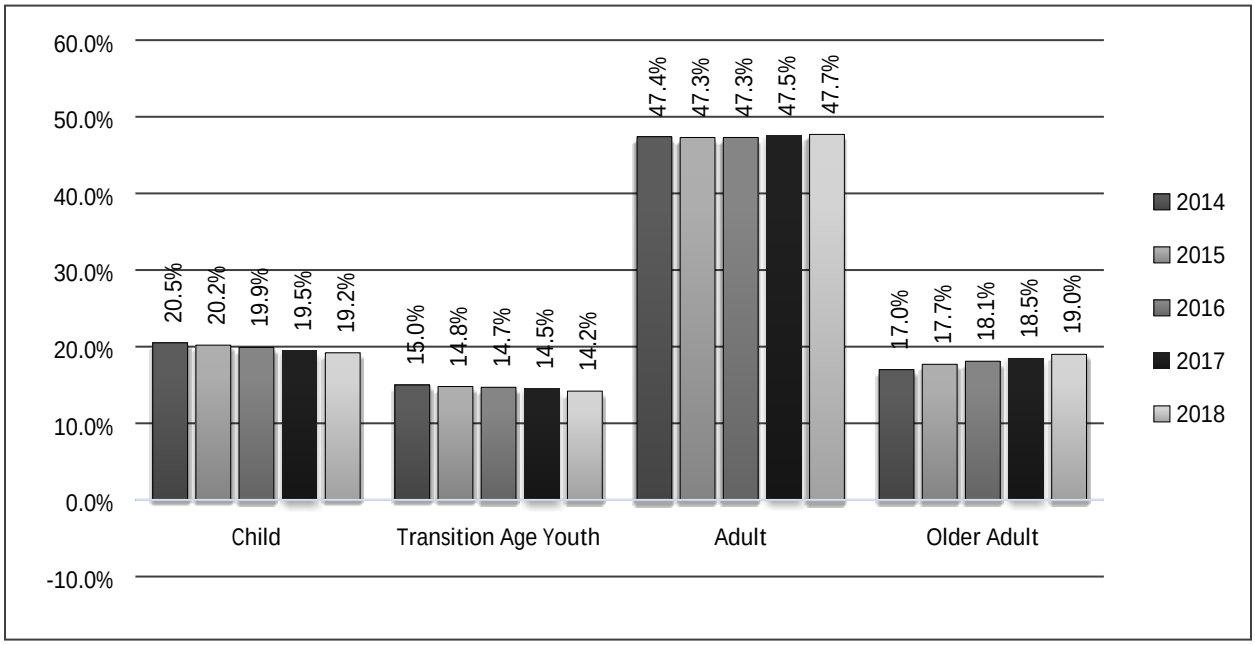
The highest percentage of individuals between 21 and 25 years old was in SA 6 (8.8%) compared to SA 5 (6.2%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (53.8%) compared to SA 1 (44.2%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 3 (6.4%) compared to SA 6 (4.7%) with the lowest percentage.

The highest percentage of individuals 65+ years old was in SA 5 (15.9%) compared to SA 6 (8.8%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT (PP) CHANGE BY AGE GROUP CY 2014-2018



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of Children in the County has decreased by 1.3 PP over the past five years. Children represented 20.5% of the total population in CY 2014 and 19.2% in CY 2018.

The percentage of Transition Age Youth (TAY) in the County has decreased by 0.8 PP over the past five years. TAY represented 15.0% of the total population in CY 2014 and 14.2% in CY 2018.

The percentage of Adults in the County increased by 0.3 PP over the past five years. Adults represented 47.4% of the total population in CY 2014 and 47.7% in CY 2018.

The percentage of Older Adults in the County has increased by 2.0 PP over the past five years. Older Adults represented 17.0% of the total population in CY 2014 and 19.0% in CY 2018.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2018

Service Area (SA)	Male	Female	Total
SA1	197,170	200,413	397,583
Percent	49.6%	50.4%	100.0%
SA2	1,118,659	1,143,618	2,262,277
Percent	49.4%	50.6%	100.0%
SA3	882,513	925,750	1,808,263
Percent	48.8%	51.2%	100.0%
SA4	608,556	577,238	1,185,794
Percent	**51.3%**	**48.7%**	100.0%
SA5	323,606	344,257	667,863
Percent	**48.5%**	**51.5%**	100.0%
SA6	515,744	541,950	1,057,694
Percent	48.8%	51.2%	100.0%
SA7	649,613	671,691	1,321,304
Percent	49.2%	50.8%	100.0%
SA8	771,878	806,178	1,578,056
Percent	48.9%	51.1%	100.0%
Total	5,067,739	5,211,095	10,278,834
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, 2019.

Differences by Gender

The highest percentage of Males was in SA 4 (51.3%) 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 (48.7%) 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 2018

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	19,759	2,888	55,602	554	26,790	2,585	108,178
Percent	18.3%	2.7%	51.4%	**0.51%**	24.8%	2.4%	100.0%
SA 2	14,851	36,670	225,047	797	124,324	7,566	409,255
Percent	3.6%	9.0%	55.0%	0.19%	30.4%	1.8%	100.0%
SA 3	10,716	84,371	175,510	628	44,274	4,013	319,512
Percent	3.4%	**26.4%**	54.9%	0.20%	13.9%	1.3%	100.0%
SA 4	13,453	49,037	193,753	796	51,201	4,008	312,248
Percent	4.3%	15.7%	62.1%	0.25%	16.4%	1.3%	100.0%
SA 5	5,107	13,760	15,637	147	46,758	3,109	84,518
Percent	6.0%	16.3%	**18.5%**	**0.17%**	**55.3%**	**3.7%**	100.0%
SA 6	95,750	7,720	293,640	780	8,517	3,329	409,735
Percent	**23.4%**	**1.9%**	71.7%	0.19%	**2.1%**	0.8%	100.0%
SA 7	7,755	15,156	227,693	618	22,313	1,655	275,191
Percent	**2.8%**	5.5%	**82.7%**	0.22%	8.1%	**0.6%**	100.0%
SA 8	60,985	40,135	182,103	935	44,330	6,942	335,429
Percent	18.2%	12.0%	54.3%	0.28%	13.2%	2.1%	100.0%
Total	228,375	249,736	1,368,985	5,255	368,507	33,208	2,254,066
Percent	10.1%	11.1%	60.7%	0.23%	16.3%	1.5%	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, 2019.

Differences by Race/Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (23.4%) compared to SA 7 (2.8%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 10.1% self-identified as AA.

The highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL was in SA 3 (26.4%) compared to SA 6 (1.9%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 11.1% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (82.7%) compared to SA 5 (18.5%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 60.7% self-identified as Latino.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.51%) compared to SA 5 (0.17%) 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 (55.3%) compared to SA 6 (2.1%) 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 (3.7%) compared to SA 7 (0.6%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 1.7% self-identified as having Two or More Races.

TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA CY 2018

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	40,346	3,664	9,353	41,571	4,588	8,656	108,178
Percent	37.3%	3.4%	8.6%	38.4%	4.2%	8.0%	100.0%
SA2	127,585	11,561	30,153	180,651	18,497	40,808	409,255
Percent	31.2%	2.8%	7.4%	44.1%	4.5%	10.0%	100.0%
SA3	97,327	9,361	24,735	132,937	15,189	39,963	319,512
Percent	30.5%	2.9%	7.7%	41.6%	**4.8%**	**12.5%**	100.0%
SA4	92,514	7,046	20,360	147,136	12,780	32,412	312,248
Percent	29.6%	**2.3%**	**6.5%**	47.1%	4.1%	10.4%	100.0%
SA5	14,157	3,191	10,342	42,983	3,845	10,000	84,518
Percent	**16.8%**	**3.8%**	**12.2%**	**50.9%**	4.5%	11.8%	100.0%
SA6	168,301	13,484	35,862	154,566	14,191	23,331	409,735
Percent	**41.1%**	3.3%	8.8%	**37.7%**	**3.5%**	**5.7%**	100.0%
SA7	104,477	8,055	21,032	107,425	10,705	23,497	275,191
Percent	38.0%	2.9%	7.6%	39.0%	3.9%	8.5%	100.0%
SA8	116,271	9,820	25,579	139,868	14,117	29,774	335,429
Percent	34.7%	2.9%	7.6%	41.7%	4.2%	8.9%	100.0%
Total	760,978	66,182	177,416	947,137	93,912	208,441	2,254,066
Percent	33.8%	2.9%	7.9%	42.0%	4.2%	9.2%	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, 2019.

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 (41.1%) compared to SA 5 (16.8%) 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 (2.3%) 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 (12.2%) compared to SA 4 (6.5%) 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 (50.9%) compared to SA 6 (37.7%) 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 (4.8%) compared to SA 6 (3.5%) 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 (12.5%) compared to SA 6 (5.7%) with the lowest percentage.

TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2018

Service Area (SA)	Male	Female	Total
SA1	49,972	58,206	108,178
Percent	46.2%	53.8%	100.0%
SA2	191,558	217,697	409,255
Percent	46.8%	53.2%	100.0%
SA3	147,609	171,903	319,512
Percent	46.2%	53.8%	100.0%
SA4	148,808	163,440	312,248
Percent	**47.7%**	**52.3%**	100.0%
SA5	39,169	45,349	84,518
Percent	46.3%	53.7%	100.0%
SA6	189,554	220,181	409,735
Percent	46.3%	53.7%	100.0%
SA7	126,836	148,355	275,191
Percent	**46.1%**	**53.9%**	100.0%
SA8	155,029	180,400	335,429
Percent	46.2%	53.8%	100.0%
Total	1,048,535	1,205,531	2,254,066
Percent	46.5%	53.5%	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, 2019.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (47.7%) compared to SA 746.1%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 7 (53.9%) compared to SA 4 (52.3%) 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 2018

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA1	813	597	98	197	66,883	159	321	57	20	95	35,538	588	402	105,768
Percent	0.77%	0.56%	0.09%	0.19%	63.24%	0.15%	0.30%	0.05%	0.02%	0.09%	33.60%	0.56%	0.38%	100.00%
SA2	4,950	48,981	155	820	120,313	6,482	4,885	1,234	1,176	7,134	195,094	7,304	2,612	401,140
Percent	1.23%	12.21%	0.04%	0.20%	29.99%	1.62%	1.22%	0.31%	0.29%	1.78%	48.63%	1.82%	0.65%	100.00%
SA3	2,302	2,555	893	14,251	93,097	426	3,614	21,974	20,611	294	136,877	4,078	11,177	312,149
Percent	0.74%	0.82%	0.29%	4.57%	29.82%	0.14%	1.16%	7.04%	6.60%	0.09%	43.85%	1.31%	3.58%	100.00%
SA4	1,445	7,595	566	3,493	76,987	1,063	20,310	1,163	5,371	4,895	175,795	5,441	1,498	305,622
Percent	0.47%	2.49%	0.19%	1.14%	25.19%	0.35%	6.65%	0.38%	1.76%	1.60%	57.52%	1.78%	0.49%	100.00%
SA5	1,478	696	70	362	51,052	4,668	1,600	1,336	3,048	1,482	15,495	596	596	82,479
Percent	1.79%	0.84%	0.08%	0.44%	61.90%	5.66%	1.94%	1.62%	3.70%	1.80%	18.79%	0.72%	0.72%	100.00%
SA6	373	124	166	389	107,015	262	2,254	837	2,361	144	286,679	395	509	401,508
Percent	0.09%	0.03%	0.04%	0.10%	26.65%	0.07%	0.56%	0.21%	0.59%	0.04%	71.40%	0.10%	0.13%	100.00%
SA7	1,758	879	503	931	60,133	161	3,195	524	1,678	197	195,563	2,653	1,308	269,483
Percent	0.65%	0.33%	0.19%	0.35%	22.31%	0.06%	1.19%	0.19%	0.62%	0.07%	72.57%	0.98%	0.49%	100.00%
SA8	2,240	488	4,922	235	132,720	616	4,402	1,464	1,570	448	170,492	5,871	3,190	328,658
Percent	0.68%	0.15%	1.50%	0.07%	40.38%	0.19%	1.34%	0.45%	0.48%	0.14%	51.88%	1.79%	0.97%	100.00%
Total	15,359	61,915	7,373	20,678	708,200	13,837	40,581	28,589	35,835	14,689	1,211,533	26,926	21,292	2,206,807
Percent	0.70%	2.81%	0.33%	0.94%	32.09%	0.63%	1.84%	1.30%	1.62%	0.67%	54.90%	1.22%	0.96%	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 Hedderson Demographic Services, 2019.

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 87.1% (N = 1,919,733) of the population (N = 2,206,807) living at or below 138% FPL spoke a LACDMH threshold language. Among these, 32.09% (N = 708,200) were English speaking, 54.9% were Spanish speaking (N = 1,211,533) and the remaining 13.0% 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 (63.2%) and Spanish (33.6%).

SA 2 reported eight (8) threshold languages: Armenian (12.2%), English (29.9%), Farsi (1.6%), Korean (1.2%), Russian (1.7%), Spanish (48.6%), Tagalog (1.8%) and Vietnamese (0.7%).

SA 3 reported seven (7) threshold languages: Cantonese (4.6%), English (29.8%), Korean (1.2%), Mandarin (7.0%), Other Chinese (6.6%), Spanish (43.9) and Vietnamese (3.6%).

SA 4 reported six (6) threshold languages: Armenian (2.5%), Cantonese (1.1%), English (25.2%), Korean (6.7%), Russian (1.6%) and Spanish (57.5%).

SA 5 reported three (3) threshold languages: English (61.9%), Farsi (5.7%), and Spanish (18.8%).

SA 6 reported two (2) threshold languages: English (26.7%), and Spanish (71.4%).

SA 7 reported three (3) threshold languages: English (22.3%), Korean (1.2%) and Spanish (72.6%).

SA 8 reported 5 (5) threshold languages: Cambodian (1.5%), English (40.4%), Korean (1.3%), Spanish (51.9%), and Vietnamese (0.1%).

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 2018

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	2,391	173	5,894	97	5,519	1,370	15,444
Percent	15.5%	**1.1%**	38.2%	**0.63%**	35.7%	8.9%	100.0%
SA 2	1,797	2,200	13,503	139	25,611	4,010	47,260
Percent	**3.8%**	4.7%	28.6%	0.30%	54.1%	8.5%	100.0%
SA 3	1,297	5,062	10,531	110	9,120	2,127	28,247
Percent	4.6%	**17.9%**	37.3%	0.39%	32.3%	7.5%	100.0%
SA 4	1,628	2,942	11,625	139	10,547	2,124	29,006
Percent	5.6%	10.1%	40.1%	0.48%	36.4%	7.3%	100.0%
SA 5	618	826	938	26	9,632	1,648	13,688
Percent	4.5%	6.0%	**6.9%**	**0.19%**	**70.4%**	**12.0%**	100.0%
SA 6	11,586	463	17,618	136	1,755	1,764	33,323
Percent	**34.8%**	1.4%	52.9%	0.41%	**5.3%**	5.2%	100.0%
SA 7	938	909	13,662	108	4,596	877	21,091
Percent	**4.4%**	4.3%	**64.8%**	0.50%	21.8%	**4.2%**	100.0%
SA 8	7,379	2,408	10,926	164	9,132	3,679	33,688
Percent	21.9%	7.1%	32.4%	0.49%	27.1%	11.0%	100.0%
Total	27,633	14,984	82,139	920	75,913	17,600	219,189
Percent	12.6%	6.8%	37.5%	0.42%	34.7%	8.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each Ethnic Group and across the Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2017 and CY 2018. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

Differences by Race/Ethnicity

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

The highest rate of prevalence of SED and SMI among the African American (AA) group was in SA 6 (34.8%) compared to SA 7 (4.4%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian/Pacific Islander (API) group was in SA 3 (17.9%) compared to SA 1 (1.1%) with the lowest percentage.

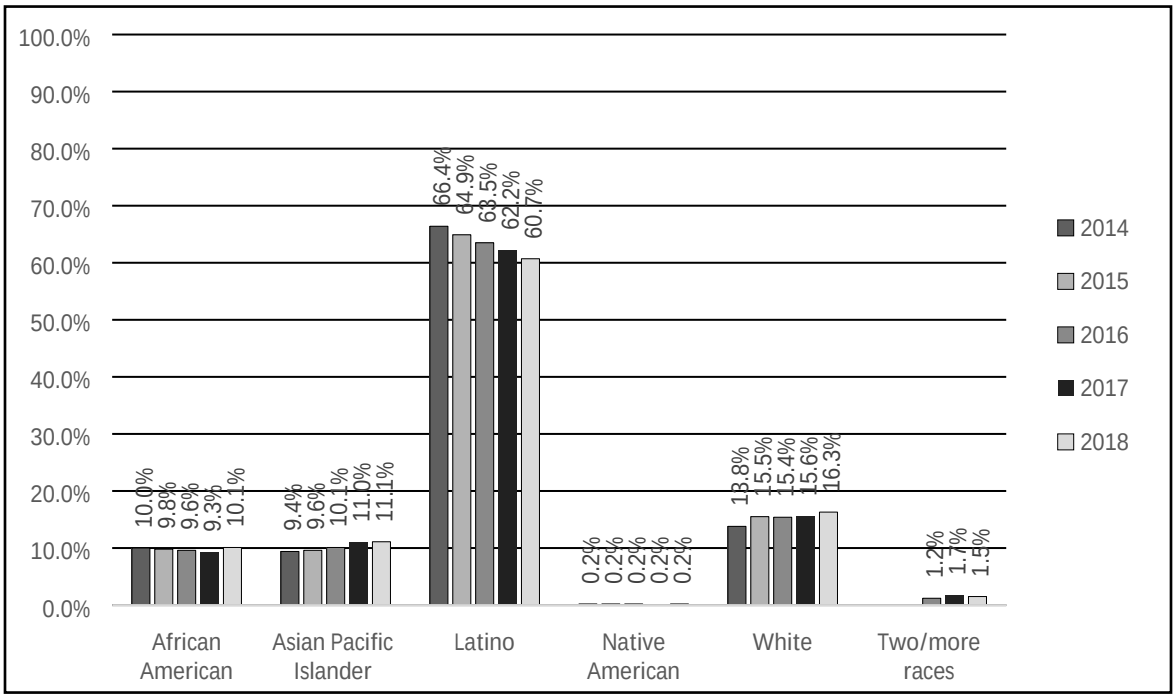
The highest rate of prevalence of SED and SMI among the Latino group was in SA 7 (64.8%) compared to SA 5 (6.9%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) group was in SA 1 (0.6%) 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 (70.4%) compared to SA 6 (5.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Two or More Races group was in SA 5 (12.0%) compared to SA 7 (4.2%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY CY 2014–2018



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of African Americans living at or below 138% FPL has increased by 0.1% from 10.0% in CY 2014 to 10.1% in CY 2018.

The percentage of Asian/Pacific Islanders (API) living at or below 138% FPL has increased by 1.7% from 9.4% in CY 2014 to 11.1% in CY 2018.

The percentage of Latinos living at or below 138% FPL has decreased by 5.7% from 66.4% in CY 2014 to 60.7% in CY 2018.

The percentage of Native Americans living at or below 138% FPL has remained unchanged at 0.2% from CY 2014 to CY 2018.

The percentage of Whites living at or below 138% FPL has increased by 2.5% from 13.8% in CY 2014 to 16.3% in CY 2018.

The percentage of category Two or More Races living at or below 138% FPL increased by 0.3 from 1.2% in CY 2016 to 1.5% in CY 2018.

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 2018

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	6,254	550	3,058	4,573	413	329	15,176
Percent	41.2%	3.6%	20.2%	30.1%	2.7%	2.2%	100.0%
SA2	19,776	1,734	9,860	19,872	1,665	1,551	54,457
Percent	36.3%	3.2%	18.1%	36.5%	3.1%	2.8%	100.0%
SA3	15,086	1,404	8,088	14,623	1,367	1,519	42,087
Percent	35.8%	3.3%	19.3%	34.7%	**3.3%**	**3.6%**	100.0%
SA4	14,340	1,057	6,658	16,185	1,150	1,232	40,621
Percent	35.4%	**2.6%**	**16.4%**	39.8%	2.8%	3.0%	100.0%
SA5	2,194	479	3,382	4,728	346	380	11,509
Percent	**19.1%**	**4.2%**	**29.4%**	**41.1%**	3.0%	3.2%	100.0%
SA6	26,087	2,023	11,727	17,002	1,277	887	59,002
Percent	**44.2%**	3.4%	19.9%	**28.8%**	**2.2%**	**1.5%**	100.0%
SA7	16,194	1,208	6,877	11,817	963	893	37,953
Percent	42.7%	3.2%	18.1%	31.1%	2.5%	2.4%	100.0%
SA8	18,022	1,473	8,364	15,385	1,271	1,131	45,647
Percent	39.5%	3.2%	18.3%	33.7%	2.8%	2.5%	100.0%
Total	117,952	9,927	58,015	104,185	8,452	7,921	306,452
Percent	38.5%	3.2%	18.9%	34.0%	2.8%	2.6%	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 2017 and 2018. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2019.

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 (44.2%) compared to SA 5 (19.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 19-20 was in SA 5 (4.2%) compared to SA 4 (2.6%) with the lowest percentage.

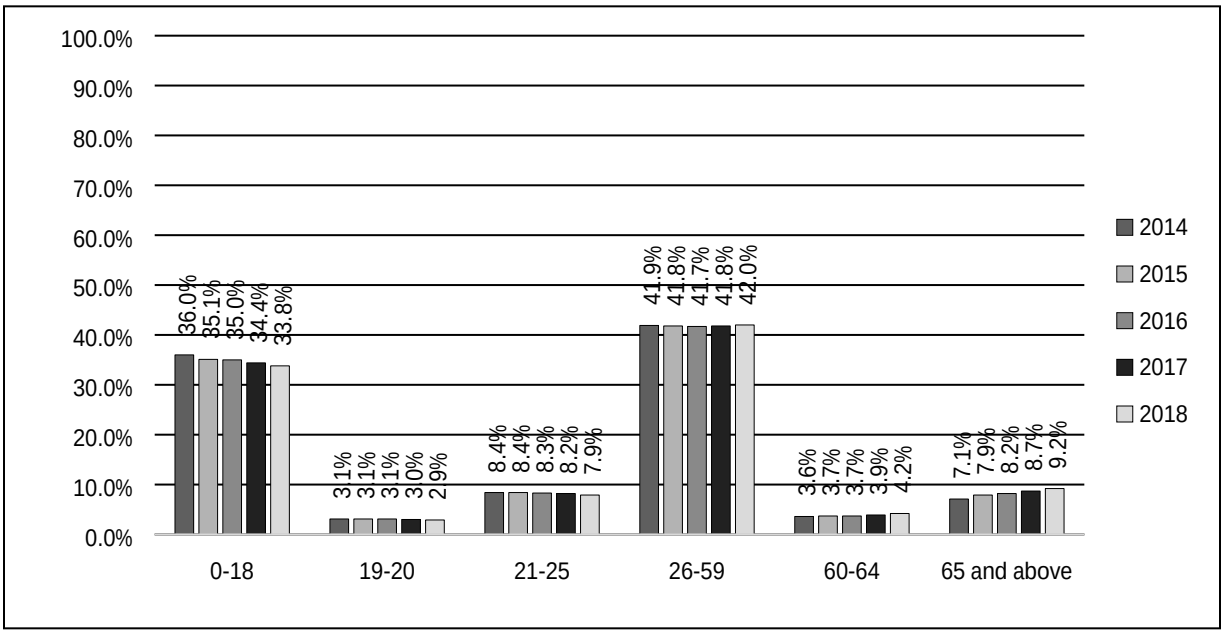
The highest rate of prevalence of SED and SMI in Age Group 21-25 was in SA 5 (29.4%) compared to SA 4 (16.4%) the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 26-59 was in SA 5 (41.1%) compared to SA 6 (28.8%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 60-64 was in SA 3 and SA (3.3%) compared to SA 6 (2.2%).

The highest rate of prevalence of SED and SMI in Age Group 65 and older was in SA 3 (3.6%) compared to SA 6 (1.5%) with the lowest percentage.

FIGURE 6: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2014–2018



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL decreased by 2.2 PP from 36.0% in CY 2014 to 33.8% in CY 2018.

The percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL decreased by 0.2 PP from 3.1% in CY 2014 and to 2.9% in CY 2018.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 0.5 PP from 8.4% in CY 2014 to 7.9% in CY 2018.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL increased by 0.1 PP from 41.9% in CY 2014 to 42.0% in CY 2018.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.6 PP from 3.6% in CY 2014 to 4.2% in CY 2018.

The percentage of individuals age 65 and older and estimated to be living at or below 138% FPL increased by 2.1 PP from 7.1% in CY 2014 to 9.2% in CY 2018.

TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA
CY 2018

Service Area (SA)	Male	Female	Total
SA1	4,697	7,916	12,613
Percent	**37.2%**	**62.8%**	100.0%
SA2	18,006	20,464	38,470
Percent	46.8%	**53.2%**	100.0%
SA3	13,875	16,159	30,034
Percent	46.2%	53.8%	100.0%
SA4	13,988	15,363	29,351
Percent	**47.7%**	52.3%	100.0%
SA5	3,682	4,263	7,945
Percent	46.3%	53.7%	100.0%
SA6	17,818	20,697	38,515
Percent	46.3%	53.7%	100.0%
SA7	11,923	13,945	25,868
Percent	46.1%	53.9%	100.0%
SA8	14,573	16,958	31,530
Percent	46.2%	53.8%	100.0%
Total	98,562	113,320	211,882
Percent	46.5%	53.5%	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 2017 and CY 2018. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2018.

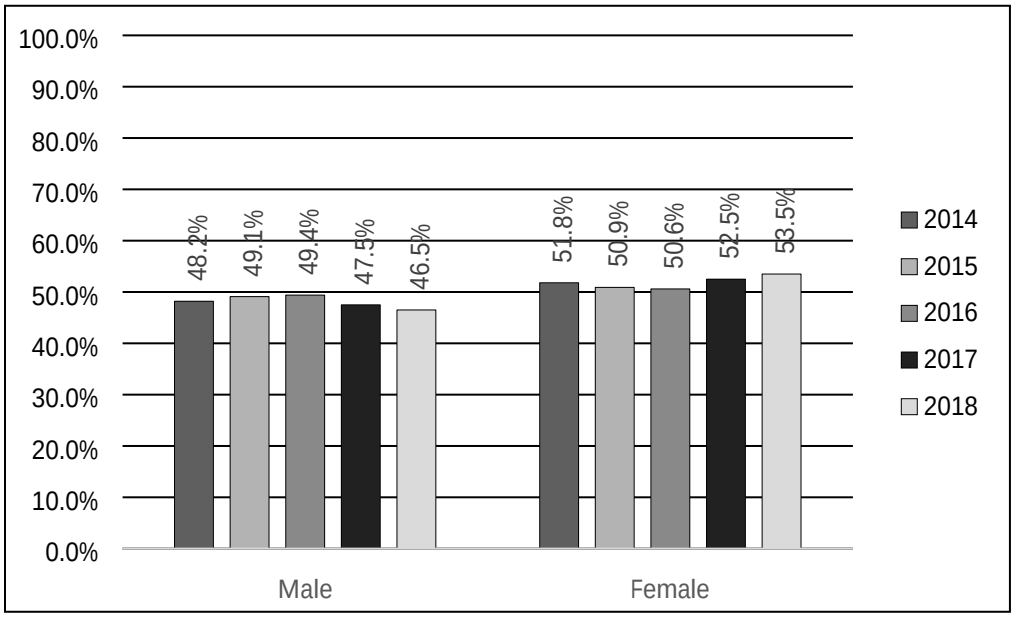
Differences by Gender

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 (47.7%) compared to SA 1 (37.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 1 (62.8%) compared to SA 2 (53.2%) with the lowest percentage.

FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2014–2018



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

The percentage of Males living at or below 138% FPL decreased by 1.7% from 48.2% in CY 2014 to 46.5% in CY 2018.

The percentage of Females living at or below 138% FPL increased by 1.7% from 51.8% in CY 2014 to 53.5% in CY 2018.

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.

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 percentage of individual between 19 and 20 years old enrolled in Medi-Cal was 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	9,181	147	8,368	35	6,514	24,244
Percent	37.9%	0.6%	34.5%	0.14%	26.9%	100.0%
SA 2	5,787	1,785	32,466	77	46,002	86,118
Percent	6.7%	2.1%	37.7%	0.09%	53.4%	100.0%
SA 3	4,544	5,548	27,360	61	11,472	48,985
Percent	9.3%	11.3%	55.9%	0.12%	23.4%	100.0%
SA 4	6,017	2,120	23,971	110	12,855	45,073
Percent	13.3%	4.7%	53.2%	0.24%	28.5%	100.0%
SA 5	2,552	257	2,466	22	7,899	13,196
Percent	19.3%	1.9%	18.7%	0.17%	59.9%	100.0%
SA 6	30,464	202	36,244	56	2,946	69,912
Percent	43.6%	0.3%	51.8%	0.08%	4.2%	100.0%
SA 7	2,845	933	34,055	56	6,805	44,695
Percent	6.4%	2.1%	76.2%	0.13%	15.2%	100.0%
SA 8	19,620	1,819	22,703	86	11,105	55,333
Percent	35.5%	3.3%	41.0%	0.16%	20.1%	100.0%
Total	81,010	12,811	187,634	503	105,598	387,556
Percent	20.9%	3.3%	48.4%	0.13%	27.2%	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 2017 and CY 2018. 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 (43.6%) compared to SA 2 and SA 7 (6.4%) with the lowest percentage.

The highest prevalence of SED and SMI in the Asian/Pacific Islander (API) group was in SA 3 (11.3%) compared to SA 6 (0.3%) with the lowest percentage.

The highest prevalence of SED and SMI in the Latino group was in SA 7 (76.2%) compared to SA 5 (18.7%) with the lowest percentage.

The highest prevalence of SED and SMI in the Native American (NA) group was in SA 4 (0.24%) compared to SA 6 (0.08%) with the lowest percentage.

The highest prevalence of SED and SMI in the White group was in SA 5 (59.9%) compared to SA 6 (4.2%) 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

Service Area (SA)	AGE GROUP						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	19,221	1,073	3,795	6,770	500	517	31,877
Percent	60.3%	3.4%	11.9%	21.2%	1.6%	**1.6%**	100.0%
SA 2	59,036	3,355	12,549	3,532	2,720	4,236	85,428
Percent	**69.1%**	**3.9%**	**14.7%**	**4.1%**	**3.2%**	**5.0%**	100.0%
SA 3	51,514	2,978	10,889	22,619	2,239	3,554	93,793
Percent	54.9%	3.2%	11.6%	24.1%	2.4%	3.8%	100.0%
SA 4	33,785	1,995	8,103	19,551	1,807	2,867	68,108
Percent	49.6%	2.9%	11.9%	28.7%	2.7%	4.2%	100.0%
SA 5	5,892	385	1,761	4,653	414	657	13,762
Percent	**42.8%**	**2.8%**	12.8%	**33.8%**	3.0%	4.8%	100.0%
SA 6	62,435	3,349	11,994	22,992	1,821	1,971	104,561
Percent	59.7%	3.2%	**11.5%**	22.0%	**1.7%**	1.9%	100.0%
SA 7	48,990	2,712	9,539	18,112	1,534	2,256	83,143
Percent	58.9%	3.3%	**11.5%**	21.8%	1.8%	2.7%	100.0%
SA 8	45,812	2,595	9,897	19,848	1,707	2,138	81,997
Percent	55.9%	3.2%	12.1%	24.2%	2.1%	2.6%	100.0%
Total	326,686	18,441	68,528	142,946	12,742	18,196	587,537
Percent	55.6%	3.1%	11.7%	24.3%	2.2%	3.1%	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 2017 and CY 2018. 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 2 (69.1%) compared to SA 5 (42.8%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 19-20 was in SA 2 (3.9%) compared to SA 5 (2.8%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 21-25 was in SA 2 (14.7%) compared to SA 6 and 7 (11.5%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 26-59 was in SA 5 (33.8%) compared to SA 2 (4.1%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 60-64 was in SA 2 (3.2%) compared to SA 6 (1.7%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 65 and older was in SA 2 (5.0%) compared to SA 1 (1.6%) 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	10,130	10,235	20,366
Percent	49.7%	50.3%	100.0%
SA 2	39,537	39,978	79,515
Percent	49.7%	50.3%	100.0%
SA 3	32,948	33,528	66,476
Percent	49.6%	50.4%	100.0%
SA 4	26,078	25,055	51,133
Percent	51.0%	49.0%	100.0%
SA 5	5,646	5,344	10,989
Percent	**51.4%**	**48.6%**	100.0%
SA 6	33,665	34,383	68,049
Percent	49.5%	50.5%	100.0%
SA 7	26,989	28,382	55,371
Percent	**48.7%**	**51.3%**	100.0%
SA 8	27,812	28,176	55,988
Percent	49.7%	50.3%	100.0%
Total	202,805	205,082	407,887
Percent	49.7%	50.3%	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 2017 and CY 2018. 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 (51.4%) compared to SA 7 (48.7%) with the lowest percentage.

The highest prevalence of SED and SMI among Females was in SA 7 (51.3%) compared to SA 5 (48.6%) with the lowest percentage

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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 (49.0%) 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 18–19

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	Other Races	Unknown	White	Total
SA 1	4,648	126	3,655	106	158	321	2,571	11,585
Percent	40.1%	1.1%	31.5%	0.91%	1.4%	2.8%	22.2%	100.0%
SA 2	2,865	876	11,233	146	816	753	7,750	24,439
Percent	11.7%	3.6%	46.0%	0.60%	3.3%	3.1%	31.7%	100.0%
SA 3	2,805	1,872	11,620	169	388	698	3,273	20,825
Percent	13.5%	9.0%	55.8%	0.81%	1.9%	3.4%	15.7%	100.0%
SA 4	5,829	1,450	10,890	160	352	385	3,929	22,995
Percent	25.3%	6.3%	47.4%	0.70%	1.5%	1.7%	17.1%	100.0%
SA 5	1,431	191	1,297	57	210	163	2,560	5,909
Percent	24.2%	3.2%	21.9%	0.96%	3.6%	2.8%	43.3%	100.0%
SA 6	16,405	346	12,240	119	244	585	1,617	31,556
Percent	52.0%	1.1%	38.8%	0.38%	0.8%	1.9%	5.1%	100.0%
SA 7	1,491	473	13,256	215	228	668	2,041	18,372
Percent	8.1%	2.6%	72.2%	1.17%	1.2%	3.6%	11.1%	100.0%
SA 8	8,642	1,076	9,066	202	437	944	4,633	25,000
Percent	34.6%	4.3%	36.3%	0.81%	1.7%	3.8%	18.5%	100.0%
Total	35,320	4,762	54,125	920	2,105	3,335	21,206	121,773
Percent	29.0%	3.9%	44.4%	0.76%	1.7%	2.7%	17.4%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Total reflects an unduplicated count of consumers served. 'No Entry' for Ethnicity (N = 108,648). Data Source: LACDMH-IS-IBHIS, September 2019.

Differences by Race/Ethnicity

Table 18 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 (52.0%) as compared to SA 7 (8.1%) with the lowest percentage.

The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (9.0%) as compared to SA 6 (1.1%) with the lowest percentage.

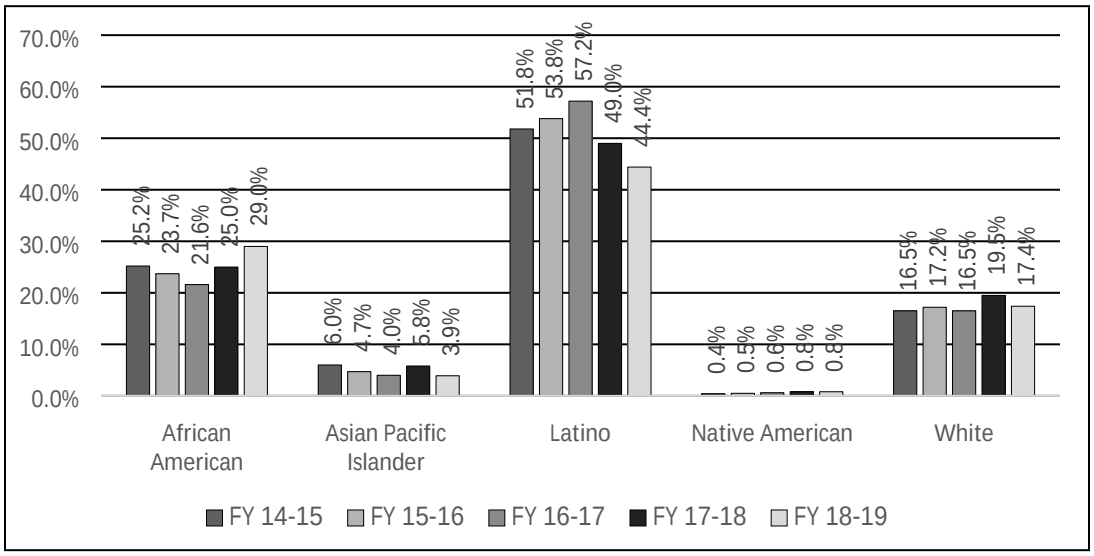
The highest percentage of Latino consumers served in outpatient programs was in SA 7 (72.2%) as compared to SA 5 (21.9%) with the lowest percentage.

The highest percentage of Native American consumers served in outpatient programs was in SA 7 (1.2%) 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 (43.3%) as compared to SA 6 (5.1%) with the lowest percentage.

The highest percentage of Two or More Races served in outpatient programs was in SA 5 (3.6%) as compared to SA 6 (0.8%) with the lowest percentage.

FIGURE 8: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY FY 14-15 TO FY 17-18



Data Source: LACDMH, IS-IBHIS, September 2019

The percentage of African Americans (AA) served in outpatient programs increased by 3.8% from 25.2% to 29% between FY 14-15 and FY 18-19.

The percentage of Asian/Pacific Islanders (API) served in outpatient programs decreased by 2.1% between FY 14-15 and FY 18-19 from 6.0% to 3.9%.

The percentage of Latinos served in outpatient programs decreased by 7.4% from 51.8% to 44.4% between FY 14-15 and FY 18-19.

The percentage of Native Americans (NA) served in outpatient programs increased by 0.4% from 0.4% to 0.8% from FY 14-15 and FY 18-19.

The percentage of Whites served in outpatient programs increased by 0.9% from 16.5% to 17.4% between FY 14-15 and FY 18-19.

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

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA1	6,285	3,488	7,885	1,268	18,926
Percent	33.2%	18.4%	41.7%	6.7%	100.0%
SA2	13,606	10,585	19,089	4,749	48,029
Percent	28.3%	22.0%	39.7%	9.9%	100.0%
SA3	15,281	9,963	13,076	2,862	41,182
Percent	37.1%	24.2%	31.8%	6.9%	100.0%
SA4	9,819	7,301	18,180	4,756	40,056
Percent	24.5%	18.2%	45.4%	11.9%	100.0%
SA5	1,678	1,658	5,518	1,594	10,448
Percent	16.1%	15.9%	52.8%	15.3%	100.0%
SA6	17,939	11,233	21,568	4,460	55,200
Percent	32.5%	20.3%	39.1%	8.1%	100.0%
SA7	13,774	8,385	12,206	2,565	36,930
Percent	37.3%	22.7%	33.1%	6.9%	100.0%
SA8	12,906	8,301	18,824	4,746	44,777
Percent	28.8%	18.5%	42.0%	10.6%	100.0%
Total	72,365	47,481	90,419	20,881	231,146
Percent	31.3%	20.5%	39.1%	9.0%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, September 2019.

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 (37.3%) compared to SA 5 (16.1%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 3 (24.2%) when compared to SA 5 (15.9%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (52.8%) compared to SA 7 (33.1%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (15.3%) compared to SA 1 (6.7%) with the lowest percentage.

TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA
FY 18–19

Service Area (SA)	Male	Female	Total
SA1	9,751	9,146	18,897
Percent	**51.6%**	**48.4%**	100.0%
SA2	24,350	23,617	47,967
Percent	50.8%	49.2%	100.0%
SA3	20,918	20,206	41,124
Percent	50.9%	49.1%	100.0%
SA4	20,504	19,500	40,004
Percent	51.3%	48.7%	100.0%
SA5	5,300	5,136	10,436
Percent	50.8%	49.2%	100.0%
SA6	27,881	27,251	55,132
Percent	50.6%	49.4%	100.0%
SA7	18,631	18,245	36,876
Percent	**50.5%**	**49.5%**	100.0%
SA8	22,921	21,781	44,702
Percent	51.3%	48.7%	100.0%
Total	114,994	115,838	230,832
Percent	49.8%	50.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Data Source: LACDMH-IS-IBHIS, September 2019.

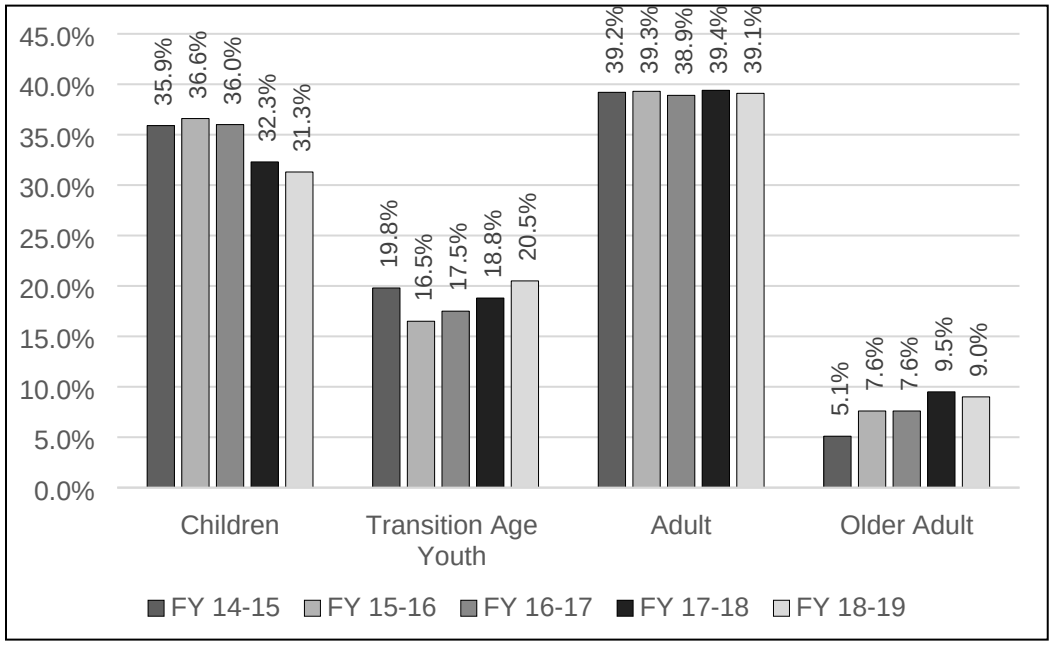
Differences by Gender

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 1 (51.6%) compared to SA 7 (50.5%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 7 (49.5%) compared to SA 1 (48.4%) with the lowest percentage.

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP FY 14-15 TO FY 17-18



Data Source: LACDMH, IS-IBHIS, September 2019.

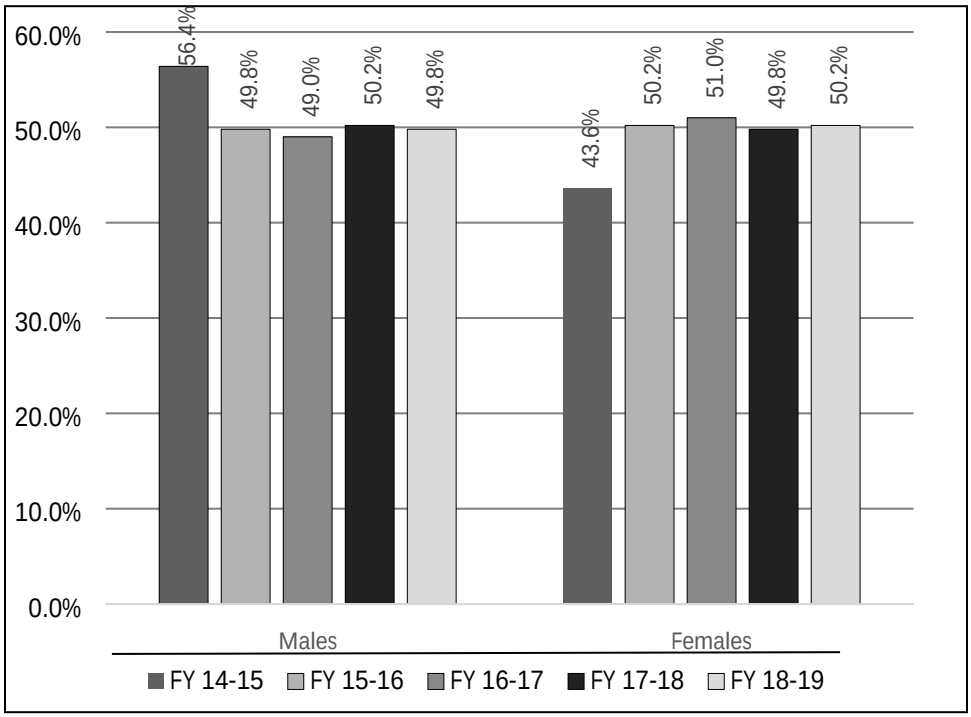
The percentage of Children served in outpatient programs decreased by 4.6% from 35.9% to 31.3% between FY 14-15 and FY 18-19.

The percentage of TAY served in outpatient programs increased by 0.7% from 19.8% to 20.5% between FY 14-15 and FY 18-19.

The percentage of Adults served in outpatient programs decreased by 0.1% from 39.2% to 39.1% between FY 13-14 and FY 17-18.

The percentage of Older Adults served in outpatient programs increased by 3.9% from 5.1% to 9.0% between FY 14-15 and FY 18-19.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER FY 14-15 TO FY 18-19



Data Source: LACDMH, IS-IBHIS, September 2019.

The percentage of Males in outpatient programs decreased by 6.6 from 56.4% to 49.8% between FY 14-15 and FY 18-19.

The percentage of Females served in outpatient programs increased by 6.6 from 43.6% to 50.2% between FY 14-15 and FY 18-19.

TABLE 20: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE FY 18-19

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	5	9	1	1	17,392	8	3	5	0	3	1,117	6	2	18,552
Percent	0.03%	0.05%	0.01%	0.01%	93.75%	0.04%	0.02%	0.03%	0.00%	0.02%	6.02%	0.03%	0.01%	100.00%
SA 2	106	1,105	25	12	36,835	524	106	17	16	260	6,851	118	59	46,034
Percent	0.23%	2.40%	0.05%	0.03%	80.02%	1.14%	0.23%	0.04%	0.03%	0.56%	14.88%	0.26%	0.13%	100.00%
SA 3	30	26	70	575	30,976	11	95	569	90	9	6,723	37	421	39,632
Percent	0.08%	0.07%	0.18%	1.45%	78.16%	0.03%	0.24%	1.44%	0.23%	0.02%	16.96%	0.09%	1.06%	100.00%
SA 4	10	115	71	104	29,894	40	602	43	19	192	6,845	86	79	38,100
Percent	0.03%	0.30%	0.19%	0.27%	78.46%	0.10%	1.58%	0.11%	0.05%	0.50%	17.97%	0.23%	0.21%	100.00%
SA 5	11	5	0	4	8,911	168	31	8	1	37	594	2	5	9,777
Percent	0.11%	0.05%	0.00%	0.04%	91.14%	1.72%	0.32%	0.08%	0.01%	0.38%	6.08%	0.02%	0.05%	100.00%
SA 6	7	1	23	18	43,835	12	86	10	6	8	9,394	8	18	53,426
Percent	0.01%	0.00%	0.04%	0.03%	82.05%	0.02%	0.16%	0.02%	0.01%	0.01%	17.58%	0.01%	0.03%	100.00%
SA 7	24	10	96	21	27,255	3	56	28	14	7	8,137	24	31	35,706
Percent	0.07%	0.03%	0.27%	0.06%	76.33%	0.01%	0.16%	0.08%	0.04%	0.02%	22.79%	0.07%	0.09%	100.00%
SA 8	17	3	652	10	35,484	10	105	20	10	10	6,137	86	130	42,674
Percent	0.04%	0.01%	1.53%	0.02%	83.15%	0.02%	0.25%	0.05%	0.02%	0.02%	14.38%	0.20%	0.30%	100.00%
Total	167	1,274	694	594	180,722	620	819	559	133	407	35,304	295	567	222,155
Percent	0.08%	0.57%	0.31%	0.27%	81.35%	0.28%	0.37%	0.25%	0.06%	0.18%	15.89%	0.13%	0.26%	100.00%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. A total of 1,328 consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 23. Another 1,888 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. Data Source: LACDMH-IS-IBHIS, September 2019.

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 180,722 (81.4%) English speaking consumers were served followed by 35,304 (15.9%) Spanish speaking consumers. The remaining 6,129 (2.8%) consumers served spoke other LACDMH threshold languages. A total 41,433 (18.7%) of the consumers served reported a primary language other than English.

SA 1 (93.8%) had the highest percentage of English speaking consumers, as compared to SA 6 (82.1%) 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 (22.7%) and the lowest percentage was in SA 1 (6.0%).

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

- SA 1: Spanish (6.0%)
- SA 2: Armenian (2.4%), Farsi (1.1%), Russian (0.6%), Spanish (14.9%), Tagalog (0.3%), and Vietnamese (0.2%)
- SA 3: Cantonese (1.5%), Korean (0.2%), Mandarin (1.4%), Spanish (17.0%), and Vietnamese (1.1%)
- SA 4: Armenian (0.3%), Cantonese (0.3%), Korean (1.6%), Mandarin (0.1%), Other Chinese (0.1%), Russian (0.5%), Spanish (18.0%), and Tagalog (0.2%)
- SA 5: Farsi (1.7%) and Spanish (6.1%)
- SA 6: Spanish (17.6%)
- SA 7: Korean (0.2%) and Spanish (22.8%)
- SA 8: Cambodian (1.5%), Korean (0.3%), Spanish (14.4%), and Vietnamese (0.3%)

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 17-18. The needs assessment section further analyzes the demographic distribution of the outpatient consumers served in the County Service Areas for FY 17-18 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 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	4,429	4,300	-129
SA 2	2,792	2,520	-272
SA 3	2,192	2,456	(+)264
SA 4	2,903	4,951	(+)2,048
SA 5	1,231	1,201	-30
SA 6	14,698	12,705	-1,993
SA 7	1,372	1,103	-269
SA 8	9,466	6,084	-3,382
Total	39,084	35,320	-3,764

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 8 with an estimated 3,382 (unduplicated) individuals in need of services. The least disparity was in SA 4 with an estimated (+)2,048 (unduplicated) individuals served beyond the estimated need for services. Overall, at the county level, there was an estimated unmet service need for 3,764 Medi-Cal Enrolled AA individuals as the number of unduplicated consumers served was 35,320 while the estimated Medi-Cal Enrolled Population with SED and SMI was 39,084.

TABLE 22: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ASIAN/PACIFIC ISLANDER POPULATION WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	183	121	-62
SA 2	2,231	747	-1,484
SA 3	6,935	1,472	-5,463
SA 4	2,651	1,079	-1,572
SA 5	321	130	-191
SA 6	253	228	-25
SA 7	1,166	307	-859
SA 8	2,274	678	-1,596
Total	16,014	4,762	-11,252

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 5,463 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated -25 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 11,252 Medi-Cal Enrolled API individuals as the number of unduplicated consumers served was 4,762 while the estimated Medi-Cal Enrolled Population with SED and SMI was 16,014.

TABLE 23: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED LATINO POPULATION WITH SED AND SMI BY SERVICE AREA FY 18-19

	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	11,092	3,345	-7,747
SA 2	43,037	9,632	-33,405
SA 3	36,268	9,296	-26,972
SA 4	31,775	8,171	-23,604
SA 5	3,269	946	-2,323
SA 6	48,045	8,491	-39,554
SA 7	45,143	8,759	-36,384
SA 8	30,095	5,485	-24,610
Total	248,723	54,125	-194,598

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 39,554 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,323 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 194,598. Medi-Cal Enrolled Latino individuals as the number of unduplicated consumers served was 54,125 while the estimated Medi-Cal Enrolled Population with SED and SMI was 248,723.

TABLE 24: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED NATIVE AMERICAN POPULATION WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	114	95	-19
SA 2	251	131	-120
SA 3	197	133	-64
SA 4	355	118	-237
SA 5	71	43	-28
SA 6	180	95	-85
SA 7	183	159	-24
SA 8	279	146	-133
Total	1,629	920	-709

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 237 (unduplicated) individuals in need of services. The least disparity was in SA 1 with an estimated -19 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for -709 Medi-Cal Enrolled Native American individuals as the number of unduplicated consumers served was 920 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 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	7,461	2,324	-5,137
SA 2	52,693	6,430	-46,263
SA 3	13,141	2,483	-10,658
SA 4	14,725	2,857	-11,868
SA 5	9,048	1,774	-7,274
SA 6	3,374	1,110	-2,264
SA 7	7,795	1,327	-6,468
SA 8	12,720	2,901	-9,819
Total	120,958	21,206	-99,752

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 46,263 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated 2,264 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 99,752. Medi-Cal Enrolled White individuals as the number of unduplicated consumers served was 21,206 while the estimated Medi-Cal Enrolled Population with SED and SMI was 120,958.

Disparity by Language

TABLE 26: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED POPULATION WITH SED AND SMI BY LANGUAGE ESTIMATED FY 18-19

Language	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
Arabic	749	167	-582
Armenian	9,110	1,274	-7,836
Cambodian	1,068	694	-374
Cantonese	5,423	594	-4,829
English	247,457	180,722	-66,735
Farsi	1,919	620	-1,299
Korean	4,374	819	-3,555
Mandarin	5,955	559	-5,396
Other Chinese	587	133	-454
Russian	1,625	407	-1,218
Spanish	164,118	35,304	-128,814
Tagalog	1,352	295	-1,057
Vietnamese	3,741	567	-3,174
Total	447,479	222,155	-225,324

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 2019.

Table 26 shows that among the Outpatient consumers in Los Angeles County, the threshold language with the greatest disparity was Spanish with an estimated 128,814 (unduplicated) Spanish speaking individuals in need of services. The least disparity was Cambodian with an estimated 374 (unduplicated) Cambodian-speaking individuals in need of services. Overall, at the county level, there was an estimated unmet service need based on language for 225,324 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 222,155 while the estimated Medi-Cal Enrolled Population with SED and SMI was 447,479.

Disparity by Age Group

TABLE 27: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED CHILDREN (0-15) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	24,906	5,763	-19,143
SA 2	75,917	12,120	-63,797
SA 3	65,870	12,733	-53,137
SA 4	43,556	7,860	-35,696
SA 5	7,541	1,308	-6,233
SA 6	81,574	13,648	-67,926
SA 7	63,342	9,962	-53,380
SA 8	59,450	8,971	-50,479
Total	422,156	72,365	-349,791

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 27 shows that among the Outpatient Children consumers, the greatest disparity was in SA 6 with an estimated 67,926 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 6,233 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 349,791 Medi-Cal Enrolled individuals as the number of unduplicated Children consumers served was 72,365 while the estimated Medi-Cal Enrolled Population with SED and SMI was 422,156.

TABLE 28: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED TAY (16-25) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	7,404	3,173	-4,231
SA 2	23,949	9,159	-14,790
SA 3	21,132	8,200	-12,932
SA 4	14,560	5,697	-8,863
SA 5	2,930	1,271	-1,659
SA 6	23,170	8,434	-14,736
SA 7	18,800	5,967	-12,833
SA 8	18,398	5,580	-12,818
Total	130,341	47,481	-82,860

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 6 with an estimated 14,736 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 1,659 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 82,860 Medi-Cal Enrolled individuals as the number of unduplicated TAY consumers served was 47,481 while the estimated Medi-Cal Enrolled Population with SED and SMI was 130,341.

TABLE 29: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ADULTS (26-59) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	8,124	7,383	-741
SA 2	34,081	16,590	-17,491
SA 3	27,142	10,796	-16,346
SA 4	23,462	14,307	-9,155
SA 5	5,584	4,203	-1,381
SA 6	27,590	16,103	-11,487
SA 7	21,735	8,433	-13,302
SA 8	23,818	12,604	-11,214
Total	171,535	90,419	-81,116

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 17,491 (unduplicated) individuals in need of services. The least disparity was in SA 1 with an estimated 741 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 81,116 Medi-Cal Enrolled individuals as the number of unduplicated Adult consumers served was 90,419 while the estimated Medi-Cal Enrolled Population with SED and SMI was 171,535.

TABLE 30: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED OLDER ADULTS (60+) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 18-19

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	737	1,206	(+)469
SA 2	5,308	4,177	-1,131
SA 3	4,431	2,362	-2,069
SA 4	3,574	3,751	(+)177
SA 5	819	1,193	(+)374
SA 6	2,765	3,301	(+)536
SA 7	2,872	1,737	-1,135
SA 8	2,857	3,154	(+)297
Total	23,363	20,881	-2,482

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 3 with an estimated 2,069 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated -536 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 2,482 Medi-Cal Enrolled individuals as the number of unduplicated Older Adult consumers served was 20,881 while the estimated Medi-Cal Enrolled Population with SED and SMI was 23,363.

Disparity by Gender

TABLE 31: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY GENDER ESTIMATED WITH SED AND SMI AND SERVICE AREA FY 18-19

Service Area (SA)	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	9,790	8,947	-843	12,744	8,554	-4,190
SA 2	38,208	21,018	-17,190	49,777	20,976	-28,801
SA 3	31,841	17,006	-14,835	41,745	17,036	-24,709
SA 4	25,201	15,800	-9,401	31,196	15,771	-15,425
SA 5	5,456	3,984	-1,472	6,653	3,984	-2,669
SA 6	32,534	20,488	-12,046	42,811	20,952	-21,859
SA 7	26,082	12,806	-13,276	35,338	13,252	-22,086
SA 8	26,877	14,945	-11,932	35,082	15,313	-19,769
Total	195,988	114,994	-80,994	255,347	115,838	-139,509

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 17,190 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 1,472 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 80,994 Medi-Cal Enrolled individuals as the number of unduplicated Male consumers served was 114,994 while the estimated Medi-Cal Enrolled Population with SED and SMI was 195,988.

Among the Outpatient Female consumers, the greatest disparity was in SA 2 with an estimated 28,801 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,669 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 139,509 Medi-Cal Enrolled individuals as the number of unduplicated Female consumers served was 115,838 while the estimated Medi-Cal Enrolled Population with SED and SMI was 255,347.

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 2016, CY 2017, AND CY 2018

Race/Ethnicity	Countywide Estimated Total Population					
	2016		2017		2018	
	N	%	N	%	N	%
African American	831,669	8.1%	870,728	8.1%	835,568	8.1%
Asian /Pacific Islander	1,435,083	14.0%	1,505,337	14.1%	1,454,863	14.2%
Latino	4,987,274	48.8%	5,003,461	48.7%	5,011,365	48.8%
Native American	19,071	0.2%	18,345	0.2%	23,716	0.2%
White	2,733,351	26.7%	2,874,777	26.6%	2,723,137	26.5%
Two or More Races	221,002	2.2%	227,125	2.2%	230,184	2.2%
Total	10,227,450	100.0%	10,272,648	100.0%	10,278,834	100.0%

The African American population increased by 3,899 between CY 2016 and CY 2018, from 831,669 to 835,568 (percent remained the same at 8.1% of the total population). The African American population decreased by 35,160 between CY 2017 and CY 2018, from 870,728 to 835,568 (percent remained the same at 8.1% of the total population).

The Asian/Pacific Islander population increased by 19,780 between CY 2016 and CY 2018, from 1,435,083 to 1,454,863 (increasing by 0.1% from 14.1% to 14.2% of the total population). The Asian/Pacific Islander population decreased by 50,474 between CY 2017 and CY 2018, from 1,505,337 to 1,454,863 (increasing by 0.1% from 14.1% to 14.2% of the total population).

The Latino population increased by 65,976 between CY 2016 and CY 2018, from 4,987,274 to 5,011,365 (percent remained the same at 48.8% of the total population). The Latino population increased by 7,904 between CY 2017 and CY 2018, from 5,003,461 to 5,011,365 (percent increased by 1.0% from 48.7% to 48.8% of the total population).

The Native American population decreased by 4,645 between CY 2016 and CY 2018, from 19,071 to 23,716 (percent remained at 0.2% of the total population). The Native American population increased by 5,371 between CY 2017 and CY 2018, from 18,345 to 23,716 (percent remained the same at 0.2% of the total population).

The White population decreased by 10,214 between CY 2016 and CY 2018, from 2,733,351 to 2,723,127 (percent decreased by 0.2% from 26.7% to 26.5% of the total population). The White population decreased by 151,640 between CY 2017 and CY 2018, from 2,874,777 to 2,723,137 (percent decreased by 0.1% from 26.6% to 26.5% of the total population).

The Two or More Races population increased by 9,182 from CY 2016 and CY 2018 from 227,125 to 230,184 (percent remained the same at 2.2% of the total population). The Two or More Races population increased by 3,059 from CY 2017 and CY 2018 from 227,125 to 230,184 (percent remained the same at 2.2% of the total population).

TABLE 33: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY TREND FOR CY 2016, CY 2017, AND CY 2018

Race/Ethnicity	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2016		2017		2018	
	N	%	N	%	N	%
African American	243,674	9.6%	230,552	9.3%	228,375	10.1%
Asian/Pacific Islander	257,191	10.1%	274,213	11.0%	249,736	11.1%
Latino	1,613,257	63.5%	1,548,943	62.3%	1,368,985	60.7%
Native American	4,840	0.2%	4,637	0.2%	5,255	0.2%
White	392,124	15.4%	386,832	15.6%	368,507	16.3%
Two or More Races	29,514	1.2%	41,803	1.7%	33,208	1.5%
Total	2,540,599	100.0%	2,486,980	100.0%	2,254,066	100.0%

The African American population living at or below 138% FPL decreased by 15,229 between CY 2016 and CY 2018, from 243,674 to 228,375 (percent increased by 0.5% from 9.6% to 10.1% of the total 138% FPL population). The African American population decreased by 2,177 between CY 2017 and CY 2018, from 230,552 to 228,375 (percent increased 0.8% from 9.3% to 10.1 of the total 138% FPL population).

The Asian/Pacific Islander population living at or below 138% FPL decreased by 7,455 between CY 2016 and CY 2018, from 257,191 to 249,736 (percent increased by 0.1% from 10.1% to 11.1% of the total 138% FPL population). The Asian/Pacific Islander population decreased by 24,477 between CY 2017 and CY 2018, from 274,213 to 249,736 (percent increased by 0.1% from 11.0% to 11.1% of the total 138% FPL population).

The Latino population living at or below 138% FPL decreased by 244,272 between CY 2016 and CY 2018, from 1,613,257 to 1,368,985 (percent decreased by 2.8% from 63.5%

to 60.7% of the total 138% FPL population). The Latino population decreased by 179,958 between CY 2017 and CY 2018, from 1,548,943 to 1,613,257 (percent decreased by 1.6% from 62.3% to 60.7% of the total 138% FPL population).

The Native American population living at or below 138% FPL increased by 415 between CY 2016 and CY 2018, from 4,840 to 5,255 (percent remained the same at 0.2% of the total 138% FPL population). The Native American population increased by 618 between CY 2017 and CY 2018, from 4,637 to 5,255 (remaining at 0.2% of the total 138% FPL population).

The White population living at or below 138% FPL decreased by 23,617 between CY 2016 and CY 2018, from 392,124 to 368,507 (percent increased by 0.9 from 15.4% to 16.3% of the total 138% FPL population). The White population decreased by 18,325 between CY 2017 and CY 2018, from 386,832 to 368,507 (percent increased by 0.7% from 15.6% to 16.3% of the total 138% FPL population).

The Two or More Races population increased by 3,694 from CY 2016 and CY 2018 from 29,514 to 33,208 (percent increased by 0.3% from 1.2% to 1.5% of the total population). The Two or More Races population increased by 8,595 from CY 2017 and CY 2018 from 41,803 to 33,208 (percent decreased by 0.2% from 1.7% to 1.5% of the total population).

TABLE 34: ESTIMATED COUNTYWIDE TOTAL POPULATION BY AGE GROUP TREND FOR CY 2016, CY 2017, AND CY 2018

Age Group	Countywide Estimated Total Population					
	2016		2017		2018	
	N	%	N	%	N	%
0-18	2,451,261	24.0%	2,422,597	23.6%	2,380,526	23.2%
19-20	309,197	3.0%	307,906	3.0%	304,749	3.0%
21-25	772,510	7.6%	765,972	7.5%	747,746	7.3%
26-59	4,834,292	47.3%	4,879,498	47.5%	4,897,871	47.7%
60-64	555,044	5.4%	580,677	5.7%	600,998	5.8%
65 and older	1,305,146	12.8%	1,315,998	12.8%	1,346,944	13.1%
Total	10,227,450	100.0%	10,272,648	100.0%	10,278,834	100.0%

The Age Group 0-18 decreased by 70,735 between CY 2016 and CY 2018, from 2,451,261 to 2,380,526 (percent decreased by 0.8 from 24.0% to 23.2%). The Age Group 0-18 decreased by 42,071 between CY 2017 and CY 2018, from 2,422,597 to 2,380,526 (percent decreased by 0.4% from 23.6% to 23.2%).

The Age Group 19-20 decreased by 6,670 between CY 2016 and CY 2018, from 309,197 to 304,749 (percent remained the same at 3.0%). The Age Group 19-20 decreased by 3,157 between CY 2017 and CY 2018, from 307,906 to 304,749 (percent remained the same at 3.0%).

The Age Group 21-25 decreased by 24,764 between CY 2016 and CY 2018, from 772,510 to 747,746 (percent decreased by 0.3% from 7.6% to 7.3%). The Age Group 21-25 decreased by 18,226 between CY 2017 and CY 2018, from 765,972 to 747,746 (percent decreased by 0.2% from 7.5% to 7.3%).

The Age Group 26-59 increased by 63,579 between CY 2016 and CY 2018, from 4,834,292 to 4,897,871 (percent increased by 0.4% from 47.3% to 47.7%). The Age Group 26-59 increased by 18,373 between CY 2017 and CY 2018, from 4,879,498 to 4,897,871 (percent increased by 0.1% from 47.5% to 47.7%).

The Age Group 60-64 increased by 45,954 between CY 2016 and CY 2018, from 555,044 to 600,998 (percent increased by 0.4% from 5.4% to 5.8%). The Age Group 60-64 population increased by 20,321 between CY 2017 and CY 2018, from 580,677 to 600,998 (percent increased by 0.1% from 5.7% to 5.8%).

The Age Group 65 and older increased by 41,798 between CY 2016 and CY 2018, from 1,305,146 to 1,346,944 (percent increased by 0.3% from 12.8% to 13.1%). The Age Group 65 and older increased by 30,946 between CY 2017 and CY 2018, from 1,315,998 to 1,346,944 (percent increased by 0.3% from 12.8% to 13.1%).

TABLE 35: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP TREND FOR CY 2016, CY 2017, AND CY 2018

Age Group	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2016		2017		2018	
	N	%	N	%	N	%
0-18	888,095	35.0%	856,137	34.4%	760,978	33.8%
19-20	77,647	3.1%	74,939	3.0%	66,182	2.9%
21-25	212,367	8.4%	203,071	8.2%	177,416	7.9%
26-59	1,059,353	41.7%	1,038,947	41.8%	947,137	42.0%
60-64	95,214	3.7%	97,941	3.9%	93,912	4.2%
65 and older	207,923	8.2%	215,945	8.7%	208,441	9.2%
Total	2,540,599	100.0%	2,486,980	100.0%	2,254,066	100.0%

Table 35 presents the estimated total population living at or below 138% FPL by Age Group for CY 2016, CY 2017, and CY 2018.

The Age Group 0-18 living at or below 138% FPL decreased by 127,117 between CY 2016 and CY 2018, from 888,095 to 760,978 (percent decreased by 1.2% from 35.0% to 33.8% of the total 138% FPL population). The Age Group 0-18 living at or below 138% FPL decreased by 95,159 between CY 2017 and CY 2018, from 856,137 to 760,978 (percent decreased by 0.6% from 34.4% to 33.8%).

The Age Group 19-20 living at or below 138% FPL decreased by 11,465 between CY 2016 and CY 2018, from 77,647 to 66,182 (percent decreased by 0.2% from 3.1% to 2.9% of the total 138% FPL population). The Age Group 19-20 living at or below 138% FPL decreased by 8,757 between CY 2017 and CY 2018, from 74,939 to 66,182 (percent decreased by 0.1% from 3.0% to 2.9%).

The Age Group 21-25 living at or below 138% FPL decreased by 34,951 between CY 2016 and CY 2018, from 212,367 to 177,416 (percent decreased by 0.5% from 8.4% to 7.9% of the total 138% FPL population). The Age Group 21-25 living at or below 138% FPL decreased by 25,655 between CY 2017 and CY 2018, from 203,071 to 177,416 (percent decreased by 0.3% from 8.2% to 7.9%).

The Age Group 26-59 living at or below 138% FPL decreased by 112,216 between CY 2016 and CY 2018, from 1,059,353 to 947,137 (percent increased by 0.3% from 41.7% to 42.0% of the total 138% FPL population). The Age Group 26-59 living at or below 138% FPL decreased by 91,810 between CY 2017 and CY 2018, from 1,038,947 to 947,137 (percent increased by 0.2% from 41.8% to 42.0%).

The Age Group 60-64 living at or below 138% FPL decreased by 1,302 between CY 2016 and CY 2018, from 95,214 to 93,912 (percent increased by 0.5% from 3.7% to 4.2% of the total 138% FPL population). The Age Group 60-64 living at or below 138% FPL increased by 4,029 between CY 2017 and CY 2018, from 97,941 to 93,912 (percent increased by 0.3% from 3.9% to 4.2%).

The Age Group 65 and older living at or below 138% FPL increased by 518 between CY 2016 and CY 2018, from 207,923 to 208,441 (percent increased by 1.0% from 8.2% to 9.2% of the total 138% FPL population). The Age Group 65 and older living at or below 138% FPL decreased by 7,504 between CY 2017 and CY 2018, from 215,945 to 208,441 (percent increased by 0.5% from 8.7% 9.2%).

TABLE 36: ESTIMATED COUNTYWIDE TOTAL POPULATION BY GENDER
TREND FOR CY 2016, CY 2017, AND CY 2018

Gender	Countywide Estimated Total Population					
	2016		2017		2018	
	N	%	N	%	N	%
Male	5,048,390	49.4%	5,067,041	49.3%	5,067,739	49.3%
Female	5,179,060	50.6%	5,205,607	50.7%	5,211,095	50.7%
Total	10,227,450	100.0%	10,272,648	100.0%	10,278,834	100.0%

Table 36 presents the estimated countywide total population by gender for CY 2016, CY 2017, and CY 2018.

The Male population increased by 19,349 between CY 2016 and CY 2018, from 5,048,390 to 5,067,739 (percent decreased by 0.1% from 49.4% to 49.3%). The Male population increased by 698 between CY 2017 and CY 2018 from 5,067,041 to 5,067,739 (percent remained the same at 49.3%).

The Female population increased by 32,035 between CY 2016 and CY 2018, from 5,179,060 to 5,211,095 (percent increased by 0.1% from 50.6% to 50.7%). The Female population increased by 5,488 between CY 2017 and CY 2018, from 5,205,607 to 5,211,095 (percent remained the same at 50.7%).

TABLE 37: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER TREND FOR CY 2016, CY 2017, AND CY 2018

Gender	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2016		2017		2018	
	N	%	N	%	N	%
Male	1,255,563	49.4%	1,181,627	47.5%	1,048,535	46.5%
Female	1,285,036	50.6%	1,305,353	52.5%	1,205,531	53.5%
Total	2,540,599	100.0%	2,486,980	100.0%	2,254,066	100.0%

Table 37 presents the estimated total population living at or below 200% FPL by gender for CY 2016, CY 2017, and CY 2018.

The Male population living at or below 138% FPL decreased by 207,028 between CY 2016 and CY 2018, from 1,255,563 to 1,048,535 (percent decreased by 2.9% from 49.4% to 46.5%). The Male population living at or below 138% FPL decreased by 133,092

between CY 2017 and CY 2018, from 1,181,627 to 1,048,535 (percent decreased by 1.0% from 47.5% to 46.5%).

The Female population living at or below 138% FPL decreased by 79,505 between CY 2016 and CY 2018, from 1,285,036 to 1,205,531 (percent increased by 2.9% from 50.6% to 53.5%). The Female population living at or below 138% FPL increased by 99,822 between CY 2017 and CY 2018, from 1,305,353 to 1,205,531 (percent increased by 1.0% from 52.5% to 53.5%).

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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 18-19

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Total
SA 1	1,906	63	1,274	51	1,248	4,542
Percent	42.0%	1.4%	28.0%	1.12%	27.5%	100.0%
SA 2	658	368	2,664	52	2,814	6,556
Percent	10.0%	5.6%	40.6%	0.79%	42.9%	100.0%
SA 3	345	471	1,831	43	782	3,472
Percent	9.9%	13.6%	52.7%	1.24%	22.5%	100.0%
SA 4	1,944	349	2,712	65	1,373	6,443
Percent	30.2%	5.4%	42.1%	1.01%	21.3%	100.0%
SA 5	430	71	348	14	1,040	1,903
Percent	22.6%	3.7%	18.3%	0.74%	54.7%	100.0%
SA 6	5,052	63	2,625	29	380	8,149
Percent	62.0%	0.8%	32.2%	0.36%	4.7%	100.0%
SA 7	354	163	2,518	103	579	3,717
Percent	9.5%	4.4%	67.7%	2.77%	15.6%	100.0%
SA8	2,952	613	2,971	86	2,006	8,628
Percent	34.2%	7.1%	34.4%	1.00%	23.2%	100.0%
Total	10,956	1,622	12,633	360	7,712	33,283
Percent	32.9%	4.9%	38.0%	1.08%	23.2%	100.0%

Note: Table excludes ethnic group 'Other' (N =596), 'Unknown' (N=811) across the SAs. Total reflects unduplicated count of consumers served with the SAs. Data Source: LACDMH-IS Database, September 2019.

Differences by Race/Ethnicity

The highest percentage of African American MHSA consumers served in outpatient programs was in SA 6 (62.0%) compared to SA 7 (9.5%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander (API) MHSA consumers served in outpatient programs was in SA 3 (13.6%) compared to SA 6 (0.8%) with the lowest percentage.

The highest percentage of Latino MHSA consumers served in outpatient programs was in SA 7 (67.7%) compared to SA 5 (18.3%) with the lowest percentage.

The highest percentage of Native American MHSA consumers served in outpatient programs was in SA 7 (2.77%) compared to SA 5 (0.36%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (54.7%) compared to SA 6 (4.7%) with the lowest percentage.

TABLE 39: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 18-19

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	13	647	4,357	796	5,813
Percent	0.2%	11.1%	75.0%	13.7%	100.0%
SA 2	241	1,107	6,598	1,878	9,824
Percent	2.5%	11.3%	67.2%	19.1%	100.0%
SA 3	9	559	3,911	747	5,226
Percent	0.2%	10.7%	74.8%	14.3%	100.0%
SA 4	9	562	6,368	1,926	8,865
Percent	0.1%	6.3%	71.8%	21.7%	100.0%
SA 5	76	206	1,890	680	2,852
Percent	2.7%	7.2%	66.3%	23.8%	100.0%
SA 6	324	1,242	7,223	1,959	10,748
Percent	3.0%	11.6%	67.2%	18.2%	100.0%
SA 7	46	547	3,720	862	5,175
Percent	0.9%	10.6%	71.9%	16.7%	100.0%
SA 8	285	1,197	8,476	2,460	12,418
Percent	2.3%	9.6%	68.3%	19.8%	100.0%
Total	768	4,726	33,270	8,719	47,483
Percent	1.6%	10.0%	70.1%	18.4%	100.0%

Note: Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS Database, September 2019.

Differences by Age Group

The highest percentage of Children MHSA consumers 0-15 years old was in SA 6 (3.0%) compared with SA 4 (0.1%) with the lowest percentage.

The highest percentage of TAY MHSA consumers 16-25 years old was in SA 6 (11.6%) compared with SA 6 (6.3%) with the lowest percentage.

The highest percentage of Adult MHSA consumers 26-59 years old was in SA 3 (74.8%) compared with SA 5 (66.3%) with the lowest percentage.

The highest percentage of Older Adult MHSA consumers 60 years old and over was in SA 5 (23.8%) compared with SA 1 (13.7%) with the lowest percentage.

TABLE 40: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 18-19

Service Area (SA)	Male	Female	Total
SA 1	3,067	2,738	5,805
Percent	52.8%	47.2%	100.0%
SA 2	5,100	4,709	9,809
Percent	52.0%	48.0%	100.0%
SA 3	2,652	2,569	5,221
Percent	50.8%	49.2%	100.0%
SA 4	4,603	4,254	8,857
Percent	52.0%	48.0%	100.0%
SA 5	1,467	1,382	2,849
Percent	51.5%	48.5%	100.0%
SA 6	5,450	5,284	10,734
Percent	50.8%	49.2%	100.0%
SA 7	2,604	2,564	5,168
Percent	50.4%	49.6%	100.0%
SA 8	6,475	5,922	12,397
Percent	52.2%	47.8%	100.0%
Total	23,938	23,481	47,419
Percent	50.5%	49.5%	100.0%

Table excludes Transgender (N = 45), Unknown Gender (N=19) across the SAs. Total reflects unduplicated count of consumers served with the SAs. Data Source: LACDMH-IS Database, September 2019.

Differences by Gender

The highest percentage of Male MHSA consumers served in outpatient programs was SA 1 (52.8%) compared with SA 7 (50.4%) with the lowest percentage.

The highest percentage of Female MHSA consumers served in outpatient programs was SA 7 (49.6%) compared with SA 1 (47.2%) with the lowest percentage.

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TABLE 41: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS
BY THRESHOLD LANGUAGE AND SERVICE AREA
FY 18-19

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	2	8	0	0	5,203	4	0	3	0	2	481	4	1	5,708
Percent	0.04%	0.14%	0.00%	0.00%	91.15%	0.07%	0.00%	0.05%	0.00%	0.04%	8.43%	0.07%	0.02%	100.00%
SA 2	46	387	1	2	6,886	284	23	1	4	77	1,696	63	21	9,491
Percent	0.48%	4.08%	0.01%	0.02%	72.55%	2.99%	0.24%	0.01%	0.04%	0.81%	17.87%	0.66%	0.22%	100.00%
SA 3	9	4	18	73	3,901	2	11	86	28	4	670	9	53	4,868
Percent	0.18%	0.08%	0.37%	1.50%	80.14%	0.04%	0.23%	1.77%	0.58%	0.08%	13.76%	0.18%	1.09%	100.00%
SA 4	4	119	5	9	6,785	13	69	4	6	56	1,342	35	9	8,456
Percent	0.05%	1.41%	0.06%	0.11%	80.24%	0.15%	0.82%	0.05%	0.07%	0.66%	15.87%	0.41%	0.11%	100.00%
SA 5	2	0	5	0	8,693	4	8	5	0	10	146	2	0	8,875
Percent	0.02%	0.00%	0.06%	0.00%	97.95%	0.05%	0.09%	0.06%	0.00%	0.11%	1.65%	0.02%	0.00%	100.00%
SA 6	2	0	5	0	8,693	4	8	3	0	3	1,571	1	2	10,292
Percent	0.02%	0.00%	0.05%	0.00%	84.46%	0.04%	0.08%	0.03%	0.00%	0.03%	15.26%	0.01%	0.02%	100.00%
SA 7	8	3	57	1	3,773	1	14	3	2	2	1,143	12	9	5,028
Percent	0.16%	0.06%	1.13%	0.02%	75.04%	0.02%	0.28%	0.06%	0.04%	0.04%	22.73%	0.24%	0.18%	100.00%
SA 8	10	2	426	4	9,791	5	67	9	7	6	1,381	61	108	11,877
Percent	0.08%	0.02%	3.59%	0.03%	82.44%	0.04%	0.56%	0.08%	0.06%	0.05%	11.63%	0.51%	0.91%	100.00%
Total	6	0	296	3	6,511	2	43	6	3	5	879	46	65	7,865
Percent	0.08%	0.00%	3.76%	0.04%	82.78%	0.03%	0.55%	0.08%	0.04%	0.06%	11.18%	0.58%	0.83%	100.00%

Note: Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS Database, September 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 82.8% followed by Spanish at 11.2 % of languages spoken. The following information highlights the threshold languages spoken among the MHSA population by Service Area.

SA 1 has two (2) threshold languages: English (91.2%) and Spanish (8.4%).

SA 2 has seven (7) threshold languages: Armenian (4.1%), English (72.3%), Farsi (2.3%), Russian (0.8%), Spanish (17.9%), Tagalog (0.7%) and Vietnamese (0.2%).

SA 3 has (6) six threshold languages: Cantonese (1.5%), English (80.1%), Korean (0.2%), Mandarin (1.8%), Spanish (13.8%), and Vietnamese (1.1%).

SA 4 has nine (9) threshold languages: Armenian (1.4%), Cantonese (0.1%), English (80.2%), Korean (0.8%), Mandarin (0.1%), Other Chinese (0.1%), Russian (0.7%), Spanish (15.9%), and Tagalog (0.4%).

SA 5 has three (3) threshold languages: English (97.5%), Farsi (0.1%), and Spanish (1.7%).

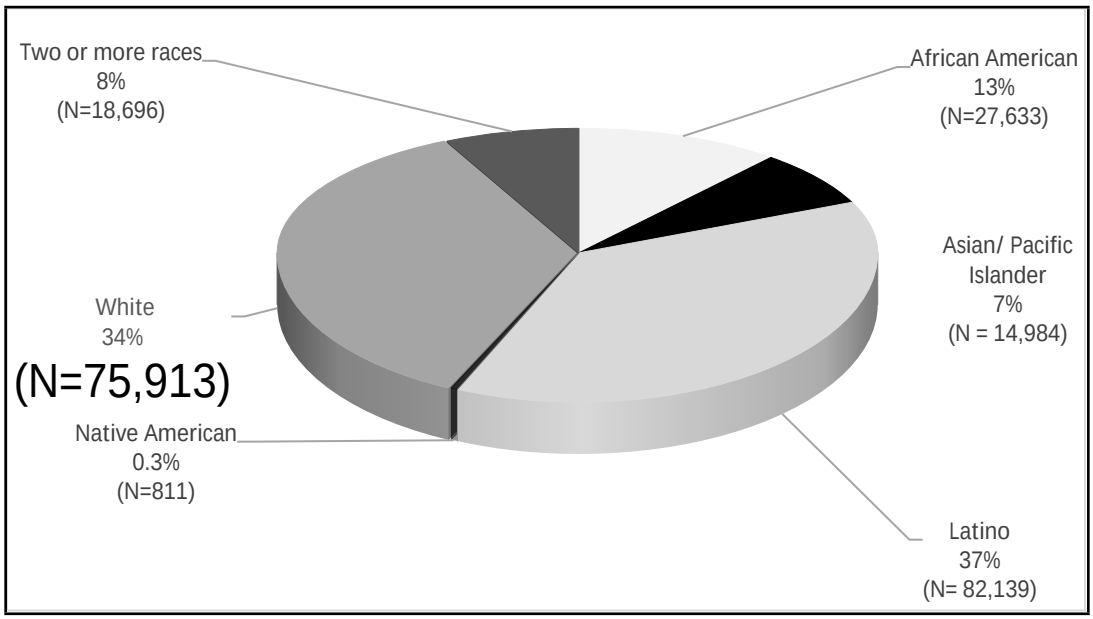
SA 6 has two (2) threshold languages: English (84.5%) and Spanish (15.3%).

SA 7 has three (3) threshold languages: English (75.0%) and Spanish (22.7%).

SA 8 has three (3) threshold languages: Cambodian (3.6%), English (82.4%), Spanish (11.6%) and Vietnamese (0.9%).

Analysis of Disparities

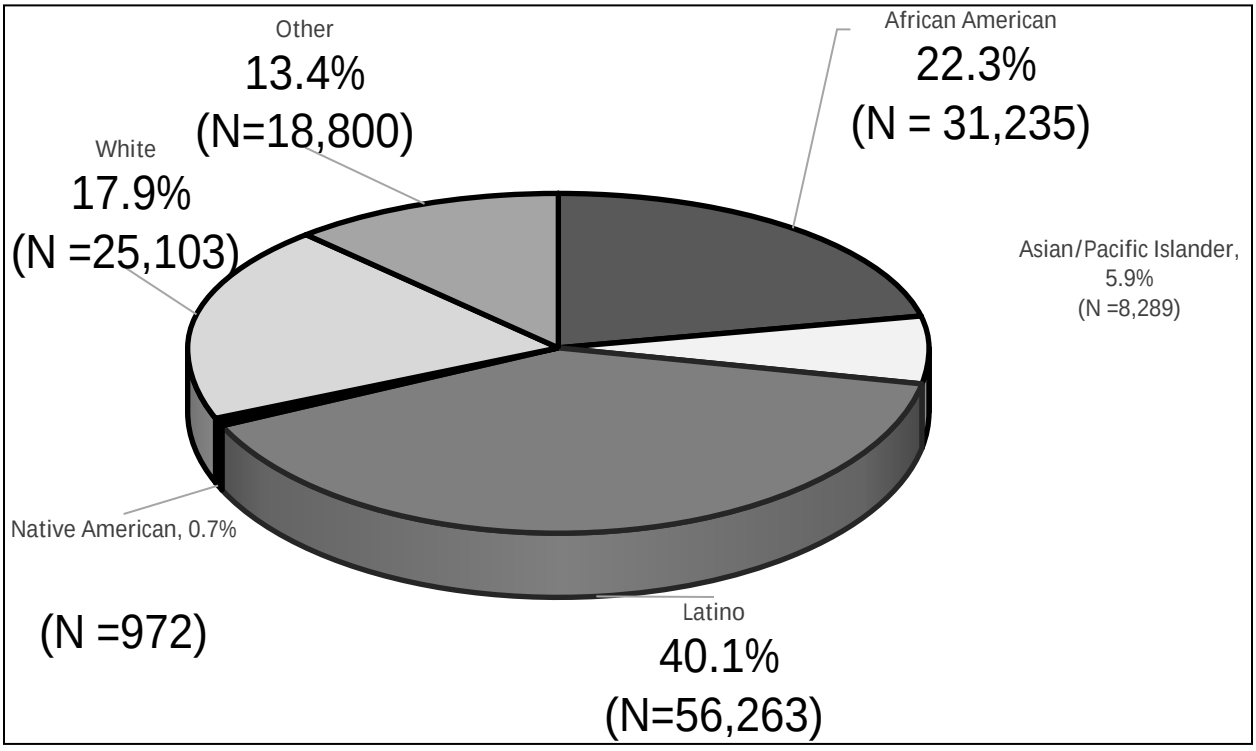
FIGURE 10: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2018



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 2016 and CY 2017.
Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

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 18-19



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 20-21.

Figure 11 shows the CSS enrolled population by Race/Ethnicity. Latinos are the largest group at 40.1%, followed by African Americans at 22.3%, Whites at 17.9%, Asian/Pacific Islanders at 5.9%, Native Americans at 0.7% and Other race/ethnicity not specified at 13.4%.

Figures 10 and 11 indicate the following:

African Americans constitute 13.0% of the population in need of services at or below 138% FPL and constitute 22.3% of the CSS consumers.

Asian/Pacific Islanders constitute 7.0% of the population in need of services at or below 138% FPL and constitute 5.9% of the CSS consumers.

Latinos constitute 37.0% of the population in need of services at or below 138% FPL and constitute 40.1% of the CSS consumers.

Native Americans constitute 0.3% of the population in need of services at or below 138% FPL and constitute 0.7% of the CSS consumers.

Whites constitute 34.0% 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 18-19

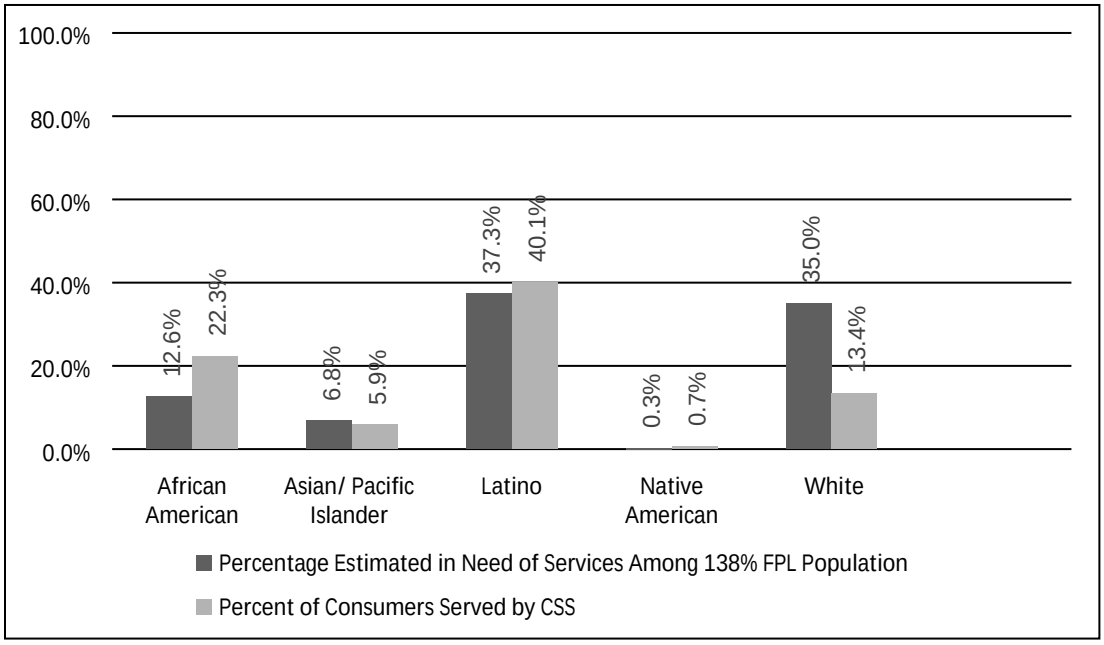


Figure 12 compares the information in Figures 10 and 11.

The percentage of African Americans receiving CSS services was the highest at 22.3% when compared with their population at or below 138%, FPL estimated in need of services at 12.6%.

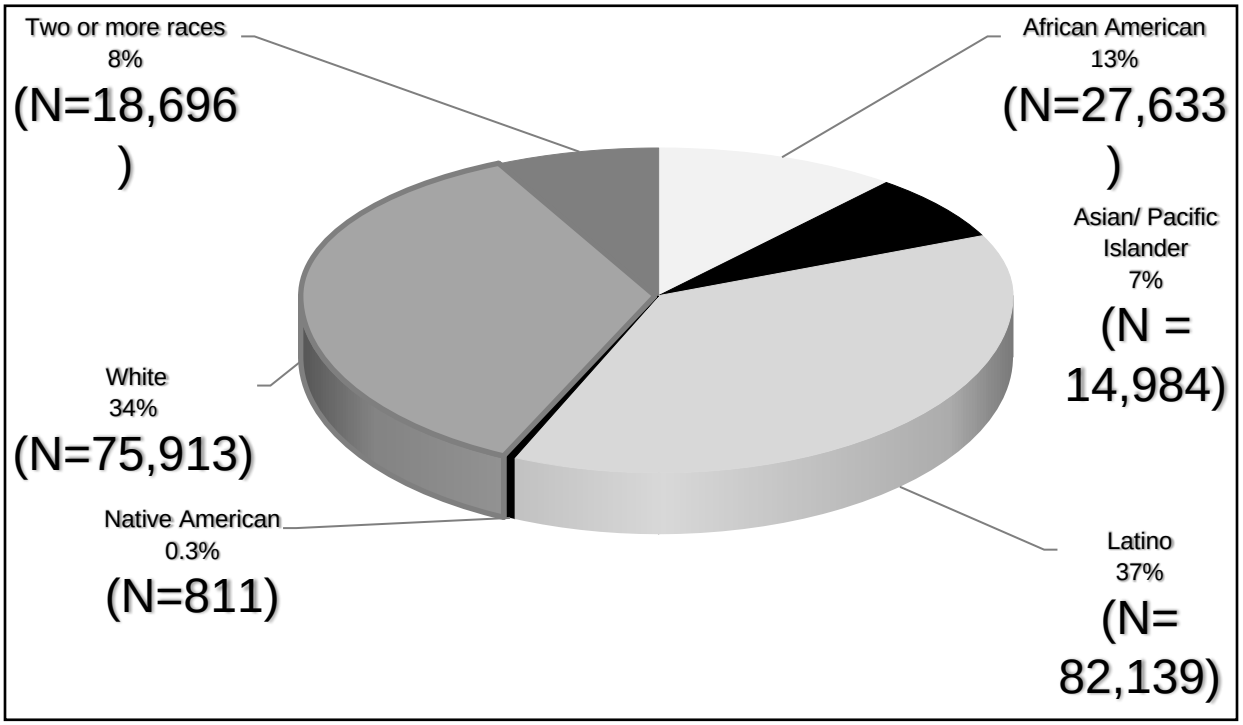
The percentage of Asian/Pacific Islanders receiving CSS services was 5.9% when compared with their population at or below 138%, FPL estimated in need of services at 6.8%.

The percentage of Latinos receiving CSS services was 40.1% when compared to their population at or below 138%, FPL estimated in need of services at 37.3%.

The percentage of Native Americans receiving CSS services was 0.7% when compared with their population of Native Americans at or below 138%, FPL estimated in need of services at 0.3%.

The percentage of Whites receiving CSS services was 13.4% when compared with their population at or below 138%, FPL estimated in need of services at 35.0%.

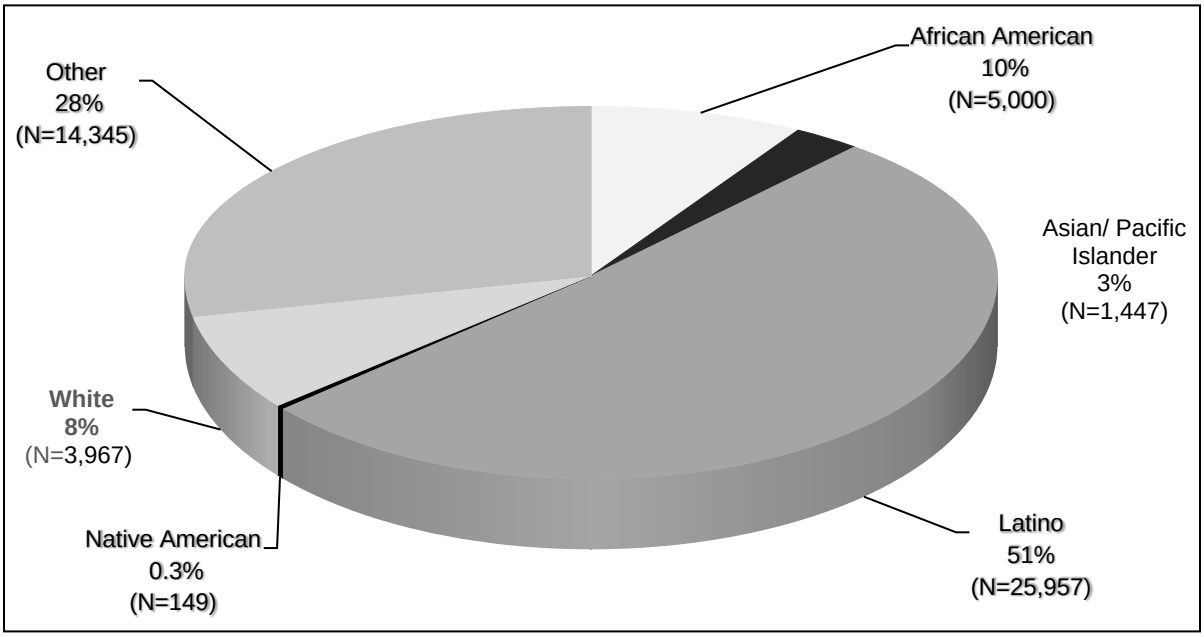
FIGURE 13: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2018



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 2017 and CY 2018. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2019.

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 18-19



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2020-21.

Figure 14 shows the PEI enrolled population by Race/Ethnicity. Latinos are the largest group at 51.0%, followed by African Americans at 10.0%, Whites at 8.0%, Asian/Pacific Islanders at 3.0%, Native Americans at 0.3% and Other at 28.0%.

Figures 13 and 14 indicate the following:

African Americans constitute 13.0% of the population in need of services at or below 138% FPL and constitute 10.0% of the PEI consumers.

Asian/Pacific Islanders constitute 7.0% of the population in need of services at or below 138% FPL and constitute 3.0% of the PEI consumers.

Latinos constitute 37.3% of the population in need of services at or below 138% FPL and constitute 51.0% 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.

White constitute 34.0% of the population in need of services at or below 138% FPL and constitute 8.0% 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 18-19

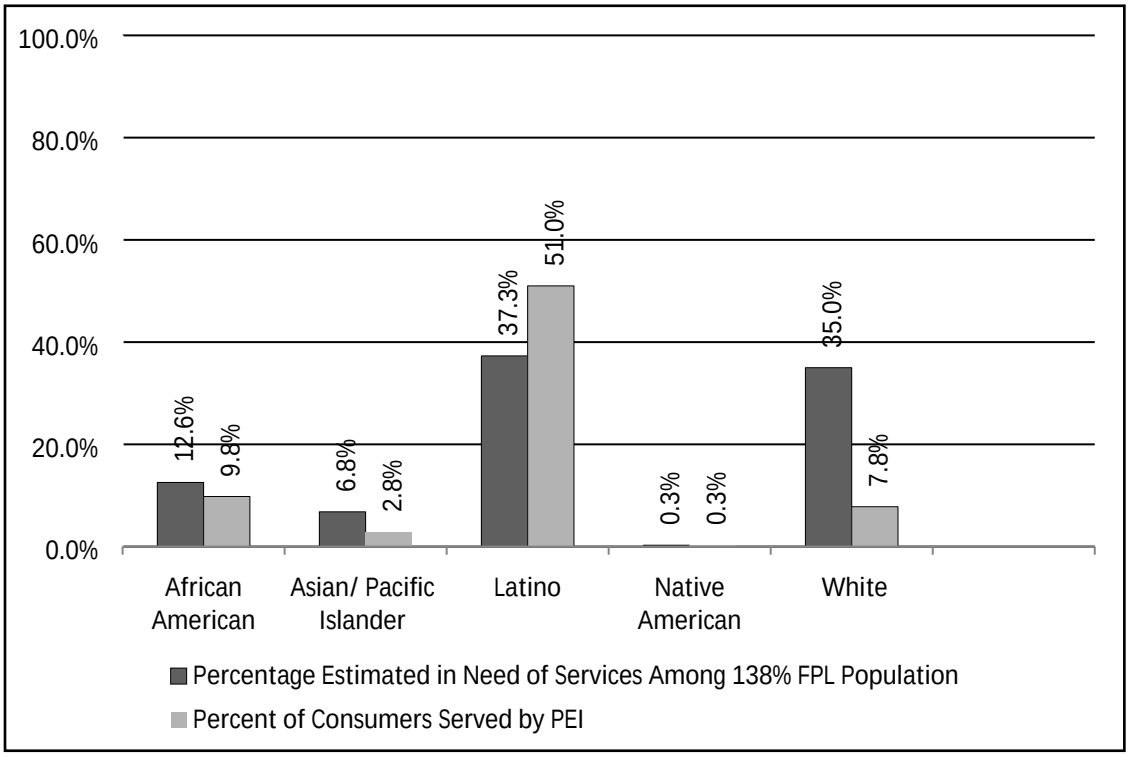


Figure 15 compares the information in Figures 13 and 14.

The percentage of African Americans receiving PEI services was 9.8% when compared with their population at or below 138%, FPL estimated in need of services at 12.6%.

The percentage of Asian/Pacific Islanders receiving PEI services was 2.8% when compared with their population at or below 138%, FPL estimated in need of services at 6.8%.

The percentage of Latinos receiving PEI services was the highest at 51.0% when compared to their population at or below 138%, FPL estimated in need of services at 37.3%.

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%.

The percentage of Whites receiving PEI services was 7.8% when compared with their population at or below 138%, FPL estimated in need of services at 35.0%.

During CY 2019, the Office of Administrative Operations - Cultural Competency Unit provided a presentation on the 2019 Cultural Competence Plan to all the Service Area Quality Improvement Councils. The goals of this presentation included:

- Familiarize service providers with the Cultural Competence Plan Requirements (CCPR)
- Promote a shared sense of responsibility to implement the CCPR in all aspects of operations inclusive of practices, policies and procedures, provision of services by clerical/support, financial, clinical, and case management staff
- Review the types of data collected under the assessment of service needs
- Review data -related concepts such as penetration rate, prevalence rate, and mental health disparities
- Present the latest data regarding system-based mental health disparities related to:
    - Race/Ethnicity
    - Age group
    - Gender
    - Language
    - Federal Poverty Level
    - MHSA Plan specific needs assessment
- Emphasize the importance of data utilization in programmatic planning, actual service delivery, and evaluation of outcomes
- Engage service providers in dialogues regarding strategies that have been implemented at the program level to:
    - Advance cultural and linguistic competence in the system of care
    - Address mental health disparities related to culture and language
- The information gathered from the presentation exercises has been included in Criterion 3 of this report, Section III. Identified Strategies

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 18-19

Criterion 3

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

August 2020

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 18-19 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, 5, 6, 7, and 8
- Asian Pacific Islander (API) in SAs 1, 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 1, 2, 3, 4, 5, 6, 7, and 8
- 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 SA 3, 4
- English in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- 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
- Vietnamese in SAs 2, 3, and 8

By age group

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

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, 5, 6, 7, and 8
- Asian Pacific Islander (API) in SAs 1, 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 1, 2, 3, 4, 5, 6, 7, and 8
- 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 SA 3, 4
- English in SAs 1, 2, 3, 4, 5, 6, 7, and 8
- 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
- Vietnamese in SAs 2, 3, and 8

By age group

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

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

- African American
- American Indian/ Alaska Native
- API (Mandarin and Korean)

- Latino
- Middle Eastern

By age group

- Children
- TAY
- Adults
- Older Adults

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), Department of Health Services (DHS), and Department of Public Health (DPH)
- 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
- Utilization of cultural competence organizational assessments, surveys, focus groups to identify and address knowledge gaps in the workforce
- Collaboration with Health Departments' (DHS, DMH and DPH) initiatives regarding cultural competence, linguistic appropriateness, and equity-based services

Additionally, during CY 2019, the Office of Administrative Operations - Cultural Competency Unit provided a presentation on the 2019 Cultural Competence Plan to all the Service Area Quality Improvement Councils (QIC). Service providers were engaged in dialogues regarding strategies that have been implemented at the program level to:

- Advance cultural and linguistic competence in the system of care
- Address mental health disparities related to culture and language

The collective strategies and practices gathered from service providers is summarized below by Service Area QIC:

Service Area 1 QIC
1. Inclusion of peers as part of treatment teams 2. Hire more bilingual staff to help provide services 3. Translation of forms into Spanish to help families and caregivers better understand how DMH services are provided
Service Area 2 QIC - Adults
1. Translation of DMH forms in other languages, i.e. Farsi for this Service Area 2. Conduct consumer satisfaction surveys at clinics

3. Translation of Consents for Services
4. Access to quality interpreter services
5. In-service/ education opportunities related to cultural competence made available to all staff throughout the year
6. On-going discussion of cultural issues in case consultation and supervision
7. Provide in-service from staff representing different cultures backgrounds, with updates on their communities, and the needs of clients from their cultures
8. Respond to any disasters/emergencies in the community
9. Increase access by providing mental health outreach services to local homeless shelters
10. 10.Facilitate groups that target certain cultures (i.e., Latina support group)
11. Participate in neighborhood council meeting and bring back information about community engagement
12. Participate in Health Neighborhood Coalition meetings in the Service Areas
13. Hire more addiction-specialized psychiatrists
14. Implement substance use intervention programs on mental health sites
15. Provide extensive training programs for residents/interns
16. Support NAMI Spanish-speaking support groups
17. Program Heads to attend monthly clergy roundtable meetings
18. Community workers to provide outreach engagement out in the community one time per week
19. Address health literacy disparities and ensure that consumers understand and provide input on treatment modalities and services
20. Ensure that client forms are in plain language and a reading level that they can all understand
21. Extend telehealth services to persons who cannot physically go to clinic sites
22. Provide interpreters via phone covering services in all languages
23. Implement client suggestion boxes at clinics
24. Conduct cultural sensitivity survey for clients annually
25. Participate in Cultural Competency Committee
26. Support peer-to-peer group training courses
27. Promote Client Run Center activities
28. Implement different outreach programs such as Museum activity, classic musical outreach, classic jazz outreach
29. Groups for anger management, healthy relationships, spirituality, women's issues, and men's issues.
30. Celebrate different cultures heritage months and "showcase" different cultures
31. Establish Cultural Competency Committee with representatives from each service division and different consumer cultures (i.e. Native American) Annual goals include: 1) training for all staff through didactic materials, videos, 2) implement procedures for tracking annual trainings, 3) establish policies and procedures that support cultural competence, 4) host trauma-focused care trainings related to various subgroups of clients/families.

Service Area 2 QIC - Children's

1. Implement different types of engaging workshops for clients/community
2. Reach out to the "forgotten or left behind populations"
3. Provide additional case management to community members (i.e. homeless youth, LGBTQ youth) even when they are not receiving therapy services. This has encouraged possible clients to seek services.)
4. Invest in phone interpreter services that clinicians use to communicate with collaterals

5. Use of language line to facilitate completion of clinical assessments, treatment plans, and family or collateral sessions
6. Easy access and linkage to FSP/WRAP services when consumers are in need of higher levels of care
7. Hold community outreach groups and education in Spanish and English
8. Present at local City Council meeting on mental health services, stigma, and underserved communities
9. Annual CLAS self-assessment and education using the 15 CLAS standards to measure staff perception of how well the agency meets each standard and gather feedback for quality improvement projects
10. Survey clients on their comfort in our lobbies and ask for feedback on how to make our lobbies more culturally content
11. Contract a Spanish translator to translate all agency forms
12. Implement groups for LGBTQ clients and their parents
13. Partner with mainstream media outlets, such as radio, TV, internet, social media, to promote m mental health awareness to reduce the stigma of mental health issues
14. Staff/Supervisor trainings on how to work with staff from different cultural backgrounds
15. Develop more training videos, sources, materials for the workforce. Currently using DMH's Cultural Competency 101 videos.
16. Provide cultural competence training resources for MDs and other medical professionals
17. short and concise videos
18. Hold internal team discussions to brainstorm ways to be more culturally sensitive
19. Provide ways to ask culturally sensitive questions during assessment

Service Area 3 QIC

1. Review cultural competence topics during clinical supervision
2. Establish programs that are specific to the LGBTQIA2-S population
3. Add LGBTQIA2-S affirming language to forms and clinic materials
4. Expand gender category on forms and IBHIS
5. Continue to grow specialized services for mental health underserved communities
6. Accommodate services to families' schedules and availability, and provide services out in the community
7. Utilize Family Centered Treatment (FCT) model to assist families to identify their multigenerational trauma patterns through the use of structured family assessments (SFA) and Family life cycle (FLC)
8. Work in collaboration with referring agencies to secure translations for families for which we do not have staff that can directly communicate in family's language
9. Provide services to Pomona schools (Not School Based)
10. Provide LGBTQIA2-S training for staff to help better understand this population and work more
11. effectively
12. Add more options for gender and sexual orientation in EHR demographics
13. Place LGBTQIA2-S affirming posters through agency locations to create a more welcoming/safe environment for clients and staff from these communities
14. Agencies to invest in additional cultural competence trainings besides DMH's webinar
15. Cultural competence trainings are required at each program
16. During the intake process, clinicians collect data regarding cultural background of clients including physical disabilities

17. Make and revise the Intake Checklist to include address the following: Cultural Considerations, Physical Challenges, and Access Issues
18. Quality Assurance staff reviews each intake to make sure these areas have been assessed and integrated into the initial assessment
19. Items must be documented as indicated “none” or “denied” if no information relevant cannot be left blank
20. Celebrate cultural events – Cinco de Mayo, Halloween, Thanksgiving, Christmas, Parents night

Service Area 4 QIC

1. Co locate substance abuse professional services
2. Provide multiple resources to walk ins such as showers, hot meals served in neighborhood, shelters, share space with L.A. CADA serving HIV at Risk African American males
3. Weekly culture and diversity trainings for all of our staff with an emphasis on advocacy
4. Conduct multiple (yearly) advocacy projects by staff (e.g. community presentations; PSA; flyer distributions; group events/celebrations for multiculturalism; policy change)
5. Provide on-going cultural competence training
6. Evaluate consumer satisfaction and perceived cultural competence/sensitivity of staff regularly
7. Provide LGBTQIA2-S competence training
8. Engage consumers in community empowerment activities, creational activities, and English lessons
9. Supervision issue - guide clinicians into conceptualizing client as a person in context (culture, ethnic, place of origin, gender sexual orientation, religious, spiritual, and language)
10. Provide tele psychiatry services for families who cannot make it to the office
11. Provide community events (free to community) that have fun, family – based activities that also educate and introduce wellbeing and self-care
12. Provide transgender competence training, Bisexual 101 competence training, and Sexuality & Gender training
13. Add trauma informed care coordinator to train/inform all non-clinical staff/medical providers of adverse trauma in various age/population/SES
14. Incorporate home and field-based psychiatric and medical services

Service Area 5 QIC

1. Provide training on how to conduct culturally competent self-help groups
2. Encourage consumers with threshold language expertise to conduct meetings (self-help support groups) in those languages
3. Host conferences on peer support and peer advocacy
4. Outreach to peer movement statewide
5. Commitment to approval and time off for ongoing cultural competence training for staff
6. Implement an open literature policy at clinics to allow access to all community-based activities
7. Provide consumers services in the language of choice/preference for treatment
8. Make language interpreter services available for psychiatry appointments
9. Support street and home-based medical and psychiatric services
10. Our children’s program has collaborated with a battered women’s shelter (sojourn) to provide services at the location

11. Outreach to schools to increase and provide school-based services
12. Incorporate social media to reach younger groups
13. Engage community members and businesses to support the needs of the communities they serve
14. Utilize services of Promotores for community outreach and education in Spanish
15. More trainings on Implicit Bias including self-assessment of personal bias

Service Area 6 QIC

1. Include medication support in community-based services
2. Invest in peer-to-peer resources
3. Hold meetings with staff focusing on discussions regarding multicultural competence
4. Co-locate DMH in pediatric offices within the community
5. Invest in staff specialization in mental health services for 0-5 population
6. Invest in technology to increase access to services i.e. telepsychiatry etc.
7. Attend/host resource fairs partnering with local colleges and universities, attend local schools to promote mental health and address stigma, partner with LAPD for community engagement
8. Utilize cultural competence when treating developmental disorders
9. Provide access to non-traditional forms of treatment (i.e. art therapy, Reiki, and healing circles)
10. Hold “diversity fishbowls” for all staff focusing on one particular aspects of diversity staff invited to observe/reflect/ask questions
11. Host monthly “family night” where information that was requested by our families are presented to further their knowledge and how to work with other supports

Service Area 7 QIC

1. Engage clients and staff in cultural groups/activities
2. Provide transportation to cultural events for clients
3. Follow the Recovery-Based Model
4. Follow the Harm-Reduction Model
5. Invest in Recovery-Centered Clinical Systems
6. Educate staff on “Common Ground” by Pat Dugan
7. Provide trainings and have more language literature for our LGBTQI2-S population
8. Implement sustainable programs that focus on homelessness
9. Provide trainings to clinical staff that focus on how to assess, treat, and document cultural factors in assessments, treatment plans, and progress notes
10. Utilize social media
11. Hire staff who have extensive experience with certain groups such as LGBTQIA2-S
12. Train foster parents and caregivers regarding mental health services to reference stigma
13. Collaborate with cultural/language specific NAMI groups
14. Provide trainings related to diverse populations – LGBTQIA2-S former foster care kids
15. Invest in community-based services
16. Collaborate with county libraries and LAUSD to increase awareness and provide education
17. Include discussion of culture at Child and Family Team meetings

18. Ask clients and families if they want to include particular foods or traditions within the context of the meeting
19. Address cultural competency at all staff meetings
20. Host cultural events in the community
21. Ensure that cultural aspects are addressed and supported during individual and group clinical supervision
22. Implement developmental disabilities group to discuss mental health and reduce stigma around seeking mental health services
23. Include feedback in clinical quality assurance chart reviews so that staff can incorporate feedback regarding culture into their treatment planning with clients

Service Area 8 QIC

1. Our office has cultural awareness events for staff
2. DMH/DCFS participates in Child Family Team (CFT) meetings that allow staff to understand the family culture in order to provide services that will be sensitive to that specific family's culture
3. Provide library-based services (homeless community and other populations use the library as a second home).
4. Establish collaborations with mental health court liaisons
5. Establish collaborations with housing agencies that provide shelter and care type services
7. Invest in child wellbeing services
8. Provide on-going cultural competence training for staff
9. Provide community education to increase mental health awareness and decrease stigma
10. Enhance field-based services
11. Engage in physical health, mental health, and substance abuse service integration
12. Staff pediatrician
13. Use of Uniper for electronic video sessions
14. Establish partnership events with local city-based human services department mental health resource fair, info dispensed at food pantries
15. Base personnel hiring practices to ensure clients language and cultural needs are met
16. Provide community psycho/pharm education in the field via participation in field base consultation with psychiatrist and case management team
17. Partner with Service Area Promotores
19. Connect clinic services Health Neighborhoods
20. Participate in clergy Meetings
21. SAAC 8 meetings to include stakeholders
22. Hold Parent cafes
24. Support parent support groups with many mental health related presentations as requested by the attendees
25. Include cultural competence presentations for staff at all monthly staff meetings
26. Carry out ongoing audits of client charts with cultural competence awareness audited in CAFA/CTP notes, and provide ongoing feedback and comments to staff concerning these areas
27. Develop and utilize cultural assessment plans to align and work with clinic goals for our providers in the county and specific Service Areas

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. This particular content organization merges sections IV and V of the CCPR structure for Criterion 3.

IV. Additional Strategies/Objectives/Actions and

V. 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 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 timelier 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.

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

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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 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

Projects/Activities/ Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
		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.

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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: o Black Infant Health o 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 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 o Received the award at the end of the month • Expanded membership to around 20 new agencies and programs. o 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 o How to file income taxes o How to claim children in the foster system, etc.

SA Health Neighborhood	Accomplishments
	• 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: o Learning how to care for, groom, and show dairy goats that will culminate with a goat show at the AV Fairgrounds. o 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: o AB2341 Nursing Home Special Services o AB 824 Transitional Housing for Homeless Youth o State budget request for mental health training for all peace officers
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: o 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 o 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 o Success stories pertaining to referrals were discussed during each meeting in an effort to continue and promote the mission of the HN.

SA Health Neighborhood	Accomplishments
	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 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 Health Neighborhood	Accomplishments

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 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: o 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.

SA Health Neighborhood	Accomplishments
	• 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. • 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.

SA Health Neighborhood	Accomplishments
	• 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. o 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. • 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:

SA Health Neighborhood	Accomplishments
	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 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:

SA Health Neighborhood	Accomplishments
	• 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 • 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

SA Health Neighborhood	Accomplishments
	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 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

SA Health Neighborhood	Accomplishments
	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.

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.

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.

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Consumers served for FY 17-18

Program/ Project/Activity	# Consumers Served by Ethnicity and Gender										Languages of Staff
	White	African American	Latino	API	American Indian	Other (Specify)	M	F	T		
N= 22,758	1,817	4,590	11,458	290	72	Multiple Ethnicity: 964 Other Ethnicity: 3,563	11,401	11,345		12	All of the threshold languages represented in the Los Angeles community.

Projects, activities and strategies related to cultural competency and elimination of disparities, FY 17-18.

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 our 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 (LE) mental health providers to provide 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.

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
2. Multidisciplinary Assessment Team (MAT) Trainings: • MAT/CFT Integration Roll Out SCPM and CFT Trainings • 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.	• Aligned with the roll out of the MAT/CFT process in SA2, SA5, and SA6, these trainings were provided to MAT agencies servicing the Santa Clarita, Chatsworth, Van Nuys, West LA, Compton, and 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 are 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 to ten 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.	• Qualitative outcomes were tracked through regularly held feedback sessions throughout the MAT/CFT implementation process. Quantitative outcomes were tracked jointly by DMH 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 2017/2018.

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
3. <u>Wraparound</u>: The Wraparound Practice Principles include: • Family Voice and Choice • Team–based • Collaboration • Community-based • Culturally Competent • Individualized • Strength based • Natural Supports • Persistent • Outcome-based These Principles of the Wraparound Program are reinforced by ongoing training and coaching on the Share Core Practice Model (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 maximizing the children, youth and families' cultural strengths and qualities so that they may find solutions within the context of their unique values and beliefs, strengths, preferred supports, and unique communities.	The Wraparound program continues to provide culturally and linguistically competent services by ensuring that services are provided in the families' preferred language. The Wraparound Program also requires providers to attend annual cultural competency trainings in order to meet the special needs of the children and families served.	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 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 4 practice performance indicators which include Engagement, Teamwork, Assess & 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, DMH 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.

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
4) <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 Resource Families and planning services. • *Routine announcements* to agencies about available DMH trainings on cultural humility and those that incorporate cultural competency (ex: Culturally Sensitive Practices, Commercial Sexual Exploitation of Children 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 LGBTQIA2-Spopulations.	• 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 have attended some of the trainings through this announcement process. • Several agencies have recruited foster parents that specifically want to work special populations youth and have matched youth into these homes for services. • Providers have shared information on topics such as developmental disabilities, CSEC, and LGBTQ populations and trainings available through their agencies or community partners. • Several agencies offer specialized treatment services to meet the needs of special populations youth. • Clinical consultation has been provided to support improvement with culturally appropriate services (ex: culture of family violence and substance abuse, gang culture).	• 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

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
• *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.	• ITFC agencies continue to recruit and train staff and foster parents to provide care and services to youth in Spanish.	
5) Family Preservation (Family Pres): A) SCPM Trainings that incorporate the element of Cultural Humility. B) Family Preservation 101	Multiple SCPM trainings were offered to FP DMH staff this fiscal year. The Family Preservation training 101 is provided to all of the DMH and Lead Agencies across all eight service areas This training incorporates the SCPM into the program. The in-home outreach counselors and clinicians are trained on the SCPM and the current policies and procedures of the FP program and highlights cultural competence and provides service providers with strategies to strengthening cultural competence in the FP program. Trainings are held within each Service Area and are coordinated with the Service Area FP Liaison, the DCFS FP staff members, and	Quantitative outcomes were collected via participant's surveys at the completion of each training session. Such outcomes are tracked by via 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

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
	the Community Based Organizations contracted by DCFS to provide services to FP. Typically, such training occurs eight to ten times per fiscal year.	conducted 1 time a year at each DMH provider site.
6) Intensive Field Capable Clinical Services (IFCCS): IFCCS is a field-based, countywide program developed in direct response to the State's expansion of services available to children and youth with intensive mental health needs that 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, and out-of-home placements. This is achieved by engaging and assessing children and their families' strengths and underlying needs through a trauma informed lens and cultural awareness. In addition to assessing for current needs, IFCCS providers are encouraged to empower children and family's voice & choice around 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	The IFCCS program continues to provide culturally and linguistically competent services by ensuring that services are provided in the families' preferred language. Target populations are consistently met every fiscal year.	The Children's Intensive Service Review (CISR) process has been implemented to evaluate the IFCCS Program. The purpose of the evaluation process is to ensure that IFCCS staff are 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 conducted by teams of two or more reviewers and can include clinicians and administrators. The IFCCS providers are 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. Throughout the CISR process, evaluators assess IFCCS provider's use of a culturally humble approach and a trauma informed lens 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.

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
(13) portals to fourteen (14) portals to include receiving them from Short Term Residential Treatment Placement (STRTP) Aftercare.		
5) Quality Services Review:	A total of five 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. .	1) FY 17-18 falls in two 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 of FY 17-18, which ended at the start of Round 4 with the Vermont Corridor Office, point to roughly 60%.

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
		2) 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 are 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.

LACDMH and DCFS developed a Shared Core Practice Model 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.

For several years now we have 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.

Given the county's diverse population, the directly operated and contract providers have placed a strong emphasis on recruiting and hiring staff to reflect the needs of the consumer population. In regard to language, there has been a concerted effort to hire Spanish-speaking staff to promote communication with the large Spanish-speaking population within the child welfare population in the county.

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Planning, Outreach and Engagement (POE) (Formally Outreach and Engagement)

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 (O&E) Team Activities
FY 18-19

Service Area 1 (Antelope Valley)
• Attended multiple joined and planned activities with 12,045 participants. The population consisted of African American, Latino, White, families, children, consumers, and individuals with various disabilities • Outreach and engagement activities included planning and facilitating well-attended special events, including a back-to-school event, Antelope Valley Community College Job Fair, a popular "Snow Day" event, reaching over 200 individuals, a June Pride event, reaching over 125 individuals, a "Day of Giving" holiday event involving over 350 local residents, and hosting a mental health café • LACDMH staff actively participated in the Antelope Valley Homeless Coalition and outreach to individuals at risk of and living with serious mental health conditions at libraries, mobile home communities, substance use treatment programs, mobile shower programs, and retail shopping locations. • Clergy breakfasts and roundtables were facilitated in SA 1, engaging diverse local faith community leaders in mental health message dissemination to their congregations
Service Area 2 (San Fernando Valley)
• Attended multiple joined and planned activities with 8,718 participants. The population consisted of Latino, African American, Armenian, White, Asian Pacific Islanders, Russian, Arabic, Iranian, and others • Two back-to-school events, one sponsored by a local health plan and the other by community-based organizations, reached over 300 individuals this year. • Suicide postvention messages and resources were provided to hundreds of local residents at a booth at the suicide prevention summit, a Government Day event, and at the LGBTQI2-S mental health conference • Cultural arts were important in SA 2; outreach at the Cinco de Mayo festival engaged over 185 individuals, and 20 consumers, family members, and local residents participated in interactive healing arts workshops • Staff conducted regular outreach at the Pacoima Winter Shelter, reaching hundreds of people experiencing homelessness with mental health support and service access information • Staff met with the Los Angeles Police Department-North Hollywood to brainstorm problem-solving approaches to responding to frequent 9-1-1 callers who have mental health needs • Clergy breakfasts and roundtables were facilitated in SA 2, engaging diverse local faith community leaders in mental health message dissemination to their congregations

Service Area 3 (San Gabriel Valley)
• Attended multiple joined and planned activities with 8,107 participants. The population consisted of Latino, Asian, Pacific Islanders, Veterans, and the community at large. • LACDMH information tables were established at the well-attended Parks after Dark summer program, the Winter Wonderland Resource Fair, Veterans Resource Expo, child and family resource fairs, and adult education fairs. • LACDMH staff participated in Girls Empowerment Conference, Adelante Mujer Latina College and Career Conference at Pasadena Community College, and a Grandparents' Day event, reaching hundreds of individuals in the community with mental health service information • Clergy breakfasts and roundtables were facilitated in SA 3, engaging diverse local faith community leaders in mental health message dissemination to their congregations
Service Area 4 (Metro)
• Attended multiple joined and planned activities with 21,537 participants. The population consisted of Latino, African American, people experiencing homelessness, LGBTQI-2S, and others • Weekly Spanish-language outreach at the Mexican, Salvadoran, and Guatemalan consulates reached hundreds of immigrants with basic information on mental health issues and culturally specific access to care. • LACDMH staff facilitated weekly "Therapeutic Thursday" group education sessions on a range of mental health topics with a diverse group of local residents at the Los Angeles State Historic Park in Chinatown • Outreach and engagement staff participated in numerous festivals and activities targeting youth and families in SA 4
Service Area 5 (West)
• Attended multiple joined and planned activities with 2,625 participants. The population consisted of the community at large from underserved cultural communities. • Weekly outreach to libraries engaged individuals at risk of and living with serious mental illness in SA 5 in mental health support and linkage to services. • A special event reached over 60 members of the Garifuna community with mental health information and service linkages in May • Clergy breakfasts and roundtables were facilitated in SA 5, engaging diverse local faith community leaders in mental health message dissemination to their congregations

Service Area 6 (South)
• Attended multiple joined and planned activities with 5,160 participants. The population consisted of African American, Latino, White, and the community at large • Outreach and distribution of mental health resource information was conducted with hundreds of individuals participating in a local mobile showers program, Parks after Dark, winter holiday events, the 27th Empowerment Congress, and Care Harbor. • At the African American Mental Health Conference, over 175 participants received mental health resource information provided by SA 6 staff • Clergy breakfasts and roundtables were facilitated in SA 6, engaging diverse local faith community leaders in mental health message dissemination to their congregations
Service Area 7 (East)
• Attended multiple joined and planned activities with 4,019 participants. The population consisted of the community at large from underserved cultural communities. • Field outreach included participating in the South Gate American Indian Resource Fair, Centro Estrella Children's Resource Fair, and Maywood Landlord-Tenant Symposium. • Staff disseminated mental health information at job fairs, Veteran events, and activities at local senior centers • Clergy breakfasts and roundtables were facilitated in SA 7, engaging diverse local faith community leaders in mental health message dissemination to their congregations
Service Area 8 (South Bay)
• Attended multiple joined and planned activities with 4,891 participants. The population consisted of community at large and underserved cultural communities. • Staff reached hundreds of individuals and workers at special events, including the Men's Empowerment Event at California State University, Dominguez Hills, Kingdom Day event, Long Beach Community College, Health in the Park, and the Longshoreman's Headquarters. • Clergy breakfasts and roundtables were facilitated in SA 8, engaging diverse local faith community leaders in mental health message dissemination to their congregations

The LACDMH UsCC Unit has established subcommittees dedicated to working with the various underrepresented ethnic and cultural populations in order to address their individual needs. These subcommittees are African/African American; American Indian/Alaska Native; Asian Pacific Islander; Deaf, Hard-of-Hearing, Blind, and Physical Disabilities; Eastern European/Middle Eastern; Latino; and Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit (LGBTQI2-S). Each UsCC subcommittee is allotted one-time funding totaling $200,000 per FY to focus on CSS-based capacity-building projects. Proposals are created and submitted via a participatory and consensus-based approach. An overview of the projects implemented is provided in the summary table below:

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
African/African American (AAA) 1. Black Immigrant Youth Empowerment Project	Completion Date: June 30, 2019.	This project was developed to engage, empower, and educate the black immigrant community to seek mental health services as well as reduce stigma and increase the capacity of the public mental health system. The implementation of this project was divided into two (2) phases: • Phase one (1) is the recruitment and training of 30 black immigrant youths on basic mental health education and public speaking skills. • Phase two (2) is the facilitation of 50 community mental health presentations countywide. Outcomes for CY 2018 o Thirty (30) black youths were recruited to be a part of this project o Participants were from eight (8) ethnically diverse racial backgrounds including: African American, Afro-Caribbean, Black, Egyptian, Ethiopian, Jamaican, Mexican American, and Nigerian o The training curriculum was completed on December 31, 2018 o Twenty-five (25) youths completed the training seminars. o The community presentations aim to promote mental health services, reduce stigma, and empower community members to access mental health services for themselves and their families. o Fifty (50) community mental health presentations were conducted.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
2. <u>The African American Mental Health Radio Campaign</u>	Completion Date: January 7, 2018	The 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 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community. Outcomes for CY 2018: o The PSAs provided culturally sensitive information, education, and resources to the African American community in Los Angeles County. Overall, this radio media campaign successfully helped to reduce stigma, increase mental health awareness, and access among African American community members. o The PSAs aired on KJLH radio on a weekly basis for a total of three (3) months. In total, 124 PSAs were aired. 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.
3. <u>Life Links - Resource Mapping Project</u>		This project has been implemented for five (5) consecutive years. Funds were allocated to develop a community resource directory called Life Links. Community resources, service providers, and agencies were identified in south Los Angeles 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. Outcomes for CY 2018: o For the fifth reprint, 15,000 booklets were ordered as of December 2018. o To date, there have been over 20,000 Life Links booklets distributed in the County

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
American Indian/Alaska Native (AI/AN) AI/AN Bus Advertising Campaign	Advertising campaign took place in SA 1 for 12 weeks from January to April 2018	The AI/AN 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, five queen-size bus posters, 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 Los Angeles 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. Outcomes for CY 2018 o A total of 12,346,100 impressions were delivered. o Advertising took place primarily in the following cities: Lancaster, Palmdale, Littlerock, Lake Los Angeles, and unincorporated areas of the County

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
Asian Pacific Islander (API) 1) API Youth Video Contest: "Go Beyond Stigma!"	This project was implemented on January 1, 2018 and was 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 3-minute videos on how mental health issues impact their 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 years) an opportunity to share how mental health issues impact their life, family, and community using video in order to increase awareness and knowledge of the signs and symptoms of mental illness and improved access to mental health services for API youth in the County. Outcomes for CY 2018: o Three (3) orientations were held for the youth on mental health issues and the art of storytelling. Thirty-nine (39) individuals attended the orientations. Their primary languages included Chinese, Cambodian/Khmer, Spanish, Hindi/Urdu, Tagalog and Thai. They included a diverse array of API ethnicities, including Cambodian, Indian, Latino, Taiwanese and Thai. o Two (2) trainings were held for the youth on how to develop a mental health video. Ten (10) individuals attended the trainings. Their primary languages included Chinese, Hindi/Urdu, and Thai. They included a diverse array of API ethnicities, including Indian, Taiwanese and Thai. o Four (4) teams composed of a total of 12 youth completed the orientation, training, and development of a video. Four (4) videos were submitted for the video contest. o Pre- and post-tests were completed by the youth participants in order to measure the impact of the participation on their awareness and knowledge of mental illness. The analysis of these results is still in progress. o Surveys were completed by the community members who attended the Awards Ceremony event at the conclusion of the project. The survey assessed the impact of the event on the attendees' awareness and knowledge of mental illness.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
2. The Samoan Outreach and Engagement Program	Completion Date: June 30, 2018	In 2018, LACDMH utilized CSS funds to continue the Samoan Outreach and Engagement Program in order to increase awareness of mental illness, knowledge of mental health resources in order to increase referrals, and enrollment into mental health services by the Samoan community. LACDMH contracted with Special Services for Groups (SSG) who partners with two 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. • This program completed its third year of implementation on June 30, 2018, during which community outreach was conducted at some colleges, churches, IMD facilities, hospitals, jails, and other community gathering sites. • Starting July 1, 2017, the program changed to focus more on referrals. As of 2018, there were a total of 12 referrals made as a direct result of this program, which resulted in two enrollments into mental health services.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
3. <u>API Mental Health Awareness Media Campaigns</u>	Completed Date: April 2019	This project includes seven (7) separate campaigns that were completed in April 2019. The campaign implementation took place in May 2018. The goal of the API UsCC Mental Health Awareness Media Campaign 2018 was to target various API communities in Los Angeles 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 PSA to target the respective target community. LACDMH's banners were developed and posted on their station's website, with a link to the LACDMH website. Some media companies also provided interview segments, outreach events, and community mental health surveys in kind. • Social media was also utilized where possible. All PSAs, segments, etc., are being posted onto the LACDMH website and used for future outreach purposes. The outcomes are still in progress. All media companies will provide a summary of the airing of the PSAs, etc., as well as viewership information. The ACCESS Helpline is tracking the number of calls received from various racial/ethnic groups by race/ethnicity and language, so that the community impact can be determined. Project summary reports will include summaries of the community surveys that were implemented and community feedback that was gathered.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
Deaf, Hard-of-Hearing, Blind, and Physical Disabilities		This subcommittee was established January 1, 2018 and held its first UsCC subcommittee meeting on January 30, 2018. The goal of this subcommittee was to reduce disparities and increase mental health access for the deaf, hard-of-hearing, blind, and physically disabled community. This group worked closely with community partners and consumers 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 capacity-building projects for FY 2018-19 with a membership roster of over 50 individuals and is actively recruiting new members.
Eastern European/Middle Eastern The Armenian Mental Health Show		A local Armenian television station, ARTN TV Station, was contracted to produce, direct, host, and broadcast a weekly mental health show in the Armenian language. The show consisted of 28 half-hour episodes, where various mental health topics were presented. The Armenian mental health show included episodes on the following topics: depression, anxiety, couple's therapy, trauma, and intergenerational issues. During the third season, the format of the show changed. It included three (3) phases: (1) an introduction that included opening remarks by a mental health professional and a host (3-5 minutes); (2) a therapy session reenactment facilitated by a mental health professional and included actors and actresses (10-15 minutes); and (3) a TV host and a mental health professional, who explained the therapy session and its process (10 minutes)

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
		Each of the actors/actresses were well-known in the community. The show provided an opportunity for the Armenian community to be educated and informed on the symptoms associated with a variety of different psychological disorders and the psychotherapeutic process. It included current psychological issues that are impacting the Armenian community in Los Angeles County. The shows were broadcasted in areas with the largest concentration of Armenians, such as La Cañada, Burbank, North Hollywood, Glendale, Pasadena, Los Angeles, and Montebello. Outcomes for CY 2018 o From August 2018 to November 2018, a total of 28 half-hour mental health shows were aired on the local Armenian television station. o The format of the show was unique as it was the first time in the history of the TV station that a show was produced showcasing what the psychotherapy process looks like as a marketing tool to reduce mental health stigma within the Armenian community. Based on the feedback provided by the TV viewers, Armenian community members felt that the show was interesting, culturally relevant, educational, and expanded their knowledge regarding mental health and how these issues present within the Armenian community. o The result of the shows surpassed all the expectations. It appeared that there was a shift in the thinking of the Armenian community about mental health conditions and its treatment approaches. o Since the show began, hundreds and hundreds of ARTN TV viewers have been calling and asking mental health related questions. After the show ended, many community members called ARTN TV requesting for it to continue and even offering new topics for discussion

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
The Arabic, Farsi, and Russian Public Service Announcement Project	Completion Date: August 31, 2019	This project was implemented on July 1, 2018 and completed on August 31, 2019. The project sought to increase mental health awareness and education to the Arabic, Farsi, and Russian speaking communities in the County, which are significantly underserved by the public mental health system. A consultant produced, implemented, posted, and tracked 42, 90-second PSAs in the Arabic, Farsi and Russian languages. There were 14 PSAs in each language. The PSAs included celebrities and/or prominent community figures from the three-targeted communities. The consultant was responsible for posting/broadcasting the PSAs for a total of eight months via different social media outlets including, but not limited to Twitter, Facebook, and You Tube. The consultant closely tracked and monitored the viewership of the PSAs and measured its effectiveness. Outcomes for CY 2018 o To date, 10 Arabic, Farsi, and Russian PSAs have been posted on YouTube, Twitter, and Facebook. o Some of the topics include post-traumatic stress disorder, domestic violence, child abuse, substance abuse, loss and grief, bullying, etc. o This project completed on August 31, 2019.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
Latino 1) The Latino Media Campaign	Completion Date: July 16, 2018	The Latino media campaign was launched on May 1, 2017 and completed on July 16, 2018. The commercials were aired on the KMEX television station and KLVE, KRCD, and KTNQ radio stations. KMEX ran a total of 138 television PSAs, a 2-day Homepage takeover, Univision.com geo-LA/Local Los Angeles Rotation - in banner video and social media. KLVE, KRCD, and KTNQ radio stations ran 501 PSAs, a 2-day Homepage takeover, and social media. In addition, 3-minute interviews with the LACDMH ESM were aired weekly on Dr. Eduardo Navarro's program at KTNQ 1020 Radio Station for nine weeks from May 11, 2017 through July 2, 2017. Another 30-minute interview for a PSA was aired on four radio stations on June 12, 2017 and June 25, 2017. Outcomes for CY 2018 o The KMEX report shows that the television campaign delivered a total of 14,501,956 impressions. o The KLVE, KRCD, and KTNQ reports showed that the radio campaign delivered a total of 12,200 impressions. o Digital campaign delivered 1,106,234 impressions. o A gross total of 15,620,390 impressions were delivered from viewers and listeners. o The media campaign reached millennials via digital, KLVE Motivational Monday social media posts, and homepage takeovers via Univision.com and at the same time, personally touched the 25-54 age group with their message on KMEX news and novellas. o KTNQ 1020 AM live interviews on Tuesdays with the LACDMH ESM, Dr. Sandra Chang, aired weekly on Dr. Eduardo Navarro's program were considered by Univision Communications, Inc., "jewels for the community" as it offered advice on topics of importance to the functioning of a happy family.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
2. The Latino Mental Health Stigma Reduction Community Theater Project	The project is scheduled to be completed by May 30, 2020.	The goal of this project was to outreach, educate, and increase knowledge pertaining to mental health services within the Latino community. By utilizing a non-stigmatizing method such as a theatrical play, Latino community members learned about the signs and symptoms associated with mental health and became familiar with the services that are available through LACDMH.
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two-Spirit (LGBTQI2-S)		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 this often underserved and marginalized population to access mental health services for themselves and empower other community members to access mental health services.

UsCC		
Strategies and Activities	Status and Progress	Monitoring/ Outcomes/Findings
LGBTQI Iranian Outreach and Engagement Project		The project involved two (2) 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. • Phase 2 included a media campaign targeting Iranian LGBTQI and non-LGBTQI community members through local Iranian talk shows, magazines, newspapers, and radio programs. Outcomes for CY 2018 o A total of 244 individuals attended the health and wellness workshops. Of those, 213 completed the pre- and post-tests. o The results of the pre/post tests showed a significant shift in participant beliefs and knowledge about LGBTQ issues. o Resources were provided at the presentations and included mental health resources, social support resources, and physical health resources. o Six (6) magazine articles were published in local Iranian magazines: Tehran Magazine and Javanan Magazine. o 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. o A total of three (3) PSAs were recorded and aired 200 times on local Iranian radio station, KIRN 670am, between the dates of February 19, 2018 to September 6, 2018. o In addition to the airing of the PSAs, KIRN 670am also broadcast 26 programs that lasted 23 minutes each every Sunday between February 25, 2018 to September 2, 2018. The radio programs featured over 18 Iranian LGBTQ allies, activists, and celebrities

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

Over the last year, LACDMH has moved toward a more robust and upstream approach to PEI services. While the focus of early intervention continues to be evidence-based practices, promising practices and community-defined evidence practices, LACDMH is in the process of implementing prevention strategies in settings such as schools and libraries where access platforms are being established. By identifying individuals with specific risk factors, particularly for trauma, and through the promotion of protective factors, such as social connectedness and engagement, a prevention service platform is being developed that:

- Raises awareness of the importance of mental and emotional wellbeing and health, the impact of trauma and the promotion of resilience strategies on systems and communities;
- Builds organizational and community capacity to promote wellbeing and resiliency and to recognize and respond to trauma and mental health needs;
- Builds bridges to mental health care when it is requested; and
- Ensures that requested services are being delivered and achieving intended impact.

Consumers Served through PEI, FY 18-19

Consumers Served	New Consumers Served
50,865 clients received services. • 67% of the clients are children • 18% of the clients are TAY • 51% of the clients are Latino • 10% of the clients are African American • 8% of the clients are White • 3% of the clients are Asian • 74% have a primary language of English • 23% have a primary language of Spanish	30,369 new clients receiving PEI services countywide: with no previous MHSA service • 23% of the new clients are Hispanic • 5% of the new clients are African American • 4% of the new clients are White • 74% have a primary language of English • 22% have a primary language of Spanish

FY 18-19 Clients served through PEI by Service Area

Service Area	Number of Clients Served	Number of New Clients Served
SA 1	4,072	2,680
SA 2	7,926	4,886
SA 3	8,996	5,639
SA 4	6797	4330
SA 5	1,725	1,178
SA 6	6,816	4,424
SA 7	7,362	4,797
SA 8	8,175	4,936

Early Intervention
Early Intervention is directed toward individuals and families for whom a short (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve mental health problems and avoid the need for more extensive mental health treatment.

FY 18-19 Evidence Based Practices (EBPs)

(Note: Some age groups show the specific age(s) clients served)

Early Intervention EBP	Descriptions
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 123 Gender: 50% Male, 50% Female Ethnicity: 59% Hispanic, 16% African American, 2% White	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. Skills 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.
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

Early Intervention EBP	Descriptions
Unique Clients Served: 311 Gender: 54% Male, 46% Female Ethnicity: 69% Hispanic, 8% African American, 1% Asian, 3% White	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.
Brief Strategic Family Therapy (BSFT) Children (ages 10-15) TAY (ages 16-18)) Unique Clients Served: 26 Gender: 46% Male, 54% Female Ethnicity: 50% Hispanic, 4% African American, 8% White	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.
Center for the Assessment and Prevention of Prodromal States (CAPPS) TAY Unique Clients Served: 43 Gender: 63% Male, 37% Female Ethnicity: 68% Hispanic, 5% African American, 9% Asian, 2% White	The focus of CAPPS is to conduct outreach and engagement specifically to those youths 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.
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6) Unique Clients Served: 1,696 Gender: 53% Male, 47% Female Ethnicity: 51% Hispanic, 13% African American, 2% Asian, 8% White	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.
Coordinated Specialty Care Model for Early Psychosis (CSC-EP) Children (ages 12-15) TAY (ages 16-25) Unique Clients Served: 2 Gender: 50% Male, 50% Female	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

Early Intervention EBP	Descriptions
Ethnicity: 100% Hispanic	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 Unique Clients Served: 305 Gender: 41% Male, 59% Female Ethnicity: 59% Hispanic, 12% African American, 3% Asian, 4% White	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.
Depression Treatment Quality Improvement (DTQI) Children TAY Adults Older Adults Unique Clients Served: 176 Gender: 35% Male, 65% Female Ethnicity: 28% Hispanic, 1% African American, 2% Asian, 3% White	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.
Dialectical Behavior Therapy (DBT) Children (ages 12-15) TAY (ages 16-20) Unique Clients Served: 131 Gender: 31% Male, 69% Female	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,

Early Intervention EBP	Descriptions
Ethnicity: 38% Hispanic, 12% African American, 4% Asian, 33% White	contingency management, skills training and acquisition (core mindfulness, emotion regulation, interpersonal effectiveness, distress tolerance and self-management), crisis management, and team consultation.
Families Over Coming Under Stress (FOCUS) Children TAY Adults Unique Clients Served: 216 Gender: 52% Male, 48% Female Ethnicity: 39% Hispanic, 4% African American, 1% Asian, 3% White	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 by building upon existing strengths and positive coping strategies as well as increasing communication and decreasing stress.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults Unique Clients Served: 42 Gender: 31% Male, 69% Female Ethnicity: 50% Hispanic, 12% African American, 2% Asian, 22% White	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.
Incredible Years (IY) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 238 Gender: 69% Male, 31% Female Ethnicity: 79% Hispanic, 5% African American, 1% Asian, 4% White	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.
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

Early Intervention EBP	Descriptions
Unique Clients Served: 4,249 Gender: 32% Male, 68% Female Ethnicity: 49% Hispanic, 11% African American, 4% Asian, 14% White	activation, exposure, cognitive modification, acceptance and mindfulness strategies and behavioral rehearsal.
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults Unique Clients Served: 2,014 Gender: 33% Male, 67% Female Ethnicity: 45% Hispanic, 6% African American, 3% Asian, 7% White	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, unipolar 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.
Loving Intervention Family Enrichment Program (LIFE) Children (ages 0-8) Unique Clients Served: 17 Gender: 41% Male, 59% Female Ethnicity: 59% Hispanic, 12% African American	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.
Managing and Adapting Practice (MAP) Young Children Children TAY (ages 16-21) Unique Clients Served: 19,070 Gender: 53% Male, 47% Female Ethnicity: 52% Hispanic, 7% African American, 1% Asian, 6% White	MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioner 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 implemented in L.A County has four areas of treatment: anxiety, depression, disruptive behavior, and trauma.
Mental Health Integration Program (MHIP) Formerly known as IMPACT Adults Unique Clients Served: 604 Gender: 25% Male, 75% Female	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

Early Intervention EBP	Descriptions
Ethnicity: 64% Hispanic, 9% African American, 4% Asian, 7% White	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.
Multidimensional Family Therapy (MDFT) Children (ages 12-15) TAY (ages 16-18) Unique Clients Served: 3 Gender: 33% Male, 67% Female Ethnicity: 67% Other, 33% White	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.
Multisystemic Therapy (MST) Children (ages 12-15) TAY (ages 16-17) Unique Clients Served: 1,680 Gender: 47% Male, 53% Female Ethnicity: 76% Hispanic, 9% African American, 2% Asian, 8% White	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).
Parent-Child Interaction Therapy (PCIT) Young Children (2-7) Unique Clients Served: 1,538 Gender: 64% Male, 36% Female Ethnicity: 50% Hispanic, 11% African American, 2% Asian, 8% White	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.
Problem Solving Therapy (PST) Older Adults Unique Clients Served: 22 Gender: 50% Male, 50% Female Ethnicity: 32% Hispanic, 4% African American, 32% White	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

Early Intervention EBP	Descriptions
	dysthymia or mild depression who are experiencing early signs of mental illness.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults Unique Clients Served: 22 Gender: 50% Male, 50% Female Ethnicity: 40% Other, 40% Asian, 20% White	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.
Prolonged Exposure - Post Traumatic Stress Disorder (PE-PTSD) TAY (ages 18-25) Adults Older Adults Directly Operated Clinics Only Unique Clients Served: 39 Gender: 20% Male, 80% Female Ethnicity: 41% Hispanic, 23% African American, 3% Asian, 13% White	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.
Reflective Parenting Program (RPP) Young Children (ages 2-5) Children (ages 6-12) Unique Clients Served: 23 Gender: 65% Male, 35% Female Ethnicity: 82% Hispanic, 9% African American, 9% White	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.
Seeking Safety (SS) Children (13-15) TAY Adults Older Adults Unique Clients Served: 3,039 Gender: 37% Male, 62% Female Ethnicity: 52% Hispanic, 8% African American, 3% Asian, 10% White	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.

Early Intervention EBP	Descriptions
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18) Unique Clients Served: 16 Gender: 56% Male, 44% Female Ethnicity: 62% Hispanic, 38% Other	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) Unique Clients Served: 5,712 Gender: 42% Male, 58% Female Ethnicity: 57% Hispanic, 10% African American, 1% Asian, 6% White	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.
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16) Unique Clients Served: 851 Gender: 71% Male, 29% Female Ethnicity: 56% Hispanic, 9% African American, 3% Asian, 4% White	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.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12) Unique Clients Served: 23 Gender: 57% Male, 43% Female Ethnicity: 17% Hispanic, 17% African American, 9% Asian, 35% White	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 3, interdisciplinary educational and pediatric consultation).

Early Intervention Outcomes of FY 17-18
(Source: MHSA Annual Update Report FY 19-20)

AGRESSION REPLACEMENT TRAINING (ART)

Children (ages 5-12) –Skill Streaming Only
Children (ages 12-15), TAY (ages 16-17)

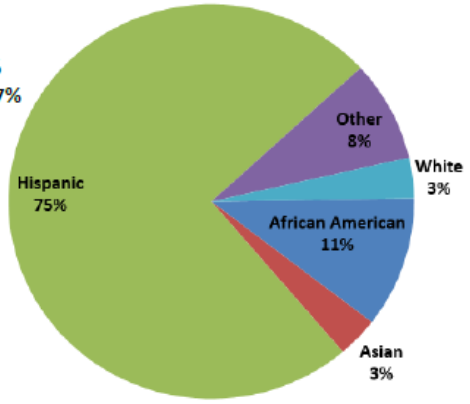
ART is a multimodal psycho-educational intervention designed to alter the behavior of chronically aggressive adolescents and young children. Its goal is to improve social skills, anger control, and moral reasoning. The program incorporates three specific interventions: skill-streaming, anger control 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

OUTCOMES

* 3,375 Treatment Cycles
* 42% reported completing the EBP
* 25% Improvement in mental health functioning

ETHNICITY & GENDER

N= 121
Male: 63%
Female: 37%



Alternatives for Families Cognitive Behavioral Therapy (AF-CBT)

Children (ages 4-15), TAY (ages 16-17)

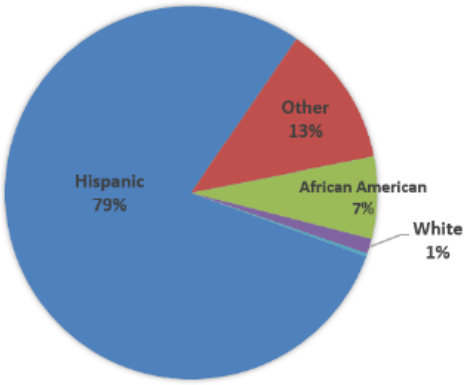
AF-CBT is designed to improve the relationships between children and parents/ caregivers in families involved in physical force/coercion and chronic conflict/hostility. This practice emphasizes training in both intrapersonal and interpersonal skills designed to enhance self-control, strengthen positive 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

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)

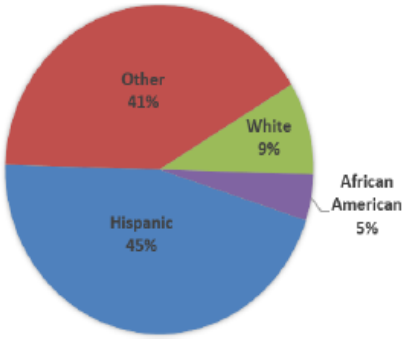
BSFT is a short-term, problem-oriented, family-based intervention designed for children and adolescents who are displaying or are at risk for developing behavior problems, including substance abuse. The goal of BSFT is to improve a youth's behavior problems by improving family interactions that are presumed 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

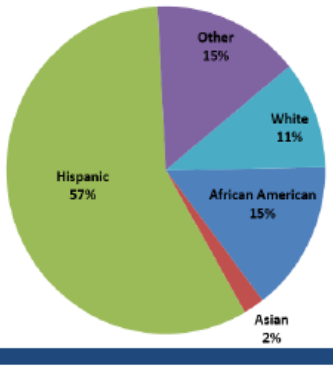
The focus of CAPPS is to conduct outreach and engagement specifically to those youth who are experiencing their first-break psychosis and early onset of serious mental illnesses with psychotic features. In order to mitigate mental health challenges and reduce the progression of these challenges into 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)

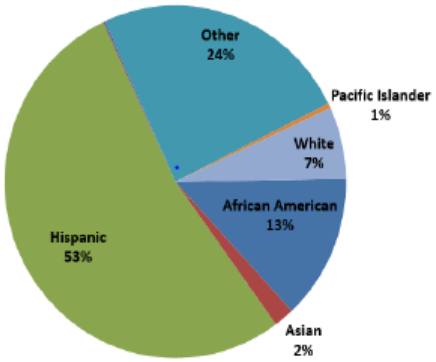
CPP is a psychotherapy model that integrates psychodynamic, attachment, trauma, cognitive -behavioral, and social-learning theories into a dyadic treatment approach. CPP is designed to restore the child-parent relationship and the child's mental health and developmental progression that have been damaged 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

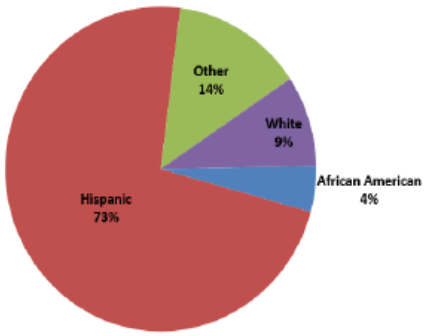
CBITS is an early intervention for children who have experienced or have been exposed to traumatic events and are experiencing difficulty related to symptoms of Posttraumatic Stress Disorder (PTSD), depression, or anxiety. To improve access to mental health care, services are delivered within the school 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

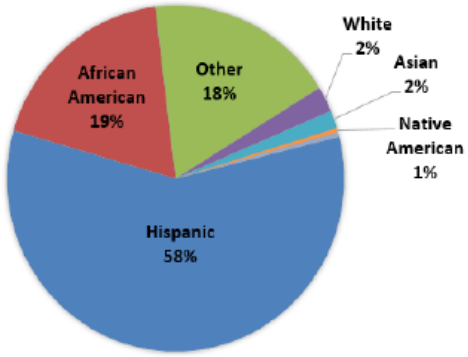
CORS is a short-term intervention designed to provide immediate crisis intervention, address identified case management needs, and assure hard linkage to ongoing services. The primary objective is to assist individuals in resolving and/or coping with psychosocial crises by mitigating additional stress 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

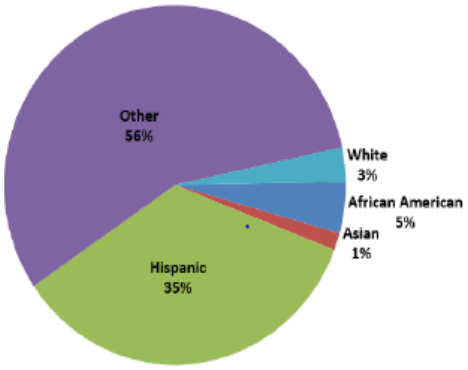
DTQI is a comprehensive approach to managing depression that utilizes quality improvement processes to guide the therapeutic services to adolescents and young adults. The psychoeducation component helps individuals learn about major depression and ways to decrease the likelihood of becoming depressed 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)

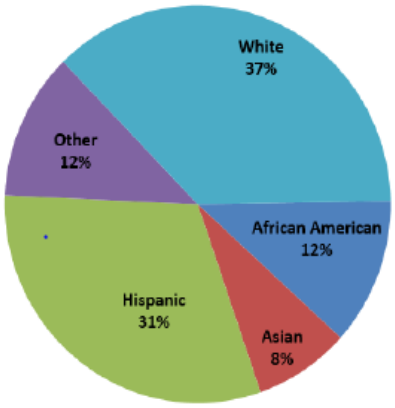
DBT serves individuals who have or may be at risk for symptoms related to emotional dysregulation, which can result in the subsequent adoption of impulsive and problematic behaviors, including suicidal ideation. DBT incorporates a wide variety of treatment strategies including chain analysis, validation, 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

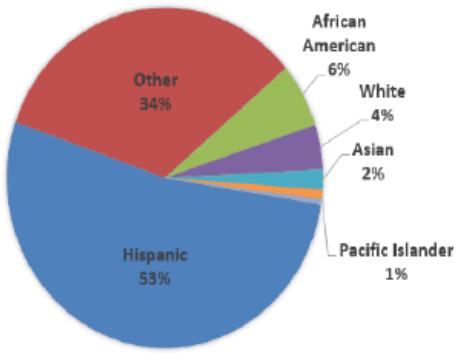
Family resiliency training for Military families, couples, and children who experience difficulties with multiple deployments, injuries, PTSD, and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and family detachment. 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)

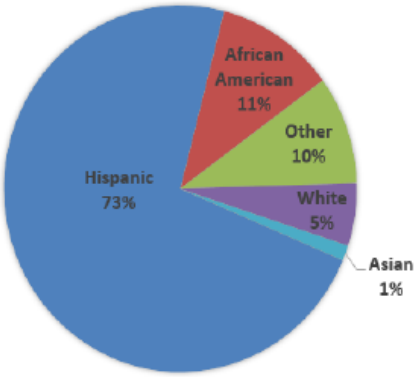
FFT is a family-based, short-term prevention and intervention program for acting-out youth. It focuses on risk and protective factors that impact the adolescent, specifically intrafamilial and extrafamilial factors, and how they present and influence the therapeutic process. Major goals are to improve 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

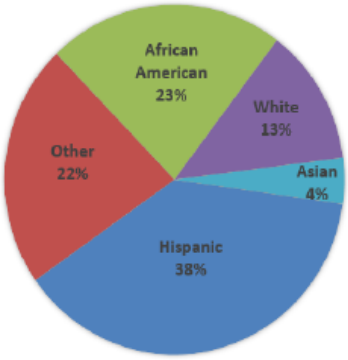
Group CBT focuses on changing an individual's thoughts (cognitive patterns) in order to change his or her behavior and emotional state. Treatment is provided in a group format and assumes maladaptive, or faulty, thinking patterns cause maladaptive behaviors and negative emotions. The group format is 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)

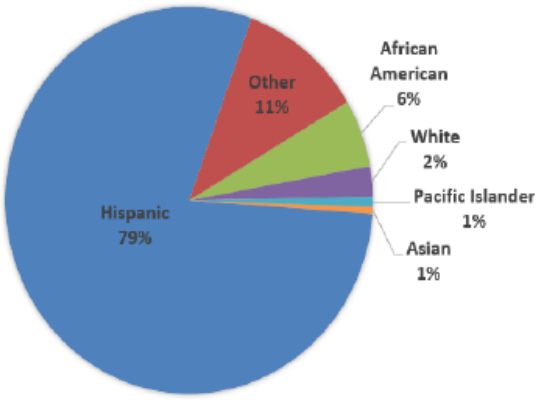
IY is based on developmental theories of the role of multiple interacting risk and protective factors in the development of conduct problems. Parent training intervention focuses on strengthening parenting competency and parent involvement in a child's activities to reduce delinquent behavior. Child 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)

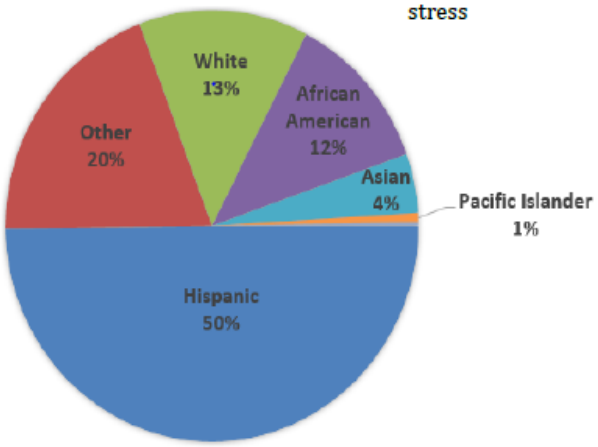
Individual Cognitive Behavioral Therapy (Ind. CBT)

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

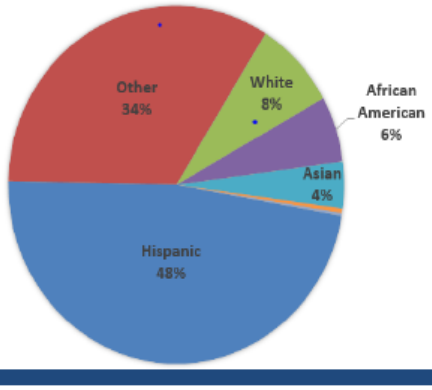
IPT is a short-term therapy (8-20 weeks) that is based on an attachment model, in which distress is tied to difficulty in interpersonal relationships. IPT targets the TAY population suffering from non-psychotic, uni-polar depression. It targets not only symptoms, but improvement in interpersonal functioning, 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)

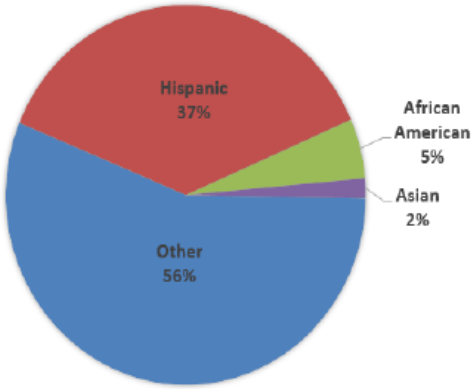
Children (ages 0-8)

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)

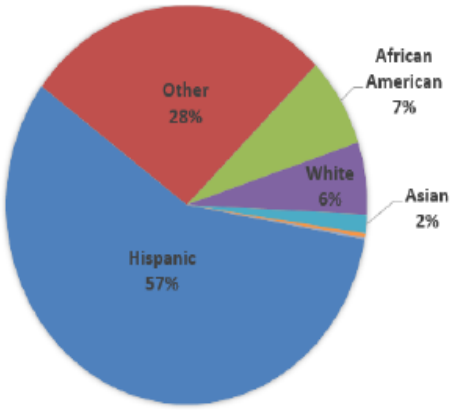
MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. Using an online database, the 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)

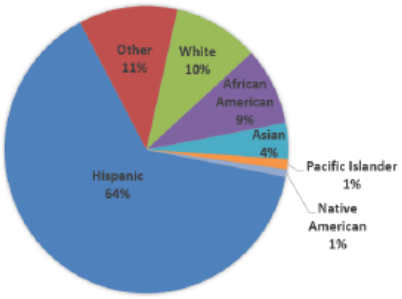
Mental Health Integration Program (MHIP) formerly known as IMPACT

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)

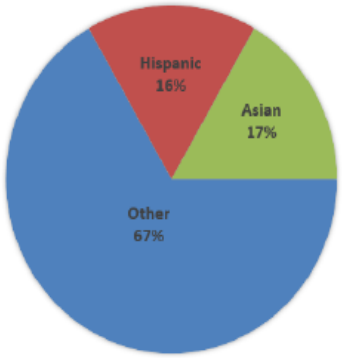
MDFT is a family-based treatment and substance-abuse prevention program to help adolescents to reduce or eliminate substance abuse and behavior/conduct problems, and improve overall family functioning through multiple components, assessments, and interventions in several core areas of life. There are 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)

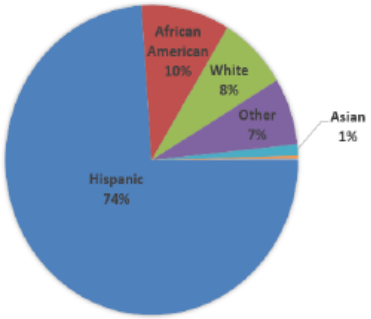
Children (ages 12-15) TAY (ages 16-17)

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

* 126 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

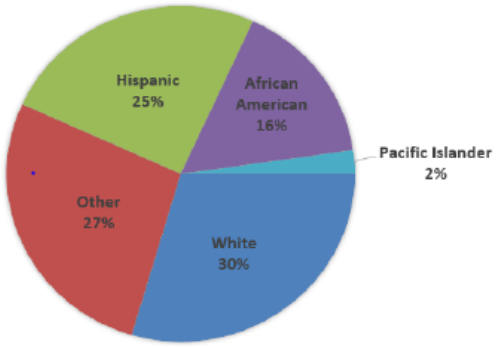
PST has been a primary strategy in IMPACT/ MHIP and PEARLS. While PST has generally focused on the treatment of depression, this strategy can be adapted to a wide range of problems and populations. PST is intended for those clients who are experiencing short-term challenges that may be temporarily impacting 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)

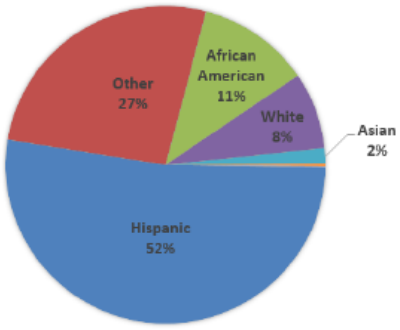
PCIT provides highly specified, step-by-step, live-coaching sessions with both the parent/ caregiver and the child. Parents learn skills through didactic sessions to help manage behavioral problems in their children. Using a transmitter and receiver system, the parent/caregiver is coached in specific 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

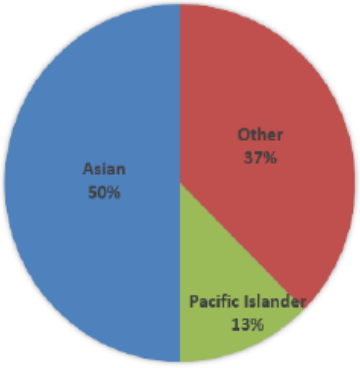
PEARLS is a community-based treatment program using methods of problem solving treatment (PST), social and physical activation and increased pleasant events to reduce depression in physically impaired and socially isolated older adults.

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

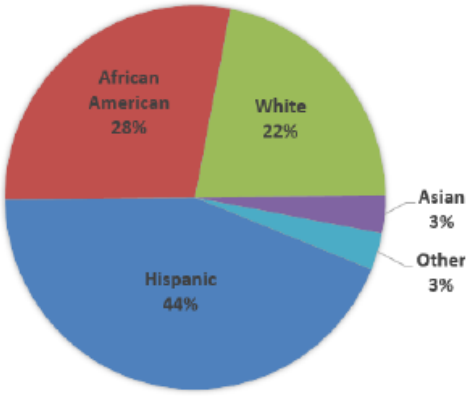
PE-PTSD is an early intervention, cognitive behavioral treatment for individuals experiencing symptoms indicative of early signs of mental health complications due to experiencing one or more traumatic events. Individual therapy is designed to help clients process traumatic events and reduce their PTSD 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)

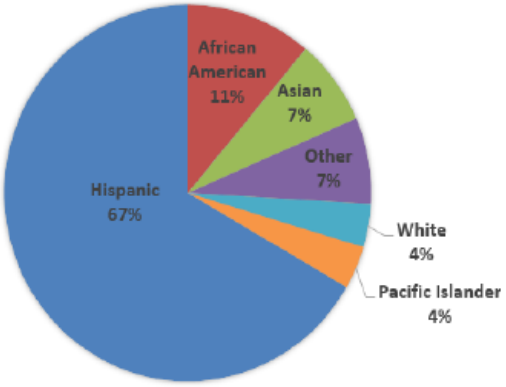
RPP consists of a 10-week workshop that includes instruction, discussions and exercises to involve parents in topics such as temperament, responding to children's distress, separation, play, discipline, and anger as they relate to issues in their own families. The workshops help parents / caregivers 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

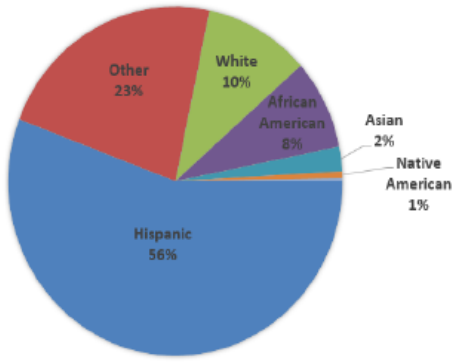
SS is a present-focused therapy that helps people attain safety from trauma or PTSD and substance abuse. It consists of 25 topics that focus on the development of safe coping skills while utilizing a self-empowerment approach. The treatment is designed for flexible use and is conducted in group or individual 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)

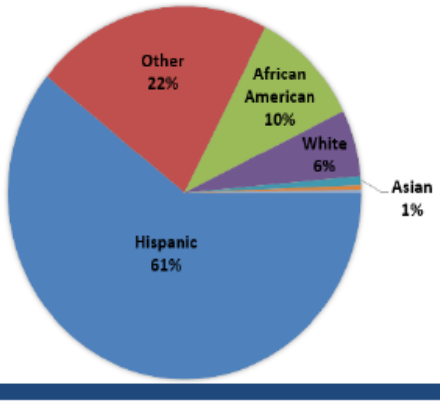
An early intervention for children who may be at risk for symptoms of depression and psychological trauma, subsequent to any number of traumatic experiences, particularly those individuals who are not currently receiving mental health services. Services are specialized mental health services delivered 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)

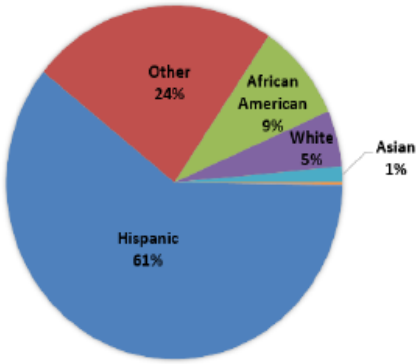
Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being 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)

UCLA Ties Transition Model (UCLA TTM)

Young Children (ages 0-5), Children (ages 6-12)

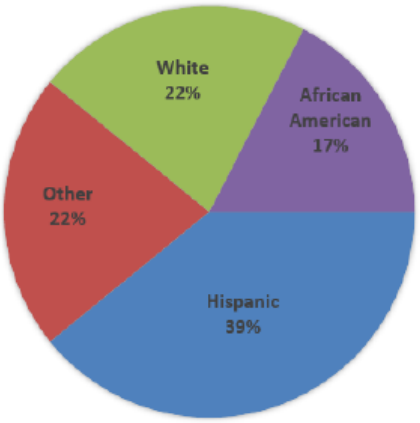
UCLA TTM is a multi-tiered transitional and supportive intervention for adoptive parents of high-risk children. Families participate in three 3-hour psycho-educational groups. Additional service and support options are available to families, including older children, for up to one year (e.g., monthly support sessions, adoption-specific counseling, home visiting if child is less than age 3, interdisciplinary educational and pediatric consultation).

OUTCOMES

* 184 Treatment Cycles
* 50% reported completing the EBP

ETHNICITY & GENDER

N=23
Male: 61%
Female: 39%



(Source: MHSA Annual Update Report FY 19-20)

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Prevention

The prevention activities and services are geared toward addressing, through awareness, education, training, outreach and/or navigation, 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. The followings are some examples of the Prevention activities for FY 18-19.

Library Child, Family and Community Prevention Programs

LACDMH partners with several county and city agencies, such as the Los Angeles County Departments of Parks and Recreation, Children's and Family Services, Public Health, Sheriff's Department, and Public Library; and the Los Angeles Unified School District (LAUSD) to deliver mental health prevention and promotion programming to populations served by those agencies. Programs with the Public Library and Parks and Recreation are the largest with over 600,000 public contacts in FY 18-19. Other partner programs served about 25,000 people combined in FY 18-19.

This program is intended to increase protective factors, thereby mitigating the impact of risk factors associated with serious psychiatric illness and negative outcomes. It is also intended to serve four primary target populations residing in underserved communities experiencing adversity: 1) young children and their parents/caregivers, 2) school-aged children, 3) TAY, and 4) older adults.

Library staff were trained to deliver several mental health promotion programs encompassing the following deliverables. There were some programs for young men of color and youths as below.

Library Programs Deliverables
FY 18-19

Library Program	Deliverable
School Readiness Smarty Pants Storytime	75,574 children and adult caregiver contacts
Triple P Library Primary Care Consultations	20 consultations
Triple P Library Discussion Groups	409 discussion groups
Triple P Outreach Primary Care Consultations	982 site visits
Triple P Embedded in School Readiness	23,284 parents reached and 27,366 children attended
Afterschool Programs	25,500 youth attended
Summer Discovery Program	9,868 child and parent attended

Library Program	Deliverable
STEAM/MAKMO	nearly 19,000 attended library programs and more than 43,000 attended outreach events
Young Men of Color/My Brother's Keeper	4,031 youth attended
Youth Empowerment	4,885 youth attended
TAY Outreach and Library Services	932 TAY attended
Career Online High School	30 enrolled and 12 graduated
Book Clubs	138 book clubs

Home Visitation Program (HVP) Expansion

HVP expansion encompasses three (3) home visiting programs: Healthy Families America (HFA), Parents as Teachers (PAT), and Nurse Family Partnership (NFP). The expansion is intended to augment traditionally delivered HVP services by integrating mental health and protective factor screenings and support to decrease risk factors and increase protective factors. The HVP Expansion will enhance the skills of home visitors who serve high-risk, low-income, pregnant women, or parents/caregivers with children between the ages of 0 and 5 years old, so that they are able to recognize mental health risk factors and refer for mental health treatment when deemed necessary.

HVP Client Demographics
FY 18-19

Cultural Factor	Count (n = 1,657)		Cultural Factor	Count (n = 1,657)
Primary Language			**Race/ Ethnicity**	
Armenian	2		*Hispanic or Latino as follows:*	
English	1,088		Caribbean	5
Mandarin	7		Central American	215
Spanish	528		Mexican/Mexican American/Chicano	836
Tagalog	1		Puerto Rican	10

Cultural Factor	Count (n = 1,657)
Declined to answer	31
Age	
0-15	7
16-25	912
26-59	733
60 or older	0
Declined to answer	5
Gender Assigned at Birth	
Male	4
Female	1,187
Declined to answer	466
Current Gender Identity	
Male	4
Female	1,187
Trans	1
Genderqueer	1
Declined to answer	464
Disability	
No	1,229
Yes	693
Difficulty Seeing	3
Difficulty Hearing	6
Mental Domain	67
Physical/Mobile Domain	6

Cultural Factor	Count (n = 1,657)
South American	28
Non-Hispanic or Non-Latino as follows:	
African	71
Asian Indian/South Asian	9
Cambodian	1
Chinese	7
Eastern European	6
European	21
Filipino	14
Japanese	3
Korean	2
Middle Eastern	9
Vietnamese	4
Others	79
More than one ethnicity	43
Declined to answer	164
Race	
American Indian	14
Asian	44
Black or African-American	183
Native Hawaiian or other Pacific Islander	5
White	741
More than one race	29
Declined to answer	683

Cultural Factor	Count (n = 1,657)
Chronic Health Condition	336
Other	275
Declined to answer	48

Cultural Factor	Count (n = 1,657)
Veteran Status	
No	1,518
Declined to answer	139

Substance Use Disorder Trauma-Informed Parent Support (SUD-TIPS)
This program provides education, screening, and linkage to substance use treatment, mental health services, and other social support services to adult parents identified by DCFS as substance using. During FY 18-19, 1,224 individuals were provided with education, while 732 people were screened. During the initial screening, questions were asked to gauge the concrete supports, parental resilience, and social connection. Of those screened, only about two-thirds reported that they have others who will listen when they need to talk about problems or if there is a crisis. About one-third reported that they would not know where to go for help if they had trouble making ends meet, or that they would not know where to go for help if they needed help finding a job. LACDMH and the Los Angeles County Department of Public Health (LACDPH) are collaboratively working to determine tools to evaluate the program's effectiveness and intended outcomes.

SUD - TIPS Client Demographics
FY 18-19

	Count (n = 732)
Primary Language	
Armenian	2
English	587
Farsi	1
Spanish	131
Declined to answer	11
Age	
15-25	155

	Count (n = 732)
Ethnicity	
Hispanic or Latino as follows:	
Central American	39
Mexican/Mexican American/Chicano	331
Puerto Rican	2
South American	7
Non-Hispanic or Non-Latino as follows:	
African	50

26-35	348
36 and older	229
Gender Assigned at Birth	
Male	281
Female	441
Declined to answer	10
Current Gender Identity	
Male	281
Female	440
Trans	1
Declined to answer	10
Disability	
No	732
Veteran Status	
No	732

Asian Indian/South Asian	3
Chinese	1
Eastern European	9
European	11
Filipino	2
Japanese	1
Korean	1
Middle Eastern	4
Other	46
More than one ethnicity	3
Declined to answer	54
Race	
American Indian	10
Asian	6
Black or African-American	104
Native Hawaiian or other Pacific Islander	3
White	199
Other	352
More than one race	28
Declined to answer	30

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 contacts towards addressing underlying needs through systems of care that prioritize equity, advance well-being, support accountability, and promote public safety.

- Annual YDD Summit
  The Annual YDD Summit is a conference designed to provide law enforcement, community-based agencies, other youth-serving agencies, and key stakeholders with training and capacity building. In July 2019, YDD and its My Brother's Keeper partners hosted the second annual Youth Development Summit with approximately 400 people, including youth, community-based organizations, county agencies, law enforcement agencies, advocates, researchers, and funders in attendance both days. In the weeks leading up to the Summit, YDD convened 15 youth members of the Steering Committee each week to facilitate a youth-led planning process for the Summit, including the development of a youth-led video describing a vision for the future of YDD in Los Angeles County and a youth-led session on each day of the Summit. In a survey administered to participants at the end of the second day of the Summit, 100% of attendees shared that they learned something that will help inform their work in the future. When asked to indicate strategies that attendees would like to see addressed in a future planning process focused on developing a countywide youth development strategy, the top three (3) strategies selected were: 1) centering youth leaders in planning and decision-making; 2) recommendations for sustainable county funding to support youth development; and 3) building upon local advocacy and research (including youth-led participatory research) that has already taken place to advance youth development efforts in Los Angeles County.

- Youth Development Services (YDS)
  Intensive case management is provided to youth identified and referred through law enforcement through contracted community-based partners. As YDD contracted providers continue to finalize their partnership agreements with referring law enforcement agencies, they have hired their first Case Managers and begun internal training and community landscape analyses to prepare to receive referrals. YDS enrolled 11 youth between April 2, 2019 and the end of the fiscal year. Another aspect of YDS is My Brother's Keeper (MBK), a trauma responsive school-based mentorship and youth development program focused on improving high school completion and reducing justice system involvement. Between April and June of 2019, the YDS-MBK providers focused on identifying school sites and laying the foundation for initial expansion in their first quarter of funding. Both school districts identified in Compton and the Antelope Valley began accepting students June 30, 2019.

Prevention and Community Outreach Services

LACDMH has expanded its PEI Community Outreach Services (COS) in order to achieve the following:

- Increase the number of individuals receiving prevention and early intervention Services
- Outreach to underserved communities through culturally appropriate mental health promotion and education services

- Provide mental health education and reduce stigma on mental health issues in our communities

COS affords an avenue for the LACDMH PEI network to provide services such as education and information to individuals who are not formal clients of the mental health system and providers who are outside the county mental health system. Often individuals, as well as their parents, family, caregivers, and other support system, who need or would benefit from prevention and early intervention mental health services do not seek traditional clinic-based services due to a multitude of factors. Community outreach is a key component in initiating and providing effective mental health supportive services to these individuals. Most programs are not evidence-based practices, but nonetheless have significant data and research indicating the effectiveness of their services. In general, these do not require that staff be clinicians.

Programs Approved for Billing PEI COS

Prevention Program	Descriptions
Active Parenting Parents of children (3-17)	Active Parenting provides evidence-based, video-based, group parenting classes that cover topics including parenting skills training, step-parenting, managing 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.
Arise 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.
Asian American Family Enrichment Network (AAFEN) Parents of Children (12-15) TAY (16-18)	AAFEN is for 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 children experience reduced family attachment and social functioning, as well as increased family conflict. The children are thus at high risk for emotional and behavioral problems. Their immigrant parents and/or primary caregivers are at high risk for depressive disorders and for being reported to the Los Angeles County Department of Children and Family Services due to corporal punishment.

Prevention Program	Descriptions
Childhelp Speak Up and Be Safe 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. The program focuses on enhancing the child's overall sense of confidence regarding 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 identities as safe.
Coping with Stress Child (13-15) TAY (16-18)	This course consists of 15 one-hour sessions, which can be offered at a pace of 2 to 4 times per week, depending on site capabilities and needs. The first few sessions provide an overview of depression, its relationship to stressful situations, and an introduction to other group members. Subsequent sessions focus on cognitive-restructuring skills and techniques for modifying irrational or negative self-statements and thoughts which are hypothesized to contribute to the development and maintenance of depressive disorders.
Erika's Lighthouse: A Beacon of Hope for Adolescent Depression Children (12-14)	Erika's Lighthouse is an introductory depression awareness and mental health empowerment program for early adolescence. The program educates school communities about teen depression, reduces the stigma associated with mental illness, and empowers 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."
Guiding Good Choices Parents of 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 the skills they need to improve family communication and family bonding. Participants learn specific strategies to help their children avoid drug use and other adolescent problem behaviors and develop into healthy adults. They also 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.

Prevention Program	Descriptions
Healthy Ideas (Identifying Depression, Empowering Activities for Seniors) Older Adults (60+)	This is a community 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.
Incredible Years (Attentive Parenting) Parents	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.
Life Skills Training (LST) 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 Children (15) TAY (16-24)	Love Notes consists of 13 lessons for high risk youth and TAY in which 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) Parents of children (0-8)	MPAP 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.

Prevention Program	Descriptions
More than Sad Parents/Teachers/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. The 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.
Nurturing Parenting Parents of children (0-18)	These are family-based programs utilized for the treatment and prevention of child abuse and neglect. Program sessions are offered in group-based and homebased formats ranging from 5-58 sessions. Programs are designed for parents with young children birth to 5 years old, school-aged children 5-11 years old, and teens 12-18 years old. Developed from the known behaviors that contribute to the maltreatment of children, the goals of the curriculum are: (1) to teach age appropriate expectations and neurological development of children; (2) to develop empathy and self-worth in parents and children; (3) to utilize nurturing, non-violent strategies and techniques in establishing family discipline; (4) to empower parents and children to utilize their personal power to make healthy choices; and (5) to increase awareness of self and others in developing positive patterns of communication while establishing healthy, caring relationships.
Peace Builders Children (0-15)	Peace Builders 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.
Prevention of Depression (PODS) - Coping with Stress (2nd Generation) Child (13-15) TAY (16-18)	This is the second-generation version of the Coping with Stress program. PODS is an eight-session curriculum developed for the prevention of unipolar depression in adolescents with increased risk. It is not meant to be a treatment for active episodes of depression. It is designed to be offered either in a healthcare setting or in schools.
Positive Parenting Program (TRIPLE P) Levels 2 and 3 Parents/Caregivers of Children (0-12)	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 (Levels 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

Prevention Program	Descriptions
	concerns. There are three seminar topics with each taking around 60 minutes to present, plus 30 minutes for question time.
Project Fatherhood Male Parents/Caregivers of Children (0-15) TAY (16-18)	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.
Psychological First Aid (PFA) 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.
School, Community and Law Enforcement (SCALE) Children (12-15) TAY (16-18)	SCALE Program is for Asian 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).
Second Step Children (4-14)	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.

Prevention Program	Descriptions
Shifting Boundaries Children (10-15)	Shifting Boundaries is a six (6) session, group based, dating violence prevention program that focuses on peer sexual harassment. The intervention consists of classroom-based curricula designed to reduce the incidence and prevalence of dating violence and sexual harassment among middle school students. The program aims to: Increase knowledge and awareness of sexual abuse and harassment; Promote pro-social attitudes and a negative view of dating violence and sexual harassment; Promote nonviolent behavioral intentions in bystanders; Reduce the occurrence of dating and peer violence; and Reduce the occurrence of sexual harassment.
Teaching Kids to Cope 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.
Why Try Children (7-15) TAY (16-18)	Why Try 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.

Suicide Prevention

The Suicide Prevention 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; linking direct services and improving 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. In response to the needs in the community, the Los Angeles County Suicide Prevention Network, with support from LACDMH, has developed a strategic plan for suicide prevention to guide

our efforts towards the goal of zero suicides in the County. Some of the key elements of Los Angeles County's approach to suicide prevention are:

- Focus on fostering prevention and well-being through connections, education, outreach, advocacy and stigma reduction
- Promote early help seeking where people know the warning signs and resources and are confident to intervene with someone they care about or get help for themselves
- Ensure a safe and compassionate response during and in response to crises by focusing on stabilization and linkages to services in the least restrictive setting
- Implement a system of short- and long-term support for individuals, families, schools and communities following a suicide attempt or death

Latina Youth Program (LYP)

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.

Consumers Served by Latina Youth Program
FY 18-19

Program/Project/ Activity	Number of Consumers Served by Ethnicity and Gender (Total 56 participants)							
	White	African American	Latino	API	American Indian	Multiple	Male	Female
Latina Youth Program	2	0	47	2	0	0	24	32
	Other Ethnicities: 0							
	Not Specified Race/Ethnicity: 5							
	Participants' Age Range							
	16-25							

During FY 18-19, LYP provided direct clinical services, outreach and education to 56 unduplicated clients, who ranged in age from birth to 25 years, and their families. Most clients were within the 16 to 25 age range. Regarding gender, more females (n = 32) than males (n = 24) participated in the program. Regarding ethnicity, the majority of program participants were Latino (n = 47); five (5) participants did not specify their race or ethnicity; two (2) identified as Whites, and two (2) as Asian/Pacific Islander. Sixty-one percent of the clients reported that English is their primary language, while 39% specified that Spanish is their primary language. With regard to diagnostic categories, the greatest percentage of participants presented with depressive symptoms (45%); other affective disorders were reported by 11% of participants; 22% of participants were diagnosed with an anxiety related disorder; 8% of program participants were diagnosed with a neurodevelopmental disorder; and 3% had problems with substance use. Although during this program year, there were six (6) suicide attempts and 26 instances of client psychiatric hospitalization, none of these were within the LACDMH funded clients. Additionally, LYP experienced no completed suicides.

LYP also provided other services in the community. LYP provided direct services in 31 schools, including 13 elementary, 6 middle and 12 high schools. Educational sessions were held at Back to School nights in all participating schools and self-care/burn-out prevention workshops were presented to school staff. Community outreach sessions focused on suicide prevention in both English and Spanish were held at Carmela Elementary. A Life Skills group at Los Nietos Middle School discussed topics related to self-love, relationships, media literacy, peer pressure, leadership skills, conflict resolution and outlook for the future. Parenting classes were presented in English and Spanish at Los Nietos Middle School and covered child development, discipline, communication skills, resiliency and abuse, substance use, and suicide prevention. Peer support groups were offered at Wilcox Elementary School and Cal State Dominguez Hills. The program staff is trained in seven (7) different EBPs:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) Honoring Children, Mending the Circle

- Managing and Adapting Practice (MAP)
- Seeking Safety (SS)
- Interpersonal Psychotherapy for Depression (IPT)
- Individual Cognitive Behavioral Therapy (Ind. CBT)
- Triple P Positive Parenting Program (Triple P)
- Aggression Replacement Training (ART).

24/7 Crisis Hotline

The 24/7 Suicide Prevention Crisis Line responded to a total of 102,790 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 12,075 callers. Korean and Vietnamese language services are also available on the crisis hotline. Additionally, various outreach events were conducted in Los Angeles and Orange County.

Call Analysis
FY 18-19

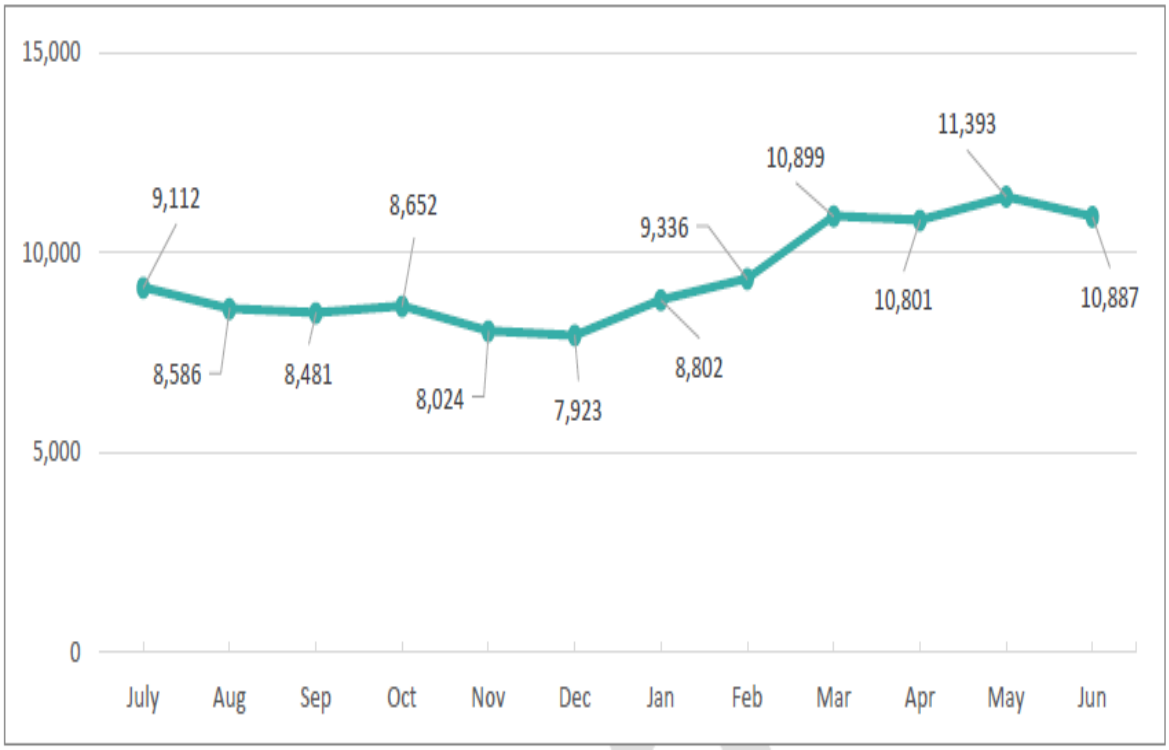
Description	Number of Call
Total Calls	102,790
Total Chats	10,089
Total Texts	17
Total*	84,069

*Calls from Lifeline, Lifeline Spanish, SPC Local Line, Teenline, and Disaster/Distress

Total Calls by Language
FY 18-19

Language	Number of Calls
Korean	46
Spanish	12,075
English	90,669
Total	102,790

Call, Chat, and Text Volume by Month
FY 18-19



Calls and Chats by Race/Ethnicity
FY 18-19

Ethnicity	Calls (n = 45,733)	Chats (n = 10,006)
White	37%	65%
Latino	37%	13%
African American	9%	10%
Asian	10%	8%
Native American	1%	1%
Pacific Islander	1%	0%
Other Race	4%	0%

Calls and Chats by Age Groups
FY 18-19

Age Groups	Calls (n = 54,327)	Chats (n = 10,006)
5 to 14	6%	18%
15 to 24	39%	52%
25 to 34	26%	18%
35 to 44	12%	6%
45 to 54	8%	4%
55 to 64	7%	2%
65 to 74	3%	1%
75 to 84	1%	0%
85 and up	0%	0%

Calls and Chats by Suicide Risk Assessment
FY 18-19

Suicide Assessment	Calls	Chats
History of psychiatric diagnosis	40%	38%
Prior suicide attempt	27%	22%
Substance abuse - current or prior	17%	4%
Suicide survivor	10%	3%
Access to gun	3%	3%

Presence of the above factors significantly increases an individual's risk for suicide attempts; thus, all callers presenting with crisis or suicide-related issues are assessed for these risk factors. Percentages are calculated based on the total number of calls in which suicide or crisis content was present.

Suicide Risk Status

Suicide Risk Status	Calls (n = 39,610)	Chats (n = 4,192)
Low Risk	45%	54%
Low-Moderate Risk	26%	25%
Moderate Risk	13%	11%
High-Moderate Risk	5%	5%
High Risk	10%	5%
Attempt in Progress	1%	0%

Percentages are calculated based on the total number of callers with reported risk levels.
Risk assessment is based on the four (4) core principles of suicide risk: suicidal desire, suicidal capability, suicidal intent, and buffers/connectedness. A caller's risk level is determined by the combination of core principles present. For example, a caller who reports having only suicidal desire, as well as buffers, would be rated as low risk. A caller with suicidal desire, capability, and intent present would be rated as high risk, regardless of the presence of buffers.

Partners in Suicide Prevention (PSP) Team

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 offers education, identifies appropriate tools, such as evidence-based practices, and provides linkage and referrals to age appropriate services.

The PSP Team is comprised of six (6) staff representing each of the four (4) age groups and includes three (3) Spanish-speaking members offers community education. They are responsible for providing best-practice training models in suicide prevention and offering linkage and referrals to age appropriate services.

PSP Team members participated in 99 suicide prevention events during FY 18-19, outreaching to more than 2,465 County residents. These events included countywide educational trainings, participation in suicide prevention community events, the 8th Annual Suicide Prevention Summit, and collaboration with various agencies and partners.

Number of PSP Trainings
FY 18-19

Training	Number of Training Offered	Number of Participants Trained
Applied Suicide Intervention Skills Training (ASIST)	5	100
Question, Persuade and Refer (QPR)	55	1,375
Youth Mental Health First Aid (YMHFA)	3	65
Assessing & Managing Suicide Risk (AMSR)	5	100
Recognizing and Responding to Suicide Risk (RRSR)	4	80

Additional trainings for trainers (building capacity):

- Recognizing and Responding to Suicide Risk: February 18, 2019
- Talk Saves Lives: March 6, 2019
- More than Sad: May 15, 2019

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 18-19, START provided 1,189 services to 306 individuals at either suicidal or homicidal risk: 165 open cases and 141 potential cases. Law enforcement agencies and schools continue to be the two (2) main referral sources. After years of services delivered in the County, START has become one of the major violence crisis management resources in addition to the law enforcement.

The number of referrals increased from 272 in FY 17-18 to 333 in FY 18-19. Clinicians triaged and determined their active status: consultation only, limited follow-up for cases either posed no threat, received services from other mental health providers, or declined START services, and active follow-up identifying as open cases.

The program served 86 open cases in FY 17-18 and 165 in FY 18-19. In FY 18-19, 134 male cases and 31 female cases were opened, and 66 of those were between the ages of 0-15; 66 were between the ages of 16-25; 32 were between the ages of 25- 59; and 1 was over the age of 59. English was the language spoken by most clients (149) followed by Spanish (13). Close to half of the open cases were identified as Hispanic at 52.12%. The clients identified as white (17.58%) was the second largest ethnic group and African Americans/blacks were third at 12.12%. To meet the clients' cultural need, one third of START clinicians are Spanish-speaking.

The reported outcomes for FY 18-19 were based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources. The three assessment tools consist of Columbia-Suicide Severity Rating Scale (C-SSRS), Structured Assessment of Violence Risk in Youth (SAVRY) and Workplace Assessment of Violence Risk-21 (WAVR-21). These three tools do not quantitatively calculate the risk levels but present the risk factors. Clinicians subjectively weigh on each risk factor to determine the total risk levels on each tool and then conclude the final risk levels after reviewing the information collected from all sources mentioned above.

For FY 18-19, the moderate suicidal risk group showed 15.15% and the high suicidal risk group of 14.55% at the beginning of the intervention. With the interventions rendered by START, high suicidal risk group decreased showing a significant drop from 14.55% to 5.45% but a rise from 69.70% to 78.18% in the low suicidal risk group. The overall variation in suicidal risk levels indicated a significant improvement in suicidality presented by the open cases as a result of the program.

Change of Suicidal Risk Levels between Initial and Most Recent Contacts FY 18-19

Risk Level	Initial Suicidal Risk Level	Most Recent Suicidal Risk Level
High	24 (14.55%)	9 (5.45%)
Moderate	25 (15.15%)	26 (15.76%)
Low	115 (69.70%)	129 (78.18%)
Early Dropout	1 (0.60%)	1 (0.61%)
Total	165	165

In FY 18-19, the moderate violent risk and high violent risk groups decreased by half in percentages: 44.84% to 22.42% for moderate violent risk group and 10.30 % to 5.45% for high violent risk group. In general, open cases presented a reduction in violent risk levels in both fiscal years.

Change of Violent Risk Levels between Initial and Most Recent Contacts
FY 18-19

Risk Level	Initial Violent Risk Level	Most Recent Violent Risk Level
High	17 (10.30 %)	9 (5.45%)
Moderate	74 (44.85%)	37 (22.42%)
Low	72 (43.63%)	117 (70.91%)
Pending to Finalize Assessment*	1 (0.61%)	1 (0.61%)
Early Dropout	1 (0.61%)	1 (0.61%)
Total	165	165

*Clinician cannot reach the client but is actively following on this case through contacts with other professionals.

START has years of partnership with various threat management teams in the Los Angeles Community College District (LACCD), the largest community college system in the nation. Through its partnership with the Los Angeles County Sheriff's Department and the LACCD, START has established protocol for managing threats in educational settings. The services include, but are not limited to, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and interventions specific to individuals; trainings extended to students and their families; and linkage to a wide range of community resources. Additionally, START participates in LAUSD's Threat Assessment Response Partners (TARP) collaborative, and the higher education Threat Assessment Regional Group Evaluation Team (TARGET) to provide on-going consultations and trainings on threat cases. START will continue with its mission to be the driving force in establishing a safe, healthy school environment in the County.

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.

The Promotores have advanced personally and professionally since 2011, when the program was initially implemented in Los Angeles County, serving Service Area 7. The program has expanded to all service areas. There are currently one hundred and fifty three (153) trained Spanish-speaking Community Mental Health Promoters in all Service Areas combined. There are a few more in SA's 7 with 25 Promoters, and SA 8 with 22 Promoters, due to the involvement with Public Health to work collaboratively for the purpose of reaching the Latino community on issues related to lead poisoning.

The Promotores continued to train community residents on a variety of modules with which they have been familiarized. Their training can be anywhere from a full 2 hour-presentation, to an abbreviated 30 minute presentation depending on the site and their needs. However, the Promotores prepared training "series" that allow for a 1.5 or 2 hour-presentation on a weekly basis over a variety of topics. Below are the topics on which the Promotores have trained and the number of presentations offered:

Number of Presentations Offered by Topics
FY 18-19

Mental Health Stigma	Depression	Anxiety	Grief and Loss	Drugs and Alcohol	Familial Violence	Child Abuse	Suicide Prevention	Childhood Disorders
710	610	557	554	478	543	465	443	1,098

(Grand Total: 5,551)

Additionally, training for Promotores is an essential component of the Promoters of Mental Health program in the delivery of mental health education and early interventions to Latino communities. The LACDMH strives to ensure that Promoters of Mental Health are exposed to information that will increase their knowledge and enhance their skills needed to implement an effective program giving them an opportunity to reflect on their Professional development. Promoters also receive supervision and consultation by the administrative team providing feedback, guidance and emotional support.

The Promoters receive:

- 128 hours of Foundational Training for new Promotores
- 36 hours of Mental Health Booster trainings spread throughout the year
- 24 hours of Group Supervision
- 24 hours of Advanced Development Group (voluntary participation)
- Individual supervision as needed
- Additional presentations from guest speakers on the following topics:
  - Immigration Laws
  - Drugs and Alcohol, including Opioids
  - Gender Identification and LCBTQ2S Issues
  - Attachment Theory and Young Children
  - Lead Poisoning and its effects
  - Psychological First Aid

Promotores de Salud/Health Promoters		
Projects/Activities/ Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Expansion of the Promoters Program	Ongoing	LACDMH expanded the Promotores Program to all Service Areas. Total Number of Promoters per Service Area for FY 18-19 • SA 1 – 17 • SA 2 – 17 • SA 3 – 20 • SA 4 – 18 • SA 5 – 15 • SA 6 – 19 • SA 7 – 25 • SA 8 – 22 Total Promotores – 153
Promoters' Collaboration with Department of Public Health (DPH)		The Department of Public Health (DPH) requested the continued assistance of the Promoters of Mental Health to outreach the Latino communities affected by the Exide Battery Plant located in the City of

Promotores de Salud/Health Promoters		
Projects/Activities/ Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
		Vernon for the third year in a row. A total of twenty seven (27) Promoters collaborated with DPH providing community outreach in affected communities. These activities included participating in community meetings and community resource fairs assisting DPH register residents for lead level blood testing and registering homes for soil clean-up and door-to-door outreach. In addition, Exide-Lead Contamination presentations were conducted at various community schools, churches and other community organizations. For this effort, in collaboration with DPH and DHS, the Promotores program received an important County award as a Top Ten Program from the County Board of Supervisors Annual Productivity and Quality Awards Program. In addition, this year DMH Promotores have also partnered with DPH, to educate the community on lead poisoning in the home, primarily from lead based paint. This is a new program that will be expanding in the coming year. The Promotores have been trained and go door to door, to educate the community on the effects of ingestion of lead based paint on the development of young children.
Promoters' Outreach	Community Event Participation	The recent political realities which include workplace raids by ICE, and the threatened separation of families, as well as fearing of becoming a "public charge" and jeopardizing opportunities for regulation of their legal status, have kept many Latino families away from public mental health services. For this reason, our outreach into "safe" community settings is even more critical to this population. A breakdown of locations where presentations were conducted are listed below: • Local Parks, in conjunction with Parks After Dark, and Summer Nights Lights Program • Churches • Libraries • Schools • Non-Profit Agencies • Swap Meets • Centro Estrella Children's Resource Fair • Job Centers

<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>Presentations delivered for FY 18-19</td><td>

Lanternman Regional Center
Police Stations
Community Centers
Older Adult Day Centers
Private Homes
City Halls
DPSS

As the Promotores are trying to reach the most disenfranchised in the Latino community, the majority of the presentations are in Spanish. Currently the Promotores are doing no more than 5% of their presentations in English. Very often, due to stigma or fear, this mental health training is the only exposure some of residents have to mental health. For this reason, tips of self-care as well as places that they may receive self-care support through groups are embedded in the trainings.

Promoters of Mental Health collectively conducted 5,521 mental health presentations throughout their service area communities, which is 1,233 more presentations than in FY 17-18, a 22% increase. They reached 44,242, which is 9,104 more people than they reached in FY 17-18, which is a 20% increase. In addition, they participated in 522 community events, which included health fairs, resource fairs, and having resource tables twice a week at both the Mexican and Salvadorian consulates.

Summary of Presentations for FY 18-19
<table>
<tr><th>SA</th><th>Number of Presentations</th><th>Number of People Served</th><th>Number of Unique Sites</th></tr>
<tr><td>*SA 1</td><td>12</td><td>55</td><td>12</td></tr>
<tr><td>SA 2</td><td>1,009</td><td>4,106</td><td>65</td></tr>
<tr><td>SA 3</td><td>384</td><td>3,208</td><td>24</td></tr>
<tr><td>SA 4</td><td>1,141</td><td>11,163</td><td>142</td></tr>
<tr><td>*SA 5</td><td>13</td><td>176</td><td>6</td></tr>
<tr><td>SA 6</td><td>675</td><td>6,229</td><td>70</td></tr>
<tr><td>SA 7</td><td>1,125</td><td>10,214</td><td>89</td></tr>
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<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><td>SA 8</td><td>1,162</td><td>9,091</td><td>148</td></tr>
<tr><td>Total</td><td>5,521</td><td>44,242</td><td>556</td></tr>
</table>
(*Promoters Teams – Trained in April and June 2019)
</td></tr>
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Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)
Existing services cross all age groups and include community-based, clinic-based, well-being and peer-run services geared toward reintegration into the community, including one or more of the following options:

(1) Transition-Age Youth (TAY) Drop-In Centers
(2) Field-based and Clinic-based Mental Health Services and Supports
(3) TAY Supported Employment Services
(4) Integrated Care Outpatient Programs
(5) Peer Run Centers, including Peer Run Respite Housing
(6) Wellness Services
(7) Probation Camp Services co-located mental health services and supports delivered on-site at the Probation Camps, delivered in conjunction with Los Angeles County Department of Health Services Juvenile Court Health Services and the Los Angeles County Office of Education.

These services focus on outpatient settings that meet a range of needs for individuals who meet the criteria for specialty mental health services. Los Angeles County's new Three-Year Plan proposes to build on the programs listed in the previous plan, enhance the integration of these programs, and capitalize on lessons learned to build a responsive and resilient comprehensive system for Outpatient Care Services countywide.

Efforts in the area of Outpatient Treatment Services will be focused on:
1. Building consistency and cohesion
- Establishment of core components that are implemented in outpatient programs across all service areas
- Core Components that are shared between Legal Entity and Directly Operated outpatient programs

2. Building a seamless continuum of care
- Smooth transitions between levels of care
- Decrease gaps in care
- Building a flexible system that accounts for fluctuations in levels of care needed by a given population of clients

3. Impacting Social Determinants of Health

- Integrated services
- Whole person perspective
- Focus on building connections, meaning, and growth

4. Emphasis on keeping people in community, rather than moving into higher levels of care or disengagement

5. Building multilevel community involvement – being responsive to community, integrating into the community, and bringing community into our programs

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Data for Clients Served through Various Outpatient Programs
FY 18-19

Age Group	Number of Unique Clients Served	Average Cost per Client
Children, Ages 0-15	24,549	$5,656
TAY, Ages 16-25	17,292	$4,020
Adult, Ages 26-59	57,948	$3,108
Older Adult, Ages 60+	14,614	$3,354

Cost is based on Mode 15 services, not inclusive of community outreach services or client supportive services expenditures

Stigma and Discrimination

The purpose of Stigma and Discrimination 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 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. The 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.

Mental Health First Aid (MHFA)

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 enhances 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.

Outcomes for Stigma and Discrimination

Through training and education, LACDMH has shown positive results in increasing knowledge about mental health and reducing stigma and discrimination towards people with mental illness. Two (2) methods were used to measure the impact of Stigma and Discrimination Reduction (SDR) trainings:

- Method 1: From July 1, 2018 through January 2019, SDR Outcomes Surveys were administered at the start and end of trainings to measures changes in attitudes and behavior toward persons with mental illness and knowledge about mental health. There are two (2) versions of the survey, the SDR Outcomes Survey-Youth version for children/adolescents and the SDR

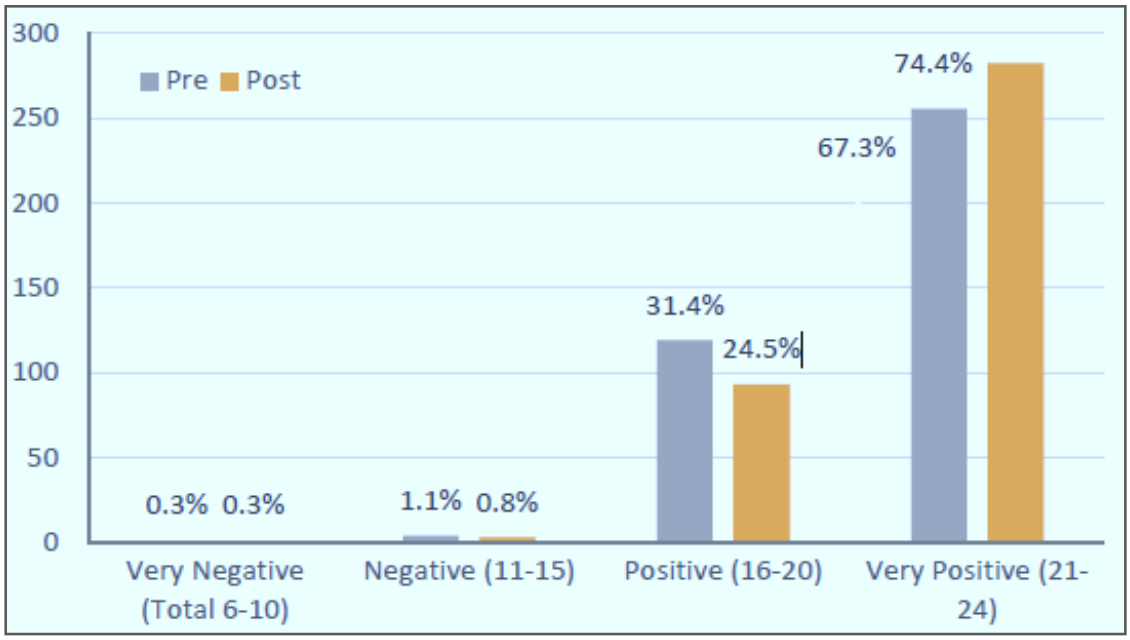
Outcomes Survey-Adult version for adults (ages 18+). Only Adult Survey data were received and are being reported.

- Method 2: In February 2019, LACDMH changed the assessment method in order to participate in a new statewide effort to assess MHSA Prevention programs, which necessitated adopting a different outcome measure that is only completed following end of training. The survey measures changes in awareness of stigma regarding persons with mental illness, attitudes and behavior toward persons with mental illness, and knowledge about mental health. Results for Method 1 based on 650 surveys received are shown below.

Survey Demographics for Method 1
FY 18-19

Description	Demographics	
Gender (n = 527)	Female: 18% Male: 16% Other: 1%	
Ethnicity (n = 537)	Latino: 47% African/African American: 16% White: 14% Asian/Pacific Islander: 17%	American Indian or Alaska Native: 1% Eastern European/Middle Eastern: 1% Other: 4%
Highest Level of Education (n = 480)	Doctoral Degree: 0.4% Master's Degree: 27% Four Year College Degree: 41% Two Year College Degree: 8%	Some College: 17% High School Diploma/GED: 5% Less than High School: 2%
Have you ever received mental health services? (n = 525)	Yes - 43% No - 56% I would rather not answer at this time - 1%	
Age Groups (n = 592)	TAY (16-25): 14% Adult (26-59): 81% Older Adult (60+): 5%	
Primary Language (n = 511)	English: 88% Armenian: 0.2% Cambodian: 0.2% Spanish: 9%	Arabic: 0.2% Farsi: 0.2% Tagalog: 2% Korean: 0.4%
Role (n = 480)	Case Manager: 20% Medical Professional: 13% Mental Health Clinician: 5% Law Enforcement: 4% Substance Abuse Counselor: 1% Clerical/Support Staff: 6%	Mental Health Consumer: 2% Family Member: 3% Student: 14% Community Member: 5% Other: 27%

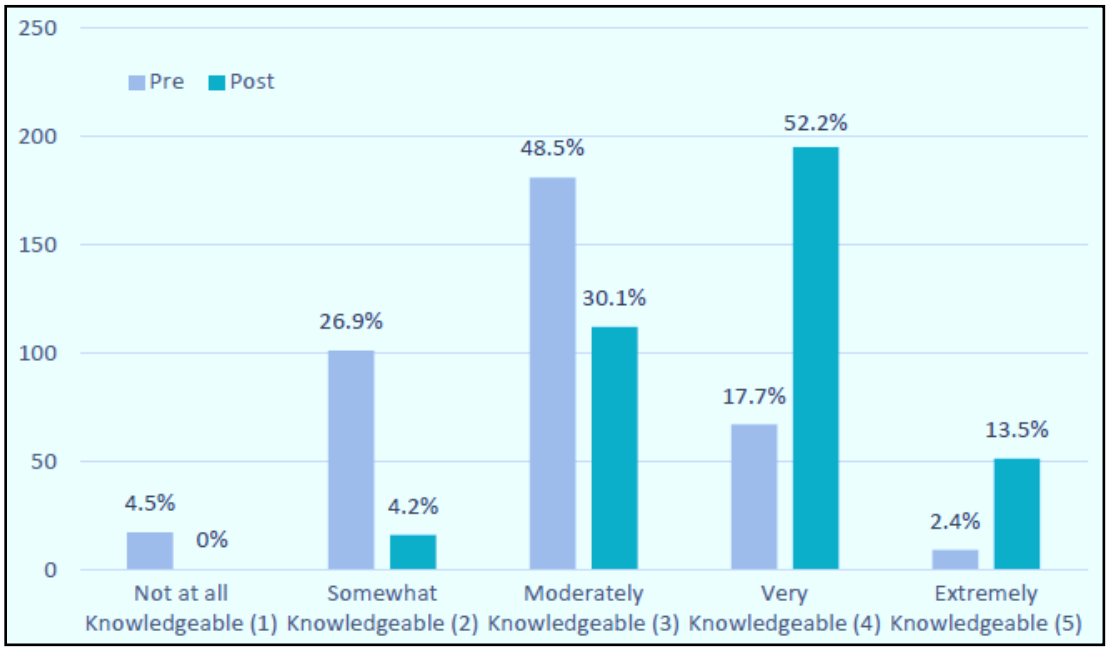
Average Attitude Score Pre- and Post-Training (n = 379)



The SDR survey has six (6) items that assess attitudes towards 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 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, which was shown in the figure below.

- The figure above shows that 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, it was still in the very positive range.
- Prior to the training, 99% of total scores were in either the positive range (119) or very positive range (255). At "post" training, 99% were still in either the range of positive (93) or very positive (282). These results are identical to ones from FY 17-18 where 99% of participants had both "pre" and "post" scores in either the positive or very positive range.
- Prior to training, 67% of participants (255) scored in the very positive range. Post training, 74% scored in the very positive (282), an increase of 7%.

Average Knowledge Score Pre- and Post-Training (n = 374)



The Figure above shows the Average Knowledge Score Pre and Post Training. SDR Outcomes Survey-Adult Version has a seventh item, "Please rate your current level of knowledge about mental health" with five response choices: not at all knowledgeable, somewhat knowledgeable, moderately knowledgeable, very knowledgeable, and extremely knowledgeable. A rise in the knowledge score from "pre" to "post" suggests a participant has increased knowledge about mental health.

- The mean average score improved by (32%) from "pre" to "post."
- Ninety-eight percent (98%) of participants either increased their knowledge about mental illness (118) or showed no change (255) because they were already knowledgeable on the subject matter.
- Prior to the training, 69% selected moderately knowledgeable (184), very knowledgeable (67), or extremely knowledgeable (9). Post training, 96% selected moderately knowledgeable (114), very knowledgeable (198), or extremely knowledgeable (51), an increase of 27%
- Prior to the training, 119 selected either not at all knowledgeable or somewhat knowledgeable. At "post", 86% of the 119 selected moderately knowledgeable (58), very knowledgeable (41) or extremely knowledgeable (10).

The 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 maintained or improved following training; and 2) training helped many participants increase their knowledge about mental health, even for those with moderate knowledge prior to training. Method 2 results based on 6,313 surveys received in FY 18-19 are shown below.

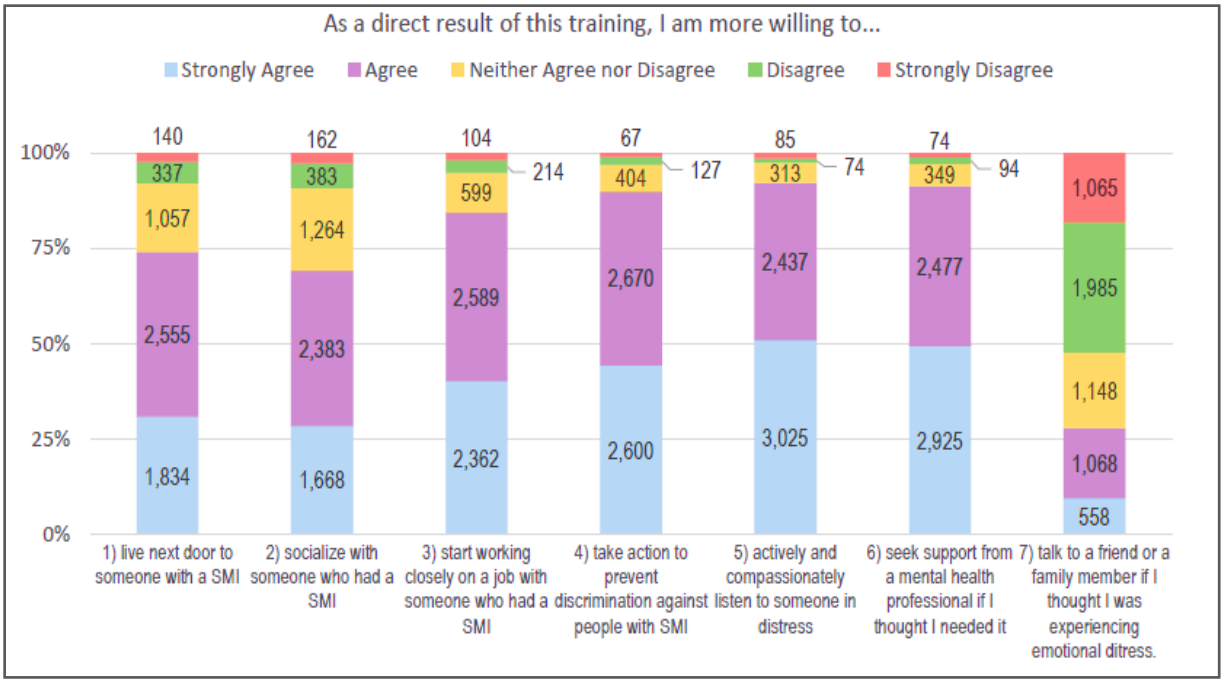
Survey Demographics for Method 2

FY 18-19

Description	Demographic	
Sex at Birth	Female: 72% Male: 9%	Declined to answer: 19%
Gender Identity	Female: 70% Male: 10%	Declined to answer: 19%
Sexual Orientation	Heterosexual: 60% Bisexual: 1%	Another sexual orientation: 1% Declined to answer: 37%
Ethnicity	Mexican/Mexican-American/Chicano: 57% Central American: 11%	Other: 8% Declined to answer: 24%
Veteran Status	Yes: 43% No: 56%	Declined to answer: 1%
Age Groups	Children (0-15): 1% TAY (16-25): 7% Adult (26-59): 64%	Older Adult (60+): 8% Declined to answer: 20%
Disability (n = 6,313)	Yes: 8% No: 68%	Declined to answer: 24%
Primary Language (n = 6,313)	English: 12.4 Spanish: 61%	Other: 6.2% Declined to answer: 20.4%
Race (n = 6,313)	White: 47% Black or African American: 1% Asian: 1%	More than one race: 2% Other: 21% Declined to answer: 28%

Through training and education, SDR trainings are intended to decrease stigma and discrimination against people who have a mental illness and increase knowledge about the topic of mental health. Charts below show changes in behavior.

Survey Responses

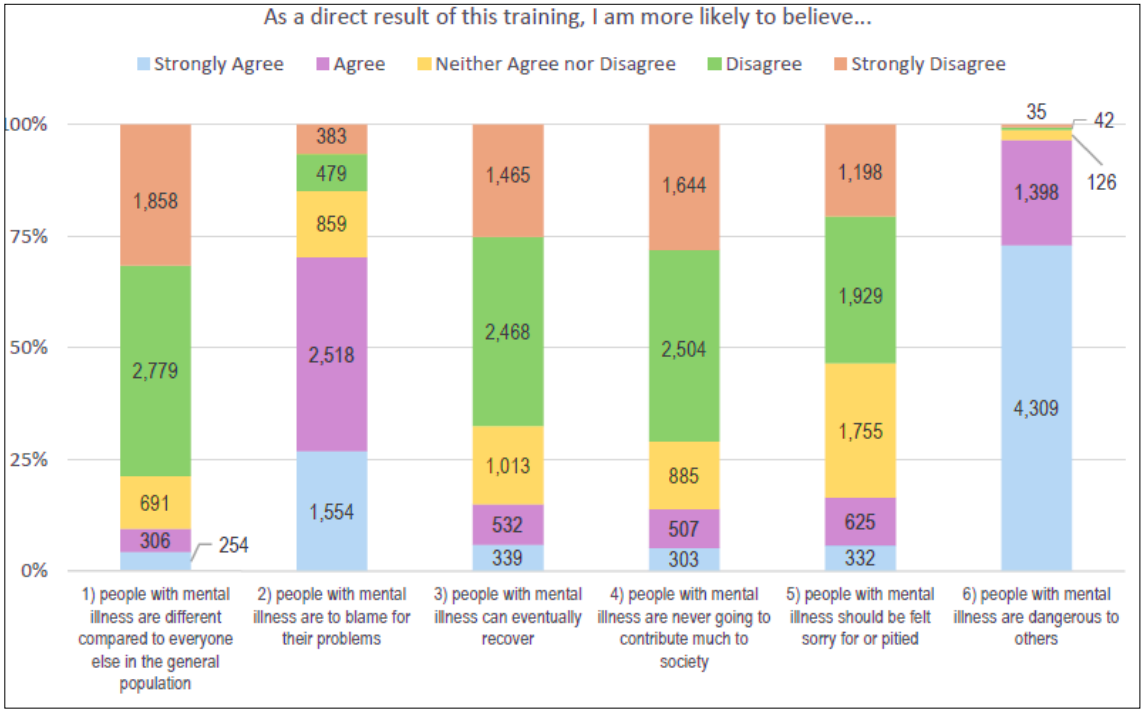


Seven (7) items on the new SDR survey (see the figure of Survey Responses above) assess the impact of SDR trainings on participants' willingness to engaging in behaviors that support rather than discriminate against persons with mental illness. Item ratings are strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. Responses in agreement suggest the participant believes the training positively influenced their future behavior (e.g. willingness to advocate for a person who has a mental illness). Results strongly suggest trainings tended to decrease the likelihood participants will discriminate against and increase the likelihood participants would act in support of people who have a mental illness:

- Across all items, at least two-thirds of participants agreed the training had a positive influence, with:
    - a low of 67% agreeing (36%) or strongly agreeing (31%) the training increased willingness to "live next door to someone with a serious mental illness"
    - a high of 91% agreeing (42%) or strongly agreeing (49%) the training increased willingness to "talk to a friend or family if I thought I was experiencing emotional distress."
- Across all items, 10% or less disagreed, with:
    - a high of 10% disagreeing (7%) or strongly disagreeing (3%) that the training increased their willingness to "live next door to someone with a SMI"

- a low of 3% disagreeing (2%) or strongly disagreeing (1%) that the training increased their willingness to "talk to a friend or family if I thought I was experiencing emotional distress."

Changes in Knowledge and Beliefs



Six (6) survey items (see the figure of Changes in Knowledge and Beliefs above) assess change resulting from attending an SDR training in knowledge about mental illness and beliefs about mentally ill people. Items may be rated: strongly agree, agree, neither agree nor disagree, disagree, and strongly disagree. Responses not in agreement suggest the participant believes training had a positive influence (e.g., decreasing the belief mentally ill people are dangerous) and agreeing to suggest the opposite, for all but the third item. Survey results suggest trainings tended to positively influence participants' knowledge about the topic of mental illness and beliefs about people who have a mental illness.

- Across all items, the majority of participants agreed the trainings had a positive influence, with:
  - a low of 52% disagreeing (34%) or strongly disagreeing (18%) the training increased their likelihood of believing, "people with mental illness are different compared to everyone else in the general population";
  - a high of 71% disagreeing (43%) or strongly disagreeing (28%) the training increased their likelihood of believing, "people with mental illness should be felt sorry for or pitied"

Results suggest SDR trainings tended to positively influence perceptions about people with mental illness, reduce the likelihood of engaging in behaviors that stigmatize and discriminate against persons with mental illness, and increase knowledge about the topic of mental health.

Older Adults Mental Wellness

For FY 18-19, the Older Adult Anti-Stigma and Discrimination Team (OA ASD) was comprised of a Community Services Counselor, a Community Worker, and a Service Extender. Occasionally, other outpatient staff provides assistances, 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 240 events during FY 18-19, outreach to more than 3,456 County residents can be attributed to these events including countywide educational presentations, community events like Resource fairs, community meetings and collaboration with various agencies. Highlights of OA ASD's accomplishments include:

- Outreached to over 3,456 individuals in Los Angeles County
- Provided over 240 presentations for seniors
- Participated in 4 Resource Health Fairs
- Increased number of workshops in SAs 2 and 8
- Developed another new presentation "Emotional Intelligence" and "Meditation and Mindfulness" to be added to the menu of topics for the Mental Wellness Series.

OA ASD provided prevention services primarily by increasing awareness of Mental Wellness for older adults throughout the County, particularly among underserved and underrepresented communities. OA ASD team continued to develop new presentation topics for seniors. The team collaborates and coordinates with LACDMH contracted agencies to provide clinical back-up and at times coordinate for other languages at the presentations when needed.

Presentations by Service Area

Service Area (SA)	Area	Number of Presentations
SA 1	Antelope Valley	4
SA 2	San Fernando Valley	72
SA 3	San Gabriel Valley	34
SA 4	LA Metro Area	30
SA 5	West LA Area	21
SA 6	South LA Area	14
Total		240

The table above shows the distribution of presentations offered throughout L.A.

County. In comparison to OA ASD initially began providing presentations for older adults, which required intensive outreach efforts, housing managers in senior housing and activity coordinators in senior centers sharing the information with each other and now contact the OA ASD Team to request presentations daily.

Location of Presentations

Type of Facility	Number of Presentations
Community Center	7
Senior Centers	66
Senior Housing	144
Other (Library, Church, City Hall)	23

The table above illustrates the type of facilities where presentations took place. In the past, most of efforts focused on settings where large audiences of older adults congregate, such as senior centers. Due to an increase in awareness of the presentations, the number of senior housing complexes increased substantially from last year of 165 to 178.

Presentation Attendance

Facility	Number of Attendants
Community Center	135
Senior Centers	1,323
Senior Housing	1,760
Other (Library, Church, City Hall)	238
Total	3,465

The table above shows the number of attendances at the different facilities. Although there were only 66 Senior Centers visited, they had a larger number of participants (1,323) in comparison to 144 Senior Housing Facilities (1,760).

Presentations in Various Languages

Language	Number of Presentations
Spanish	67
Korean	8
Farsi	3
Mandarin	7
Russian	9

The table above shows the languages other than English provided for the presentations: Spanish, Korean, Farsi, Russian and Mandarin. Request for Spanish has increased due to centers sharing information on the Wellness series.

Presentation Topics

Presented Topics	Number of Presentations
Bullying	12
Depression and Anxiety	15
Good Sleep	15
Grief and Loss	5
Health, Wellness, and Wholeness	16
Healthy Aging Bingo	28
Hoarding	22
Holiday Blues	30
Isolation	6
Life-Life Transitions	12
Medication Management	7
Preserving your Memory	25
Resiliency	15
Elder Financial Exploitation: Scams	16
Stress Management	3
Substance Use	2
Emotional Intelligence	7
Other (Resource fairs, community meetings)	4

A variety of topics were requested from the Mental Wellness Series and presented. The "Holiday Blues" presentation was very popular during the holidays as it addresses challenges faced by seniors who have experienced losses or feel alone during the holidays and provides some strategies to combat feelings of sadness. The presentation on "Hoarding" provides helpful information on the difference between hoarding, collecting and cluttering. It helps seniors understand the illness and how to get or help others.

Source: Mental Health Services Act-Three Year (MHSA) Program & Expenditure Plan,
FY 20-21 through 22-23.

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.

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.

FBAC is comprised of clergy, faith community members, and lay leaders of diverse congregations throughout Los Angeles County. FBAC holds monthly 2-hour meetings at various locations, convening participants in discussions and presentations on topics of spirituality and mental health.

FBAC's projects/activities contribute to LACDMH's provision of culturally and linguistically competent services by welcoming individuals and groups of all faith, linguistic, cultural, socio-economic, ability, health, mental health, sexual orientation, and gender identities in Los Angeles County to meet and discuss topics related to spirituality and mental health. Also, FBAC members engage in dialogue, informational presentations, and training experiences that increase their understanding of and access to mental health resources.

FBAC plans for projects that will address cultural and linguistic competent service delivery, reduction of disparities, and access to mental health services. For example, FBAC plans to translate into Spanish and Korean, and widely disseminate the *Spiritual Self-Care Manual and Toolkit: Empowering People in their Wellness and Recovery,* published by LACDMH in 2012. FBAC aims to build the capacity of more faith communities to facilitate spiritual self-care groups in diverse congregations throughout Los Angeles County. Furthermore, the program plans to facilitate training sessions for FBAC participants in English, Spanish, and Korean, on suicide prevention, emotional intelligence, grief and loss, and mental health 101.

SPIRITUALITY: FBAC		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
• Monthly meetings of the Faith-Based Advocacy Council and the Faith-Based Advocacy Council Executive Board	FBAC Council and Executive Board meetings were held on a monthly basis, for two hours each. During this report period, topics covered in presentations by non-profit, community-based organizations and public sector agencies in Los Angeles County included: the risk of psychosis among youth who use	Council meetings, held at a variety of congregations in venues throughout Los Angeles County, convened an average of 30 faith community and lay leaders and DMH outreach and

SPIRITUALITY: FBAC		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
	marijuana, supporting people living with mental illness, volunteering with law enforcement agencies to assist victims of traumatic events, and learning about diverse faith communities' efforts to increase mental health and socio-economic wellbeing.	engagement staff to share information on the integration of spirituality and mental health. Executive Board meetings convened 12-15 faith community leaders to plan Council meetings and prioritize topics.
• Participation in training related to cultural competency	The conference on the Moral Injury: Pathways to Recovery was held on May 29 - 31, 2019. LACDMH partnered with Volunteers of America (VOA) to host a three-day conference on Moral Injury at the University of Southern California (USC), the FBAC participated in trainings and helped organize it with clergy and led a booth at the event. • Faith/spiritual community leaders, stakeholders, staff, and community members learned how to help people who have experienced trauma, violence, and/or war. The conference focused on the concept of moral injury and evidence-based healing modalities. Leading experts in the field presented seminars on the arts, new research, and spiritual and community responses. Work groups on research, policy, and practice related to moral injury convened over the course of the three-day intensive training experience. • Learning Session Topics: Leaving Prison Before You Get Out, Resilience Strength Training for Veterans, Transforming Moral Injury Across the Professions, Social and Emotional Arts on a Shoestring, Evidence-Based Intercultural Spiritual Care, Insights into Moral Injury from	387 attendees (including 323 registered attendees, 14 VOA staff, 8 DMH staff, 42 faculty/presenters) participated in a variety of plenary, workshop, and work group sessions. Chaplains certified with the Board of Chaplaincy Certification, Inc., were awarded contact hours for continuing education credit.

SPIRITUALITY: FBAC		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
	Jewish Texts, Moral Injury among Child-Welfare Involved Parents, Professionals, and Youth, Spiritual and Community Responses to Moral Injury, War-Related Moral Injury, Transforming Spiritual Impasse, and Spiritual Care of Veterans and their Families.	

Workforce Education Training (WET)

The WET Division coordinates the majority of Department-wide training offerings for Directly Operated and Contracted programs. The WET Division is tasked with full responsibility for the implementation of the MHSA–WET Plan in Los Angeles County.

MHSA WET funded projects are focused on at least one of the following:

- 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
- Train the mental health workforce about the consumer culture and the promotion of hope, wellbeing, and recovery
- Culturally responsive and linguistic enhancement of interpreters and the clinicians that utilize them

WET		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
1) <u>Training and Technical Assistance: Public Mental Health Partnership (PMHP)</u> The mission of the University of California, Los Angeles (UCLA)-LACDMH PMHP is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across the County; and to do so in the context of a transparent, trusting partnership with LACDMH that generates benefits for both UCLA and public health communities. The PMHP is comprised of two sections focused on serious mental illness - the Initiative for		

WET		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
Community Psychiatry (ICP) and the FSP Training and Implementation Program.		
2) <u>Navigator Skill Development Program</u> • Health Navigation Certification Training This program trains individuals employed as community workers, medical case works, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. • Family Health Navigation Certification Training This program trains staff working with family members of children served in the public mental health system to navigate and advocate medical concerns on behalf of their children's needs in both the public health and mental health systems. • Interpreter Training Program (ITP) ITP offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English speaking mental health providers.		During FY 18-19, this training was offered to 40 participants. During FY 18- 19, this training was offered to 40 participants. 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
3) <u>Learning Net System</u> LACDMH is developing an online registration system that manages both registration and payment for trainings and conferences coordinated by LACDMH.		This system is being developed in multiple phases and projected to be completed FY 20-21.
4) <u>Charles R. Drew Affiliation Agreement - Pathways to Health Academy Program</u> This academic and internship program is for high school students in Service Area 6 interested in behavioral health careers including mental health.		During FY 18-19, 14 students participated, with 93% representing un- or under- served communities. Of these students, 57% spoke a second language.
5) <u>Intensive Mental Health Recovery Specialist Training Program</u> This program prepares individual, mental health consumers and family members, with a minimum of 2 years of college		

WET		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
credit, to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor and 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.		During FY 18-19, 45 individuals completed the training. Of these participants, 76% represented individuals from un- or under- served populations, and 51% spoke a second language, other than English.
6) <u>Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System</u> • Parent Partners Training Program This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. • Parent Partner Training Symposium The three-day symposium was held twice during the fiscal year and was attended by approximately 200 parent partners, each symposium.		The training program supports employment of parents and caregivers of children and youth consumers. During FY 18-19, 259 parents were trained. These training opportunities covered a wide range of topics including 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; suicide prevention, etc.
7. Continuum of Care Reform (CCR) CCR provides comprehensive transformation of foster care system with the intent of achieving permanency planning for foster youth and their families. LACDMH provided the following trainings:		

WET		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
• Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families • Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth and Families • Integrating a Peer Support Program into Children and Youth Serving Systems • Being in the Child Welfare System: A Youth Perspective • Child and Adolescent Needs and Strengths (CANS) Overview • CANS – Training of Trainers • CANS – Transformational Collaborative Outcomes Management (TCOM) for Thought Leaders • Permanency Values and Skills for Child, Welfare, Probation and Mental Health Professionals		
8) Financial Incentive Programs • Mental Health Psychiatrist Student Loan Repayment Incentive Eligible psychiatrists who have not participated in or have received funds from the Mental Health Psychiatrist Recruitment Incentive program, receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000. • Mental Health Psychiatrist Recruitment Incentive Program This program targets recruitment of potential Mental Health Psychiatrist for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in LACDMH and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at LACDMH, and an additional payment of $25,000 upon completion of the second year of continuous service. • Mental Health Psychiatrist Relocation Expense Reimbursement Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by LACDMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves LACDMH within one-year from employment start date, the full reimbursement amount must be repaid.		During FY 18-19, a total of 17 mental health psychiatrists where awarded. Of these awardees, 13 (76%) identified as representing ethnic minorities and 7 (41%) spoke a second language. During FY 18-19, one individual was recruited and awarded. During FY 18-19, 2 individuals were awarded, with 100% representing under or un- served communities and one (50%) speaking a second language. During FY 18-19, this program awarded stipends to 4 Nurse Practitioner, 70 MFT and 70 MSW students. During

WET		
Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
• Stipend Program for MSWs, MFTs, and Psychiatric Nurse LACDMH provides second-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 service the traditionally unserved and underserved populations of the County.		this award cycle, all stipends were awarded. During this cycle, 82% of recipients identified from populations recognized as un- or under- served. Likewise, 71% spoke a threshold language. In addition to the stipends, 6 post-doctoral fellows were also funded as part of the Department's Psychology Post-Doctoral Fellowship Program.

Criterion 3 Appendix

Attachment 1: Acronyms

Attachment
1_Acronyms CR 3_Upc

Attachment 2: MHSA Three Year Program and Expenditure Plan FY 17-18 through FY 19-20

MHSA 3 yearplan FY
17-18 through FY 19-2

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 18-19

Criterion 4

Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

August 2020

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 competence in all Los Angeles County Department of Mental Health (LACDMH) operations. Administratively, the CCC is housed within the Office of Administrative Operations (OAO) Cultural Competency Unit (CCU). 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 (SAs)' clinical and administrative programs, front-line staff, and management essential for sustaining the mission of the Committee.

CCC Mission Statement and Motto

"Increase cultural awareness, sensitivity, and responsiveness in the County of Los Angeles Department of Mental Health's response to the needs of diverse cultural populations to foster hope, wellness, resilience, and recovery in our communities." In recognition of the richness of cultural diversity, the committee's motto is "Many Cultures, One World."

CCC Leadership

The CCC is led by two (2) Co-Chairs who are elected annually by members of the Committee. The roles and responsibilities of the Co-Chairs include:

- Facilitate all monthly 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's goals, activities and recommendations at various Departmental venues
- Represent the CCC at the Department's "YourDMH" and UsCC Leadership meetings, among others

The Department's 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 the Departmental Quality Improvement Council (QIC). This structure facilitates communication and collaboration for attaining the goals as set forth in the Department's QI Work Plan and the Cultural Competence Plan (CCP) to reduce disparities, increase capacity, and improve the quality and availability of services. Relevant CCC decisions and activities are reported to the membership at the monthly Departmental QIC meeting.

For CY 2019, the CCC leadership was composed of:

- CCC Co-Chairs (community representatives)
- Ethnic Services Manager

CCC Membership

The membership of the CCC is culturally and linguistically diverse. For Calendar Year (CY) 2019, the CCC membership reached sixty six (66) members. Of this number, sixteen (16) members are Males and fifty (50) members are Females.

The CCC members specifically reported and described their own racial/ethnic identity exactly as stated below:

- African American
- American
- Armenian
- Asian
- Black, Black American
- Caucasian
- Filipino
- Hispanic, Indigena Latina, Latina, Bolivian, Latino, Mexican, Mexican American, Spaniard/Latino/American Indian
- Irish and German
- Italian
- Japanese
- Jewish
- Korean
- Native Indian
- Spanish
- White

The following thirteen (13) languages were represented in the CCC membership for CY 2019:

- American Sign Language (ASL)
- Armenian
- English
- German
- Hebrew
- Igbo
- Japanese
- Korean
- Portuguese
- Russian
- Spanish
- Swahili
- Tagalog

Additionally, the CCC membership consisted of culturally diverse groups such as consumers, family members, community members, advocates, and LGBTQIA2-S groups. The staff functions of the members included volunteers, administration, management, and front line. Furthermore, diverse organizations were represented in the CCC membership.

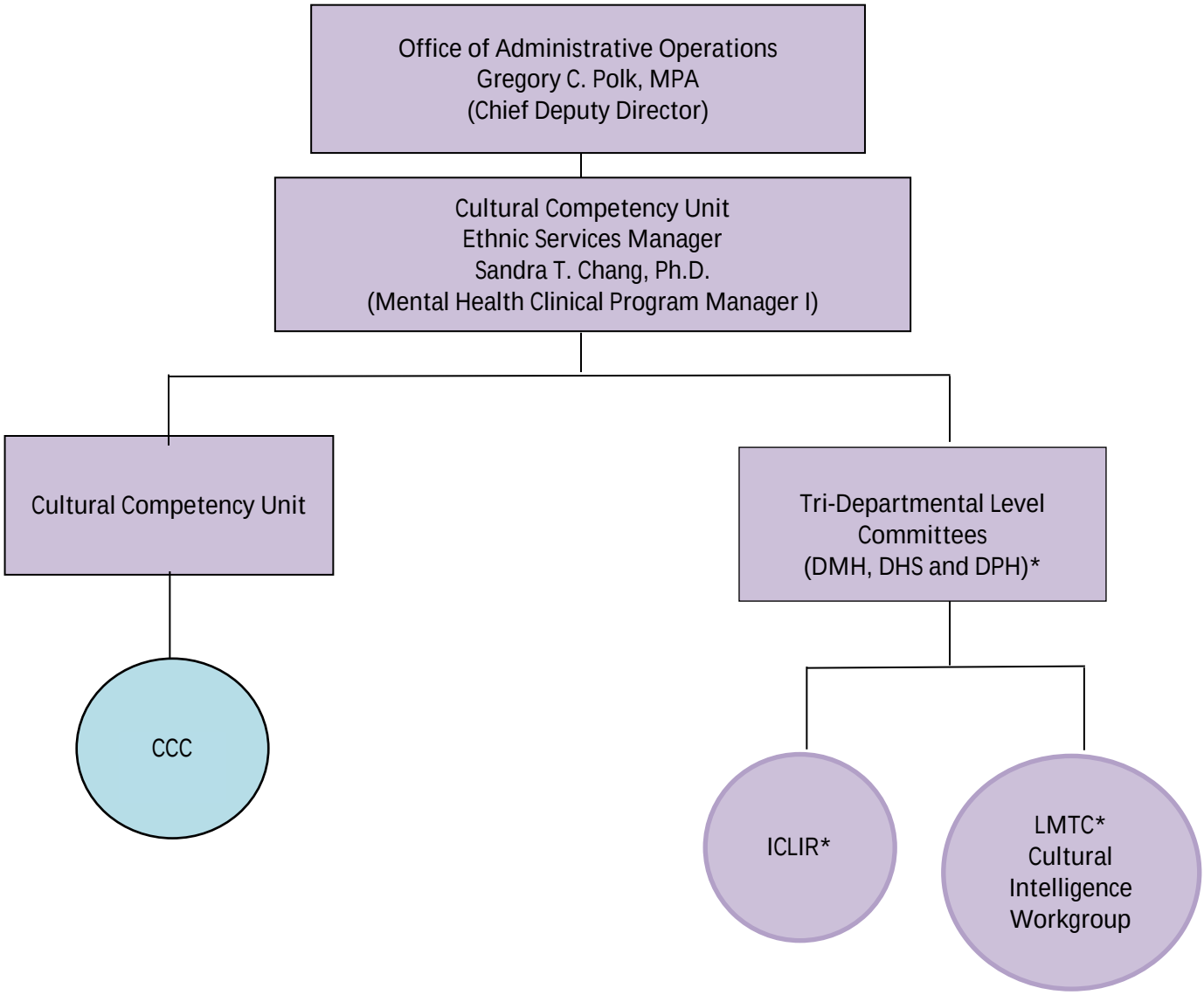
- Consumer-based Organizations:
  - Asian Coalition
  - Disability Rights California
  - Latino Coalition
  - Los Angeles County Client Coalition
  - Peer Resource Center

- Community-based Organizations:
  - Academy of East Los Angeles (AELA)
  - Greater Los Angeles Agency on Deafness (GLAD)

- Directly Operated and Contracted/Legal Entity Providers:
  - Alafia Mental Health
  - Asian Pacific Counseling and Treatment Centers (APCTC)
  - El Centro Del Pueblo
  - Five Acres
  - North East Mental Health Clinic
  - Pacific Clinics
  - San Fernando Valley Community Mental Health Clinic
  - Southern California Health and Rehabilitation Program (SCHARP) & Barbour Medical Association
  - Stars, Inc.
  - Star View Behavioral Health and Community Services
  - The Children's Center of the Antelope Valley
  - Victor Treatment Center

- LACDMH Administration
  - ACCESS Center
  - Service Area Advisory Committee (SAAC) 2
  - Cultural Competency Unit
  - Underserved Cultural Communities Unit
  - Workforce, Education and Training (WET) Division
  - Human Resources

Organizational Chart of the CCC, FY 18-19

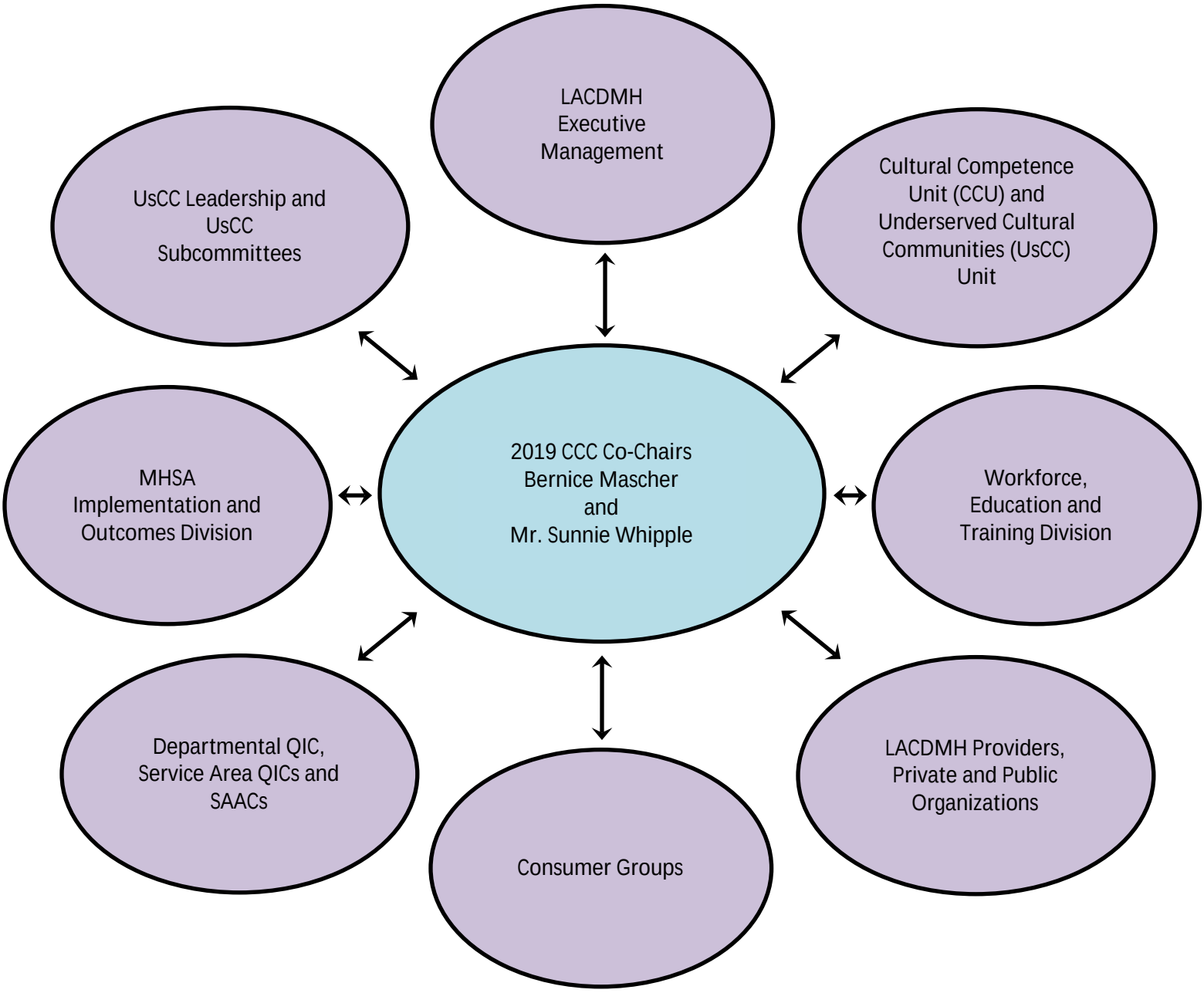


* DMH = LACDMH, DHS = Department of Health Services and DPH = Department of Public Health

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 CCC 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 competence to be addressed, it proceeds to operationalize its goals and objectives. For CY 2019, the CCC membership decided on a model that combines workgroup activities and monthly presentations to ensure cultural competence and linguistic appropriateness in the departmental programs and projects.

Throughout the year, CCC members actively identified initiatives of interest to be presented during monthly committee meetings. At the end of each presentation, the committee provided feedback and recommendations to ensure the inclusion of cultural competence in all LACDMH services. In CY 2019, the CCC engaged in discussions and provided feedback for the departmental programs, projects and policies listed below:

- "YourDMH's Vision and Guidelines" presentation provided by the Underserved Cultural Communities (UsCC) Unit
- The 2018 CCC Annual Report and Work Plan for 2019 provided by the ESM
- Discussion regarding the DMH Policy & Procedure 200.02, "Interpretation Services for the Deaf and Hard of Hearing Community" led by the ESM and ACCESS Center staff
- Discussion regarding the DMH Policy & Procedure 200.09, "Culturally and Linguistically Inclusive Services" led by the ESM
- The "2019 CCC Workgroup: Intergenerational Trauma, Healing and Stigma Reduction – Description, Objectives, and Activities" led by CCU staff
- "Understanding the Complexities of Intergenerational Trauma When Working with Communities of Color" presentation delivered by Dr. Allen Lipscomb
- Multicultural Mental Health Conference Planning: a collaborative effort between the Workforce, Education and Training (WET) Division and the CCU
- Review and Discussion of the Cultural Competency Research Workgroup Handout led by a Co-Chair
- Discussions on the Development of the "CCC's YourDMH Charter" led by the Co-Chairs and the ESM
- Discussion on the Implementation of the Cultural Exchange Segment, titled "Share Your Culture" led by the Co-Chairs
- The "Share Your Culture: Armenia" Presentation provided by a DMH staff
- The "Share Your Culture: Germany" Presentation delivered by a Co-Chair
- The "Share Your Culture: Ecuador" Presentation delivered by a CCC member
- The "Share Your Culture: El Salvador" Presentation delivered by a CCC member
- Discussion regarding a new CCC Project: Development of Cultural Competency Webinars led by the ESM
- Presentation on the LACDMH Bilingual Certified Capabilities provided by LACDMH Human Resources Bureau

Review and Recommendations to County Programs and Services

As an advisory group to the Department as mandated by DHCS' Cultural Competence Plan Requirements (CCPR), the CCC provides feedback and recommendations to various programs. The collective voice of the CCC is also represented at the "YourDMH" 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 competence and linguistic appropriateness are included in new projects and initiatives. The programs and projects reviewed by the CCC in CY 2019 are summarized below:

1. <u>YourDMH's Vision and Guidelines</u>
   In January 2019, the UsCC Unit delivered a presentation on the "YourDMH" Vision and Guidelines to gather input and feedback from the CCC members. The following recommendations and feedback were provided:
   - Develop ways to access to the "YourDMH" meetings with low cost transportation services
   - Re-examine the membership composition of the "YourDMH" and adhere to the Mental Health Services Act (MHSA) in regards to the membership composition rate
   - Consider the housing component in the implementation of the new "YourDMH"
   - Offer stipends for childcare as parent participation is a component that has been overlooked as it relates to stakeholder involvement
   - Provide information on whether each SAAC would work with a specific school or with the school district in the area to negotiate hosting the "YourDMH" meetings
   - Make the "YourDMH" file and information be readable and accessible to the blind community
   - Provide more trainings for the community on leadership, advocacy, and leadership roles in preparation for the implementation of YourDMH

2. <u>The 2018 CCC Annual Report and Work Plan for 2019</u>
   In January 2019, the ESM presented the 2018 CCC Annual Report and the recap of the CCC Work Plans for 2019 based on the group's agreements during the annual retreat held in December 2018. The topics of the work plan included: CCC workgroup, guest speaker presentations, and opportunities to advance cultural competence in the community. The information was reviewed by the CCC membership in order for the committee to make final decisions on its areas of concentration for 2019. The CCC membership was engaged in discussion and

voted on having one workgroup for 2019 and monthly presentations related to cultural competence in the Department and the community.

3. Policy & Procedure 200.02, "Interpretation Services for the Deaf and Hard of Hearing Community"
   In February 2019, the CCC membership welcomed a follow-up presentation on the Policy and Procedure 200.02, "Interpretation Services for the Deaf and Hard of Hearing Community," previously titled "Hearing Impaired Mental Health Access," delivered by the ACCESS Center. The CCC members were informed about the revised draft based on the feedback from the CCC. For example, the wording "hearing impaired" was changed to "deaf and hard of hearing" throughout the policy.

   The CCC membership appreciated the changes and provided the following additional feedback:
   - Provide more information regarding 24/7 access for interpretation services
   - Offer access to scribing services through a mobile application
   - Make an effort to look for vendors who have more capabilities, in particular recognizing the diverse community of Los Angeles County. In regards to interpreters, they must be trained to work effectively in psychiatric settings
   - Emphasize the importance of the partnership between the CCC and the ACCESS Center, specifically in regards to feedback related to any changes to any policies and procedures
   - Coordinate services with interpreters, including ASL interpreters, for meetings, therapeutic sessions, and Psychiatric Medical Response Teams (PMRT) emergency deployment
   - Provide more clarification in regards to "signs in English and other languages, denoting the TTY/TDD telephone numbers" in the Section 3.6 as some wordings are outdated and recommend using "Video Relay Service (VRS)"
   - Provide more training for interpreters in the ACCESS Center or any mental health settings
   - Make sure to translate materials when taking into account the family of the consumer who is deaf and hard of hearing

4. Policy & Procedure 200.09, "Culturally and Linguistically Inclusive Services"
   In March 2019, the ESM engaged the Committee in the process of developing a "Culturally and Linguistically Inclusive Services" Policy and Procedure. The CCC membership had the opportunity to review, discuss, and provide feedback on the draft of the Policy and Procedure 200.09. The CCC feedback and recommendations for this brand new policy included:
   - Add redefinition for "Cultural Identity" to the policy
   - Include the definitions of culture, CCPR and CLAS Standards
   - Include examples of "alternative formats" (i.e., audio and videos) in the following bullet: "DMH makes available written materials as brochures, forms, signage, provider directories, beneficiary handbooks, appeal and grievance

notices, denial and termination notices in threshold languages and in alternative formats that are easily understandable to meet the special language and communication needs of constituents

- Add the words “resilience” and “hope” to the following bullet: “supports consumer-driven and wellbeing programs that are recovery-focused, and rich in opportunities for peer involvement”

5. 2019 CCC Workgroup: Intergenerational Trauma, Healing and Stigma Reduction
In March 2019, the CCC discussed and planned activities for the 2019 CCC Workgroup in regard to name, objectives, and projects. The CCC membership provided the following recommendations:

1) Description
   - CCC members voted and unanimously agreed to keep the name of the workgroup as is “Intergenerational Trauma, Healing and Stigma Reduction.” The CCC affirmed that this workgroup title incorporates all communities of color while also encompassing attention to trauma and genocide.
   - Definition: What is the workgroup about?
     - Child Abuse/Discipline
     - Cultural genocides (i.e., Armenian, Cambodian, Jewish, indigenous communities in countries that experienced colonization)
     - Barriers to service accessibility - Ideas to assist in reducing the stigma
     - Psycho-education for Intergenerational Families with Trauma – culture specific; focusing on youth as they are experiencing the repercussions of trauma from the first and second generations
     - Deferred Action for Childhood Arrivals (DACA)
     - Native American trauma – breaking the norms, cycle of drug use, alcohol use, etc.
     - Working with families to break the cycle of trauma and abuse
     - Historical trauma – how it impacts the intergenerational family units
     - Effects of war trauma– behavior or a sense of shame that is transmitted to children, internment camps
     - The trauma of separation – multigenerational trauma; separation from home, country, land and family
     - Impact of the loss of culture and identity

2) Objectives
   - The following objectives were selected by the Committee members as areas of focus for CY 2019:
     - Raise awareness on the impact of intergenerational trauma
     - Create a collection of recovery/resilient stories that address trauma
     - Develop trainings – with or by the community to train clinicians; training panel

- Develop questions and answers that connect to the trainings to be developed by the CCC

- The following objectives were tabled for CY 2020:
  - Workshops/Presentations on different topics related to intergenerational trauma and include a survey to go with the workshop
  - Develop educational products such as booklets and webinars
  - Summits/Conferences, roundtable discussions, bringing in various groups (i.e., Armenian, Jewish, and Native American communities to share their experiences with genocide)

3) Workgroup Activities
   - Review online research regarding cultural competence, sensitivity, humility diagram
   - Collect stories of trauma, healing and stigma reduction
   - Develop and publish stories – part one: booklet, part two: develop/create a webinar
   - Consider inclusion of a video camera booth – at conferences, where participants sit and share their stories related to trauma and their journey to wellness, resiliency, and hope
   - Package products in a training format
   - Work with UsCC on developing stories

6. <u>Special Presentation on "Understanding the Complexities of Intergenerational Trauma When Working with Communities of Color"</u>
   In April 2019, Dr. Allen Lipscomb was invited to deliver a PowerPoint presentation in regards to Intergenerational Trauma with Communities of Color. The purpose of this presentation was to anchor the goals and activities of the Intergenerational Trauma, Healing, and Stigma Reduction Workgroup. The CCC members received this presentation with great interest and praised the learning opportunity for deepening their insights on the intergenerational trauma issues in culturally and racially minority communities. The presentation highlights included:
   - Historical/intergenerational trauma
   - The complexity of historical trauma and its effects on the individual
   - Trauma reenactment
   - Culture as a protective factor
   - Effects of cultural trauma on the individual and the collective
   - Macro and micro interventions based on cultural sensitivity and cultural humility
   - Factors contributing to resiliency and healing
   - Resources for the community and are these resources meeting the needs of the community

- Intercultural comfort dichotomy: when the consumer is censoring what and how they share information with the therapist based on fear of being hospitalized or services being taken away
- Intracultural congruence dichotomy: when a consumer/client is working with a therapist who looks like the person/client, speaks the same language, etc.

The CCC membership was appreciative of this presentation and provided the following feedback:

- Appreciate focusing research on Intergenerational Trauma, specifically looking at environmental factors that can lead to substance abuse as well as the trauma that is passed down from generation to generation
- Include history of the Native American genocide that occurred on this land and discuss the lack of acknowledgement about it, which may lead to more cultural compassion and the healing of the Native American community
- Provide more clarification in regard to epigenetic
- Use terms with cultural sensitivity (i.e., "healing" is a better word to use than "recovery" from a Native American perspective)
- Inquire what the best treatment modalities could be used to address historical trauma

7. <u>Multicultural Mental Health Conference Planning: Collaborating Effort between the Workforce, Education and Training (WET) Division and the CCU</u>

In May 2019, the CCC meeting was utilized to provide information on the Multicultural Mental Health Conference scheduled for June 18, 2019. The CCU was responsible for planning and implementing this conference. The CCC membership appreciated the information provided by the CCU and discussed the opportunities for participation. The LACDMH's Workforce Development Division (WDD), previously known as the Workforce Education and Training (WET), also joined this meeting to facilitate the CCC members' conference registration in person.

Additionally, an in-depth discussion was held by the CCC memberships regarding their experience attending the Multicultural Mental Health Conference in June 2019. Committee feedback:

- A member commented she liked the whole conference, especially the presentation from Dr. Bryant Marks on implicit bias
- Another member stated that the 2019 Multicultural Mental Health Conference was one of the best well organized conferences
- Another member commented it was a beautiful conference. She particularly enjoyed Dr. Jorge Partida's, LACDMH Chief of Psychology, presentation and stated that the workshops were excellent.
- A member commented that she really enjoyed the conference, but Spanish interpreters did not provide adequate services
- Members were also impressed with the quality of the food served and conference bags

- Several members commented they really enjoyed the Zumba activity
- The resource tables and consumer art exhibits were described as beautiful
- The PowerPoint with inspiring quotes developed by the CCU was "mesmerizing" ·
- Dr. Sandra Chang, ESM and conference chair was especially thanked for making community members in attendance to the conference "feel loved."

8. Review and Discussion of the Cultural Competency Research Workgroup Handout

In June 2019, the Co-Chairs presented the Cultural Competency Research Handout, which included important definitions and research findings regarding on cultural competence, cultural humility, cultural safety and other related topics. This handout summarized the accomplishments under two goals:

- To define cultural competence and find the latest research
- To learn to work better together, with the members, with the Department, and to establish intercultural relationships, including improving communication

The Cultural Competency Research Handout included the following six (6) topics:

1) Related Terms and Definitions
2) Recent Research and Related Information
3) References and Tips for Effective Cross-Cultural Engagement
4) Education, Enhancement and Assessment
5) Models
6) Cultural Competence Across the Continuum

The CCC members were informed about the workgroup research findings and engaged in discussion. After reviewing the Cultural Competency Research Handout, the following feedback was gathered:

- A member shared her own definition of cultural competence as "Living wisely in diversity"
- The membership agreed to advocate for multicultural awareness and all underserved groups
- A suggestion was made to implement an on-going agenda item dedicated to highlight different cultural groups during monthly meetings
- A strong emphasis was made on the importance to also recognize diversity within a given cultural group
- The Co-Chairs stated they hope to work with an Indigenous group in Canada, which focuses on Cultural Safety, and learn more about what they do as well as to invite them as future multicultural conference speakers.

9. Discussions on the Development of the "CCC's YourDMH Charter"

In July, August, and September 2019, the CCC membership discussed the development of the CCC's YourDMH Charter. The Co-Chairs facilitated these discussions with the assistance of the ESM. The purposes of the "YourDMH" Charter were defined as follows:

- Identify subcommittee goals, leadership structure and membership specifications
- Develop group priorities, which outline the group structure and operations
- Establish autonomy to incorporate cultural practices
- Specify voting processes, meeting activities, etc.

The content of discussions and feedback gathered from the CCC membership include:

1) Charter Purpose and Core Values
    - Include intentional and deliberate language
        - Prioritize our cultural background, heritage and values
        - Prioritize safe spaces for people to heal
        - Prioritize the values of where individuals come from
        - Provide services "from the heart"
        - Include 'other avenues' for consumers to receive traditional medicine such as natural/holistic medicines as part of their mental health care
        - Suggest the following language: "Look for other avenues to receive wellness"
    - Identify additional core values than the ones currently listed on the YourDMH guidelines and incorporate them in the CCC charter
        - Cultural competence
        - Linguistic appropriateness
        - Spirituality
    - Ensure that the legislators listen to the voice of community members in terms of holistic medicine and other culture-specific means to achieve healing
    - Include State and Federal requirements as related to the CCC functions

2) Structure
    The Co-Chairs led the CCC members' discussion regarding the structure of CCC meetings and solicited input. Members agreed to the following:
    - CCC monthly meetings that are open to the public
    - Attendance is recorded
    - Staff from LACDMH can attend but cannot vote or become Co-Chairs
    - Meeting agendas vary from month-to-month
    - Meetings should be geared toward the group's stakeholder priorities
    - CCC Co-Chairs need to attend "YourDMH" meetings to represent the committee
    - CCC advocates for underserved populations with mental health disparities identified through data review, presentations and meeting discussions
    - CCC holds an annual retreat at the end of each calendar year to review accomplishments, vote on organizational cultural competence areas of concentration, and recruit members for the following year

- CCC reinforces the collaborative team atmosphere among community members

CCC Feedback

- The ESM suggested the following to be added: “Meeting agenda may vary depending on the current activities of the group, community needs and requests for presentations on issues of concern as set forth in the CCPR
- Incorporate accessibility for communities with disabilities and that accommodations should be provided
- Emphasize the importance of CCC representation at other subcommittee meetings (e.g. UsCC or representatives from those subcommittees to come to the CCC meetings)
- Request a budget for projects, the UsCC and Service Area Advisory Committees (SAAC) have their own annual budgets and the CCC does not
- Provide a budget for the CCC to support the outreach efforts, specifically a budget in order to engage SAACs and other communities in CCC meetings; and to support volunteers
- Have the thirteen threshold languages represented at the CCC meetings
- In terms of the composition of the CCC, the members would like to see the following:
  - Ensure that the CCC incorporates the faith-based community
  - Bring the youth perspective to the committee
  - Include persons who have “lived experience” such as consumers, peers, families, youth, young adults, and all age groups
- Suggest that it is important to respect or value the non-traditional spiritual practices of the Native American community in regard to including the faith-based community
- Recommend establishing the difference between religion and being spiritual
- For the charter to include language that addresses “faith-based/spiritual communities representing diverse cultural practices”

3) Membership Composition and Functions

The membership reviewed and agreed to the following functions:

- Participate in Cultural Competence workgroups, projects, and activities
- Actively engage and move CCC goals and projects forward
- Participate in decision-making processes and efforts to accomplish goals of the Committee

CCC Feedback

- Find a way for the information that is covered in the CCC meetings to be made available to the general public
- Make the information available on the Department’s cultural competency webpage

- Utilize technologies that can incorporate to share the CCC meeting topics
- Emphasize that the CCC serves as an advisory group to LACDMH in the charter

4) CCC Workgroups
   - Workgroups are elected annually at the beginning of each calendar year by majority vote
   - Each workgroup will have two co-leads
   - Workgroup reports and updates will be provided at CCC meetings as scheduled for this purpose
   - CCC will provide ongoing monitoring and feedback regarding workgroup activities and products
   - Workgroups will arrange for guest speakers, discussion forums, and other activities

   CCC Feedback
   - Inquire about the possibility of the CCC budget for outside activities
   - Create an intersectionality workgroup, given that younger age groups are choosing to identify themselves by their intersectional identities, to not only highlight their identities and communities, but also to address how intersectionality of health practices can be more beneficial in addressing health disparities

5) Voting Privileges
   Based on the CCC discussion, the charter will include the following:
   - Voting privileges for members who have attended at least 50% of the meetings
   - Membership automatically expires after two years. This applies to members who have not attended a meeting in two years
   - A member may choose to reapply for a new term of membership two months prior to the expiration of their term
   - There are no term limits for regular voting members

   CCC Feedback
   - Offer clear information on the voting process: who keeps track of the voting; how the voting takes place; paper ballot or democratic vote by show of hands
   - Provide information on what happens when there is not enough eligible voters by either phone or in-person
   - Ensure an Ad-Hoc group to include members from diverse backgrounds
   - Emphasize the importance of the CCC voice at “YourDMH” and other departmental meetings
   - The CCC membership agreed to keep the wording as “stakeholders” rather than “members” in the CCC Charter

6) Group Decisions
   - The CCC membership agreed that 75% is a fair vote in regards to voting out members for ethical or behavioral issues
   - The CCC membership agreed to combine the following two statements together:
     - Voting includes decisions to elect or reelect Co-Chairs or other leaders of the group
     - Decisions to remove a current leader of a group
   - Any changes to the CCC Charter or bylaws have to be proposed as official business and conducted during Committee meetings
   - Records of official business proposed, and votes conducted, including tallied votes, must be kept in the CCC meeting minutes

7) Leadership Terms
   - The Co-Chairs commented that some stakeholder groups may have a secretary or a treasurer, however, the CCC presently only has two Co-Chairs. The "YourDMH" guidelines specifies it is important that every group establish and standardize what the group's leadership terms are.

8) Co-Chair Terms
   - Co-Chairs are elected annually by the CCC members, by majority vote
   - Serve for a term of one year with a re-election option
   - Provide leadership for the Committee
   - Motivate member participation and engagement
   - Conduct and facilitate all group meetings as Co-Chairs
   - Determine the agenda for all meetings in cooperation with the CCU
   - Add the website link at the end of the CCC charter
   - The ad-hoc subcommittees will be appointed by Co-Chairs as needed
   - Represent the interests and official positions of the CCC at quarterly "YourDMH" full meetings and other relevant events

9) CCC Budget
   - Request more discussion on the budget and the CCC members agreed to discuss the budget development in the later meeting

10. <u>Discussion on the Implementation of the Cultural Exchange Segment, titled "Share Your Culture"</u>

In July 2019, the CCC membership was asked to provide input on an idea of including exchanging cultural backgrounds and practices as an on-going CCC meeting agenda item. The CCC members were very excited about this project and agreed to include it as an on-going agenda item. The CCC members were invited to sign-up for a ten minute segment to share about the cultures that they identify with. During CY 2019, the committee generated four "Share Your Culture" Presentations. Some of them were developed and delivered by CCC consumer members, thereby affirming their public speaking skills and the power of their voice and experiences to educate others on cultural diversity, social justice, and equity.

The “Share Your Culture” Presentations created an energetic atmosphere during meetings demonstrated by thoughtful discussions, deepened relationships amongst the membership, increased knowledge, and appreciation for the cultural expertise of the group.

11. The “Share Your Culture: Armenia” Presentation
    In August 2019, the first presentation as “Share Your Culture” project was delivered by a DMH staff who presented on the Armenian culture. The presentation included a PowerPoint summarizing the Armenia’s history, geographic information, agricultural products, musical instruments, population, travel attractions, and Armenian genocide. The Committee appreciated the presentation and voiced the importance of remembering the history of genocide across many cultural groups. Additionally, the CCC expressed appreciation and engaged with the presenter asking multiple questions to increase their knowledge regarding this culture, practice some words in Armenian and enjoyed the Armenian food shared by the presenter.

12. The “Share Your Culture: Germany” Presentation
    In September 2019, a Co-Chair delivered the “Share Your Culture” presentation on Germany. She spoke about her personal story and experiences pertinent to the diverse cultures was exposed to while growing up in Germany. She introduced the membership to German cultures inclusive of languages, history, patterns of immigration, diverse communities, social interaction styles, and common stereotypes. The presenter also introduced committee members to different German foods, which the CCC members enjoyed. The membership responded with great interest and appreciation for the information shared by the presenter.

13. The “Share Your Culture: Ecuador” Presentation
    In October 2019, the CCC membership welcomed a presentation on Ecuador. This presentation was delivered by a CCC consumer member and his parents, who are also members of the committee. The content included the origin of country’s name, diverse cultures, geography, nature and biodiversity, tourist attractions, general history, agricultural products, and languages. Ecuadorian food was also brought by the presenter and the Committee praised this elaborate presentation which also included an exhibit of Ecuador’s national emblems, photographs, paintings and other artifacts.

14. The “Share Your Culture: El Salvador” Presentation
    In November 2019, the CCC membership was exposed to a presentation on El Salvador provided by a CCC consumer member. The presenter developed a PowerPoint which included detailed information regarding her country’s geographical location, national emblems such as its flag and what each symbol represented, populations inclusive of indigenous communities, languages, religions, foods, tourism, nature, agricultural products exported to other countries, history, immigrant influences, civil war, and social justice issues. The CCC membership welcomed this presentation with deep appreciation and praised the presenter for all her dedication to providing a comprehensive overview with

personal highlights that brought the information to life. The members also enjoyed the cultural artifacts and Salvadoran food shared by the presenter. Additionally, this presentation affirmed the experiences of other Salvadoran committee members who committed to participating in the future recording on this presentation.

1. Discussion on a new CCC Project: Development of Cultural Competency Webinars
   In October and November 2019, the CCC membership was informed that, in response to the knowledge gaps identified by the CC Organizational Assessment Survey results, the CCU was planning to develop a series of the Cultural Competence Webinars.

   - The ESM proposed the idea of the CCC creating a webinar as a final product for the 2019 "Intergenerational Trauma, Healing and Stigma Reduction" Workgroup
   - The members reached the agreement that this webinar will give the CCC visibility and create an impact in the training of staff
   - Possible additional webinars could include the "Share and Show Your Culture" information

   The recommendations and input gathered from the Committee include:
   - Webinar to developed separately from CCC monthly meetings
   - Include "Share Your Culture" presentations to be recorded as CCC webinars on cultural diversity and client culture
   - Recommend creating a panel presentation that could be recorded and the topic would be connected to the "Intergenerational Trauma, Healing, and Stigma Reduction" workgroup
   - Ensure that CCC presenters discuss and agree on the message the CCC would like to disseminate
   - Suggest recipes made available for the CCC members as well as having a gift for the member who is presenting in the "Share Your Culture" segment
   - Seven (7) CCC members agreed to be presenters for the "Share Your Culture" Webinar
   - Eleven (11) CCC members agreed to collaborate in the development of the "Intergenerational Trauma, Healing and Stigma Reduction" Webinar

Human Resources Report

Presentation on the LACDMH Bilingual Certified Capabilities

In December 2019, LACDMH Human Resource Bureau delivered a presentation on the bilingual capability of Department and its bilingual certification process for employees. The presentation covered the following:

- Compensation is paid to employees who are required to use a language in addition to English on a frequent and continuing basis
- Policies or references; County Code 6.10.140

- Eligibility for Bilingual Bonus: permanent or temporary employees may qualify for bilingual bonus if their assignment requires fluency in a foreign language (including American Sign Language)
- Employee must possess knowledge of and sensitivity to the culture and needs of the foreign language clientele
- Certification - Upon determining a bilingual need exists, the Department must certify that the employee possesses the required fluency in the requested foreign language
- A specific assignment may require any one or a combination of reading, writing and speaking fluency
  - Upon successful testing, the employee is certified
  - Request to initiate the bilingual bonus is entered in the Personnel Action Request (PAR) system and continues until the employee's assignment no longer requires use of the bilingual proficiency
  - Bilingual Bonus is terminated if the employee is out on leave for 60 days or more. If the employee's job changes or the employee goes to a location where there is no longer a need for bilingual certification, then the bonus will be terminated
- Data regarding languages represented by DMH's workforce
  - LACDMH has approximately 5,300 employees
  - Approximately 1,860 receive a bonus for speaking, reading and writing in another language
  - LACDMH pays bilingual bonus for 40 different languages. If there is a specific language not listed and there is a need for it, the Department will approve the language and certify the employee once the employee has successfully passed the bilingual certification test
- Recruitment
  - HR sends out canvass letters for bilingual language proficiency based on the needs of each area
  - Programs may call HR to request a canvassing of a certification list to meet the language needs of the unit
  - LACDMH will test employees who respond to canvass letters to ensure they are proficient in the second language
  - Some exams are specifically for Spanish-speaking because of the high demand in the client population
- Exam Process
  - Participants who are required to speak in the subject language must be able to converse on matters ranging from activities of daily living to business arrangements
  - Employees must achieve a grade of "acceptable" or better to pass the bilingual exam
  - Testing is done on an individual basis
  - If successful, a bilingual proficiency certificate is issued to the employee

  The feedback and questions from the CCC membership included:

  - A CCC member asked what is the final score an employee must have to pass the test and HR staff replied there is a standard testing form that is utilized by DHR across the board. The categories by which fluency is measured are reading, writing, and fluency

- Another member asked if the certificate for fluency is available to consumers. HR presenter confirmed that the bilingual certification is only available for LACDMH temporary or permanent employees. The certification is also available to contracted employees, if they are working for LACDMH for a temporary basis
- A member asked to provide more detailed information about the exam and presenter responded that the test consists of testing the employee's speaking, reading, writing fluency.

Cultural Competence Organizational Assessment

LACDMH conducted a system wide organizational assessment, which surveyed 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, management, and administration staff functions
- Review of the focus group's 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 were provided in a comprehensive report that summarized the findings. This information will inform future cultural and linguistic competence strategies to reduce mental health disparities. The Department will continue utilizing these recommendations to improve its system of care in the area of cultural and linguistic competency. *See Criterion 8 for detailed information.*

The CCC discussed and agreed to focus on the strategic areas identified in the LACDMH Cultural Competence Organizational Assessment. These strategic areas include:

- General knowledge regarding cultural competence, mental health disparities, equity and inclusion
- Culture and language-based services provided by the Department
- Departmental strategies to reduce stigma and mental health disparities
- Policies and Procedures pertinent to cultural and linguistic competence
- Workforce development and engagement
- LACDMH committees that address cultural diversity
- Cultural Competence trainings

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.

Training Plans

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.

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

CULTURAL COMPETENCE PLAN UPDATE – FY 18-19

Criterion 5

Culturally Competent Training Activities

August 2020

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 Requirements, which affirm 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 their 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 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.

- This policy enhances staff capabilities to carry out mandated requirements associated with their positions.
- 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 Division (OAO – WET) regarding new training needs.
- Supervisors may authorize or require an employee's attendance at any approved in-service training conducted within LACDMH. The in-service training must be job related and should directly add to her/his work performance.

Table 1: LACDMH Three-Year Training Plan, FY 17-18 through FY 19-20

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 17-18		
Innovative training feature • 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: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing Specialty Mental Health Services (SMHS)
Training alternative 1 • Foundational cultural competence trainings o Diversity Skills for the 21st Century Workforce o 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: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS
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 OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 3 • Annual cultural competence related conferences	• Same as above	• 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	• 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: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS
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

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
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: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS
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	• Same as above

	(Administrative Programs)	
TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
<u>Training alternative 4</u> • 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
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

Training alternative 2 • Cultural Competence related – SMHS offered by the OAO-WET Division. Examples of brand new trainings: o DMH Clinicians: Culturally Competent COVID-19 Mental Health Intervention with Faith-Based Organizations and Churches o Resilience Check-ins with DMH Clinicians involved in the Speaker's Bureau	• 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 o Introduction to interpretation in mental health settings o Advanced mental health interpreter's training o Use of interpreter services in mental health settings • Increasing Mental Health Clinical Terminology in specific threshold language (i.e. Armenian, Korean, Mandarin, and Spanish)	• 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
Refers to any trainings, inclusive of conferences that have been introduced to the cadre of offerings provided through the OAO-WET Division

B. Foundational Cultural Competence Trainings

- "Cultural Competency (CC) 101"
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 has been made available to the entire LACDMH workforce, inclusive of Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs.

  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"
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.

- "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 may 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.

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. ***See section II below for specific details.***

D. Language Interpreters Series

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. 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.

- Advanced Interpreting in Mental Health

  This training is designed specifically for the clerical and clinical staff who facilitate bilingual and bicultural communication in Family and Mental health settings. The training will provide the knowledge and skills necessary to be effective when facilitating communication between mental health providers and limited English proficient (LEP) consumers. The ethical principles that guide the work of Mental Health Interpreting and the ethical decision-making process are addressed. Exercises, group activities, role-playing, and videos are incorporated in the training to enhance integration of material. This is not a language enhancement program. However, resources to access Mental Health terminology in several languages are provided. The use of psychometric tests across languages is not included.

- Cross-Cultural Communication and the Therapeutic Use of Interpreters

  This workshop is designed to train monolingual English-speaking psychiatrists and clinicians to work effectively with interpreters and to ensure equality of access and service delivery in meeting the requirements of Federal and State laws. This workshop offers practitioners an opportunity to enrich their understanding of the diverse idioms of distress; culture bound syndromes, cultural constructions, and explanatory mental health beliefs. It provides participants with knowledge and skills to understand the unique dynamics that play out in the therapeutic triad among the provider, consumer and interpreter. Some of these dynamics include language, culture, verbal and non-verbal communication, and communication in low and high context culture. Strategies to improve communication and service delivery within the therapeutic triad are outlined and practiced. To maximize effective communication, techniques are modeled and practiced throughout the training session.

- 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 conducted in Mandarin.

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.

- Candidates tested for bilingual proficiency as part of the examination process, if successful, are issued a Language Proficiency Certificate.
- 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.
- 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 18-19)

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 of FY 18-19 offerings include:

- Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
- Supervision of Peer Specialists Training
- Addressing Stress Burnout

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

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 2: Examples of materials used to inform programs of the annual cultural competence training requirement)

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 3: 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 Cultural Competence Plan Requirements, PowerPoint explaining the NACT elements and utilization to track trainings)

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

  (See Attachment 4: LACDMH Legal Entity contract)

II. <u>Annual Cultural Competence Trainings</u>

LACDMH provides over 300 training offerings during each Fiscal Year (FY), with topics covering a wide spectrum of culturally relevant issues: race/ethnicity, age group, underserved cultural populations, lived experience concerns, language interpreter trainings, and culture-specific conferences. 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 5: Inclusion of Cultural Responsiveness in Trainings)

Furthermore, the OAO-WET Division tracks 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 6: LACDMH Training Evaluation Form).

Trainings offered by the OAO-WET Division are in accordance to areas of cultural competency content specified in the Cultural Competence Plan Requirements. Each year, the CCU collaborates with the OAO WET Division in conducting a brief analysis to determine the content themes represented of each training. This practice allows LACDMH to ensure that cultural competence trainings expose staff to various levels of skill acquisition. Examples of training content themes include:

- Cultural formulation
- Multicultural knowledge
- Cultural sensitivity
- Cultural awareness

- Client culture/family inclusion
- Social/cultural diversity
- Service integration and outcomes
- Co-occurring disorders
- Language interpreter services
- Underserved populations (i.e. justice-involved, homelessness, gender, sexual orientation and age group specific, among several others)

(See Attachment 7: Cultural Competence Trainings by Content Category)

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Table 2: Examples of cultural competence-related specialty mental health trainings offered by the OAO-WET Division, FY 18-19

Title of Trainings
Adult
Addressing Challenging Behaviors and Problem-Solving/Decision-Making Process
Sex Offender Assessment, Treatment and Management
African American
Substance Use and Treatment Among African Americans and Transitional Age Youth
American Indian/Alaska Native
Substance Use and Treatment Among American Indian/Alaska Native Youth
Asian Pacific Islander (API)
Applied Suicide Intervention Skills Training (ASIST) - Korean
Recovery 101 & Peer Support 101: Effectively Integrating API Peers Into Clinical Treatment Team
Children
Advanced Parent Child Interaction Training
Behavior Talks: Helping Caregivers Manage & De-escalate Challenging Behaviors in Children and Youth
Commercial Sexual Exploitation of Children 101
Commercial Sexual Exploitation of Children and Youth (CSECY)
Commercial Sexual Exploitation Identification Tool (CSE-IT)
Commercial Sexual Exploitation of Children (CSEC) 101 for Community Agencies
Integrating a Peer Support Program into Children and Youth Serving Systems
Shared Core Practice Model with an Emphasis on Underlying Needs
Treatment of Infants with Substance Abusing Mothers: An Interdisciplinary Approach
Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population
Treatment of Infants with Substance Abusing Mothers: An Interdisciplinary Approach
Children's Making of Meaning of Their Self in Relation to the World of People, Things and Their Own Self
Being in the Child Welfare System: A Youth Perspective

Title of Trainings
Building Capacity through Intergenerational Family Networks
Conferences
24th Annual Asian American Conference
8th Annual Multidisciplinary Assessment Teams Provider Conference
Mental Health Multicultural Conference
American Indian/Alaska Native Conference
LGBTQIA2-S Conference
Asian Pacific Islander Conference
Deaf Mental Health
How Deaf Mental Health is Unique
Eating Disorders
Treating disordered Eating with Cognitive Behavioral Therapy (CBT-E)
Foster Care
Being in the Child Welfare System: A Youth Perspective
Gender
Helping Women Recover (HWR): A Gender-Responsive Treatment Program for Trauma and Substance Abuse
Healing Trauma: A Brief Intervention for Women
General Cultural Competency
Cultural Competence: Becoming an Ally
Cultural Humility
Culture Communication Self Reflection
HIV/AIDS
HIV Assessment and Treatment in the Age of Survival
Hoarding
Harm Reduction and Hoarding
Older Adults and Hoarding Disorder
Homelessness
Co-Morbidity of Personality Disorders, Homelessness and Substance Abuse

Title of Trainings
Housing Liaison Specialist Training
Fair Housing
Housing 101
Implicit Bias
Acknowledging and Managing the Hidden Bias of Good People: Implications for Los Angeles County Employees and the Communities they Serve
Implicit Bias Workshop
Justice System
Motivational Interviewing in Forensic Contexts
Fundamentals in Effective Work with LGBTQI2-S Youth in the Juvenile Justice System
Adapted DBT Core Training for Juvenile Justice Staff
Adapted Dialectical Behavior Therapy (DBT) for Juvenile Hall Staff: Part 1 Introduction
Adapted Dialectical Behavior Therapy (DBT) for Juvenile Hall Staff: Part 3 - Program Evaluation, Planning and Sustainability
Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
Dialectical Behavior Therapy (DBT) For Justice Involved Consumers
Engaging Probation Youth
Forensic Issues In Mental Health Treatment
Integrating Dialectical Behavior Therapy (DBT) into Individual Treatment with Juvenile Justice Youth
Motivational Interviewing in Forensic Contexts
Professional Roles and Boundaries in Juvenile Justice Settings
Safety And Crisis Prevention/Interventions When Working With Forensic/Justice Involved Consumers
Seeking Safety Initial Training for Juvenile Justice Mental Health
Sex Offender Assessment, Treatment and Management
The Invisible Wound: Promoting Healing Via Trauma Informed Care Consciousness- Forensic Focus
Trauma Informed Treatment Approaches for Juvenile Justice Involved Youth: Theory and Practice
Addressing Challenging Behaviors and Problem-Solving/Decision-Making Process
Latino
Assessment and Diagnostic Considerations Across the Lifespan: Latino Consumers
The Mental Health Needs Among LatinX Immigrant Children and Families
Assessment and Diagnostic Considerations Across the Lifespan: Latino Consumers
Community Models which Promote Mental Health Support for Latinos

Title of Trainings
Entrenamiento de Especialista de Pares CORE
Emotional CPR - Spanish
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit (LGBTQIA2-S)
Addressing Street Drugs and Sexual Health In the LGBTQ+ Community: Understanding the Connections
LGBTQ+ Competency Training: Knowledge for Reducing Barriers to Permanency for LGBTQ and Gender-Variant Children/Youth in the Child Welfare System
Core Practice Concepts in Working with LGBTQ Youth
Diverse LGBTQ+ Coming Out Issues: Ways to Build Resilience in the Face of Family and Community Adversity
Fundamentals in Effective Work with LGBTQI2-S Youth in the Juvenile Justice System
Mental Health Interpreter Training
Introduction to Interpreting in Mental Health Settings
Cross-Cultural Communication and the Therapeutic Use of Interpreters
Increasing Mental Health Clinical Terminology - Armenian
Increasing Mental Health Clinical Terminology - Korean
Increasing Mental Health Clinical Terminology - Mandarin
Increasing Mental Health Clinical Terminology - Spanish
Introduction to Interpreting in Mental Health Settings
Advanced Interpreting in Mental Health
Middle Eastern
Stigmatized and Taboo Topics: Working With Middle Eastern Refugees
Understanding the Intergenerational Transmission of Genocide Trauma
Multi-Age Groups
Intersectionality-Poverty and Chronic Stress in Vulnerable Populations
Parent Partners
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
Parent Partners Training Program
Parent Partner Training Symposium
Peers

Title of Trainings
Core Peer Specialist Training
Core Peer Specialist Train the Trainer
Integrating a Peer Support Program into Children and Youth Serving Systems
RECOVERY 101 And Peer Support 101
Strategies for an Effective Peer Workforce
Intersectionality-Poverty and Chronic Stress in Vulnerable Populations
Suicide Prevention
Recognizing and Responding to Suicide Risk (RRSR) Essential Skills for Clinicians
Suicide Prevention Summit
Recognizing and Responding to Suicide Risk
Supervisors/Management
Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
Supervision of Peer Specialists Training
Addressing Staff Stress Burnout
Transition Age Youth (TAY)
Trauma Informed Care for TAY

Total number of unique trainings = 99

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 18-19*

Program Name	Title of Trainings
Outpatient Services Division	• Older Adult Consultation Medical Doctor's Series • Community Diversion and Re-Entry Program for Seniors Training and Consultation Series: Team was offered to mental health staff with professional expertise in geriatric medicine, gero-psychiatry, case management/community resources, substance use, and other resources. The ongoing training & consultation is designed to upgrade the training knowledge base and skills of all mental health staff through case presentation and consultation • Public Speaking Club Graduate Curriculum: LACDMH held Speaker Club graduate programs for consumers who successfully completed Public Speaking curriculum to enhance and practice on their public-speaking skills • Older Adult Legal Issues/Elder Law Trainings and Consultation: As part of ongoing multi-disciplinary Older Adult Consultation team trainings, LACDMH provided training and Elder Law consultation, curriculum training development and coordination on Elder Law for LACDMH and LACDMH-contracted clinical and nonclinical staff on best practices for working with older adult populations • Hoarding Forum: The training provides information on the differences between interventions and treatments for hoarding disorder. It describes cultural, socioeconomic, health and safety factors related to hoarding. In addition, the training covers the importance of an accurate physical and mental health assessment in developing an effective hoarding intervention plan
Continuum of Care CCR	• Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families: This training addresses, the psychological hazards associated with the provision of care to children, youth and families with trauma histories. It specifically addresses the impact of various traumatization on clinicians as well as supervisors of clinicians who work with the complexly traumatized. The role of effective competency-based supervision implementation is emphasized as a protective factor for clinicians and as a facilitative factor for treatment efficacy for clients. It provides supervisors with current information in competency-based supervision and how this can be applied to clinicians involved in trauma-informed care. This training offers subsequent booster sessions to reinforce concepts learned. • Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families: This 6-hour training reviews the use of competency-based supervision as a methodology to ensure that the essential components of trauma-informed care are correctly implemented and monitored. Trauma-informed supervision has been demonstrated to be a significant protective factor in conjunction with support of trauma informed self-care. Knowledge, skills, and attitudes regarding trauma informed care, secondary trauma, the role of supervision within those, and positive self-care

Program Name	Title of Trainings
	practices are explored. This training series includes one (1) didactic training session, and two (2) to three (3) subsequent phone booster sessions to reinforce concepts learned. • Integrating a Peer Support Program into Children and Youth Serving Systems: This training is designed primarily to prepare supervisors, managers, and leaders in Short-Term Residential Therapeutic Programs (STRTP) to understand the philosophy and practice of Family Support interventions, CCR core values and outcomes. This training reviews family finding techniques to assist with achieving permanency. It also demonstrates how Youth Advocate and Parent Partner best practices can improve family outcomes and CCR reform effort by complementing clinical treatment and the Child and Family Team planning process. • Being in the Child Welfare System - A Youth Perspective: CCR implementation has reshaped the culture of residential treatment. Once CCR is fully implemented, STRTP is the "last resort" intervention aimed at ensuring the youth stay on a path to permanency. This training is aimed at ensuring that providers understand the youth's perspective of being in this system of care. • Child and Adolescent Needs and Strengths (CANS) – Overview: This 6-hour training is designed to provide LACDMH, Los Angeles County Department of Child and Family Services (DCFS), Los Angeles County Probation Department, and Contracted Provider staff with an overview of Transformational Collaborative Outcomes Management (TCOM) and the California Integrated Practice-CANS assessment. TCOM is a framework for managing the business of personal change, and CA IP-CANS is a collaboratively completed measure of youth and family needs and strengths developed to support level of care and intervention planning for child welfare-involved youth. TCOM's overall framework, key concepts and how its multilevel approach directly benefits children and families will be presented. Participants learn how CANS facilitates the linkage between the child/adolescent assessment process and the design of individualized service plans. • CANS – Training of Trainers: This training is designed for LACDMH, DCFS, Probation, and Contract Providers who, following the successful completion of the CA IP-CANS Overview training, wish to provide classroom-based training as well as coaching on the CA IP-CANS to staff within their own organizations. TCOM is a framework for managing the business of personal change, and CA IP-CANS is a collaboratively completed measure of youth and family strengths developed specifically for child welfare-involved youth. The standard TCOM and CANS training curricula are presented. • CANS – TCOM for Thought Leaders: This training is designed for supervisors and managers from LACDMH, DCFS, Probation, and Contract Providers (STRTP and FFA) who are interested in learning about TCOM as a framework for managing the business of personal change. Shifting from managing services (time spent) to managing transformations (helping people change their lives in some important

Program Name	Title of Trainings
	way) is the fundamental objective of TCOM, accomplished through the use of collaborative process. TCOM underlies the California Integrated Practice-CANS (CA IP-CANS) assessment, a measure of youth and family strengths and needs developed specifically for child welfare-involved youth. The training presents how CA IP-CANS and TCOM facilitate the monitoring of clinical and functional outcomes. • Permanency Values and Skills for Child, Welfare, Probation and Mental Health Professionals: Every child needs a "no matter what" family for a lifetime. This includes children with special needs, sibling groups, older adolescents and children across all backgrounds and cultures. Adolescents need lifetime families, skills for successful adulthood and resources to support their safety and well-being. One of the core values of the CCR is permanency. This training supports the goal of permanency for children and youth involved in the child welfare system. The training also provides tools for addressing and working with youth who say "no" to permanency. Lastly, participants are provided strategies to support the achievement of permanency for Child Welfare involved children and youth including those stepping down from residential settings.
Integrated Correctional Health Services (ICHS)	These trainings were designed to train Mental Health Staff to better identify, respond, and intervene with men and women identified as having mental health needs while incarcerated in County jails • Commission on Correctional Health Conference • Mental Health Update/SUDs Signs Symptoms • Catalyst Learning/Manager Mental Health Training • Catalyst Learning/Manager Mental Health Train-Trainer • PTSD/Mental Health Treatment within Corrections • Personality Disorders • Engaged Leadership • National Conference for Nurse Practitioners • Advanced Cardiovascular Life Support

**Source: MHSA Three-Year Program and Expenditure Plan, FYs 20-21 through 22-23*

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 8: Examples of trainings with one-month follow-up conducted by WET)

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Criterion 5 Appendix

Attachment 1: Interpreter Trainings, FY 18-19

Attachment 1
Interpreter Trainings F

Attachment 2: 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 3: OAO-CCU Annual Cultural Competence Training Attestation form

CC training
attestation 9-12-18.p

Attachment 4: LACDMH Legal Entity Contract

LACDMH Legal Entity
Contractual Agreemer

Attachment 5: Inclusion of Cultural Responsiveness in Trainings

Inclusion of Cultural
Responsiveness Train

Attachment 6: LACDMH Training Evaluation Form

DMH_Training_Evaluation_Form_2018.pdf

Attachment 7: Cultural Competence Trainings by State content category and sample training bulletins, FY 18-19

Cultural Trainings Listing 2018-2019.doc

2018-19 Cultural Competency Bulletins.

Attachment 8: Examples of trainings with one-month follow-up conducted by WET, FY 18-19

5-16-19 Law & Ethics Training -1 M

4-26-19 Seeking Safety -1 Month Foll

4-17-19 Understanding Doc

4-4-19 COS Documentation Trai

4-1 2 & 3-2019 -Introduction to Inte

3-27-19 Diving Deeper Training - 1

2-20-19 Occupational Resilie

2-19-19 Occupational Resilie

2-6-2019 -Hearing Voices that are Distr

1 28 29 & 30 2019 -Introduction to Inte

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 18-19

Criterion 6

County's Commitment to Growing a Multicultural Workforce

August 2020

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 targets for workforce development efforts, FY 18-19:

1) **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.

2) **Mental Health Promotoras**
   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 18-19.

3) **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 18-19.

4) **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.

5) **Introduction to Social Rehabilitation Specialists**
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.

6) **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.”

7) **Intensive Mental Health Recovery Specialist Training Program**
The Intensive Mental Health Recovery Specialist Training Program prepares consumers and family members, with a minimum of two (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.

8) **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

9) 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.

10) 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.

11) Parent Partner Training Symposium

This three-day long symposium was held twice during FY 18-19 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.

12) Mental Health Psychiatrist Student Loan Repayment Incentive

This financial incentive program continued through FY 18-19 with the intent 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.

13) **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 one (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.

Collectively, these 13 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 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 13 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:

Community Worker
East San Gabriel Valley Mental Health Center is an adult outpatient clinic located in the City of Covina with an opening for a Community Worker in the outpatient clinic. The Community Worker provides case management services and rehabilitation services to clients with severe and persistent mental illness in order to support their recovery and may also provide field based services as needed.

<u>ESSENTIAL JOB DUTIES</u>

- Provide Targeted Case Management services that include assisting consumers with obtaining and maintaining housing, benefits establishment, vocational rehabilitation and linkage of consumers to community resources

- Complete all required documentation associated with on-going treatment services, such as progress notes, Community Functioning Evaluation form, Mental Health Triage and Client Treatment Plans
- Provide individual rehabilitation and group services to help clients develop appropriate coping skills and engagement in meaningful activities that promote wellness
- Provide field based outreach services to consumers to assist with housing and interface with community resources and provide treatment as needed

Psychiatric Social Worker II (Spanish Speaking)
The Service Area 5 Administration has an opening for a PSW II-Spanish Speaking PSW to join an excellent dynamic Homeless Services Team (formerly SB 82 Mobile Triage Team). This position is part of a multidisciplinary field-based team, involving outreach and engagement with vulnerable, disengaged individuals who have fallen through the cracks and are not getting themselves into services without help coming to *them* in the community. The specific target populations include veterans and older adults (whether homeless or not) and homeless individuals ages 18+.

ESSENTIAL JOB DUTIES

- Provide clinical triage and assessment, may open up a clinical chart in IBHIS or provide short term services through COS billing, with the goal of connecting someone to housing, benefits establishment, retrieval of identification documents, or to longer services such as Full Service Partnership
- Work closely with other team members, homeless services professionals in other agencies as well as other DMH staff within EOB, jails, courts, and psychiatric hospitals to advocate for a client's needs
- Close collaboration with members of law enforcement, fire, clergy, hospital emergency departments, local health clinics, and any other service provider that intersects with homeless persons

Bilingual Spanish Speaking Licensed or License eligible Psychiatric Social Worker Mental Health Clinician
Juvenile Justice Mental Health Programs is recruiting a bilingual Spanish-speaking, licensed or licensed eligible Psychiatric Social Worker or Mental Health Clinician for the program co-located at Camp Afflerbaugh, a locked juvenile detention center operated by Probation Department. Seeking individuals committed to working with adolescent offenders in a challenging environment. Services provided seven (7) days a week and all clinicians work either a Saturday or a Sunday and two (2) evenings until 8:30pin as part of their regular weekly work schedule.

DESIRABLE QUALIFICATIONS:

- A strong desire to work with adolescent offenders
- Experience working with multi-disciplinary teams
- Ability to manage challenges of working in a co-located program
- A high degree of adaptability and flexibility

Intermediate Typist Clerk

The Specialized Foster Care Program (SFC) is seeking a motivated, positive and experienced individual to fill the position of Intermediate Typist Clerk. Candidates with excellent administrative, organizational, verbal and written communication skills are encouraged to apply. The new hire is expected to work with the IBHIS System, DCFS referral portal and the electronic referral tracking system. The position is located at the Zev Yaroslavsky Family Support Center, 7555 Van Nuys Blvd, Van Nuys, CA 91405.

DESIRABLE QUALIFICATIONS:

- Strong verbal and written communication skills
- Ability to multi-task, prioritize multiple assignments and meet deadlines
- Ability to work independently, attend to details, follow through on instructions and monitor pending tasks
- Knowledge of computer software programs: 1BHIS, Word, Outlook and Excel
- Adaptability to meet program needs in a fast paced environment and challenging situations

Psychiatric Social Worker I/II

The Long Beach Child and Adolescent Program is seeking a qualified, motivated individual who has an interest and experience working with children, youth and their families in an outpatient mental health setting.

ESSENTIAL JOB DUTIES

- Provide family, individual, group, and case management services to clients, ages 4 to 25, and their families
- Prepare in-depth diagnostic and psychosocial assessments and treatment plans
- Participate in interdisciplinary team meetings and case conferences
- Serve as Officer of the Day and provide crisis intervention services for walk-in clients, assist with emergency hospitalizations, and take crisis and intake telephone calls
- Complete clinical documentation and other administrative documentation
- Perform other duties as assigned by Program Head

Psychiatric Social Worker II or Mental Health Clinician II

Hollywood Wellness Center is seeking a Spanish speaking Psychiatric Social Worker II or Mental Health Clinician II for its Wellness program located in the Hollywood area. The individual selected for this position will deliver mental health services to an adult/older adult population

ESSENTIAL JOB DUTIES

- Complete adult assessments, screenings, and triages
- Provide individual and group rehabilitation/psychotherapy, case management , consultation, and crisis intervention

- Conduct weekly chart reviews
- Provide field based services including outreach and engagement
- Actively participate in multi-disciplinary team meetings
- Assist in coverage as the Officer of the Day

Psychiatric Social Worker II/Mental Health Clinician II
Child Welfare Division (CWD) Wraparound Program has a transfer opportunity for a PSW II or MHC II within the Central Administration Team located in the Superior Court Building at 600 S. Commonwealth Ave., Los Angeles. The Wraparound Program is a growing and vibrant child focused family-centered, strengths-based, needs-driven planning process.

ESSENTIAL JOB DUTIES
- Develop training curriculum for the Wraparound Program
- Facilitation of trainings to Service Area (SA) staff and Wraparound Providers
- Assist SA staff with the implementation of the Children's Intensive Services Review (CISR)
- Consults with Wraparound Providers on Case Rate Supports and Services (CASS) Claims submitted in the Wraparound Tracking System (WTS)
- Evaluates adherence to the guidelines on Case Rate by the Wraparound Providers
- Complete other administrative tasks for Supervisor, Program Head or District Chief as needed.

Staff Assistant
The Countywide Housing, Employment and Education Resource Development (CHEERD) Division is seeking a Staff Assistant **I** to fill a vacant position for the Interim Housing Program (IHP), Employment and Education, Integrated Mobile Health Team (IMHT)—Full Service Partnership (FSP) and Homeless FSP units. The individual selected for this administrative position will be located at 695 S. Vermont Ave.,10th Floor, Los Angeles, CA 90005. Work days are Monday-Friday with a 5/40 or 9/80 work schedule.

ESSENTIAL JOB DUTIES
- Provide administrative support to management
- Enter FSP referrals into the Service Request and FSP Tracking Systems
- Track Service Request dispositions, create reports and provide follow-up as needed
- Review IHP referrals and a large volume of client information for completeness and follow-up with providers as needed. Electronically file and enter information into an Access database
- Manage group email boxes and triage incoming emails
- Update and maintain the employment and education information on the Wellness Center WIKI website
- Maintain and update various directories and group email contact lists
- Coordinate conference calls and meetings

Clinical Psychologist I/II

Juvenile Justice Mental Health is recruiting a Clinical Psychologist I/II for the program co-located at Dorothy Kirby Center (DKC), a locked juvenile residential center operated by Probation Department. Seeking individuals committed to working with adolescents in a challenging environment. At DKC, services are provided seven (7) days a week and all clinicians work a 4/40 schedule Sunday-Wednesday or Wednesday-Saturday and two (2) evenings until 8:30pm as part of their regular weekly work schedule.

ESSENTIAL JOB DUTIES

- Complete diagnostic assessments and treatment plans
- Provide crisis intervention services, individual and family therapy, including family outreach and engagement
- Provide Seeking Safety and Dialectical Behavioral Therapy (DBT) groups
- Participate in multi-disciplinary team meetings with youth and partner agencies to address the youth's goals while at DKC and assist with transitioning the client back to the community upon release
- Assist in coverage of individual, groups, and multi-disciplinary team meetings in the assigned clinician's absence as the Officer of the Day (OD)
- Completion of documentation on a daily basis in the Probation Electronic Medical Record (PEMRS) system
- Possible Intake Coordinator responsibilities to conduct clinical assessments at the LA County Juvenile Halls

II. 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.

Chiefs' Background Information

- **Chief of 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.

- **Chief of Peer & Allied Health Professions** – 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)

- **Chief of 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.

- **Chief of 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.

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 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. LACDMH's nursing culture is empowered through opportunities to engage in high quality continuing education opportunities, exposures to professional psychiatric-mental health nursing literature, and introductions to the professional nursing associations and membership committees that write the Scope and Standards of Practice with practice competencies. These added strengths help to promote more positive and effective interactions, teamwork, and demonstrations of respect for multiple diversities among our staff. **– *Lu Ann Sanderson, 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, Chief of Peer and Allied Health Professions***

- "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, 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, Chief of Social Services***

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The following section presents each Chiefs' role conceptualization and a brief summary of goals and strategies pursued during CY 2019.

I. 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 for 2019	Strategies	Status/Contributions/Accomplishments
1. Supportive work environment and education Promote a supportive workplace environment with continuing education for development of psychiatric-mental health nurses and psychiatric technicians.	• Establish communications • Build clinical team relationships • Deliver continuing education	• Fostered bi-directional communications among DMH RNs and Psychiatric Technicians through email, personal communications, and quarterly Chief Nurse's meetings. • Encouraged RNs to develop team improvement projects that result in positive changes in the workplace environment. Mentored three (3) RNs in professional abstract development that lead to the delivery of three (3) presentations at the 33rd Annual American Psychiatric Nurses Association conference. Presentations received 1st and 2nd place awards. • Initiated relationship with American Nurses Association that lead to 90 RNs receiving a 21-hour psychiatric nursing review course and 13 RN's accomplished national certification.
2. Nursing Programs and Recruitment Facilitate plan for placement of nurses within the context of multidisciplinary teams in DMH clinics	• Contact NP nursing programs to obtain potential candidates for placement within DMH • Add the Psychiatric-Mental Health NP students to DMH clinical practice settings to bring more cultural awareness to the clinical teams and the client populations (e.g., new perspectives, keen interests, diverse backgrounds, and multiple language capacities to enhance the services that are sensitive to clients with cultural and linguistic diversities.)	• Established relationships with two (2) affiliated university psychiatric NP programs that resulted in clinical placements within LACDMH: Spring = four (4) students, Summer = eight (8) students; Fall = 11 students. LACDMH clinical opportunities with multi-disciplinary teams contributed to successful graduation for eight (8) NP students in 2019. Awarded four (4) NP graduate stipends.
3. Introduce and implement Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation (OPPE/FPPE)	• Explore LACDMH Advanced Practice Registered Nurses (APRN) knowledge base and experiences with peer review processes • Develop policy	• Established regular quarterly meetings with DMH APRNs. • Prepared/reviewed/discussed initial draft policy for APRNs (CNSs and NPs) defining

Goals for 2019	Strategies	Status/Contributions/Accomplishments
	• Initiate peer review process and build capacity	their roles, practice guidelines, and participation in OPPE/FPPE processes • Pending policy development
4. Class Specifications – Nurses Series	• Collaborate with Human Resources to update language used in Class Specifications, encourage standardization of duty statements that align with professional practice	• Revised the following Nurse class specifications: o Assistant Mental Health Counselor RN o Mental Health Counselor RN o Sr. Mental Health Counselor RN o Clinical Nurse Specialist o Nurse Practitioner The revisions to the nurse class specifications listed above are in various levels of final stages.

II. Chief of Peer and Allied Health Professions

- Serve as the primary subject matter expert on Peer Workforce for the Department
- Provide advocacy around issues 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 ensuring collaboration and integration of the workforce on clinical teams
- Collaborate and/or lead discipline-specific efforts on staff recruitment and retention, staff training and program development (Peer Resource Centers, Peer Full Service Partnerships, Help@Hand, etc.)
- Serve as a DMH liaison to the labor union, professional organizations and myriad of external partners

Goals for 2019	Strategies	Status/Contributions/Accomplishments
1. Policy: Peer Certification	• Provide technical assistance to the State of • California to establish certified Peer Support Specialist as a behavioral health discipline and Peer Support Service as a Medicaid reimbursable behavioral health service when provided by a certified Peer Support Specialist	• Assisted in the development of an FAQ document • Supported County Behavioral Health Directors Association in responding to the sunshine document for creating a new certification under appropriate state level department(s). • Continued to provide subject matter expertise to Senator Jim Beall and other sponsors of the Peer Certification Bill SB 803
2. Professional Development: A. Peer Trainings	• Provide professional development for Peer Certification • Create a Peer workforce integration and a recovery oriented practice organization • Trainings: o Intentional Peer Support Trainings o Community Inclusion Trainings o WRAP o Recovery Oriented Cognitive Therapy o Peer Leadership Academy o Peer Navigation Training Program	• Peer and Allied Health Professions trainings received approval towards the end of FY 19-20. Delivered four training sessions to 77 participants from June 2019 through December 2019. o One session: Honest, Open and Proud (HOP) is a training program conducted by trained leaders with lived experiences with the objective of reducing the self-stigma associated with mental illness. o Three sessions: Intentional Peer Support 5-Day Core Training- Participants learn the tasks and principles of IPS, examine assumptions about who they are, and explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of “service.” IPS is all about opening up new ways of seeing, thinking, and doing, and examine how to make this possible.

Goals for 2019	Strategies	Status/Contributions/Accomplishments
B. Specialty Roles	• Develop role, relevant training, and recruit, train and deploy as needed Peer Support Specialists to serve in these specialty roles: o Tech Peer o Attempt/Loss Survivor (suicide) o Recovery Agent (supported decision making) o Employment Peer o Education Peer o Housing Peer o Respite Peer	• Built in a supported education approach into a Kaiser grant strategy as a means of establish the framework for education peer specialty. • Participated in a workgroup with Corporation for Supportive Housing to design IPS supported employment for at-risk/homeless. • Completed and deployed Digital Health Literacy Curriculum (DHCL) and Training for Service Extenders as foundational training for Tech Peer Specialty. • Consulted with LACDMH telehealth program to develop modules on telehealth etiquette and telehelath application modules for the DHCL.
C. Supported Education for Peer Workforce	• The purpose of this project is to develop and implement mechanisms that provide specialized support to current Peer Staff, Peer Volunteers and referred mental health clients 18 years or older in seeking professional growth through educational advancement, and more specifically by obtaining a high school diploma. Aim(s): o Obtain Grant or County funding. o Procure supported education program services using the funding. o Graduate 75 participants seeking high school completion through the program within the funding period. o Evaluate program effectiveness, establish permanency, and bring to scale as needed.	• Grant approved for full $300,000 for 24 months.

Goals for 2019	Strategies	Status/Contributions/Accomplishments
3. Program: A. Peer Resource Center Expansion (PRC)	• Assess and develop strategies within the PRC at LACDMH Headquarters (PRC- HQ) that will improve program services and serve as a blueprint for future PRCs. • Expand PRC services throughout the County. Initial expansion site will be located at the MLK Behavioral Health Center. • Establish at least one directly operated PRC within each Service Area.	• Completed assessment of PRC-HQ and began development of a blueprint for future PRCs. • Developed and submitted for DMH management review the initial staffing and budget plan for PRC at MLK Behavioral Health Center.
B. Peer Respite Expansion	• Development of new Peer Respite programs such as for T.R.I.E.S.T.E. and the LAC - USC Wellness/Restorative Village.	• Visited the Wellness Center at the Historic General Hospital, as well as hosted a visit to our Peer Resource Center to begin collaboration. • Facilitated the ongoing Peer Respite Roundtable for current providers to identify best practices, challenges and new developments.
C. Peer Support Specialists (Peer SS) FIRST -- INN 5	The Peer Support Specialists Field-based Intensive Recovery Service Teams (FIRST) is an MHSA Innovation project that aims to contract with Legal Entity provider(s) to develop two (2) teams, primarily staffed by Peers, that will provide intensive field-based serivces to high-need individuals who are largely justice involved. Project includes awarding contracts, implementation support and monitoring.	• Worked with County Counsel to revise Request for Services (RFS) solicitation document. • Revised spending plan and prepared Service Request for submission to Executive Mangement for approval of budget and issuance of solicitation.

III. 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 (SME) 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 2019	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 • Reviewed existing language in Class Specifications for Psychology items and collaborated with HR in drafting changes including: o Elimination and replacement of the Associate Behavioral Health Consultant item, with Psychology Intern, Psychology Fellow I and Psychology Fellow II o Review and revision for the Clinical Psychologist I (CPI), Clinical Psychologist II (CPII), and Supervising Psychologist items.
2. Build capacity and competency for Psychological Testing and Assessment to improve services to diverse and under-represented communities	• Create training protocols to assure clinical psychologists have needed competency and capacity to provide psychological testing and assessment services normed on the diverse populations served. • Identify Testing and Assessment leads to implement countywide services including design, assess, and implement all aspects related to psychological testing, training, and service implementation.	• Implementation of the Testing and Assessment workgroup which has been meeting monthly • Two CPIIs have been identified as DMH Testing and Assessment Practice and Training workgroup leads • DMH Psychological Testing and Assessment Service Policy and Procedure has been completed and uploaded to departmental Compliance Bridge platform • Designed a four-course training curriculum to assure Testing and Assessment clinical competency for all DMH psychologists. Two of four Training modules was completed and provided on brief assessment tools and neuropsychological tool overview was provided to a cohort of psychologists

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		• Testing and assessment: cultural factors in assessment, offered in Spanish and English • Neuropsychological tool overview offered as three repeated trainings. Same with the brief assessment tools • Work with CIOB for identification of Testing and Assessment tools, billing codes, clinical guidelines and service implementation • Completed referral form and process for psychological testing services, disseminated to all Service Areas • Identification and implementation of Brief Battery Assessment tools and protocols inclusive of clinical guidelines and use of telehealth in brief assessments, screener tools.)
3. Review of EBPs to evaluate effectiveness with diverse and under-represented communities	Review existing EBPs for effective implementation, consistently effective outcome measures greater than non-treatment participation, assurance of cultural and linguistic relevance for identified service populations. Provide recommendations for continuation of high performing EBPs with outcomes greater than 50% improvement Reduce or eliminate EBPs with outcome measures less than 50% effectiveness	• Chief of Psycho reviewed current EBPs and provided recommendations regarding their validity, reliability and effective continued implementation.
4. Promote core competencies of psychologists working in Public Mental Health	Assure all DMH Psychologist have demonstrated familiarity and success with identification, and regular implementation of core competencies for Clinical Psychologists.	• Continued offering the 6-hour CEU training "Core Competencies for Clinical Psychologists"

Goals for 2019	Strategies	Status/Contributions/Accomplishments
	Evaluate ability of DMH Clinical Psychologist to implement Core Competencies in all aspects of work within DMH.	• Developed a process to evaluate competency and application of core competencies for clinical psychologists particularly as related to the application and effective delivery of culturally competent services o Offered professional performance evaluations for psychologists on individual and as requested basis o Face to face professional development plan to assure psychologist operating at height of practice • Increased opportunities and venues for psychologists to function as Subject Matter Experts (SME), by creating six (6) Clinical Specialty Practice Committees: o Developmental Disorders o Personality Disorders o Eating Disorders o Co-occurring, Substance Use and Mental Health Disorders o Justice-Involved, Community Re-entry, and Re-integration o Children and Youth
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.	• Developed the curriculum in collaboration with the District Attorney's Office as a three-part training specifically tailored for attorneys and court staff

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		o Successful delivery of the Justice Involved Diversion curriculum to attorneys, bailiffs, and other court staff • Conducted an internal assessment of available treatment slots in the system for clients diverted for community re-entry and reintegration services. Completed in September 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. Identify opportunities for increased collaboration with Faith-Based Organizations and their Leaders.	Keynote addresses and presentations delivered in CY 2019: • Keynote at the Faith-Based Leadership Annual Breakfast • Keynote at the Armenian Genocide Commemoration • Keynote at the American Indian/Alaska Native Conference • Filipino Conference • Latinos Unidos Conference • Mental Health and Immigration Conference • Mental Health Multicultural Conference • NAMI of Southern California Conference
7. Obtain input from psychologists regarding professional development opportunities, work satisfaction, and efficacy of clinical work with underserved communities in efforts to increase quality of services offered, particularly to	• Facilitate focus groups and individual consultation meetings with Department psychologists. • Assure psychologists are operating at height of practice in any and all assigned areas of work. • Evaluate psychologist clinical competencies and ability to effectively deliver clinical care specific	• Conducted focus groups to evaluate psychologist environment of care and effective implementation of competent treatment protocols. • Completed eight distinct focus groups assuring participation of all DMH employed psychologists.

Goals for 2019	Strategies	Status/Contributions/Accomplishments
Specialty Treatment and underserved populations	to the linguistic and cultural needs of populations served.	
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.	• Workgroup Training and Professional Development committee has been meeting once per month since its implementation at the end of CY 2018 • Accomplished the addition of new psychology doctorate training programs that had no previous affiliation agreement with the Department.
9. Help design and implement service programs that create a more welcoming environment for LGBTQ clients and family members	• Coordinate with existing subject matter experts (SME) and contracts to create proposal for a more sensitive and inclusive LGBTQ service environment.	• Drafted initial service innovation proposal to include identification of a countywide LGBTQIA2-S SME • Under supervision and in collaboration with Chief Medical Officer, identified and onboarded the countywide LGBTQIA2-S SME. In this role, she will coordinate directives to create an inclusive and welcoming environment for LGBTQIA2-S clients within DMH Directly Operated programs.
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.	• Assured that all ACCESS Center clinical staff participate in “Vicarious Trauma and Self Care” trainings.
11. Collaborate with the LACDMH CCU projects (i.e. diffusion of information	• Establish collaborations with the ESM and CCU to determine areas of participatory involvement	Delivered keynote addresses at the following events:

Goals for 2019	Strategies	Status/Contributions/Accomplishments
related to departmental cultural competence initiatives)	and support to further the development of culturally competent and sensitive practices.	• Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR) Action Plan Launch • Labor Management Transformation Council's Cultural Intelligence Workgroup Launch at Martin Luther King campus.

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IV. 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 2019	Strategies	Status/Contributions/Accomplishments
1. Complete initial Needs Assessment of LAC DMH Social Work (SW), and Marriage and Family Therapy (MFT) staff to determine the Practice Needs of the respective disciplines, identify opportunities for	• Continue in-person convening meetings launched in July 2018.	• Completed in-person visits with **244** LACDMH *line* SW and MFT staff, and **72** LACDMH Mental Health Clinical Supervisors (staff in this classification are either SW or MFT Practitioners). Visits took place across the eight (8) LA County Service Areas and across Countywide Programs (e.g. Mental Health Court Linkage Program, Intensive Care Division

Goals for 2019	Strategies	Status/Contributions/Accomplishments
improvement, and empower staff to advocate for program specific needs.		(previously known as County Resource Management/CRM). **<u>Findings</u>:** • **LACDMH SW and MFTs working in Mental Health Court Linkage** are key frontline workers to facilitate *Alternatives to Incarceration* for individuals who have been charged with/arrested for engaging in activities/behaviors that potentially were influenced by existing mental health symptoms. Many of these individuals are of African-American and Latino/Latina heritage/ethnicity. ***Challenges/System-generated:*** LACDMH Mental Health Court Linkage SW and MFT staff do not have access to the Jail POWER Charts that house critical information needed to facilitate a holistic and robust assessment of the individual, which subsequently informs the recommended treatment plan seeking to address in part various social determinants of health that were contributing factors to activities/behaviors engaged in by the individual. **<u>Action taken</u>:** • Consulted with Program Manager and other LACDMH Leadership associated with the Mental Health Court Linkage Program regarding existing barrier to gaining access to POWER Charts and steps that can be taken to ameliorate barriers. Feedback received

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		from various DMH Leaders was access to POWER Chart is an on-going challenge. • Access to Jail POWER Charts would provide DMH Mental Health Court Linkage with needed clinical data to inform recommendations to court that could include alternatives to incarceration. Data shows that African-American and Latinx population make up a large portion of the jail population. Provision of appropriate alternatives to incarceration (e.g. access to mental health and/or substance use treatment; access to services that are steeped in cultural humility, etc.), informed by clinical information in the Jail POWER Charts, might have an impact on this abysmal statistic and foster recovery and integration into/participation in community for impacted individuals. **<u>Next Step</u>:** • Revisit in 2020, engagement with needed leaders, regarding LACDMH SW and MFT staff being provided access (only what is needed) to the POWER Chart in order to provide robust care coordination/treatment planning to facilitate *Alternatives to Incarceration*. **<u>Findings</u>:** • Various "System" opportunities for improvement" and Program Specific Needs were identified during in-person visits: **"System" Opportunity for Improvement:** One system improvement identified was gaining

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		efficiencies with the communication of updated/new Programs and new Resources. Knowledge of new and/or updates to Programs, as well as new Resources are critical for Coordination of Care, and Access to Services and Resources to address the Social Determinants of Health. **Gap:** Staff are not consistently provided with updates on new/updated Programs and Resources. **Initial Action taken/Accomplishment:** Chief of Social Services provided information to LACDMH Line SW and MFT staff and MHCS regarding Resources (e.g. Transportation Benefit available to Medi-Cal beneficiaries enrolled in Medi-Cal Managed Care Plan) to facilitate access to needed services and access to care. LACDMH SW and MFT staff shared in convening meetings that some clients have transportation challenges that serve as a barrier to Access to Care. Chief of Social Services also provided additional updates that can support enhancement of client care. **System" Opportunity for Improvement:** A second system improvement identified was the need for a structured "Orienting Period" for newly hired Line SW and MFT staff. This "Orienting Period" would provide staff with designated time to take requisite trainings, review requisite Policies and Procedures, and complete other critical activities to provide a foundation to support their success as a clinician, which includes but is not limited to provision of culturally sensitive and relevant services. **Gap:**

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		No formal and structured "Orienting Period" existed across the DMH Directly Operated Clinics. **<u>Accomplishment</u>:** • Developed a structured "Orienting Period" for newly hired LACDMH SW and MFT staff and launched Pilot Period. **<u>Findings</u>**: • **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. Native American, African American, Transition Age Youth, etc.) Based on the current understanding of LACDMH SW and MFT staff, some of these non-traditional/non-Western oriented interventions are not reimbursable by Medicaid claiming rules and/or Providers in our System of Care require training in order to utilize these culturally sensitive and appropriate interventions). As a result, this can contribute to interventions not consistently being utilized that honor the culture of the individual receiving services. **<u>Accomplishment</u>**: • Chief of Social Services collaborated with the Supervisory and Managerial Staff along with Administrative Leadership to provide an opportunity for LACDMH American Indian

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		Counseling Center staff to attend a training on Native-American-specific clinical interventions to support development and maintenance of health family systems. **<u>Next Step</u>:** • Chief of Social Services to collaborate with LACDMH SME (e.g. Quality Assurance staff) regarding the utilization of non-traditional interventions like drumming, storytelling via poetry/lyrical poetry, etc. that honor various cultural populations and lend to increased engagement with members of these populations and movement on their respective recovery journeys. Determination to be made how these non-traditional interventions can be utilized within the framework of Medicaid payment guidelines.
2. Launch New SW and MFT Hire Orienting Period	• Convene a Workgroup of LACDMH Program Managers to develop the structure for a New SW and MFT Hire Orienting Period. • Launch Pilot of New SW and MFT Hire Orienting Period. • Evaluate efficacy of Pilot and make needed amendments	• An Orienting Period for newly hired SW and MFT staff provides an opportunity during the first two (2) weeks of employment for staff to take trainings such as Implicit Bias and Cultural Competency. Completion of this training during the Orienting Period, prior to providing services, can create an enhanced awareness of biases and associated impacts on provisions of services and thus positions the SW and MFT to plan for and provide more culturally competent services. • Workgroup consisting of LACDMH Program Managers met in 2019 to identify the “problem to

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		be solved" by developing a New SW and MFT Hire Orienting Period Structure, and the needed elements to be included. Desired outcome of Orienting Period is that new SW and MFT staff members will have needed foundational tools, which include but are not limited to trainings that support provision of culturally sensitive and relevant services, to facilitate success in their roles and functions as LACDMH SWs and MFTs. **<u>Accomplishments</u>:** • New SW and MFT Hire Orienting Period Structure developed. Orienting Period takes place during the first 2 weeks of employment at DMH. Elements of the Orienting Period include: review of identified Policies and Procedures; completion of requisite trainings via the Learning Net; completion of the Integrated Behavioral Health Information System/IBHIS Clinical Practice Training; shadowing of staff to learn both the administrative and clinical aspects of the work processes/workflows new staff will be expected to complete; and establishing foundation for supervisor-supervisee relationship. • Pilot launched of new SW and MFT Hire Orienting Period Structure. • Collaboration with DMH's American Indian and Counseling Center (AICC) Team and our Administrative Team facilitated the opportunity for DMH AICC staff to participate in Trainings that intentionally focused on the dissemination of Native-specific psychoeducation, interventions

Goals for 2019	Strategies	Status/Contributions/Accomplishments
		and strategies that subsequently supported our staff in the provision of culturally relevant services to the Native population served by DMH.
3. Support Structure to facilitate attainment of licensure	• Complete assessment and evaluation to determine contributing factors to lack of success with passing Clinical Licensure Exam. • Complete assessment and evaluation of gaps in Clinical License Exam support structure within LACDMH. • Engage in collaborative discussions with LACDMH Clinical Leadership regarding elements of proposed Support Structure.	**Findings:** • No standard Clinical License Exam Support Structure exists across LACDMH Programs. • Some staff, who have English as a Second Language (ESL), express challenges with taking the written Clinical Exam. **Accomplishment:** • Completed research and provided findings, via e-mail communication to LACDMH unlicensed SW and MFT staff that test accommodations can be made for individuals who have ESL and meet certain thresholds/criteria. **Next Step:** • Collaborate with LACDMH Clinical Leadership regarding the enhancement of the Clinical License Exam Support Structure. Elements of the support structure include but are not limited to: a) Framework development of a system wide structured Clinical License Exam Study Group, and b) Development of 1:1 mentorship

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 18-19

Criterion 7

Language Capacity

August 2020

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 (2)	English and Spanish
2 (8)	Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog and Vietnamese
3 (7)	Cantonese, English, Korean, Mandarin, Other Chinese, Spanish and Vietnamese
4 (6)	Armenian, Cantonese, English, Korean, Russian and Spanish
5 (3)	English, Farsi, and Spanish
6 (2)	English and Spanish
7 (3)	English, Korean, and Spanish
8 (5)	Cambodian, English, Korean, Spanish, and Vietnamese

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 Hedderson Demographic Services, 2019.

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.) They 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 18-19, funding in the amount of $600,500 was dedicated to cultural competence trainings, inclusive of conferences sponsored by the Department, delivered through the WET Division. The budget for Human Resources trainings involving cultural competency such as Diversity, Employee Discrimination Prevention, and Sexual Harassment Prevention remained at $50,000. Training funds are also allocated for clinical staff and supervisors from Directly Operated and Contracted providers to optimize service delivery for various cultural groups, such $51,282 for the

commercially sexually exploited youth trainings, $142,082 for the LGBTQI2-S trainings and $72,851 for language interpretation trainings which continue to be offered annually.

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 Mental Health Clinical Terminology in Armenian, Korean, Mandarin, and Spanish
These trainings are intended to increase cross-cultural knowledge and skills with in serving communities that speak the threshold language targeted by the training. The Mental Health Trainings aim 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: 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 $200,000 per FY to implement culturally and linguistically competent projects, totaling $1,400,000. Every FY, each UsCC subcommittee is allotted one-time funding totaling $200,000 to focus on CSS-based capacity-building projects. The membership from the each subcommittee generates conceptual ideas for capacity building projects, which are turned into proposals by the UsCC Unit, and presented for approval. The UsCC projects are voted via a participatory and consensus-based approach within each subcommittee. Please refer to Criterion (CR) 1 and CR 3 for additional details.

Another example is the Countywide Community Mental Health Promoters Program has been expanded in all eight Service Areas. During FY 18-19, LACDMH had 153 mental health Promoters actively engaging the Latino community across the county.

Language Translation and Interpretation Services
LACDMH currently allocates funding for language translation and interpretation services for meetings and conferences.

- $138,279 for language interpretation services, which allows consumers to participate in various departmental meetings and conferences
- $79,324 for language translation services
- $146,650 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.

II. Services to persons who have Limited English Proficiency (LEP)

III. Provision of bilingual staff and/or interpreters for the threshold languages at all points of contact

IV. Services to LEP consumers beyond the threshold languages

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.

The ACCESS Center facilitates a wide array of services such as:

- Deployment of crisis evaluation teams
- Information and referrals for Specialty Mental Health Services (SMHS)
- Language Line for interpreter services to serve the caller in their preferred language, including face to face American Sign Language interpreter services for clinic appointments

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- After-hours gatekeeping of acute inpatient psychiatric beds
- After-hours DMH point of contact for PRO and special/critical incident reporting
- 24-hour notification to DMH service providers of after-hours activity
- Coordination of Out-of-County and Out-of-State referrals for Medi-Cal beneficiaries
- Collaboration with local Medi-Cal health management organizations (HMOs)
- Acts as a back-up Disaster Operations Center (DOC) providing assistance and crisis intervention following natural or man-made disasters.

TABLE 2: SUMMARY OF APPOINTMENTS FOR ASL SERVICES
FY 14-15 to FY 18-19

Fiscal Year (FY)	Number of Assigned Appointments
FY 14-15	1,137
FY 15-16	1,058
FY 16-17	1,242
FY 17-18	1,140
FY 18-19	983
TOTAL	5,560

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: DMH, EOTD, ACCESS Center, FY 14-15 to FY 18-19.

Table 2 presents the number of assigned sign language interpreter services appointments for the five prior FYs. The ACCESS Center coordinated 983 requests for sign language

interpreter services in FY 18-19. This number represents a 16% decrease in the ASL appointments from 1,140 in FY 17-18. The number of ASL appointments may vary based on the demand for ASL services requested by the deaf and hard of hearing community. One possible scenario is presented by consumers entering the system with more acute symptoms that require a greater frequency of treatment sessions. Once stabilized, the frequency and types of mental health treatment modalities may decrease, thereby resulting in fewer requests for sign language services.

For FY 18-19, the ACCESS Center accommodated all requests for sign language interpreter services with some minor exceptions: 1) instances in which the consumer requested a specific interpreter and when this interpreter was not available. The ACCESS Center's procedure is to offer another interpreter and the consumer makes the decision to accept working with the alternate ASL interpreter; 2) the request was at short notice and made outside of the specified timelines per policy and procedure.

LACDMH Policy and Procedure 200.02, "Interpreter Services for the Deaf and Hard of Hearing Community", formerly known as Hearing Impaired Mental Health Access

In August 2018, the Ethnic Services Manager (ESM) presented this policy to the departmental Cultural Competency Committee for review and recommendations for content updates. The CCC has representatives of the deaf and hard of hearing community represented in its membership.

Below is a summary of the committee's recommendations for the policy revision:

- 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 was revised accordingly. It is now titled "Interpreter Services for the Deaf and Hard of Hearing Community" and has been posted in the LACDMH Intranet, under the Compliance, Privacy, and Audit Services webpage.

Once LACDMH Policy and Procedure 200.02 was finalized, the Cultural Competency Unit (CCU) provided updates regarding the policy revisions to throughout the system of care inclusive of:

- Quality Improvement Council
- Service Area-based Quality Improvement Committees
- Underserved Cultural Communities (UsCC) Leadership Group
- Access for All UsCC Subcommittee
- LACDMH Policy Committee

- ACCESS Center staff
- LACDMH executive management
- The Health Agency's Institute for Cultural and Linguistic Inclusion and Responsiveness (ICLIR)

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TABLE 3: Five-Year Trend in non-English Language Calls Received by ACCESS Center

Language	CY				
	2015	2016	2017	2018	2019
Albanian	0	0	0	0	1
Amharic	0	0	1	0	2
Arabic	6	16	8	18	21
Armenian	80	130	128	65	32
Bahasa	0	1	0	0	0
Bengali	0	1	0	2	5
Burmese	0	0	0	2	2
Cambodian	0	7	10	26	19
Cantonese	46	40	46	73	59
Farsi	58	56	178	59	40
French	2	2	1	1	1
German	1	0	0	0	0
Greek	1	0	0	0	0
Hebrew	1	0	0	0	0
Hindi	0	0	0	1	1
Hmong	0	0	0	0	1
Hungarian	3	0	0	0	0
Japanese	2	4	2	6	6
Khmer	3	1	0	0	0
Korean	108	116	140	224	149
Luganda	0	0	0	1	0
Mandarin	62	86	82	166	126
Persian	0	1	5	4	3
Polish	0	1	0	1	0
Portuguese	0	1	1	1	1
Punjabi	1	0	2	1	1
Romanian	0	1	0	0	0
Russian	12	16	37	13	25
Serbian	0	2	0	0	0
Slovak	0	1	0	0	0
***Spanish (LISMA)**	1,089	1,474	2,303	1,370	1,373
****Spanish ACCESS Center**	6,159	6,040	6,150	6,612	6,398
Spanish Subtotal	7,248	7,514	8,453	7,982	7,771
Tagalog	7	10	9	16	10
Thai	1	0	7	0	5
Urdu	0	0	0	1	1
Vietnamese	17	28	195	34	26
TOTAL	7,659	8,035	9,305	8,697	8,308

Note: * Effective 10/13/2016 at 12:01 am, the new Language Interpretation Services Master Agreement (LISMA) is provided by the following: Language Line Services Inc, TransPerfect Translations International, Inc, and Worldwide Interpreters, Inc.

**ACCESS Center Spanish speaking employee assisted with interpreter services. Data Source: Virtual Contact Center (VCC) effective 11/29/2013; LACDMH ACCESS Center, CY 2015 to CY 2019.

Table 3 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2015 through CY 2019. Over the past five years, the majority of the requests for non-English language calls, other than Spanish, were for Korean (N=737), followed Mandarin (N=522), Armenian (N=435), Farsi (N=391), and Cantonese (N=264).

In CY 2019, ACCESS Center staff provided language interpreter services in the Spanish language for 6,398 calls. An additional 1,373 Spanish language calls were interpreted through a language interpreter service vendor. Approximately, 94% of the non-English calls received by ACCESS Center staff were in Spanish (N=7,771), followed by Korean (N=149) at 1.8%, and Mandarin (N=126) at 1.6%. For the remaining languages, a total of 262 calls were received in CY 2019 and accounted for 3.2% of all non-English calls.

The Service Area 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

Language Interpretation Services

Language interpretation services are offered and provided to LEP consumers free of charge. LACDMH Policy No. 200.03, Language Translation and Interpreter 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 Interpreter 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 Interpreter Services for the Deaf and Hard of Hearing Community.)***

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) Form

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
- Treatment concerns
- Medication concerns
- Uncomfortable
- Not a good match

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TABLE 4: REQUEST FOR CHANGE OF PROVIDER BY
REASONS AND PERCENT APPROVED
FY 16-17 to FY 18-19

Reason(s)[1]	FY 16-17		FY 17-18		FY 18-19	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A – Time/Schedule	148	90.8%	235	87.2%	181	91.2%
B – Language	128	96.2%	144	88.9%	171	94.2%
C – Age	76	87.4%	85	89.4%	81	90.1%
D – Gender	172	91.5%	246	94.3%	208	90.4%
E – Treating Family Member	25	92.6%	32	93.8%	36	91.7%
F – Treatment Concerns	330	92.7%	430	89.8%	355	88.2%
G – Medication Concerns	222	91.0%	276	87.0%	82	87.8%
H – Lack of Assistance	332	91.2%	427	85.9%	386	88.6%
I – Want Previous Provider	84	92.3%	89	83.1%	96	86.5%
J – Want 2nd Option	98	89.9%	155	89.0%	135	91.9%
K – Uncomfortable	553	92.0%	613	89.6%	584	90.8%
L – Insensitive/ Unsympathetic	330	92.2%	398	89.7%	389	91.3%
M – Not Professional	240	91.6%	309	90.9%	305	91.8%
N – Does Not Understand Me	424	91.2%	509	88.8%	472	90.9%
O – Not a Good Match	555	91.7%	693	90.3%	781	90.9%
P – Other	373	92.6%	509	87.2%	669	91.9%
R – No Reason Given	102	86.4%	109	91.7%	127	84.3%
Total	4,192	91.7%	5,259	89.1%	5,058	90.6%

Note: [1]Multiple reasons may be given by a consumer. Data Source: DMH, PRO, October 2019

Table 4 shows the number of requests for COP by reasons and percent approved for FYs 16-17, 17-18, and 18-19. Data on the requests for COP is based on monthly COP logs submitted to PRO.

According to the FY 18-19 data, the most frequent reason for a COP request was “Not a Good Match (N=781),” and the least frequent reason for a COP request was “Treating a Family Member (N=36).”

Consumer Perception Surveys/Beneficiary Satisfaction Surveys

The effectiveness of linguistic and cultural services as perceived by consumers is assessed annually. LACDMH administers four Consumer Perception Surveys (CPS) in spring and fall:

- The Mental Health Statistical Improvement Program (MHSIP) survey for adults and older adults
- The Youth Satisfaction Survey (YSS) and YSS-family version (YSS-F) for youth and their families

Both surveys contain items regarding service accessibility, cultural sensitivity, social connectedness, participation in treatment planning, functioning, outcomes, and general satisfaction which are compared against the State and national averages.

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 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.

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 2017 to CY 2019

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019										
May	3,885	94.3%	1,619	82.9%	4,982	85.6%	616	89.7%	11,102	88.3%
2018										
Nov	2,886	94.6%	1,185	82.9%	4,470	85.5%	472	88.8%	9,013	88.0%
May	4,213	94.9%	1,979	82.4%	5,422	86.1%	609	89.6%	12,223	88.3%
2017										
Nov	4,158	94.7%	1,944	82.6%	5,119	85.2%	499	91.0%	11,720	88.3%
May	2,209	95.4%	1,107	86.0%	3,299	84.5%	432	86.4%	7,047	88.2%

Note: The "N" represents the number of responses with a value of 4 or 5 (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 2017 and May 2019.

Table 5 reports the percentage of consumers and families in families in CY 2017, CY 2018 and May 2019 that agreed to strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." More specifically, a total of 88.3% (N = 11,102) 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. This number did not change from the May 2018 survey period and is a 0.1 PP increase from May 2017 (88.2%).

A close review of the table also reveals that among Families and Adults, there was a slight decline in the percentages over the Spring and Fall survey periods as follows:

- The totals for Families show that there was a 0.6 PP decrease from May 2018 (94.9%) to May 2019 (94.3%)
- For Adults, there was a 0.5 PP decrease from May 2018 (86.1%) to May 2019 (85.6%).
- For Older Adults, there was a 0.1 PP increase from May 2018 (89.6%) and a 0.3 PP increase from May 2017 (86.4%) to May 2019 (89.7%).
- For Youth, the percentages fluctuated over time in that there was a 3.6 PP decline from May 2017 (86.0%) to May 2018 (82.4%) and then an increase of 0.5 PP from May 2018 to May 2019 (82.9%).
- Overall, in the May 2019 survey period, Youth were the least satisfied age group and Families were the most satisfied age group in terms of the cultural sensitivity of services.

V. Required translated documents

In accordance to Federal and State guidelines, LACDMH supports the translation of clinical forms and consumer informing materials in an effort to provide culturally and linguistically appropriate services. LACDMH Policy and Procedure 200.03: Language Translation and Interpreter Service standards regarding language translation an interpreter services to ensure that under no circumstances a beneficiary is denied access to mental health services due to language barriers. It emphasizes that Non-English or LEP consumers have the right to language assistance services at no cost in t heir primary or preferred language. This policy also delineates the step-by-step procedures to be followed by service providers. Additionally, it provides basic information regarding the difference between language interpretation and language translation services and identifies the Los Angeles County threshold languages.

Furthermore, 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 Appendix for Policies cited in this section and Attachment 6: Request for Interpretation and Translation Services Form.)***

The CCU provides technical support to Directly Operated and Legal Entities/Contracted providers who seek information on the procedures to be followed for language translation completion and quality review for accuracy and cultural meaning. 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.

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
Acknowledgement of Receipt						X					X		
Adult FSP Client Satisfaction Survey	X	X		X	X	X	X	X		X	X	X	X
Authorization for Request or Use/Disclosure of Protected Health Information (PHI)	X	X	X	X	X	X	X	X	X	X	X	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	
Child and Family Team Meetings Brochure						X					X		
Client Congress Flyer	X	X		X	X	X	X	X		X	X	X	X
Consent for E-mail						X							
Consent for Services	X	X		X	X	X	X	X		X	X	X	
Consent for Staff/Volunteer/Intern Observation						X							
Consent for Tele-mental Health Services				X		X		X		X	X	X	
Consent for Text Messaging/Video Chat						X							
Consent for TMS Transcranial Magnetic Stimulation						X							
Consent of Minor						X							
Consent to Photograph/Audio Record				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
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

Forms and Brochures	THRESHOLD LANGUAGES												
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Korean	Mandarin*	Russian	Spanish	Tagalog	Vietnamese
Health Information Exchange						X							
Hope, Wellness and Recovery	X	X		X	X	X	X	X		X	X	X	X
LACDMH Advance Health Care Directive Acknowledgement Form				X		X		X		X	X	X	
LACDMH Notice of Privacy Practices						X					X		
Medication Consent and Treatment Plan						X							
Medication Treatment Authorization Request Form						X							
Multidisciplinary Assessment Teams Brochure						X					X		
Notice of Action A (Assessment)	X	X		X	X	X	X			X	X	X	X
Notice of Action E (Lack of Timely Service)	X	X		X	X	X	X			X	X	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		
SA Provider Directories	X	X	X	X	X	X	X	X	X	X	X	X	X
Supportive Counseling Services						X					X		
Tele-mental Health Services Brochure						X					X		
Transitional Age Youth FSP Brochure	X	X			X	X	X	X			X	X	X
Treatment Foster Care Brochure						X							
Underserved Cultural Communities Flyer						X							

* Cantonese and Mandarin threshold language are covered under Other Chinese in written form
Data Sources: Quality Assurance Division and Cultural Competency Unit

Table 6 presents a snapshot summary of departmental forms and brochures that have been translated into the threshold languages.

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.

Criterion 7 Appendix

Attachment 1: LACDMH Policy 602.01 – Bilingual Bonus

602.01 Bilingual Bonus

Attachment 2: List of LACDMH Bilingual Certified Staff

LACDMH Bilingual Certified Staff CY 20:

Attachment 3: LACDMH Policy 200.03 – Language Translation and Interpreter Services

200.03 Language Translation & Interp

Attachment 4: LACDMH Policy 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community

200.02 Interpreter

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

OFFICE OF ADMINISTRATIVE OPERATIONS – CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 18-19

Criterion 8

Adaptation of Services

August 2020

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. Below are some examples:

1. Peer Run Centers: The LACDMH Peer Resource Walk-In

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

Every PRC staff member has lived-experience. PRC Team includes the following positions:

- Chief of Peer and Allied Professions – Executive Oversight
- Mental Health Clinical Program Manager III – Management Oversight
- Mental Health Services Coordinator II – Team Leader
- Housing and Health Navigators (Two)
- Employment Specialist
- Art and Recreation Specialist
- Computer Specialist
- WOW Volunteers with lived-experience

Services are based on the following commitments:

- Form heart forward connections with every visitors.
- A comfortable, safe, and non-judgmental environment to all.
- Place of clear intention:
- Develop a positive connection with all visitors through peer support

Visitors can be linked to the following types of services:

- Mental Health Services
- Physical Health Services
- Food
- Clothing
- Hygiene Facilities
- Housing Services
- Homeless Healthcare
- Temporary Shelter
- Benefit Establishment
- Legal Services
- Education and Job Training
- Volunteer and Employment Opportunities
- Los Angeles Homeless Services Authority (LAHSA) winter shelter pick up.

Recreational activities at the PRC

- Chess Group
- Jewelry Group
- Job Club
- Barbershop
- Art Group
- Guitar Lesson
- Singing and Healing
- NAMI
- Poetry and Creative Writing
- Social and Cultural Events

Figure 1: Population Served by the PRC

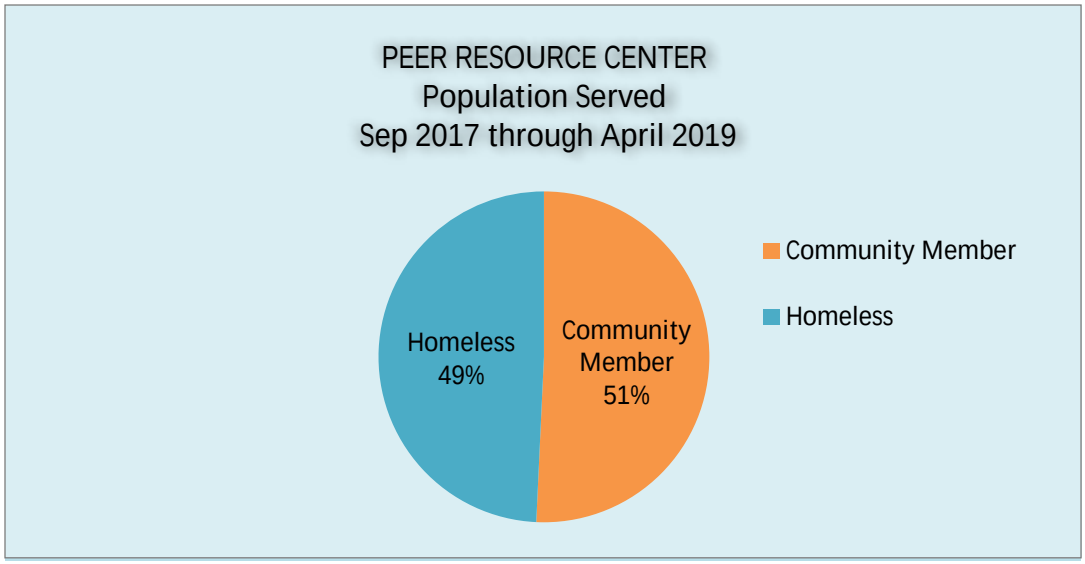
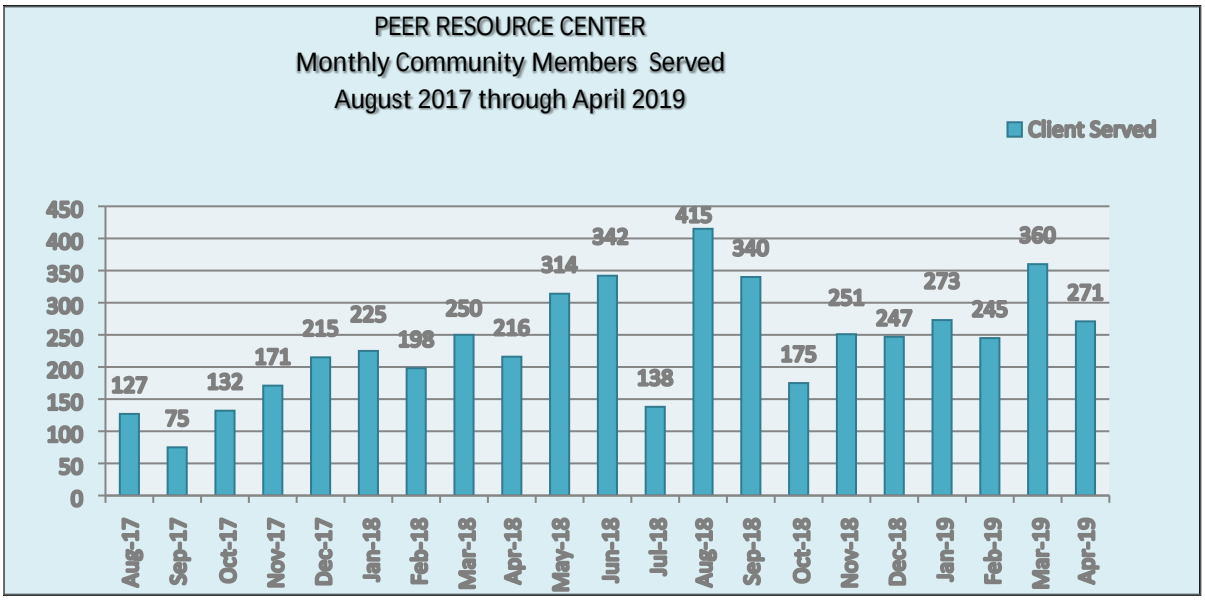


Figure 2: Persons Served at the PRC



2. 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.

3. TAY Drop-in Centers

These 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 when access to these centers is even more crucial.

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 E. 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

4. Service Extenders

Service Extenders are peer volunteers with lived experience, whose personal journeys inspire other consumers. Being a part of the Older Adult inter-disciplinary team, 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. Service extenders receive supervision from professional clinical staff within the program in which they are placed.

II. Responsiveness of Mental Health Services

LACDMH remains committed to pursuing culturally relevant means to outreach to and served underserved communities in other to increase accessibility to services, fight against stigma, and reduce mental health disparities. The efforts summarized below highlight the Department's responsiveness to the cultural and linguistic needs of our communities via traditional and non-traditional approaches in service delivery.

1. Capacity Building Projects by the Underserved Cultural Communities (UsCC) Unit in collaboration with the seven UsCC subcommittees

The seven UsCC subcommittees include:

- African/African American (AAA)
- American Indian/Alaska Native (AI/AN)
- Asian Pacific Islander (API)
- Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
- Eastern European/Middle Eastern (EE/ME)
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

Every Fiscal Year, each UsCC subcommittee is allotted one-time funding totaling $200,000 to focus on CSS-based capacity-building projects. The membership from the each subcommittee generates conceptual ideas for capacity building projects, which are turned into proposals by the UsCC Unit, and presented for approval. The UsCC projects are voted via a participatory and consensus-based approach within each subcommittee.

UsCC projects and their outcomes for FY 18-19

AAA

3) <u>Black Immigrant Youth Empowerment Project</u>
The Black Immigrant Youth Empowerment Project was implemented on July 1, 2018 and was completed on June 30, 2019. This project was developed to engage, empower, and educate the black immigrant community to seek mental health services as well as reduce stigma and increase the capacity of the public mental health system. The implementation of this project was divided into two phases: Phase one is the recruitment and training of 30 black immigrant youth on basic mental health education and public speaking skills; Phase two is the facilitation of 50 community mental health presentations countywide

4) <u>The African American Mental Health Radio Campaign</u>
The 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 30-second and 60-second Public Service Announcements (PSAs) to provide mental health education to the African American community.

Outcomes for CY 2018:

- The PSAs provided culturally sensitive information, education, and resources to the African American community in Los Angeles County. Overall, this radio media campaign successfully helped to reduce stigma, increase mental health awareness, and access among African American community members.

5) 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 Los Angeles 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.

Outcomes for CY 2018:

- For the fifth reprint, 15,000 booklets were ordered as of December 2018
- To date, there have been over 20,000 Life Links booklets distributed in the County

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 Los Angeles 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.

Outcomes for CY 2018:

- A total of 12,346,100 impressions were delivered
- Advertising took place primarily in the following cities: Lancaster, Palmdale, Littlerock, Lake Los Angeles, and unincorporated areas of the County

API

3) API Youth Video Contest: "Go Beyond Stigma!"

This project was implemented on January 1, 2018 and was 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 the County.

Outcomes for CY 2018:

- Three (3) orientations were held for the youth on mental health issues and the art of storytelling
- Two (2) trainings were held for the youth on how to develop a mental health video and four (4) teams composed of a total of 12 youth completed the orientation, training, and development of a video

4) Samoan Outreach and Engagement Program

In CY 2018, LACDMH utilized CSS funds to continue the Samoan Outreach and Engagement Program in order to increase awareness of mental illness, knowledge of mental health resources in order to 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.

This program completed its third year of implementation on June 30, 2018, during which community outreach was conducted at some colleges, churches, IMD facilities, hospitals, jails, and other community gathering sites. Starting July 1, 2017, the program changed to focus more on referrals. As of 2018, there were a total of 12 referrals made as a direct result of this program, which resulted in two (2) enrollments into mental health services.

5) API Mental Health Awareness Media Campaigns

This project includes seven (7) separate campaigns that were completed in April 2019. The campaign implementation took place in May 2018. The goal of the project was to target various API communities in Los Angeles 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.

All media companies provided a summary of the airing of the PSAs, etc., as well as viewership information. The ACCESS Helpline tracked the number of calls received from various racial/ethnic groups by race/ethnicity and language, so that the community impact can be determined. Project summary reports will

include summaries of the community surveys that were implemented and community feedback that was gathered.

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

1) The Deaf, Hard of Hearing, Blind, and Physical Disabilities UsCC subcommittee

This 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 FY 18-19 with a membership roster of over 50 individuals and is actively recruiting new members.

EE/ME

1) Armenian Mental Health Show

A local Armenian television station, ARTN TV Station, was contracted to produce, direct, host, and broadcast a weekly mental health show in the Armenian language. The show consisted of 28 half-hour episodes, where various mental health topics were presented. The Armenian mental health show included episodes on the following topics: depression, anxiety, couple's therapy, trauma, and intergenerational issues. During the third season, the format of the show changed. It included three (3) phases:

- Phase 1: Introduction that included opening remarks by a mental health professional and a host (3-5 minutes)
- Phase 2: A therapy session reenactment facilitated by a mental health professional and included actors and actresses (10-15 minutes)
- Phase 3: A TV host and a mental health professional, who explained the therapy session and its process (10 minutes). Each of the actors/actresses were well-known in the community.

The show provided an opportunity for the Armenian community to be educated and informed on the symptoms associated with a variety of different psychological disorders and the psychotherapeutic process. It included current psychological issues that are impacting the Armenian community in Los Angeles County. The shows were broadcasted in areas with the largest concentration of Armenians, such as La Cañada, Burbank, North Hollywood, Glendale, Pasadena, Los Angeles, and Montebello.

Outcomes for CY 2018:

- From August 2018 to November 2018, a total of 28 half-hour mental health shows were aired on the local Armenian television station

2) The Arabic, Farsi, and Russian Public Service Announcement (PSA) Project

This project was implemented on July 1, 2018 and completed on August 31, 2019. The project sought to increase mental health awareness and education to the Arabic, Farsi, and Russian speaking communities in the County, which are significantly underserved by the public mental health system. A consultant produced, implemented, posted, and tracked 42, 90-second PSAs in the Arabic, Farsi and Russian languages. There were 14 PSAs in each language. The PSAs included celebrities and/or prominent community figures from the three-targeted communities. The consultant was responsible for posting/broadcasting the PSAs for a total of eight months via different social media outlets including, but not limited to Twitter, Facebook, and You Tube. The consultant closely tracked and monitored the viewership of the PSAs and measured its effectiveness.

Outcomes for CY 2018:

- 10 Arabic, Farsi, and Russian PSAs have been posted on YouTube, Twitter and Facebook
- Some of the topics include Post Traumatic Stress Disorder (PTSD), domestic violence, child abuse, substance abuse, loss and grief, and bullying.

Latino

1) Latino Media Campaign

The Latino media campaign was launched on May 1, 2017 and was completed on July 16, 2018. The commercials 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 takeover, 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 Dr. Sandra Chang, 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.

Outcomes for CY 2018:

- The KMEX report shows that the television campaign delivered a total of 14,501,956 impressions
- The KLVE, KRCD, and KTNQ reports showed that the radio campaign delivered a total of 12,200 impressions
- Digital campaign delivered 1,106,234 impressions
- A gross total of 15,620,390 impressions were delivered
- The media campaign reached millennials via digital, KLVE Motivational Monday social media posts, and homepage takeovers via Univision.com and at the same time, personally touched the 25-54 age group with their message on KMEX news and novellas.

2) Latino Mental Health Stigma Reduction Community Theater Project
The goal of this project was to outreach, educate, and increase knowledge pertaining to mental health services within the Latino community. By utilizing a non-stigmatizing method such as a theatrical play, Latino community members learned about the signs and symptoms associated with mental health and became familiar with the services that are available through LACDMH. The project is scheduled to be completed by May 30, 2020.

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.

Outcomes for CY 2018:

- 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.

2. Promotores de Salud/Health Promoters

The Community Mental Health Promoters Program was originally implemented by the Latino UREP UsCC subcommittee in 2009 as a capacity-building project that awarded four community-based organization to recruit, train, monitor and support the activities of the very first cohort of LACDMH Promoters. A second wave of implementation took place in 2011, focusing specifically in Service Area 7. Since the expansion of the Mental Health Promoters Program has reached the eight Service Areas. During FY 18-19, LACDMH had trained one hundred and fifty three (153) Spanish-speaking Community Mental Health Promoters representing all Service Areas.

This countywide expansion builds system capacity and promotes access to health services by increasing the community's knowledge about mental health through the outreach, engagement, community education, social support, and advocacy activities led by the 153 mental health promoters. These natural leaders 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 LACDMH Mental Health 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. 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. The Community Mental Health Promoters effectively connect with underserved communities with high rates of mental health stigma and facilitate navigation of systemic cultural and linguistic barriers they often experience.

Mental Health Promoters program has been expanded to all Service Areas, totaling 153. Below is a summary of the number of Promoters by Service Area:

- SA 1 - 17
- SA 2 - 17
- SA 3 - 20
- SA 4 - 18
- SA 5 - 15
- SA 6 - 19
- SA 7 - 25
- SA 8 - 22

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.

During FY 18-19, Promoters of Mental Health collectively conducted 5,521 mental health presentations throughout their Service Area communities, which is 1,233 more presentations than those completed in FY 17-18, a 22% increase. Their community outreached figures also show a 20% increase in FY 18-19. In addition, they participated in 522 community events, which included health fairs, resource fairs, and having resource tables twice a week at both the Mexican and Salvadorian consulates.

Overall, CY 2019 was a year of significant growth for the Mental Health Promoters program. The number of trained Promoters increased, allowing for a similar increase in the number of community presentations and individuals served. This CY was also the first time Mental Health Promoters expanded to SAs 1 and 5, making the program available countywide. Given the success of the program for Spanish-speaking Latinx individuals, there are plans to expand the Mental Health Promoters approach to the English-speaking Latinx group and other cultures pending additional funding and staff.

Additionally, the Mental Health Promoters received over 120 hours of training and coaching to be able to provide educational workshops to primarily Spanish-speaking and underserved communities within Los Angeles County.

3. Linkage Programs: Jail Transition and Linkage Services, Mental Health Court Programs, and Service Area Navigation

These linkage programs focus on connecting persons involved with the criminal justice system to essential services such as mental health and housing.

Jail Transition and Linkage Services- The program addresses the needs of individuals in collaboration with the judicial system by providing outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. 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 Mental Health Court Linkage Program includes the Court Liaison Program and the Community Reintegration Program (CRP) under its umbrella:

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 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: 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; linkage 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.

The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants who have a mental health conditions and 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 who have a mental illness and 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 upcoming release from prison. The staff also work along side specialized community mental health agencies and Directly Operated programs to assist them with re-entry to their communities.

The Service Area Navigators assist individuals and their family members to access mental health and other supportive services. In this role, the navigators engage in joint planning efforts with community partners, community-based organizations such as schools, faith-based organizations, other County departments, health service programs, and self-help as well as advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services.

4. Intensive Care Division (ICD)

As a result of continuous departmental reorganization efforts during CY 2019, the Countywide Resource Management (CRM) integrated with the Managed Care Division and changed its name to the Intensive Care Division. The role of the ICD includes planning, developing, and implementing urgent care centers and enriched residential programs for specialized populations while managing all administrative, clinical, and fiscal aspects of programs that serve the most severely ill individuals. It also coordinates functions to maximize the flow of clients between various levels of care and community-based mental health services and supports.

The scope of intensive services provided by the ICD include acute psychiatry; subacute facilities; enriched residential services; Crisis Residential Treatment Programs; Urgent Care Centers; and Psychiatric Health Facilities. Additionally, the ICD is responsible for authorizing specialty treatments such as Day Treatment Intensive, eating disorders, and electroconvulsive therapy. The Continuing Care Unit, located in the Access Center, which is operated by ICD during the day, authorizes ambulance services and transport for subacute admissions when clients are either indigent or when we transfer out of-county.

Psychiatric Urgent Care Centers (UCCs)
Psychiatric/behavioral Health UCCs are Medi-Cal certified and Lanterman Petris Short (LPS) designated free-standing crisis stabilization units that provide rapid access to mental health evaluation and assessment, crisis intervention and medication support 24- hours per day, 7 days per week. Integrated services are available for persons who have co-occurring substance use disorders. Services focus on stabilization and linkage to recovery-oriented community-based resources.

5. 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. This program promotes the expectation that clients are successfully reintegrated into their communities upon discharge and that all care providers participate in client transitions.

6. Full Service Partnerships (FSP) Program Redesign
This new FSP pilot program restructures contracts to better address the mental health needs of vulnerable children and adults in Los Angeles County. The redesign moved FSPs from an “existing slot-based” approach to a team-based model with modified program parameters and performance-based criteria. LACDMH welcomed its current network of contracted Child and Adult FSP program providers to participate to ensure integrated services meet the needs of children and adults requiring the most intensive care and result in better mental health outcomes. The goal is to formally roll out a redesigned county wide FSP program within the next two FYs that includes existing and new providers.

7. Innovation (INN) Programs*
The overarching goal of Innovation projects is to introduce new approaches to improve the quality of mental health services and achieve greater outcomes for persons experiencing chronic and severe mental illness.

<u>True Recovery Innovation Embraces Systems That Empower (TRIESTE)</u>
The California Mental Health Services Oversight and Accountability Commission (MHSOAC) authorized LACDMH to use MHSA Innovations revenue of $116 million

over a five-year period to pilot a comprehensive, human need-based approach to serve people with severe and persistent mental illnesses, with a particular emphasis on those who are homeless. The Department seeks to implement a pilot project called TRIESTE which targets individuals suffering with untreated serious persistent mental illness. Once implemented, this pilot will replicate the community-based approach made famous Italian city, Trieste, renowned for being the jurisdiction that delivers "the finest system of mental health care in the world."

The goal of LACDMH's TRIESTE is to improve upon the entire clinical continuum by targeting "wellbeing" as a holistic outcome through services and resources that address the social determinants of health. The pilot project adds significant services to the existing continuum of acute and urgent care, such as 24/7/365 drop-in centers with kinship services delivered by trained and certified peers, a broad continuum of interim and permanent housing types, training, education, supported employment, occupational and recreational therapy, family support, legal and benefits assistance, all as part of a design that aims to promote not only independence but also inclusion and purpose in community for those receiving services.

Hollywood is an ideal location for LACDMH to test this pilot. The Hollywood business community is strongly invested in making this project a successful reality. LACDMH intends to begin a year-long stakeholder engagement process with the Hollywood community to solicit input on the design and implementation. The Department is currently in negotiations for a sole source contract with a leading non-profit provider of program services and fiscal sponsorship. LACDMH plans to seek approval from the Los Angeles County Board of Supervisors to allow the contractor to initiate the first year of planning that focuses primarily on the stakeholder process and the development of the program itself, as well as to implement the program in years 2 through 5.

<u>INN 2: Community Capacity Building to Prevent and Address Trauma</u>
This project centers on building the capacity of the community to identify and support community members at risk of trauma or experiencing trauma. The project aims to utilize the assets of the community to test strategies that allow local communities to work together in ways that will ultimately lead to better mental health and reductions in trauma, through the building of shared community values, leadership development and community member empowerment.

Through a solicitation process 10 lead agencies, two (2) in each County Supervisorial District were identified to establish community partnerships in geographically-defined communities. The identified communities have a high concentration of inequalities, among them poverty, unserved and underserved populations, poor health outcomes, educational limitations as well as unemployment. Each selected organization and their community partners identified specific strategies based on their community's interests. Beyond the implementation of selected strategies, each community partnership is responsible for building the

capacity of the specific communities to work collectively toward supporting community identification and reduction of trauma, as outlined in the solicitation.

Strategies include:

- Building Trauma Resilient Families targeting children ages birth to five and their caregivers who have experienced trauma and/or are at risk for trauma. Activities include 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 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 early care/education and school settings to reduce stress experienced by children.
- Outreach and engagement to TAY (ages 16-25) and TAY peer support groups to outreach and engage TAY who are at risk of or experiencing trauma as a result of homelessness.
- Coordinated employment through a standardized employment assessment tool, a network of businesses within a specific community will be created that will provide coordinated job opportunities to individuals who are mentally ill and have experienced homelessness. Job opportunities will be sought out in the competitive employment market and through the development of social enterprises within the neighborhood.
- Community Integration for individuals with a mental illness with recent incarcerations or who were diverted from the criminal justice system. A community response involving the creation of a consortium of law enforcement, the courts and community agencies designed to reduce re-incarcerations.
- Geriatric Empowerment Model designed to outreach, engage and house homeless older adults.
- Culturally competent non-traditional self-help activities for families with multiple generations experiencing trauma, including engagement, intergenerational story- telling and intergenerational mentorship programs.

Since the implementation of the INN 2 project, there have been a two-day kick off and five (5) Learning sessions, attended by INN 2 lead agencies, community partners and community members, filled with brilliant and informative keynote speakers, along with INN 2 partner presentations. The INN Team has attended, called-in and/or reviewed the minutes from over 250 community partner, provider and TAY network meetings. With the two-day kick-off event on September 17 and 18, 2018, the agencies worked diligently through the end of the calendar year to complete hiring, attend and/or implement Initial trainings, build partnerships within their communities, establish community partner subcontract agreements when applicable, develop screening tools and begin to implement their proposed programs. In the first fiscal year of the project, the innovation team provided in

excess of 25 trainings solely for INN 2 providers and their community partners/members.

There were 51 individuals hired across the INN 2 projects, 27 subcontract agreements approved, 166 provider trainings provided, 291 INN 2 events, 79 outreach efforts, touching 1,000+ TAY and families, 85 different activities delivered and over 100 community focus groups/meetings conducted.

The inception of the events tracker, and data entered from July 1, 2019 forward, has made the process of tracking events, activities, meetings, trainings and outreach in real time much more accessible. There have been 132 "activities" with 792 participants, 233 "events" attended by 7,896 people, 109 trainings delivered by providers to community partners, communities, etc., educating 2,164 individuals in a number of topics as they relate to trauma. The providers continue to expand their community capacity and to reach out to engage and include new members of the community, since July there have been 239 "community partner and TAY network meetings", informing 3,496 community partners and members. Lastly, for those projects including a component of "outreach," there have been 249 outreach events in the past six months, reaching 7,076 individuals.

<u>INN 3: Help@ Hand (Formerly Technology Suite)</u>

Help@Hand (previously known as the Innovation Technology Suite) is a multi-county and city collaborative project which aims to use a menu of innovative digital mental health solutions, to increase access to care and wellbeing. Based on initial learnings from the first year of the project, LACDMH focused its local target populations to accomplish the following:

- Focus on engaging college, graduate, and vocational students with a set of technology applications that aim to meet their mental health and well-being needs and/or assist in linking them to appropriate levels of care and supports
- Improve mental health and well-being of County employees by increasing access and engagement to digital technologies supporting mental health and wellbeing
- Improve mental health and well-being of County residents by increasing access and engagement to digital technologies supporting mental health and wellbeing Improve engagement among individuals receiving services at LACDMH through digital mental health and well-being tools

After receiving approval from the MHSOAC on October 26, 2017, LACDMH entered into an agreement with the California Mental Health Services Authority (CalMHSA), a Joint Powers Authority utilized by counties, to facilitate the administrative functions such as fiscal, contract, and project management, of this multi-county and city project. The participation agreement was approved by the Los Angeles County Board of Supervisors in February 2018. Participating county mental health departments aim to bring technology-based mental health solutions into the public mental health system with objectives to:

- Increase access to the appropriate level of care
- Reduce stigma associated with mental illness by promoting mental wellness

- Detect and acknowledge mental health symptoms sooner
- Increase purpose, belonging, and social connectedness of individuals served
- Analyze and collect data to improve mental health needs assessment and service delivery

Los Angeles, Kern and Mono counties participated in vendor selection for technologies in February 2018 and selected 7 Cups and Mindstrong as initial vendors. In April 2018, Orange and Modoc counties were approved to join the Technology Suite and, in September 2018, ten (10) additional counties were approved, for a total of 15 counties and cities. During the early summer of 2018, RSE was selected as an outreach, engagement and marketing firm and the University of California, Irvine as the evaluator of the project. Significant learning was accomplished in the initial phase of the project with the piloting of the first two applications. LACDMH piloted the Mindstrong care application at Harbor-UCLA's outpatient Dialectical Behavioral Therapy (DBT) program as a strategy to promote early detection of emotional dysregulation. LACDMH also piloted 7Cups as a digital tool (application and web-based) to increase social connectedness through chat and well-being through growth paths and educational, self-help content.

Many providers reflected positively on the use of the digital DBT diary card to improve treatment with greater ease of use with the electronic diary card compared to the paper diary cards. The digital diary cards could therefore provide a better view into clients' functioning between sessions, and the data was more useful within sessions. Providers noted several initial challenges to implementation such as the lack of hardware (e.g., computers in provider offices to review client Mindstrong data in session), issues with integrating Mindstrong into the clinical workflow and the DBT treatment model, and initial reluctance of some providers to try digital tools. Many of these challenges have been addressed due to strong clinical leadership. LACDMH is currently exploring options for expanding the use of a digital diary card.

<u>INN 4: Transcranial Magnetic Stimulation (TMS)</u>
TMS is the Food and Drug Administration (FDA) approved for the treatment of depression and is a non-invasive treatment that can enhance or suppress the activity of neurons in targeted areas of the brain through the use of electromagnetic stimulation. According to the American Psychiatric Association best practice guidelines for the treatment of major depressive disorder, TMS is now a first-line treatment for depression that has not responded to one antidepressant medication (APA 2010) as well as being effective for treatment-resistant depression.

In April 2018, LACDMH was approved to implement a Mobile TMS program via in a mobile van outfitted with the technology, delivered to fully consenting clients receiving services in adult outpatient programs. The target population includes individuals receiving outpatient services that have a depression as a major part of their psychiatric symptoms and one or more of the following:

- Resistance to treatment with psychopharmacologic agents as evidenced by a lack of a clinically significant response to at least two psychopharmacologic agents in the current depressive episode

- Inability to tolerate psychopharmacologic agents as evidenced by two trials of psychopharmacologic agents from two different agent classes
- History of response to TMS in a previous depressive episode
- A history of response to electroconvulsive therapy (ECT) in a previous or current episode or an inability to tolerate ECT, or is a candidate for, but has declined ECT and TMS is considered a less invasive treatment option.

TMS uses precisely targeted magnetic pulses similar to those used in Magnetic Resonance Imaging (MRI) to stimulate key areas of the brain that are underactive in clients with depression. The client reclines comfortably in the treatment chair and is awake and alert during treatment. An electromagnetic coil is then placed directly to the target area of the brain where the device generates magnetic fields that alter the electrical activity of neurons. During treatment, the client hears a clicking sound and feels a tapping sensation on the head. The client can go back to their normal activities immediately after treatment. Treatment can last between 3-45 minutes and is administered once per day for 5 consecutive days per week for 4-8 weeks. Because of the nature of the TMS treatment, individuals with a history of seizure disorder and those with metal implants in the head or upper torso (e.g., cardiac pacemakers) are excluded.

The goals of the INN 4 Mobile TMS project include:
- Provide access to new and effective treatment to clients with chronic and severe mental illness
- Increase adherence to treatment by bringing the treatment to the client
- Reduce use of other resources (i.e., psychiatric hospitalization, emergency room visits intensive supportive services, etc.)
- Improve social and occupational functioning that would lead to successful community reintegration
- Increase the quality of life of clients with histories of poorly treated depression.

Provision of service began on May 30, 2019 with the implementation of the Mobile TMS Unit. This unit operates utilizing a van that has been modified to allow a small treatment team to deliver TMS services. Clients of Directly Operated LACDMH clinics are referred to the TMS program by their outpatient providers (psychiatrists or clinicians). After receiving referrals, clients have an in-person consultation with the TMS program director (Marc Heiser, MD, PhD) during which their symptoms, treatment history, and medical history are reviewed, and a safety screening form and initial symptom rating scales are completed. The treatment is explained and demonstrated for and discussed with the potential clients. If they are interested and the treatment is appropriate, an informed consent form is completed and they are scheduled for their initial treatment. While the TMS unit has been at one location, the program has received referrals and treated clients from six LACDMH clinics located throughout the County (including Service Areas 2, 3, 5 and 8).

The TMS client satisfaction survey is completed by clients at the end of treatment. The Satisfaction Survey includes 11 items that assess satisfaction with various

aspects of TMS treatment and the impact of TMS on the client's overall well-being and functioning. Overall, a majority (72%) of respondents were very satisfied or satisfied with their TMS experience as the Figure shows below.

INN 5: Peer Support Specialist Full Service Partnership

LACDMH received approval from the MHSOAC on April 26, 2018 to implement two (2) teams comprised mostly of peer support specialists to provide intensive field-based services to individuals with multiple challenges including justice involvement. *PeerSS FIRST* services are provided by individuals with lived experience in mental health, either as consumers or family members. They receive support by clinical staff. The two PeerSS FIRST provide a full array of mental health services ranging from peer support to medication management as well as 24-hour on-call coverage. Successful implementation of PeerSS FIRST will expand the role of peers from an adjunct or supportive service provider to a leading member of the treatment team and the primary contact for every service recipient. PeerSS FIRST proves the effectiveness of peer staff and peer-based services. Solicitation documents are under final review with an anticipated release date in January or February 2020.

INN 7: Therapeutic Transportation (TT)

LACDMH received approval from the MHSOAC on September 27, 2018 to implement 20 teams across the County and across multiple shifts to transform the County's approach to responding to individuals placed on an involuntary hold or at significant risk of being placed on a hold through engagement, support and recovery-focused interventions. TT is a collaboration with the Psychiatric Mobile Response Teams (PMRT). It uses especially-equipped vans driven by a clinic driver and staffed with mental health clinicians and peer support specialists. Staff offer a supportive and expedited response to transportation, as well as initiate supportive case management to begin the recovery of mental health symptoms and/or trauma from the first point of contact. TT staff are trained in crisis intervention, engagement, therapeutic support, and de-escalation approaches. The vans are equipped with technology that allow for clients and staff to engage in tele-psychiatry services. Each TT team responds to transport a client who is on a hold or to intervene on the streets to avoid the need for an involuntary hold. TT staff may transport a client and/or their family members when the staff determine that the client requires transportation for emergent or non-emergent situations. TT staff determines appropriateness of the client based on an evaluation and observation of the clients' current behaviors and checks if there is no risk involved with transporting the client. TT may be utilized to transport a client to a clinic, urgent care center and any other social service agency. These services decrease the wait time and improve response times for PMRT and transportation.

8. Outpatient Care Services

Formerly known as Recovery, Resilience and Reintegration (RRR) RRR services were reevaluated to consider its transformation to a comprehensive system for Outpatient Care Services countywide. These services focus on outpatient settings that serve a wide range of persons who meet the criteria for specialty mental health

services across all age groups. Services include Transition-Age Youth (TAY) Drop-In Centers; Field-based and Clinic-based Mental Health Services and Supports; TAY Supported Employment Services; Integrated Care Outpatient Programs; Peer Run Centers, including Peer Run Respite Housing; Wellness Services; and Probation Camp Services with co-located mental health services.

9. Technological Advancements*

Provider Directory

As a result of the Final Rule Mental Health Plans (MHPs), this project makes the comprehensive LACDMH Provider Directory available to beneficiaries in both electronic and print formats (upon request). It includes both Directly Operated as well as contract providers, groups, and individuals. This project started in February 28, 2018 and was completed in May 1, 2019. Interactive solution can display locations on GIS maps and print as PDF that meets ADA requirements for persons with visual disabilities and is machine readable. The Provider 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

Patient's Rights Change of Provider App

The objective of this project 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 App also tracks State mandated requirements that are related to any request for change of providers. For Directly Operated users, the Microsoft CRM Dynamics Application is in the Execution Phase in the Sandbox Development environment. This project empowers consumers by automating the process by which they can request a change in provider services from either a Directly Operated centers or contracted Legal Entities. The project started in May 10, 2018 and was completed in December 20, 2019. This App met reporting requirements for CMS Medi-Cal Specialty Mental Health Consolidation Waiver program.

1) *Digital Workplace: WI-FI Access at LACDMH Clinics and Admin Sites*
   The project started in July 1, 2018 and completed in June 30, 2019. 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. This project added Wi-Fi to 40 more sites, bringing total LACDMH sites with Wi-Fi capability to 51.

2) *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 July 2, 2018 and the projected completion date is June 30, 2019.

3) *Mental Health Resource Locator & Navigator (MHRLN)*

The objective of this project was to improve access to care (capacity management). This project builds application that tracks availability of beds at 24-hour mental health treatment facilities in LACDMH's network of care, such as psychiatric acute inpatient hospitals, sub-acute hospitals, and residential treatment facilities. It allowed users to look up bed availability based on filtering criteria and geo location. The demo was presented to Board of Supervisor deputy and received approval to proceed with full application build. This project started in May 10, 2018 and was completed in December 20, 2019.

4) *Patients Complaints and Grievance Portal*

This project sought to improve quality of care via a portal application for the general public, including clients and family members, to report grievances and appeals online, while also allowing LACDMH Patients' Rights Office staff to more easily receive, track and triage grievances and appeals to ensure timely resolution. Phase I involved the development of a public-facing site for external users to have the ability to submit Grievances/ Appeals to LACDMH's Patient's Rights Office. In Phase II, a cloud-based application was developed for internal staff to process received grievances. The project started in April 20, 2018 and the Phase I was completed. The Patients Complaints and Grievance portal is available as of January 30, 2019.

5) *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

To fulfill state Final Rule network adequacy requirements, this project automates extraction of data from the NACT and supplements with IBHIS and legacy IS claiming data to document details of the Mental Health Provider Network for Los Angeles County for Quarterly Submission of Network Adequacy Certification. This project was implemented on February 28, 2018 and completed on March 7, 2019.

6) *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, with the purpose 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.

In FY 18-19, LACDMH and libraries upgraded the hardware and software in all 27 existing consumer/family labs in service settings at LACDMH clinics and wellness centers, replacing 100 PCs, 100 monitors with built in privacy screens, and 30 printers. Also, devices were added to the Peer Resource Center at the LACDMH Headquarters Building. This project started in July 2017 and the expected completion date is June 30, 2022.

**Source of information: MHSA Three Year Program and Expenditure Plan, FY 20-21 through 22-23.*

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 1: 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 Improvement and Quality Assurance

1. 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 2018 and May 2019. 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).

The Consumer Perception Surveys (CPS) were distributed at randomly selected outpatient and day treatment programs between May 13, 2019 and May 17, 2019. Survey data was gathered from youth (ages 13-17) using the Youth Services Survey (YSS, Youth), 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, Families).

Table 2: Percent of Consumers / Families by Age Group who Strongly Agree or Agree With the "Location of Services was Convenient" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*	*N*	*%*
2019										
May	4,170	91.2%	1,817	84.8%	5,138	83.6%	644	89.1%	11,769	86.6%
2018										
Nov	2,755	90.3%	1,213	84.9%	4,297	82.2%	455	85.6%	8,720	85.8%
May	4,213	92.8%	1,979	84.3%	5,422	83.7%	609	86.6%	12,223	86.9%
2017										
Nov	4,158	91.7%	1,944	82.5%	5,119	82.5%	499	88.4%	11,720	86.0%
May	2,209	92.8%	1,107	84.3%	3,299	83.7%	432	89.5%	7,047	87.0%

Note: The "N" represents the number of responses with a value of 4 or 5 (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 2017 and May 2019.

Table 2 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Location of services was convenient." Among Families and Adults, there was a decline in percentages over the Spring and Fall survey periods. More specifically, for Families, for the Spring survey periods, there was a 1.6 PP decrease from May 2018 (92.8%) to May 2019 (91.2%), and, for Adults, there was a 0.1 PP decrease from May 2017 and 2018 (83.7%) to May 2019 (83.6%). For Youth, there was a 0.5 PP increase from May 2017 and 2018 (84.3%) to May 2019 (84.8%). For Older Adults, the percentages fluctuated over time in that there was a 2.9 PP decline from May 2017 (89.5%) to May 2018 (86.6%) and then an increase of 2.5 PP from May 2018 to May 2019 (89.1%). Overall, in the May 2019 survey period, Adults were the least satisfied age group and Families were the most satisfied age group in terms of location of services.

Table 3: Percent of Consumers / Families by Age Group Who Strongly Agree or Agree with the "Services Were Available at Times that Were Convenient" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019										
May	4,230	92.7%	1,817	85.1%	5,549	90.3%	688	94.2%	12,284	90.5%
2018										
Nov	2,801	91.8%	1,206	84.4%	4,669	89.3%	493	92.8%	9,169	89.6%
May	4,213	93.5%	1,979	84.5%	5,422	90.5%	609	93.8%	12,223	90.6%
2017										
Nov	4,158	92.7%	1,944	83.1%	5,119	90.2%	499	95.2%	11,720	90.0%
May	2,209	93.4%	1,107	86.3%	3,299	90.3%	432	94.0%	7,047	90.8%

Note: The "N" represents the number of responses with a value of 4 or 5 (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 2017 and May 2019.

Table 3 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Services were available at times that were convenient." A total of 90.5% (N = 12,284) of the consumers and families that participated in the May 2019 survey period reported they agreed to strongly agreed with the statement, "Services were available at times that were convenient." There was a 0.3 PP decline from 90.8% in May 2017 and a 0.1 PP decline from 90.6% in May 2018.

Among Families and Adults, there was a slight decline in percentages over the Spring and Fall survey periods. More specifically, for Families, there was a 0.8 PP decrease from May 2018 (93.5%) to May 2019 (92.7%), and, for Adults, there was a 0.2 PP decrease from May 2018 (90.5%) to May 2019 (90.3%). For Older Adults, there was a 0.4 PP increase from May 2018 (93.8%) and a 0.2 PP increase from May 2017 (94.0%) to May 2019 (94.2%). For Youth, the percentages fluctuated over time in that there was a 1.8 PP decline from May 2017 (86.3%) to May 2018 (84.5%) and then increase of 0.6 PP from May 2018 to May 2019 (85.1%).

Overall, in the May 2019 survey period, Youth were the least satisfied age group and Older Adults were the most satisfied age group in terms of time of services.

Table 4: Percent of Consumers / Families by Age Group Who Strongly Agree or Agree with the "Staff Were Sensitive to My Cultural/Ethnic Background" Item

Survey Period	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019										
May	3,885	94.3%	1,619	82.9%	4,982	85.6%	616	89.7%	11,102	88.3%
2018										
Nov	2,886	94.6%	1,185	82.9%	4,470	85.5%	472	88.8%	9,013	88.0%
May	4,213	94.9%	1,979	82.4%	5,422	86.1%	609	89.6%	12,223	88.3%
2017										
Nov	4,158	94.7%	1,944	82.6%	5,119	85.2%	499	91.0%	11,720	88.3%
May	2,209	95.4%	1,107	86.0%	3,299	84.5%	432	86.4%	7,047	88.2%

Note: The "N" represents the number of responses with a value of 4 or 5 (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 2017 and May 2019.

Table 4 reports the percentage of consumers and families in CY 2017, CY 2018, and May 2019 that agreed or strongly agreed with the statement, "Staff were sensitive to my cultural/ethnic background." Results show that on average, consumers/families 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. Approximately, 86.6% (N = 11,769) of the consumers/families who participated in the May 2019 survey period reported they agreed or strongly agreed with the statement, "Location of services was convenient." This represents a 0.3 PP decline from May 2018 and a 0.4 PP decrease from May 2017.

A total of 88.3% (N = 11,102) 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. This number did not change from the May 2018 survey period and is a 0.1 PP increase from May 2017 (88.2%).

Table 5: Three-Year Trend in Overall Satisfaction for May Survey Periods by Age Group

Year	Families		Youth		Adult		Older Adult		Total	
	N	%	N	%	N	%	N	%	N	%
2019	4,334	93.0%	1,996	90.4%	5,444	86.7%	684	91.6%	12,458	89.9%
2018	4,340	93.1%	2,061	86.7%	5,553	87.0%	618	90.3%	12,572	89.3%
2017	2,279	94.2%	1,151	88.3%	3,385	87.3%	450	89.7%	7,265	89.9%

Note: The "N" represents the number of responses with an average value of 3.5 or higher 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 2017 and May 2019.

Table 5 presents the three-year trends in overall satisfaction for the May 2017, May 2018, and May 2019 survey periods by age group. For Youth and Older Adults, the percent of those who are highly satisfied has increased over the past survey period. For Families and Adults, this percentage has decreased slightly.

Overall, during the May 2019 survey period, 89.9% (N = 12,458) of consumers and families reported high overall satisfaction as determined by an average score of 3.5 or greater on all survey items. All of the age groups were above the goal range except for Adults, who were below the lower threshold (86.7%).

Among Families and Adults, there was a slight decline in the percentages over the Spring and Fall survey periods. More specifically, for Families, there was a 0.6 PP decrease from May 2018 (94.9%) to May 2019 (94.3%), and, for Adults, there was a 0.5 PP decrease from May 2018 (86.1%) to May 2019 (85.6%). For Older Adults, there was a 0.1 PP increase from May 2018 (89.6%) and a 0.3 PP increase from May 2017 (86.4%) to May 2019 (89.7%). For Youth, the percentages fluctuated over time in that there was a 3.6 PP decline from May 2017 (86.0%) to May 2018 (82.4%) and then an increase of 0.5 PP from May 2018 to May 2019 (82.9%).

Overall, in the May 2019 survey period, Youth were the least satisfied age group and Families were the most satisfied age group in terms of the cultural sensitivity of services.

2. 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

1. Non-Clinical Performance Improvement Project (Non-clinical PIP)
   Peer Resource Center Pilot
   The Peer Resource Center (PRC) pilot was developed to support community members residing-in, working-in, or visiting the neighborhood directly surrounding the LACDMH Headquarters (HQ). Community members regularly visited the administrative building seeking mental health and other community resources. They would receive general information assistance from the Emergency Outreach and Triage Division (EOTD), PRO, and other rotating programs. Additionally, a large number of homeless individuals, who appeared to be in need of assistance and were prime candidates for engagement efforts, also resided in the area.

   The PRC is the Department's first DO peer-run program. The staff roster included five, full-time, LACDMH employees and five, Wellness Outreach volunteers all dedicated to providing peer support services. The PRC's visitors receive referrals/linkages to services and participate in the PRC's daily activities (i.e., Movie Mondays, chess and guitar lessons, and job readiness) at any given visit. The PRC also offers mental health resources, information on LACDMH programs and services, linkages to essential public assistance and social service programs inclusive of housing support, job training, legal aid, and volunteer opportunities. The goal of the PRC was 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."

   In December 2018, the PRC non-clinical PIP concept was proposed and developed to ensure PRC services were peer-driven, promote resiliency/recovery, and embrace the cultural, linguistic, and historical differences of the neighboring community. Baseline data collection using a PRC Improvement Survey with PRC visitors indicated a need for support with making healthy choices, developing autonomy and independence, and engaging in society through maintaining relationships and purposeful activity. Data also suggested a need for the PRC program to emphasize relationship building and incorporation of the community's diverse cultural and linguistic needs. Lower general satisfaction scores and limited

support in crisis prevention strategies were also identified as target areas for improvement. In April 2019, EQR approved the project as a FY 18-19 non-clinical PIP concept. The EQR team offered their technical assistance (TA) in April 2019, May 2019, and August 2019.

The stakeholders involved in the non-clinical PIP concept were the Office of the Discipline Chiefs, Peer Services, the PRC Staff, SSA 5 LE/Contracted providers, peer employees, and one peer volunteer. Development of the PIP concept included interviews with management and staff and gathering consumer feedback. Information gathered through interviews with PRC management and staff supported the addition of an onsite supervisor and supplementary training for peer staff and supervisors. Consumer participation was facilitated through reviewing open-ended suggestions from the PRC Suggestion Box and the development and administration of the PRC Improvement Survey. This survey collected PRC visitor experiences of the PRC staff, programs, and overall program satisfaction. The survey was administered over a two-week period once prior to the intervention in July 2019 and once just after the initial intervention, training PRC staff to use the skills of the Intentional Peer Support (IPS) model, in September 2019.

The non-clinical PIP concept FY 18-19 activities and interventions included implementation of a training series for the PRC staff beginning with the IPS training model, reorganizing the PRC program oversight and management to include executive staff who had experience with peer services, and surveying PRC visitors at regular intervals to receive feedback about the program services and staff. Results from the post-intervention PRC Improvement Survey suggested an improvement in general satisfaction and in PRC staff being respectful of PRC visitors' cultures. However, these results should be interpreted with caution due to different samples of PRC visitors in the baseline and post-intervention collection periods. There was no evidence that the IPS model training intervention had an impact on the PRC visitor responses, as there was a short period of time between the intervention and survey collection and the impact may need more time to be fully implemented.

This PIP project was presented at EQRO system review in September of 2019. The review team determined that it not meet the State Department of Health Care Services (DHCS)'s standards for an active non-clinical PIP. This finding was attributed to the project's limited focus on engagement and linkage to the Specialty Mental Health Services (SMHS) for Medi-Cal beneficiaries. Thus, the project concluded. LACDMH will continue to support the PRC's expansion and improvements as a quality improvement activity in collaboration with the Chief of Peer and Allied Professions.

2. Clinical Performance Improvement Project (Clinical PIP)
   Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)
   This Departmental clinical PIP entitled was rated as active and ongoing by the EQRO at the FY 19-20 site visit. The goal of this project is to improve the quality

of services delivered to LACDMH consumers experiencing CODs by improving access to integrative, multidisciplinary treatment models that address mental health (MH) and substance use simultaneously. These treatment models are intended to directly address and mitigate the impact of substance use upon consumers' MH symptoms as well as enhance their ability to reduce substance use and improve MH functioning by coping and practicing safety. Out of 16 applicable standards in EQRO's validation tool, 14 were considered met and two (2) were considered partially met, resulting in a rating of 93.75%.

However, the EQRO team also made suggestions to improve the PIP, including tracking service utilization for Mental Health Services and Targeted Case Management as performance indicators, examining whether Seeking Safety is associated with decrease in these services, creating a code in IBHIS to specifically track Seeking Safety utilization, and comparing hospitalization rates to LE and contract sites that are not using Seeking Safety as a reference group.

In Phase I of this project, which began in February 2019, interventions targeted the services consumers receive from Substance Abuse Counselors (SACs) in 12 DO clinics. Specifically, the SACs started implementing treatment strategies targeting co-occurring MH and substance use problems, including Seeking Safety (SS), a specific Evidence-Based Practice (EBP) for trauma and substance use. Other interventions included SS theme-based consultation calls, an expanded curriculum on interventions for COD, and administrative documents to define and provide guidance on the role of the SACs.

Phase II of this project includes the rollout of multidisciplinary treatment groups co-led by SACs, Clinicians, and Clinical Pharmacists. These groups are intended to address the lack of cohesion among treatment team members and to ensure that consumers receive interventions that target mental health and substance use simultaneously. Progress is evaluated by improvement in 7-day and 30-day re-hospitalization rates as well as engagement and retention of consumers with CODs in mental health services.

*Source of information: Annual Report on Quality Improvement, Report Period: July 1, 2018 to December 31, 2019

3. Staff satisfaction: 2019 Cultural Competence Organizational Assessment

In response to the State's Cultural Competence Plan Requirements (CCPR), the Office of Administrative Operations – Cultural Competency Unit (OAO-CCU) conducted a Cultural Competence Organizational Assessment to determine the workforce's knowledge regarding the Departmental initiatives and strategies on cultural and linguistic competence currently in place as related to service planning, delivery and evaluation. To accomplish this goal, LACDMH contracted a third-party evaluation team, Davis Y. Ja & Associates (DYJA), a San Francisco-based consulting firm to co-create the Cultural Competence Organizational Assessment Tool (CCOAT). This online survey was made

available to all LACDMH Directly Operated, Legal Entities/Contracted, and Administrative Programs.

The 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).

Project Methodology

It was determined that the best approach for the CCOAT would be to include quantitative and qualitative items for data collection. A total of nine (9) focus groups were conducted to inform the quantitative content of the CCOAT. These focus groups included the voice of consumers, family members, peers, and staff. Based on themes that emerged from the focus groups, the consultant team proposed a set of items to be included in the CCOAT.

A. Qualitative Data: Focus Groups

The focus groups were facilitated with 91 participants during the period of October 2017 to November 2017 at the LACDMH headquarters. Five (5) focus groups were conducted with consumers, family members, and peers. Spanish interpreter services were made available for those focus groups. The remaining four (4) focus groups were comprised of LACDMH staff inclusive of clerical/support, direct service providers and management, and were conducted in English.

Focus Group Findings

The following key themes emerged from the qualitative focus groups:

- The issue of stigma as a barrier to receiving high quality care
- The need for linguistic appropriate services and written material for LACDMH consumers
- The important role spirituality plays in mental health recovery among persons of color
- The critical role of generational and other forms of trauma that need to be addressed in the treatment process
- The need for ongoing staff training on culturally appropriate services
- The success of the Wellness Outreach Worker program that helps empower consumers

B. Quantitative Data: CCOAT Survey Development & Distribution

Following the analysis of the themes that emerged from the focus groups, the CCOAT was developed to contain items related to five (5) key conceptual components of cultural competence as follows:

(1) Services and Outreach
(2) Services Provided to Consumers

(3) Policies and Procedures
(4) Training and Staffing
(5) Programs and Committees

The final CCOAT consisted of a total of 62 quantitative items. Additionally, the survey included seven (7) open-ended qualitative questions designed to provide opportunities for staff feedback regarding the enhancement of the Department's responsiveness to the cultural and linguistic needs of Los Angeles County communities. The CCOAT was distributed via emails sent by the OAO-CCU. The email invitation for participation was inclusive of Legal Entities and Contracted providers to complete the survey online from December 1, 2018 to January 15, 2019, a period of six weeks. All data were reported in the aggregate with no meaningful way of identifying any individual respondent.

Data Analysis

Once data were collected and cleaned, the factor analysis was conducted to empirically test whether responses grouped around the five (5) conceptual components mentioned above or if the data indicated that a different grouping of items would be more appropriate. The factor analysis, using maximum likelihood for factor extraction and Oblimin rotation supported that, with one exception for items related to American Sign Language (ASL), the subscales encapsulated unique content areas associated with (1) Services and Outreach, (2) Services Provided to Consumers, (3) Policies and Procedures, (4) Training and Staffing, and (5) Programs and Committees. It appeared that in each of those core subscales, individuals who felt more favorable toward content represented by any single individual item were more likely to feel favorable toward content on other items within that subscale.

Respondent Demographic and Work Experience Findings

In total, 2,489 individuals started the survey and 1,673 (67.2%) completed the CCOAT.

- *Gender-identification* (Refer to Table 1): While 5.6% of the survey participants elected to not identify their gender, 71.2% of the responding participants identified as female, 22.8% identified as male, and .2% identified as non-binary or a third gender
- *Education* (Refer to Table 2): Survey participants were highly educated relative to the general population, with nearly 50% of participants having a Master's Degree or Doctorate Degree
- *Dominant racial/ethnic identities* (Refer to Table 4): Over one-third of respondents (36.4%) identified as Latino or Spanish; 23.5% of participants identified as White, 19.3% as Black or African American and 16.9% as Asian. Relatively fewer respondents identified as American Indian or Alaska Native, Native Hawaiian or other Pacific Islander, Middle Eastern or North African
- *Languages besides English spoken* (Refer to Table 6): Of the 986 respondents who were bilingual or multilingual, over half were Spanish speakers. The next most frequently spoken languages were Armenian, Chinese, and Tagalog with close to 5% of multilingual providers speaking one of these languages
- *Age* (Refer to Table 7): Of the 993 respondents who volunteered their age, the average age was 26.7 years

- *Personal and family experience with mental health issues* (Refer to Table 8): Of the 855 who chose to respond to the question related to whether they lived with a mental illness (5.6%) or had a family member who had experienced a mental illness (66%), nearly a third identified they had both personal experience and family experience with mental health issues (28.4%)
- *Current positions* (Refer to Table 9): All but 22 respondents who completed the survey identified as employees of LACDMH (98.7%). Regarding their current positions, the majority of respondents was direct or outreach service providers (35.7%) or clerical/support staff (16%). Slightly over 6% were executive or managerial level employees; and 10.8% supervisory staff
- *Years of LACDMH work experience*: On average, the respondents had worked at LACDMH for 12.4 years, with nearly 20% of respondents being within their first year of employment. Additionally, 55% of respondents had worked at LACDMH for less than three (3) years.
- *Cultural competence training* (Refer to Table 12): Over 80% of the respondents had attended at least one (1) LACDMH-sponsored cultural competence training, with 31.7% having attended more than one (1) training, and 18% not yet having pursued/completed a cultural competence training in the past 12 months

See Attachment 2: Cultural Competence Organizational Assessment Report for details on data tables referenced above.

Analysis of CCOAT Subscale Individual Items

A multivariate analysis of variance determined that there were no differences on any of the subscales across staff function or Service Area. The analysis of subscale individual items includes the following:

(1) *Services and Outreach*: The respondents most strongly agreed with statements related to providing services for all consumers, in diverse languages, with particular services for persons from marginalized groups and different cultural backgrounds (Refer to Table 15). There were a few areas in which respondents answered neutrally and the range responses showed greater variability, which included the items related to ASL, advertisement of services, and consulting with community members

(2) *Services Provided to Consumers*: The respondents agreed to strongly agree with nearly all items (Refer to Table 16). The strongest agreement, with the least variability, was with the item that LACDMH understands that honoring consumers' culture is an important part of customer service. Two (2) areas of relative weakness, with highly variable responses, were the provision of reports to consumers and local communities and involving consumers in evaluation of services

(3) *Policies and Procedures*: A few areas of relative strength emerged, including strong agreement and relatively little variability that LACDMH works to follow federal policies related to cultural competence (Refer to Table 18). Areas of relative weakness, with greater variability in responding, were the notions that LACDMH develops policies through collaboration with employees and consumers

(4) *Training and Staffing*: There was a strong agreement with relatively little variability on the item that cultural competence trainings are available, and that LACDMH provides training on implicit or unconscious bias about cultural differences (Refer to Table 17).

Areas of relative disagreement included training staff on issues related to spirituality and providing opportunities for staff to be involved in decision-making around culturally competent services

(5) *Programs and Committees*: There was more variability in agreement related to the strength of cultural competency programming (Refer to Table 19). Respondents, on average, agreed that Programs and Committees were focused on cultural competency, representing multiple agencies and cultural groups, and including members in stigma reduction activities. When compared to other subscales of the CCOAT, this was an area of relative weakness.

See Attachment 2: Cultural Competence Organizational Assessment Report for details on data tables referenced above.

Interpretation of Findings

Overall, results of quantitative and qualitative analyses suggest that the majority of participants agreed that LACDMH meets many aspirational goals related to cultural competence. Additionally, the staff who believed the Department met cultural competence goals in one area were more likely to believe that LACDMH met cultural competence goals in other areas. Within the quantitative results, most respondents felt that LACDMH provides good to superior cultural competence trainings. Much of the respondents either agreed or strongly agreed with those perspectives. There was one (1) notable exception to collective understanding of cultural competence – in the area of ASL. Many respondents identified less familiarity with services being offered in ASL.

Many recommendations emerged as a result of the survey – in particular as reactions to open-ended questions including providing more advanced trainings on a more regular basis, improving the integration of community members into training and decision-making, and increasing the diversity of staff hires. Suggestions were also made to align trainings based on the communities served in each Service Area.

Despite the overall positivity of the results, as part of the process of developing the CCOAT, a small group of consumers involved in focus groups shared their feelings about the services they had received from the providers. Several consumers voiced concerns regarding insensitive provider relationships as well as issues with the use of poorly trained interpreters sitting in direct service appointments. Some felt that access to psychotherapy in diverse languages was limited; others felt that staff needed further training in addressing issues related to generational trauma.

The qualitative component of the CCOAT also provided some affirmation of the focus groups comments. Over 300 respondents requested additional trainings with a focus on cultural diversity, languages and experiences of providers, as well as being able to better practice across diverse groups and better awareness of implicit and unconscious bias. They further reinforced the need for better trained interpreters as well as more time to attend trainings. Suggestions were also made to ensure that supervisors and managers were equally trained in cultural practices. Additional suggestions that emerged in response to qualitative questions included:

- More advanced trainings in diverse and accessible forms such as the African American conference and a comorbidity of substance use and mental illness training

(e.g., videos, newsletters, hands-on, interdepartmental training, cultural dialogues, cultural exhibits, and etc.)

- More cultural humility training and implicit bias training for providers, clinical staff, non-clinical staff, management, and all employees
- More training on specific populations, including specific cultural groups (e.g., LGBTQ, trauma survivors, Native American communities, diverse gender identities, deaf and hard of hearing) and in diverse lived experiences (e.g., trauma survivors and trauma-informed care, developmental-disabilities, immigration, homelessness populations, etc.)
- More training in diversity of languages, with special requests in areas of ASL and Spanish language. Participants requested additional training in multiple languages, with desires to be bilingual. Participants also indicated needs for better access to interpretation and Language Line Services. Respondents requested more bilingual staff and more bilingual consumer materials
- More time and permission to attend trainings – either as a result of being pressured to provide services, trainings filling on the first day, or trainings being mandated as part of an employment issue rather than being desired by the employee
- More training for supervisors and management, including both the cultural competence of supervisors and management, as well as practices related to management (e.g., hiring more diverse providers, more supportive management styles, more accountability for decision-making)

Recommendations

- LACDMH should consider ongoing use of the CCOAT and improvements over time within specific areas can be tracked
- Suggestions from both consumers and providers recommend a consumer-oriented survey. Given the differences between consumers' and providers' perspectives, this would contribute to knowledge gaps regarding cultural competence.

See Attachment 2: Cultural Competence Organizational Assessment Report for additional details

3. Grievances and Complaints

As mandated by the State Department of Health Care Services (DHCS) Program Oversight and Compliance, the Quality Improvement Division 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.

Beneficiary Problem Resolution

Grievances, appeals, expedited appeals, state fair hearings, expedited fair hearings, Notice of Actions (NOAs), and requests for change of provider are consumer and provider

activities that LACDMH monitors, evaluate for trends, and report to the Departmental Quality Improvement Council. This is an on-going Quality Improvement Work Plan monitoring activity, as specified by our DHCS contract.

Notices of Action

NOAs are required when any of the following actions occur with a Medi-Cal beneficiary

- NOA-A: Denial of Services Following Assessment
- NOA-B: Reduction of Services
- NOA-C: Post Service Denial of Payment
- NOA-D: Delay in Processing a Beneficiary Grievance or Appeal
- NOA-E: Lack of Timely Services

In accordance with Title 9, CCR, Chapter 11, Subchapter 5, and the MHP Contract, LACDMH must have problem resolution processes that enable beneficiaries to resolve problems or concerns about any issues related to performance, including the delivery of SMHS. The Department is required to meet specific timeframes and notification requirements related to these processes.

As mandated by the DHCS, Program Oversight and Compliance (2012-2013), the QID facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. As a MHP, LACDMH shall insure that a procedure is in place where by issues identified as a result of grievance, appeal, or expedited appeal processes are transmitted to the MHP's QIC, the MHP's administration, or another appropriate body within the MHP (DHCS, Oversight and Compliance 2012-2013).

TABLE 6: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS
FY 18 - 19

Category	Process			
	Grievance	Exempt Grievances	Appeal	Expedited Appeal
Access				
Service not Available	0	0		
Service not Accessible	0	0		
Timeliness of Services	0	0		
24/7 Toll-Free ACCESS Line	0	0		
Linguistic Services	0	0		
Other Access Issues	0	0		
Access – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Quality of Care				
Staff Behavior Concerns	**23**	**0**		
Treatment Issues or Concerns	**43**	**0**		
Medication Concern	**8**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**0**	**0**		
Quality of Care – Total by Category	**74**	**0**	**N/A**	**N/A**
Percent	**81.3%**	**0%**		
Change of Provider – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**		
Confidentiality Concern – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
Other				
Financial	0	0		
Lost Property	0	0		
Operational	0	0		
Patients' Rights	0	0		
Peer Behaviors	0	0		
Physical Environment	2	0		
Other Grievance not Listed Above	15	0		
Other – Total by Category	**17**	**0**	**N/A**	**N/A**
Percent	**18.7%**	**0%**	**N/A**	**N/A**
Grand Totals	**91**	**0**	**N/A**	**N/A**

Note: Grievances and Appeals Data is limited to Medi-Cal beneficiaries. Data Source: DMH PRO – ABGAR Form FY 18-19, Oct 2019

In FY 18-19, grievances and appeals were collected and reviewed by the PRO and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required by California's DHCS for Medi-Cal beneficiaries only. The Department's PRO continued to finalize the electronic Grievance and Appeals reporting system. This system will be available to beneficiaries and providers who file complaints on behalf of beneficiaries. Hard copies will continue to be accepted by PRO. The system required many modifications to be in line with Final Rule regulations, which was a collaborative effort with the Department's Quality Assurance Program and Chief Information Office.

Table 6 shows the total number of inpatient and outpatient beneficiary grievances and appeals by category. Ninety-one grievances were received in FY 18-19. Of the beneficiary grievances received, 81.3% (N=74) were related to Quality of Care and the remaining 18.7% (N=7) were categorized as "Other." In FY 18-19, there were no inpatient and outpatient grievances related to Access, Change of Provider, or Confidentiality Concerns.

TABLE 7: INPATIENT AND OUTPATIENT APPEALS' DISPOSITION AND TOTAL NOTICE OF ADVERSE BENEFIT DETERMINATION/NOTICE OF ACTION ISSUED FY 18 - 19

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
Appeals Resulting from NOABD NOA							
Denial Notice	0	0	0	0	0	0	2,579
Payment Denial Notice	0	831	430	0	0	0	2,354
Delivery System Notice	0	0	0	0	0	0	194
Modification Notice	0	0	0	0	0	0	16
Termination Notice	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice	0	0	0	0	0	0	5,632
Financial Liability Notice	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	0
Total	**0**	**831**	**430**	**0**	**0**	**0**	**10,775**

Note: Data Source: DMH PRO – ABGAR Form FY 18-19, October 2019

Table 7 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 10,775 NOABDs or NOAs issued in FY 18-19. Fifty-two percent of the NOABDs or NOAs determined were Timely Access Notices (N=5,632), followed by Denial Notices (N=2,579) at 24%, and Payment Denial Notices (N=2,354) at 22%. There were no beneficiary appeals resulting from a NOABD or NOA in FY 18-19.

TABLE 8: INPATIENT AND OUTPATIENT GRIEVANCES' DISPOSITION FY 18 -19

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	23	0
Treatment Issues or Concerns	0	43	0
Medication Concern	0	8	0
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	0	0
Quality of Care – Total by Category	**0**	**74**	**0**
Percent	**0%**	**97.3%**	**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	0
Patients' Rights	0	0	0
Peer Behaviors	0	0	0
Physical Environment	0	2	0
Other Grievance not Listed Above	0	0	15
Other – Total by Category	**0**	**2**	**15**
Percent	**0%**	**2.6%**	**100%**
Grand Totals	**0**	**76**	**15**

Data Source: DMH PRO – ABGAR Form FY 18-19, October 2019.

Table 8 shows the disposition of 91 grievances in FY 18-19. Out of the 76 grievances that were resolved, 97.3% pertained to Quality of Care (N=74) and the remaining 2.6% were categorized as Other (N=2). Out of the 15 grievances that were referred, 100% were categorized as Other (N=15). There were no grievances pending as of June 30, 2019.

APPENDIX

Attachment 1: LACDMH Legal Entity Contract

LACDMH Legal Entity
Contractual Agreemer

Attachment 2:

CCOAT Assessment
Final Report_ revise