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 19-20

Criteria 1-8

Jonathan E. Sherin, M.D., Ph.D.
Director

August 2021

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

2021 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 (CCU) annually updates the Cultural Competence Plan and makes it available to the LACDMH Executive Management, Directly Operated and Contracted/Legal Entity Providers, and Stakeholder groups such as the Cultural Competency Committee, Service Area-based Quality Improvement Committees, and Service Area Leadership Teams. Additionally, Cultural Competence Plan presentations based on annual updates are delivered at various Departmental venues. The goal of these presentations are to ingrain and foster a shared responsibility in order to advance social equity, cultural relevance and linguistic inclusion within the system of care. Annual update reports are posted on the Cultural Competency Unit webpage and can be accessed at https://dmh.lacounty.gov/ccu/

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: Cultural Competency Committee
- 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 2021 Cultural Competence Plan Report is based on data and programmatic information for Fiscal Year 19-20.

TABLE OF CONTENTS

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 1

Commitment to Cultural Competence

August 2021

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 to 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.

<u>The impact of COVID-19 on LACDMH system of care</u>

In the midst of concerted efforts for survival and wellbeing, uncertainty and distress, grief over lost lives, and disruptions of multiple layers of daily routine, LACDMH remained focused on its mission. Clinical and administrative personnel provided their expertise to overcome the multiplicity of challenges that impinged upon a system of care as large and complex as LACDMH. The Department prioritized the delivery of virtually-driven mental health services and supports to care for the most vulnerable individuals and communities experiencing the disproportionate impact of the pandemic. Such disproportionate impact exacerbated mental health conditions, isolation, and loneliness, among others. The Department's efforts to meet these needs resulted in several improvements in service delivery, including:

- System wide technological advancements for the provision of virtually-driven mental health services
- Creation of virtual spaces for consumers, family members, and community members to experience social connectivity such as virtual Cultural Competence Committee, Underserved Cultural Communities (UsCC) subcommittees and Faith-Based Advocacy Council
- Virtual trainings for staff to build the necessary skills and confidence with new technologies
- Implementation of a COVID-19 webpage in LACDMH's website which contains a plethora of mental health and social service resources. This webpage can be accessed at: http://dmh.lacounty.gov/covid-19-information
- Enhancements to the 24/7 LACDMH Help Line with these new specialized features: COVID-19 emotional support, the Veterans Warm Line, and the Wellbeing Line for healthcare and first responders
- On-line collaborations with the Los Angeles County Board of Supervisors and sister Health Departments to disseminate mental health expertise among County employees and management
- Development of on-line COVID-19-related community guidelines and articles, presentations and trainings, messaging, and resources on mental health and beyond to foster hope, wellbeing, recovery and resiliency in the community

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

LACDMH continues implementing Policies and Procedures (P&Ps) as well as key documents that strengthen the infrastructure of the Department. This collection of documents ensures effective, equitable and responsive services for constituents, while providing a solid and supportive infrastructure for its workforce. Table 1 below provides a snapshot of the P&Ps currently in place that are directly related to cultural competence:

TABLE 1: LACDMH POLICIES, PROCEDURES, AND OTHER INFRASTRUCTURE DOCUMENTS RELATED TO CULTURAL COMPETENCE

TYPE	INFRASTRUCTURE DOCUMENTS

Strategic Plan, Overarching Policies, and Practice Parameters	• LACDMH Strategic Plan 2020-2030
	• Policies and Procedures (P&Ps)
	  ○ Policy No. 200.09 – Culturally and Linguistically Inclusive Services
	  ○ Policy No. 200.03 – Language Translation and Interpreter Services
	  ○ Policy No. 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community
	• Parameters for Clinical Programs (ClinP)
	  ○ ClinP-8 – Delivery of Culturally Competent Clinical Services
	  ○ ClinP-9 – Referral to Self-Help Groups
	  ○ ClinP-10 – Wellness Centers
	  ○ ClinP-11 – Lifestyle Counseling or Healthy Living Programs
	  ○ ClinP-13 – Department of Mental Health Peer Advocates
	  ○ ClinP-15 – Assessment and Integration of Spiritual Interests of Clients in Their Wellness and Recovery
	  ○ ClinP-16 – Family Engagement and Inclusion for Adults
	  ○ ClinP-18 – Co-Occurring Developmental Disabilities
	• Parameters for Medication Use (Med)
	  ○ Med-8 – Psychotropic Medication in Children and Adolescents
	  ○ Med-9 – Review of Psychotropic Medication Authorization Forms for Youth in State
	• Parameters for Psychotherapy (Psych)
	  ○ Psych-5 – Psychotherapy with Children, Adolescents, and Their Families
	  ○ Psych-6 – Family Therapy Techniques with Families of Adult Children
	• Parameters for Special Considerations (SC)
	  ○ SC-6 – Older Adults

TYPE	INFRASTRUCTURE DOCUMENTS
	○ SC-7 – Assessment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-8 – Treatment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-9 – Access to Care After Discharge from Psychiatric Hospitals and Juvenile Justice Programs
Additional Policies and Procedures Related to Cultural Competence	• Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Ensuring Access to Benefits and Care for Veterans and Their Families • 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

(See Criterion 1 Appendix for detailed information)

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

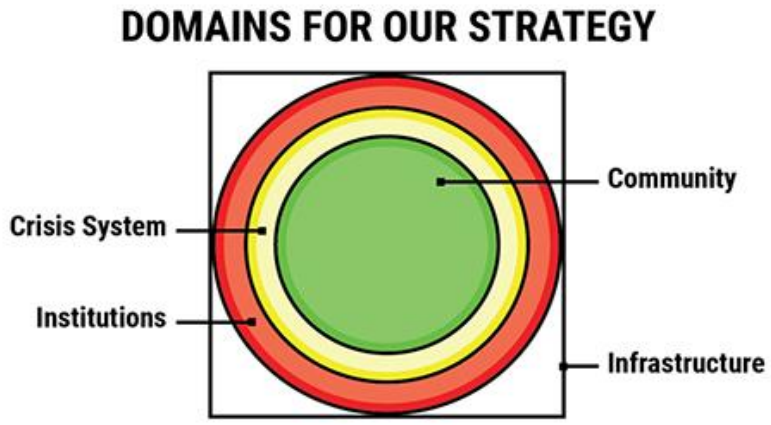
Consistent with the Cultural Competence Plan Requirements (CCPR) and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), LACDMH recognizes and values the racial, ethnic, cultural and linguistic diversity of its communities. The vision of the 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 Strategic Plan 2020-2030 guides the Department to pursue its mission to optimize hope, wellbeing and life trajectory of Los Angeles County's most vulnerable communities. The means to accomplish this lofty goal include service accessibility and opportunities that promote independence, personal recovery, social connectedness, and community reintegration. The strategic plan is based on the following fundamental values and principles, which specify the importance of cultural competence, equity, and collaborations with consumers as well as the community:

- **Client driven** – where we engage consumers, families, communities and all of our grassroots stakeholders as full collaborators in transformation, from care delivery to systems redesign.
- **Community focused** – where the needs and preferences of the communities are recognized and where resources are specially designed and aggressively deployed to meet them.
- **Equitable and culturally competent** – where consumers, family members and communities are cared for equitably and where services are delivered with cultural respect.
- **Accessible and hospitable** – where all services and opportunities are readily available, easy to find, timely and welcoming to everyone.
- **Dedicated to customer service** – where our core calling is to provide premier services to all of our customers, from consumers and families to DMH staff and the vast network of contractors.
- **A heart-forward culture** – where we hold sacred the humanity, dignity and autonomy of those we serve because everyone has the right to flourish and to live a healthy, free and fulfilling life.
- **Collaborative** – where we recognize that we cannot go it alone and that we need the expertise, dedication and teamwork of many other departments and the full range of community partners.
- **Continuous improvement** – where care is focused on meeting the needs of those we serve through best practices, where decisions are tailored and informed by outcomes and where ongoing efforts to increase our impact are built into our work at every level, every day.

Figure 1: LACDMH Strategic Plan Domains



- The ***Community domain***, represented by the green circle signifies our north star where we always prefer, and strive, to provide resources. We aspire to have enriched, welcoming and inclusive communities where human needs are met in a responsive, effective, age informed and culturally competent manner across the County and where falling out of community is neither common nor acceptable.

- The ***Crisis System domain***, represented by the yellow ring, includes the intensive care resources needed to help individuals in crisis who are falling out of community. It signifies our interface with clients experiencing crises and includes both real-time response and triage services as well as facility-based treatment for stabilization. With adequate crisis system resources in place, episodes of homelessness, prolonged or repeated out of home placement, incarceration (the institutions of our day) and recidivism in general can be avoided.

- The ***Institutions domain*** is represented by the red ring, where our broad portfolio of re-entry resources (including compelled treatment) is deployed to help clients who have fallen out of community into the "open-air" asylum of the street, the "closed-air" asylum of the jail, and the personal asylum of deep isolation. Institutions signify the "open-air" asylum of the streets and the "closed-air" asylum of the jails, neither of which is an acceptable place for engagement and care, let alone habitation.

- The ***Infrastructure domain*** signifies the departmental engine that takes care of our numerous support operations. Being ever-present and enterprise-wide, the administrative domain provides us with a foundation for everything we do, from staffing and contracting to managing our technology, facilities and budget to supporting stakeholder engagement and communications.
  (See Criterion 1 Appendix, item 2 for more detailed information)

Cultural and linguistic competence commitments can be found throughout the four domains of the Strategic Plan and its appendices as summarized in the table below.

TABLE 2: CROSSWALK OF LACDMH STRATEGIC PLAN 2020-2030 DOMAINS AND THE CULTURAL COMPETENCE PLAN REQUIREMENTS (CCPR)

Strategic Plan Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Page	CCPR Criterion (CR) 1-8*
Community Domain	1. Goal 1A: Prevention Services	"To this end, the navigation, coordination and follow-up across our system must be improved to ensure that individuals of all ages, families and communities get the resources they want and need (Strategy 1A.3). And, every strategy will be viewed through the lens of culture to ensure we are providing outreach and engagement that takes into consideration individuals' *cultural backgrounds and linguistic needs."*	9	CR 1, CR 3 and CR 8
	2. Goal 1C: Outpatient Mental Health Care Strategy 1C1: Assessment and Care Planning	"Emphasize a whole-person approach to assessment o Integrate individuals' comprehensive needs including behavioral health, physical health and social support during assessments through the lens of their *culture and native language* o For children, include developmental and educational needs"	12	CR 2 and CR 3
	3. Strategy 1C.3 Outpatient Care	"*Conduct culturally and linguistically specific outreach" to* engage underserved communities in understanding what outpatient services are available to them and how to access care o Expand outpatient clinic hours into the evenings and weekends in order to more effectively engage these communities and provide services to enhance accessibility o Support communities in advocating for equity of resources and services"	13	CR 3, CR 4, and CR 8

Strategic Plan Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Page	CCPR Criterion (CR) 1-8*
Crisis System Domain	Goal 2: Intensive Care Strategy 2.1: Real-Time Crisis Response	"Build a real-time, robust, well-coordinated, recovery-oriented and client- and family-centered crisis response network ○ Integrate high-quality crisis response services into every community and staff them with well-trained, *culturally competent* and caring first responders who work to resolve crises safely, for both youth and adults, and make every attempt to avoid the need for hospitalization"		CR 3, CR 5, CR 6, and CR 8
Institutions Domain	Goal 3: Re-entry initiatives Strategy 3.1 Identifying and Connecting with the Deeply Isolated	"Identify co-occurring disorders that may be further isolating individuals ○ Train staff to understand the associated stigmas attached to co-occurring disorders and inter-generational trauma within the cultures represented ○ *Understand the various healing practices different cultural groups* observe and incorporate those into how DMH delivers services" "Evaluate any systemic issues within DMH that may be promoting or enabling the isolation ○ Train front-line and clinical staff in *cultural humility and sensitivity* in order to better demonstrate empathy for increased cultural competency"	16	CR 2, CR 7 and CR 8 CR 1, CR 7 and CR 8
Infrastructure Domain Cont.	Goal 4: Organizational support Strategy 4.3: Outcomes	"Process consumer grievances, complaints and appeals through the lens of culture relating to the background of that individual ○ Ensure equity in the reviews to help address racial and ethnic disproportionality in access to and delivery/quality of care" "Improve training and professional development to increase the skills and capabilities of departmental staff ○ Create a true learning organization by building the capacity for staff to manage projects and improve the quality of programs and services ○ *Infuse cultural competency training* in every new employee orientation	19	CR 1, CR 7 and CR 8 CR 5, CR 6, and CR 8

Strategic Plan Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Page	CCPR Criterion (CR) 1-8*
Infrastructure Domain		○ Conduct regular and frequent staff trainings to increase their *cultural competency*, with a focus on staff who directly engage with clients in outpatient and inpatient settings" "Collect and utilize data to analyze service utilization by communities of color to address disparities and inequities in the system of care ○ *Conduct cultural competency assessments* to better understand the demographic characteristics of communities ○ Work to improve data collection to track and specify the *cultural composition of DMH consumers* beyond broad ethnic category labels" "*Translate key documents for DMH consumers* into the top 13 languages spoken in L.A. County to capture the elements of culture ○ Ensure documents like consent for services, treatment plans and assessments are widely *available in-language and capture culturally specific details* that will help enhance the delivery of care to the consumer"		CR 2 CR 1 and 7
Addendum B	What We Heard Goal 1C – Outpatient Mental Health Care	"Even when individuals can access the care they need, they rarely experience being active members of the care team. Many individuals and their families find DMH clinics to be unwelcoming or stigmatizing. And there are not enough clinic staff *with the appropriate language skills and cultural competence* to adequately serve LA County's diverse communities"	23	CR 1, CR 6, and CR 7
Addendum C	**Sample Tactics** Goal 1A – Prevention Services - *Active Tactics*	"Expanding the Promotores de Salud Mental (Spanish Speaking) and the Mental Health Promoters (Multicultural and Multilingual) Programs: These programs provide specialized mental health prevention services in the community by trained community residents familiar with the language and culture"	25	CR 8

* Specifications for the CCPR, Criterion 1 -8
  - CR 1: Commitment to Cultural Competence
  - CR 2: Updated Assessment of Service Needs
  - CR 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
  - CR 4: Client/Family Member/Committee within the County Mental Health System
  - CR 5: Cultural Competence Training Activities
  - CR 6: County's Commitment to growing a Multicultural workforce: Hiring and Retaining Cultural and Linguistically Competent Staff
  - CR 7: Language Capacity
  - CR 8: Adaption of Services

This space was intentionally left blank

Key to the provision of equitable, inclusive, and meaningful mental health services is the aim to continuously advance cultural and linguistic effectiveness within the Department. LACDMH has a well-established Cultural Competency Unit (CCU) which promotes a collective sense of shared responsibility for the delivery of services that address health inequities and meet the needs of Los Angeles County's diverse communities.

The CCU functions are based on the following premises:

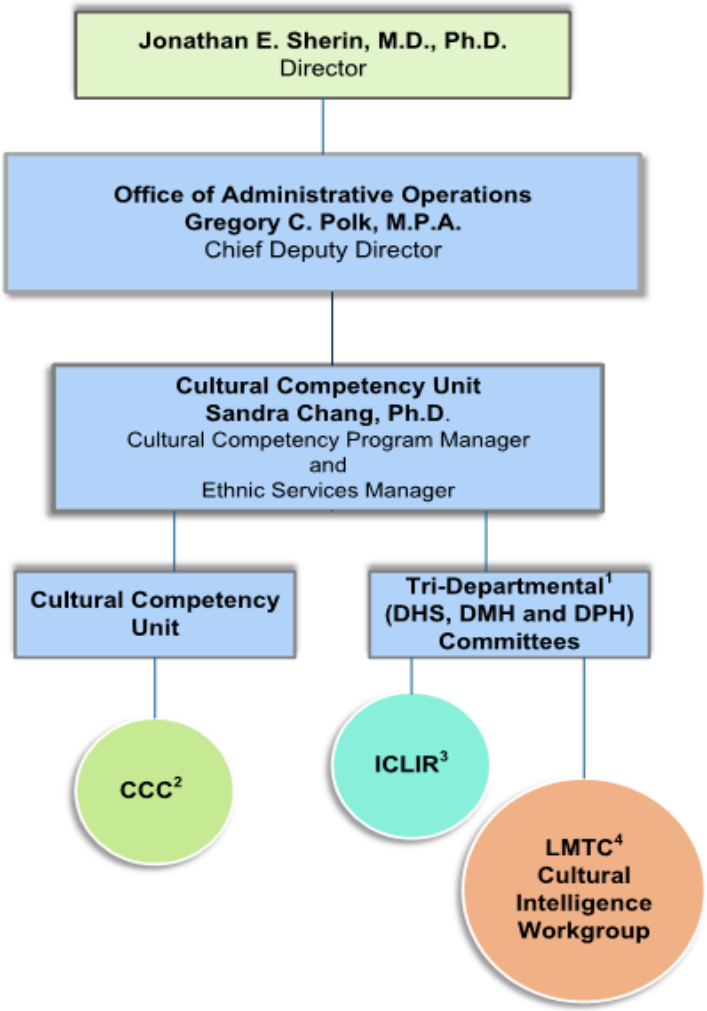
- Cultural competence involves honoring the cultural and linguistic preferences of persons receiving services in order to support their process of healing, recovery, resiliency, and wellbeing
- LACDMH's clinical and administrative programs are most effective when they operate as an integrated network that take into consideration the cultural and linguistic needs of the communities served
- The development and delivery of culturally and linguistically responsive, accessible, and relevant services require collaborative approaches with constituents, community-based organizations and the community as a whole
- Becoming a culturally competent, inclusive, and responsive system of care is a developmental process that requires listening, learning and connecting LACDMH with the voice of constituents, their family members, and communities.

The CCU is actively involved in assisting LACDMH employees, clinical and administrative programs, and management to integrate cultural and linguistic competence in the service delivery framework. The most salient functions of the CCU include:

- Enforce the Federal, State and County regulations pertinent to cultural and linguistic inclusion and responsiveness
- Develop policies and procedures (P&Ps) that highlight the essential role of cultural competence in the provision of relevant and meaningful services
- Conduct system-wide cultural competence organizational assessments aimed at identifying the cultural competence knowledge gaps in LACDMH workforce and developing action plans to address them
- Develop and implement annual Cultural Competence Plans
- Develop and deliver cultural competence trainings and presentations at various departmental venues, LACDMH-sponsored conferences, cross-county and State level summits, community-based organizations, and the community at large
- Interface with key stakeholder groups such as CCC, consumer groups, Service Area Leadership Teams (SALT), Underserved Cultural Communities (UsCC), Community Leadership Team (CLT) and Mental Health Commission
- Promote language justice by facilitating offerings of communication and language assistance services which support the participation of consumers, family members, and community members in various stakeholder meetings
- Partner with LACDMH programs the development and implementation of new initiatives that will advance cultural and language competence
- Partner with other Los Angeles County Health Departments to advance the goals written into cultural ending with the competence as priorities of the Los Angeles County Board of Supervisors
- Partner with other Los Angeles County Health Departments to advance the cultural and linguistic competence priorities of the Los Angeles County Board of Supervisors

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

Cultural Competency Unit
Organizational Chart

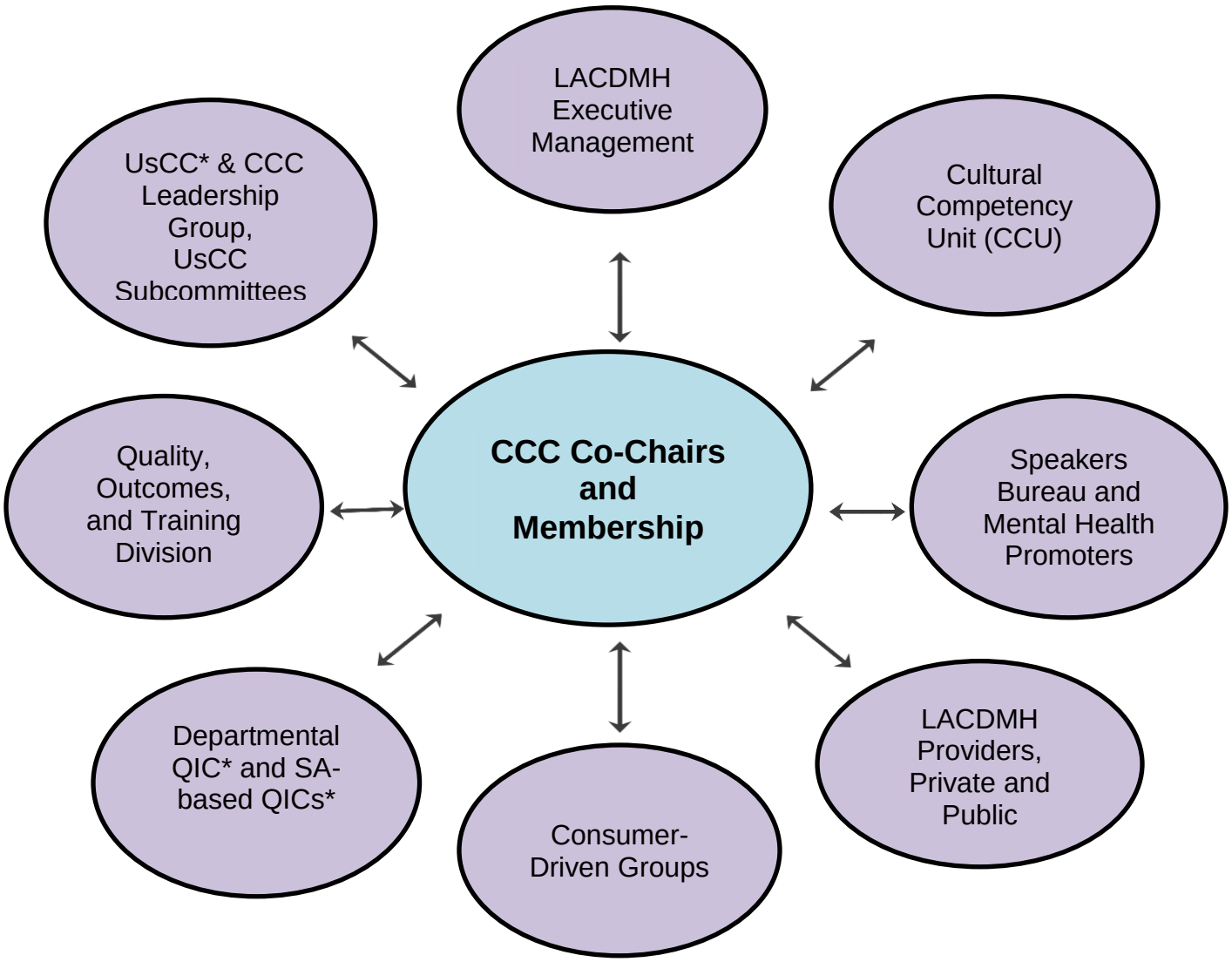


[1] DHS= Department of Health Services, DPH=Department of Public Health
[2] Cultural Competence Committee
[3] Institute for Cultural and Linguistic Inclusion and Responsiveness
[4] Labor Management Transformation Council

The CCU believes that striving for higher levels of cultural inclusiveness, equity, and effectiveness requires partnerships within and outside the system of care. These on-going partnerships ensure meaningful service integration, implementation of best and promising practices, and utilization of the collective wisdom of community-based organizations, stakeholder groups, consumers, family members and peers. The CCU has made meaningful connections with the community at large via the departmental Cultural Competency Committee (CCC). The CCU holds to the CCC as its advisory group for the infusion of cultural competency in all of Los Angeles County Department of Mental

Health (LACDMH) operations. The CCC membership includes the cultural perspectives of consumers, family members, advocates, peers, community-based organizations, and staff from Directly Operated (DO), Contracted and administrative programs. The mission of the CCC is to "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." *See Criterion 4 for more detailed information.*

Figure 2: CCC Departmental Partnerships and Collaborations, CY 2020



***** UsCC = Underserved Cultural Communities
SALT= Service Area Leadership Teams
QIC = Countywide Quality Improvement Council
QICs = Quality Improvement Committees

Stakeholder Engagement

LACDMH takes pride in its robust and ever growing stakeholder process. 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. These dialogues produce essential feedback and guidance for the Department to focus on community-driven stakeholder priorities and develop action plans for enhanced service provision with shared goals of hope, recovery, and wellbeing.

Additionally, YourDMH includes partnerships with diverse groups of stakeholders such as the Service Area Leadership Teams (SALT), Underserved Cultural Communities (UsCC), Cultural Competency Committee, Community Leadership Team (CLT) and Mental Health Commission. This collaborative approach drives the planning, implementation and evaluation of system wide endeavors, among them the Mental Health Services Act (MHSA) Three-Year Plan.

Despite significant challenges and constraints caused by the COVID-19 pandemic, LACDMH sponsored a considerable number of virtual community engagement events including conferences and special events highlighting cultural diversity and the voice of consumers and family members. For example, the 2020 WERISE event

WERISE

May 2020 marked the third consecuti.ve year of the WERISE campaign launched by LACDMH. Well into the COVID-19 pandemic, WERISE 2020 commemorated "May is Mental Health Awareness Month". WERISE efforts focused on supporting communities and individuals connect with their resilience, experience healing and uphold collective hope through virtual platforms. The goal of the virtually-conducted event, in the words of LACDMH's director, Jonathan E. Sherin, M.D., Ph.D., was "to drive a heart-forward movement that will bring the County together as we all struggle with difficult emotional experiences that are being shared across our collective in an unprecedented way right now."

Programming highlights included:

- One-on-one virtual conversations
- Live performances by diverse artists and celebrities
- A Teen Town Hall with participation of licensed clinicians from LACDMH's Speakers Bureau on standby to support participants
- Family-friendly activities like story time and art workshops
- Fireside chats with community leaders and grassroots organizations

- A live event honoring the military and veterans on Memorial Day weekend
- A virtual prom

County residents were provided relevant resource information and support 24/7 at dmh.lacounty.gov, and access the Help Line by calling 1-800-854-7771 or texting "LA" to 741741.

WERISE 2020 successfully engaged youth and broader audiences, dramatically expanding the audience from prior years' events. The success of this event was evidenced by the following outcomes:

- 15 million social media impressions
- 5.4 million social media
- 2.3 million media coverage
- 3 million radio PSA viewing
- 354,000 broadcast views of the digital programming inclusive of 32 community partners and 42 artists and influencing role models

The programming was available in English and Spanish. Interesting participant demographics were gathered and demonstrated that in terms of gender, 72% identified as female and 28% identified male. The event reached audiences as young as 13 years of age: 9% indicated being 13-24 years old and 45% self-identified as being between the ages of 25-34. Self-reports of participants also revealed that the majority resided within the United States.

New Initiatives related to Social Equity

LACDMH has continued and augmented its efforts to address issues of social equity. While exercising its commitment to address issues of racial equity and language justice, LACDMH strives to provide services that are in the preferred language of consumers. It is important to note that Los Angeles County is home to multiple cultural and linguistic communities. L.A. County has 13 threshold languages and serves consumers and communities beyond these. Additionally, there are other countless concerted efforts made on a daily basis in clinical and administrative operations to honor the cultural and linguistic needs of the communities including LGBTQIA2-S and persons with physical and developmental disabilities. Support services are also made available to staff who provide direct clinical services and who work with stakeholder groups.

In the span of one year, L.A. County and the Department experienced the unprecedented challenges of COVID-19, violent acts against racial, ethnic and cultural underserved communities as well as social unrest. Throughout CY 2019, LACDMH collaborated with the Chief Executive Office and joined other County departments in developing and implementing workgroups and strategies around social justice. LACDMH was an active participant in the Los Angeles County Anti-Racism, Diversity, and Inclusion (ARDI) Initiative to combat racism, especially systemic racism and its detrimental effects upon Black and other underserved groups in the County. Furthermore, in June 2019, LACDMH contracted an independent consultant to conduct an initial analysis and operationalize the Department's commitment to address ARDI within its organizational culture.

***Advancing Racial Equity in LACDMH* (ARE)**

A workforce-based effort aimed at laying a foundation for sustainable racial justice work within LACDMH via the implementation of Action Learning Communities and Intergroup Dialogues.

Action Learning Communities (ALC)

The primary goal of the ALC was to build an intra-departmental community of LACDMH staff committed to advancing racial equity. ALC members identified various actions needed to address equity issues for Black, Indigenous, and People of Color (BIPOC) communities. The ALC process engaged staff in identifying key issues pertaining to racism and racial equity within the Department, proposing recommendations, and setting the foundation for an initial pathway for racial equity. With the assistance of the consultant, ALC participants reviewed these issues and grouped them into five general categories:

- Eliminating Workplace Racial Micro-Aggressions and Conflict
- Culturally Congruent Care/Collaboration/Social Justice
- Racially Equitable Hiring, Advancement, and Supervision
- Equitable Pay and Resources/Cross-Departmental Partnerships, Collaboration, and Community Engagement
- Leadership, Management, and Accountability

Intergroup Dialogues (IGD)

IGDs engaged interested LACDMH staff members an opportunity to create a safe space to hold dialogues on matters of race, racism, and specifically anti-Black racism, and to develop ideas on how to promote racial equity in LACDMH.

LACDMH COVID-19 Webpage

LACDMH supports the wellbeing of Los Angeles County residents and communities. The Department recognized that news and updates about COVID-19 were triggering anxiety, panic, frustration and depression. To support L.A. County residents' mental health needs, LACDMH published a collection of materials and resources on its COVID-19 webpage, where visitors find tips, articles, and services to optimize wellbeing during COVID-19 response and recovery efforts. The webpage is available at https://dmh.lacounty.gov/covid-19-information/. Resources include:

1) Materials that address mental health and wellbeing needs and concerns, translated into the threshold languages
   - Coping with Stress During Infectious Disease Outbreaks
   - Maintaining Health and Stability During COVID-19
   - Staying Connected During Physical Distancing
   - Alleviating Fear and Anxiety During Essential Trips in Public
   - Understanding the Mental Health and Emotional Aspects of COVID-19
   - Coping with the Loss of a Loved One
   - Your Wellbeing on Your Terms brochure

2) LACDMH's 24/7 Help Line at (800) 854-7771 is available to provide mental health support, resources and referrals. LACDMH facility updates are available here

3) LACDMH has partnered with Headspace to offer a collection of mindfulness and meditation resources – for free – to all L.A. County residents. The free Headspace Plus subscription includes access to hundreds of science-backed guided meditations in English and Spanish, as well as movement and sleep exercises to help manage stress, fear and anxiety related to COVID-19.

4) LACDMH is also a part of PsychHub's COVID-19 Mental Health Resource Hub, which is dedicated to providing free resources to help people address their mental health needs during the COVID-19 pandemic.

5) Resources for Coping with Coronavirus (COVID-19)
- COVID-19 Resource and Information Guide, National Alliance on Mental Illness (NAMI)
- Coping with Stress, Center for Disease Control and Prevention
- Coping with a Disaster or Traumatic Event, Center for Disease Control and Prevention
- Taking Care of Your Emotional Health, Center for Disease Control and Prevention
- Video: Managing Stress & Anxiety, National Institute of Mental Health (NIMH)
- Mental Health and Psychosocial Considerations During COVID-19 Outbreak, World Health Organization
- Emotional Wellbeing During The COVID-19 Outbreak, National Suicide Prevention Hotline
- 7 science-based strategies to cope with coronavirus anxiety, The Conversation
- Reducing Stigma During COVID-19, Center for Disease Control and Prevention
- Long-Term Impact of COVID-19: Your Mental Health, Cedars-Sinai

6) Resources for Families, Parents and Children
- How to Talk to Kids About Coronavirus, The New York Times
- Helping Children Code with Emergencies, Center for Disease Control and Protection
- 10 tips for talking to your kids about COVID-19 with your kids, PBS SoCal
- Helping Children Cope with Emergencies, Centers for Disease Control and Prevention
- Coping After a Disaster, U.S. Department of Health and Human Services
- Just For Kids: A Comic Exploring The New Coronavirus, NPR
- How to Talk to Your Anxious Child or Teen About Coronavirus, Anxiety and Depression Association of America
- Q&A: Masks or Face Coverings for Children During COVID-19, HealthyChildren.org

7) Resources for Physical Distancing
- How to Fight the Social Isolation of Coronavirus, AARP
- Community Connections in Times of Physical Separation, Each Mind Matters
- Tips for Physical distancing, Quarantine, and Isolation During an Infectious Disease Outbreak, Substance Abuse and Mental Health Services Administration

- Working Remotely During COVID-19: Your Mental Health and Wellbeing, American Psychiatric Association Foundation
- Strategies for Coping with Isolation and Loneliness During the Coronavirus Pandemic, Northwestern University

8) Resources for Healthcare Providers
- First Responder Resources, LACDMH
- Psychological Effects of Quarantine During COVID-19 – What Healthcare Providers Need to Know, The Center for the Study of Traumatic Stress
- For Providers and Community Leaders: Helping People Manage Stress Associated with the COVID-19 Virus Outbreak, U.S. Department of Veterans Affairs
- Sustaining the Wellbeing of Healthcare Personnel during Coronavirus and other Infectious Disease Outbreaks, Center for the Study of Traumatic Stress
- Mental Health and Infectious Disease Outbreaks (Executive Summary and Literature Review), LACDMH

9) Resources for Workers
- Coronavirus 2019 (COVID-19) Resources for Workers, California's Labor Federation
- Worker Safety & Health During COVID-19 Pandemic: Rights & Resources, National Employment Law Protection
- Do's & Don't for Essential Workers, CDC

10) Resources for General Mental Health Management
- Coping with a Disaster or Traumatic Event, Center for Disease Control and Prevention
- Taking Care of Your Emotional Health, Center for Disease Control and Prevention
- PsychHub, Well Being Trust
- Disaster Distress Helpline, Substance Abuse and Mental Health Services Administration
- Facilitating Mindfulness, UCLA Mindfulness Research Center

11) Resources for Community and Peer Support
- Peer Support Network, Project Return (PRPSN)
- California Peer-Run Warm Line, Mental Health Association of San Francisco
- Self-Help Support Groups, Share!
- Teens Helping Teens, Teen Line Online
- Support Services, Project Return Peer Support Network

12) Resources for Offering Support
- COVID-19: How You Can Help, County of Los Angeles
- Become an L.A. Works Partner & Find Volunteers, L.A. Works
- How to Partner with Los Angeles Regional Food Banks, LA Food Bank
- Survey – Organizations Providing Services During COVID-19, Los Angeles County Department of Public Health

13) For General COVID-19 Information, Recommendations & Updates:

- Los Angeles County Department of Public Health's Coronavirus website
- Los Angeles County's COVID-19 website
- Los Angeles County's Roadmap to Recovery website
- California Department of Public Health COVID-19 updates
- Centers for Disease Control and Prevention (CDC) Coronavirus updates
- World Health Organization (WHO) Coronavirus website
- LA County residents can also call 2-1-1 or visit 211 LA's website
- Los Angeles County COVID-19 Drive-up Mobile Testing Locations – English & Spanish
- County of Los Angeles Covid-19 Mapping of FOOD resources
- Los Angeles County Public Defender's Office COVID-19 Page
- Superior Court of California, County of Los Angeles COVID-19 News and Resource Center
- California Department of Corrections and Rehabilitation COVID-19 Information
- COVID-19 Response, Philanthropy CA
- COVID-19 Resources, HOPE: Hispanas Organized for Political Equality

LACDMH Speakers Bureau

This initiative was implemented in response to the COVID-19 pandemic and beyond as a joint effort between the Chief of Psychology Team and the Cultural Competency Unit. The Speakers Bureau functions as a specialized public communication, clinical and community intervention resource comprised of approximately 90 highly skilled, licensed mental health clinicians with extensive media and public-speaking experience. Its members are Subject Matter Experts (SME) who are culturally competent and linguistically certified to provide services and interventions in all threshold languages of Los Angeles County, e.g., Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog and Vietnamese as well as Thai, Urdu and Hindi.

Furthermore, the Speakers Bureau intentionally includes specialized cultural representation of several underserved communities such as American Indian and Alaska Native; Asian, Asian American, and Pacific Islander (AAPI); Black and African American; Latino inclusive of Latinx and Central American communities; Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Asexual and Two-Spirit Communities (LGBTQIA2-S); Multi-Racial and Multi-Ethnic; Older Adults; Persons Experiencing Homelessness; Persons with Physical Disabilities; Faith-based and spirituality; and Veterans. Collectively, Speakers Bureau members contribute to over 200 areas of clinical expertise. The Speakers Bureau is also enriched by the inclusion and collaboration with Specialty Treatment Leads, Faith-Based Liaisons and Promotores de Salud (Health Promoters). Speakers Bureau members represent the underserved communities served by LACDMH because they are active, engaged members of these communities and thus reflect the concerns, culture and language of their respective communities. Speakers Bureau members facilitate culturally competent interventions, problem-solve and assist communities in navigating the complexities often associated with access to competent care and resources, during and beyond the COVID-19 pandemic.

COVID-19 Priority Places Map

The pandemic has taken a ruthless toll on underrepresented communities, especially for Black, indigenous and people of color (BIPOC.) These communities have experienced a disproportionate rate of infections, hospitalizations, and deaths in Los Angeles County in addition to detrimental economic impacts caused by the pandemic. The Department worked with the LACDMH+UCLA Public Partnership for Wellbeing (PPfW) to create a COVID-19 Priority Places Map. Using data on the intersection of highest week-over-week averages in COVID-19 cases and communities with vulnerable and high-risk populations, a total of 30 communities across Los Angeles County were identified at the greatest risk for adverse outcomes from COVID-19. This information has been key in driving the Department's response to the communities most impacted by the pandemic.

Multicultural and Multilingual Media Campaigns

LACDMH continued designing and implementing massive public communications efforts that specifically targeted COVID-19 highly impacted communities. LACDMH has continued outreaching to Los Angeles County communities to provide support and promote mental health via multiple hyper local/ethnic media outlets. LACDMH Media efforts were supported by Cause Communications, a woman/LGBTQ founded nonprofit organization. Hyper local/ethnic media were used to promote mental health messages. The messaging included coping with COVID-19 challenges, supporting frontline workers' mental health, promoting resilience and wellbeing, support via the Department's 24/7 Help Line, online resources offered by LACDMH and partner orgs, virtual wellbeing events, and free subscriptions to Headspace. Examples of hyperlocal targeted media products include digital billboards, Metro and bus line advertisements, radio and TV spots, posters at WIC offices, displays and handouts at commonly frequented community sites, including COVID-19 testing and vaccination locations. LACDMH's media outreach campaign continues to engage the County's culturally and linguistically diverse communities with placements in English, Spanish, and Chinese newspapers; television programming in English and Spanish; radio programming in English, Spanish, Chinese, Korean, Persian, Armenian, and Vietnamese; WIC offices postings; top outdoor media companies across the County and through social media.

TABLE 3: MULTI-MEDIA CAMPAIGNS BY MEDIA OUTLET TYPE, LANGUAGE, CHANNEL AND COMMUNITY DEMOGRAPHICS

MEDIA TYPE	LANGUAGE	CHANNEL	DEMOGRAPHICS
Television	English	NBC-TV and Spectrum Cable	30% Latino 20% Asian 22% African American 28% Diverse groups
	Spanish	KMEX-TV, KFTR, KVEA-TV, and KWHY-TV	82% Latino 3% Asian 1% African American 14% Diverse groups
Out of Home	English, Spanish, and Chinese	Digital Billboards, Bus Interior Cards, Rail Interior and Exterior	50% General Market (All ethnic Groups) 50% Latino
		Full Bus Backs, Strategic Shelters, and Digital Rail Station Kiosks	100% General Market (All ethnic Groups)
		Static Building Wall	100% General Market (All ethnic Groups)
		1-Sheet Posters and 30-Sheet Posters	60% Latino 30% General Market (All ethnic Groups) and African American 10% Asian
		Digital Geo-Fencing	40% General Market (All ethnic Groups) 25% Latino 15% African American 10% Asian 10% Diverse groups
Radio	English	KCRW-FM, KPCC-FM, KROQ-FM, KAMP-FM, KTWV-FM, iHeart Streaming, KJLH-FM, KDAY-FM, KPWR-FM, and KLOS-FM	58% Latino 10% Asian 17% African American 15% Diverse groups
	Spanish	KLVE-FM, KSCA-FM, KXOL-FM, KLAX-FM, and KLLI-FM	88% Latino 1% Asian 1.5% African American 9.5% Diverse groups

MEDIA TYPE	LANGUAGE	CHANNEL	DEMOGRAPHICS
Cont. Radio	Chinese	KWRM-FM	97% Asian 3% Diverse groups
	Korean	Radio Korea	97% Asian 3% Diverse groups
	Persian and Armenian	KIRN-FM and Radio Jan 107.5 HD	97% Persian/Armenian 3% Diverse groups
	Vietnamese	Saigon Radio	97% Asian 3% Diverse groups
Print	English	Los Angeles Times and Los Angeles Sentinel	37% General Market 30% Latino 18% African American 8% Asian 7% Diverse groups
	Spanish	Los Angeles Times (Español) and La Opinión Newspaper	89% Latino 11% Diverse groups
	Chinese	ICITI News and WeChat	96% Asian 4% Diverse groups
WIC Offices	English and Spanish	Posters	African American 14% American Indian 1% Asian/Filipino/Pacific Islander 7% Latino 42% White 28% Multiracial 1% Diverse groups 7%

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:

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 organizations 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. The Promotores program existed only as a pilot in Spanish for Service Areas 7 and 8 up to CY 2018. The expansion to other Service Areas, one at a time, took place during CYs 2018 and 2019 to varying degrees of service capacity depending on each Service Area's implementation framework. During FY 19-20, LACDMH trained 126 Spanish-speaking Community Mental Health Promoters representing all Service Areas.

This countywide expansion builds system capacity, reduces mental health stigma, 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 126 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.

Community Ambassador Network (CAN)

Community Ambassadors are trusted members of the community who are trained and hired as lay Mental Health workers. The Ambassadors help nurture healthy and racially equitable communities by empowering others, raising awareness and mobilizing change while infusing much needed funding and jobs into our most disenfranchised populations. CAN focuses on those communities which have been disproportionately impacted by the pandemic, systemic racism, police violence and the resulting civil unrest, or that are otherwise marginalized. LACDMH launched CAN by leveraging the existing network of trusted community-based organizations currently implementing the Innovation 2 Project - Developing Trauma Resilient Communities through Community Capacity Building project (INN 2). By repurposing unspent INN 2 funds, existing providers were able to create 197 Community Ambassador positions.

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.

Linkage programs
Linkage programs connect community members to essential services that include treatment, housing, and other mental health services throughout Los Angeles County. LACDMH has three linkage programs: Jail Transition and Linkage Services, Mental Health Court Linkage, and Service Area Navigation.

Jail Transition and Linkage Services 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 jail. 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 is to successfully link individuals to community-based services not the streets, thereby decreasing the possibilities of re-incarceration and unnecessary emergency/acute psychiatric inpatient services.

Mental Health Court Linkage Program operates with two MHSA-funded sub-programs:

- The Court Liaison Program is a problem-solving collaboration between the Department and the Los Angeles County Superior Court. Its mental health clinicians are co-located at courts countywide. This recovery-based program serves adults who have a mental health conditions and/or co-occurring disorders and who 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 systems, improve access to mental health services and supports, and enhance continuity of care.
- The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants with a mental health conditions including persons with co-occurring substance use. The goal of CRP is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. Also, this program provides admission to two specialized mental health contract facilities for judicially involved individuals with mental health conditions who voluntarily accept treatment in lieu of incarceration.
    - **Men's Community Reintegration**
      The Men's Community Reintegration Program (MCRP) serves adult males ages 18 years and older, who are returning to the community from incarceration including persons conditionally released to the program by the courts. The focal population is adult male consumers with moderate to high criminogenic risk

factors, along with co-occurring mental health conditions and other conditions. The program uses an evidence-based model to identify the unique needs of this population aimed at addressing criminogenic risk factors that place consumers at risk for re-offending and recidivism. The treatment services offered by MCRP are forensically focused and aimed at (1) reducing recidivism; and (2) helping consumers successfully reintegrate back into society from incarceration. Along with specialty-designed treatment services, successfully working with this population requires coordination with jail/prison staff, courts, probation/parole officers, and public defenders. Staff must provide progress reports to court and must often take consumers to court and/or show up in court with consumers.

- **Women's Community Reintegration program (WCRP)**

  The mission of the WCRP is to empower women with hope, alternatives, and skills for a better tomorrow. The main goal is to assist women who have been incarcerated to reintegrate and become successful members of their communities. Women's Community Reintegration Program is a field-based program offered throughout Los Angeles County. WCRP Teams are mostly made up of Community Health Workers with lived experience, some with incarcerated lived experience.

  Service Area Navigation Teams assist individuals and families in accessing mental health and other supportive services. The program is based on the navigators ability to network with community-based organizations to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry in a variety of settings that would make the long-standing goal of "no wrong door" achievable.

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.

Due to COVID-19 Pandemic Health Emergency in March 2020 and the Civil Unrest on May 2020, business as usual was significantly impacted. Both law enforcement and LACDMH had to accommodate staff who were not able to report to the office, lessening staffing for programs. Law enforcement personnel was reassigned to local emergency centers.

The Law Enforcement Programs extended their services to various demographic groups. In FY 19-20, the majority of the clients served were adults (76.21%) referred by the law enforcement agencies (72.5%). Additionally, 61% were hospitalized, 31% homeless and 3.35% arrested after committing felony or misdemeanor. Within the group of clients with arrest history, 44.33% were charged with felony and 55.67% with misdemeanor.

Therapeutic Transportation Pilot Program

LACDMH entered into an agreement with Los Angeles Fire Department (LAFD) to implement the Therapeutic Transportation Pilot Program to increase its capacity to provide mental health crisis services. The goals of this Innovation 7 Project include optimizing access to mental health services that enhance the quality of such services to underserved populations; reducing the use of LAFD and Los Angeles Police Department (LAPD) resources for mental health emergency responses; and leveraging partnerships to develop a community-driven approach toward improving outcomes for individuals experiencing emergencies related to mental health. The Department evaluates the benefits of utilizing this therapeutic transport response to determine its effectiveness as an alternate or augmented asset for dispatching to emergency calls. This program is scheduled to operate 24 hours a day, seven days a week.

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 19-20, 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.

Housing Division

LACDMH’s Housing Division provides services to people experiencing homelessness through its network of Homeless Full Service Partnership (FSP) programs, which outreach to persons experiencing homelessness and assist them with obtaining housing. These specialized FSP services coupled with Intensive Case Management Services (ICMS) are provided to consumers matched to LACDMH's housing resources. Once in permanent supportive housing, consumers are supported to reach their recovery goals, including gainful employment. LACDMH also assists homeless clients in securing temporary housing through Project Room Key (PRK) resources. LAHSA provides funding

to assist all people in PRK to secure permanent housing. LACDMH continues to expand its permanent housing resources by providing investments in the capital development of housing (dedicated to LACDMH consumers), flexible housing subsidy pool, Enriched Residential Care Program and contracts with the Housing Authorities for subsidies through Section 8 and Shelter Plus Care.

Enriched Residential Care Program (ERC)

This program facilitates LACDMH's ability to subsidize the rent for consumers who live in Board and Care homes and have no income. LACDMH is also able to pay an enhanced rate to the Board and Care operators. LACDMH has intentionally worked to develop housing opportunities both interim and permanent in each Service Area to ensure accessibility for clients. Due to several factors such as community acceptance and opportunity, some areas do have more housing opportunities in comparison to others. However, LACDMH continues to pursue opportunities for geographic disbursement of housing in all parts of the County.

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. The HOME program provides field-based outreach, engagement, support and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry; and providing linkage to appropriate services (including mental health services, substance use and housing).

The majority of the HOME staff functions revolve 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 19-20, 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 FY 19-20, the START Program was significantly impacted by the pandemic after schools were closed due to COVID-19 Health Emergency in March 2020. The staff re-directed their clinical services to crisis calls. During FY 19-20, over 5,000 services were reported. The demographics of START clients who are predominantly male (87.50%), under age 16 (60.12%), English-speaking (88.09%), Latino (46.43%), White (23.21%) and African Americans (14.88%). To ensure delivery of cultural competent services, START team has the following linguistic capabilities: 11 Spanish-speaking, one Mandarin/Taiwanese-speaking, one Korean-speaking, one Farsi-speaking, one Burmese-speaking out of 27 members. The START Program provided 67 trainings to 3,338 attendees. The training topics include bullying, de-escalation of violent behaviors, targeted school violence, orientation to START services, suicide prevention, mental health awareness, and outreach.

Health Neighborhoods (HN)

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 mission of the Health Neighborhoods is to form a collaboration of community partners working to build thriving communities in underserved areas through prevention, improved coordination, and strong support networks through the Community Change and integrated Service Delivery models. To meet the specific needs of a defined community, place-based Health Neighborhoods must remain organic in nature with shared leadership and a shared commitment by all three Health Agency Departments and community stakeholders.

Each year, the Health Neighborhood coalitions continue to expand and diversify their existing networks to improve coordination, collaboration and effective use of resources to support neighborhood residents, and address existing health inequities prioritized by community members in each Health Neighborhood. The table below summarizes the Health Neighborhoods across the eight Service Areas.

TABLE 4: HEALTH NEIGHBORHOODS BY SERVICE AREA

SA	Health Neighborhood (HN) Name
SA 1	• Antelope Valley
SA 2	• Northeast San Fernando Valley • Panorama City/Van Nuys
SA 3	• El Monte • East San Gabriel Valley
SA 4	• Hollywood • Boyle Heights
SA 5	• Palms/Mar Vista Intergenerational • Venice/Marina Del Rey • Pico/Robertson
SA 6	• South Los Angeles
SA 7	• East Los Angeles
SA 8	• Long Beach • Hawthorne

Health Integration

The revamped structure for this interdepartmental initiative under the Los Angeles County Board of Supervisors involves three Health Departments: 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 in September of 2019. 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

The vision behind the Action Plan is for ICLIR to have a living mechanism to advance culturally and linguistically integrated health practices across the three Departments. ICLIR launched its Action Plan on September 19, 2019 at an event that gathered subject matter experts from DHS, DMH and DPH and organized them into Action Plan specific workgroups. Based on areas of expertise, DHS, DMH and DPH subject matter experts would work together in identifying feasible pathways to advance cultural and linguistic responsiveness within and across the three Departments.

The COVID-19 pandemic swooped the ICLIR Action Plan during its first quarter of implementation, causing an unexpected and uncontrollable halt. The expertise of ICLIR members was needed to support each Department’s emergency response to COVID-19. Nonetheless, the disproportionate impact of the pandemic on culturally and linguistically underserved communities and multi-layered demands on all departments gave way to organic ICLIR collaborations undertaken in support of coordinated health integration.

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.

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-Training Unit incorporate a multiplicity of cultural competency elements as listed below:

- Ethnicity
- Age
- Gender identity
- Sexual orientation
- 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-related trainings offered during FY 19-20)

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

Planning, Outreach and Engagement (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:

- Access for All, formerly known as Deaf, Hard-of-Hearing, Blind, and Physical Disabilities
- American Indian/Alaska Native (AI/AN)
- Asian Pacific Islander (API)
- Black and African Heritage, formerly known as African/African American (AAA)
- 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.

Below is a brief summary of UsCC projects implemented during FY 19-20:

Black and African Heritage

1) *Community Agents of Change Network Project*
   The purpose of the project was to disseminate mental health awareness, education, and community resources to African American community members who reside in SA 6 - South Bay and SA 8 - South Bay. This project aimed to educate and empower the African American community about the importance of mental health care to build awareness and community connections by training community members to become Community Agents of Change Educators (CACE). Additionally, this project had a goal of increasing community member involvement in the LACDMH stakeholder process.
2) *African American Youth Community Ambassador Network Project*
   The purpose of the project was to educate and empower Black youth about the importance of mental health care to build awareness and community connections. This project aimed to increase mental health awareness through educational workshops, the arts (dance, music, drama, poetry, etc.), and other outreach and engagement activities that are culturally sensitive to this community. This project targeted SA 1 African American youth ages 12-25.

American Indian/Alaska Native (AI/AN)

1) AI/AN Community Symposiums Project
The purpose of the Community Symposiums project was to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing. Attendees of the Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by community members. Symposium topics included traditional ways of healing and education, art and music as medicine, suicide prevention and harm reduction, and historical trauma to intergenerational resilience.

2) AI/AN Educational Public Service Announcement (PSA) Project
A media consultant was contracted to produce five 60-second PSAs. The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting), production/filming, and post-production (editing, voice-over, and delivery).

3) AI/AN Video Showcase Project
A media consultant was contracted to produce a Video Showcase project that included two (2) videos:

- The first video was developed with the intent to be played in the clinic and to provide viewers with information on how to access services, the process of accessing

services, and available services including intake, case management, medication management, substance abuse counseling, housing resources, etc.

- The second video was a five (5)-minute video highlighting AICC, as well as other providers serving the AI/AN community with the intent to be played on social media platforms.

4) AI/AN Mental Health Conference

The theme of the conference was "Native Health and Resilience." Its goals were to inform participants of mental health issues unique to the AI/AN community; improve participants' ability to recognize when to refer an AI/AN community member for mental health services; provide participants with useful information on available mental health resources for AI/AN community members; and improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers.

Asian Pacific Islander (API)

1) API Families – Supporting through Recovery

This project aimed to increase awareness about mental health related struggles that API consumers and their family members experience to decrease mental health related stigma and encourage early access of services. The overarching goal of this project was to develop a Mental Health Informational Booklet specifically designed for API family members and friends to understand the scope of mental illness, address their fears and questions, and offer suggestions on how to care for and assist their loved ones. the booklet would be translated into five (5) API languages (specifically Khmer, Simplified Chinese, Korean, Tagalog, and Vietnamese) and distributed to clinics and community-based agencies that serve API consumers and family members.

2) API – Sharing Tea, Sharing Hope

This project aimed to increase awareness about mental health to decrease mental health related stigma and encourage early access of services within the API community: Cambodian, Chinese (Mandarin or Cantonese), Tagalog, Vietnamese, and Korean. The focus of this project was to conduct mental health outreach to the API community using a mobile teacart service, and/or online virtual tea salons via Zoom. Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various outreach events. Through sharing of tea, the goal was to create a space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma and gaps in mental health service delivery in the various API communities.

Access for All

1) PSA Development Project

This project consisted of collaborating with a media consultant to develop the concept and produce a 30-second PSA targeting the Deaf, Hard of Hearing, Blind, Physically Disabled communities throughout the County. The goal of the PSA was to promote mental health services, increase awareness, reduce stigma, and increase the capacity of public mental health system.

2) Deaf, Hard of Hearing, Blind, and Physical Disabilities Peer-to-Peer Network

The Peer-to-Peer Network Project aimed to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community members into advocacy and activism around mental health issues that are affecting their community. Community members with lived experience were trained to become Community Advocates and Activists around issues related to mental health. In addition, they were given the responsibility to conduct community presentations regarding mental health and mental health resources.

3) Deaf, Hard of Hearing, Blind, and Physical Disabilities Clinical Mental Health Training

A mental health training specifically addressing the mental health needs and treatment modalities pertaining to the Deaf, Hard of Hearing, Blind, and Physically disabled community was made available for licensed clinical staff at LACDMH Directly-Operated clinics and contracted providers. This project aimed to provide mental health clinicians with an opportunity to be trained on identifying and treating the unique mental health needs and challenges faced by this community. The consultant was responsible for developing the training curriculum and facilitating the one-day clinical trainings that were conducted using a virtual platform due to social distance guidelines.

Eastern European/Middle Eastern

1) Parenting Seminars for the Arabic Speaking Community Project

The project was designed to increase knowledge about effective parenting practices and accessibility to mental health services for Arabic speaking community members. The goal of the project was to conduct the parenting seminars, and to provide mental health linkage and referral information pertaining to the services offered by LACDMH.

2) The Armenian Mental Health Show Project

The Armenian Mental Health Television Show was developed to help increase knowledge and awareness about mental health issues and treatment modalities and services available for the Armenian community. The local the Armenian-Russian Television Network (ARTN) was contracted to produce, direct, host and broadcast this weekly mental health show in the Armenian language.

3) The Russian and Farsi Speaking Mental Health Theatrical Performances Project

This project was developed for the purpose of increasing mental health access and reducing disparities for the Russian and Farsi speaking communities. The goal of this project was to increase mental health awareness and education among the targeted cultural groups and promote mental health services offered by the LACDMH.

Latino

1) The Latino Comic Book Project – Cómics Que Curan (Comics that Heal)

The Latino Comic Book project was developed to engage Latino Transition Age Youth (TAY) in a dialogue about mental health awareness and education. Latino TAY, ages 16-25, were recruited countywide to participate in creating their own 2-page comic about their mental health struggles and experiences. The overarching goal of this project was to display stories written by Latino Youth in a Comic book. The comic book would be used as an outreach tool to educate the community about the mental health issues that Latino youth are experiencing and initiate a community dialogue about their mental health needs and the services that they need.

2) The Latino Mental Health Stigma Reduction Community Theatre Project - "De Sabios y Locos Todos Tenemos Un Poco"

This project was developed to increase awareness and education about mental health issues in the Latino community. Through this theatrical play, the community will gain an inside look into the world of those who suffer from a mental health condition. The Latino community was educated on how to access mental health services and understand some of the cultural biases associated with suffering from a mental health condition. The play was conducted in the Spanish language.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two-Spirit (LGBTQI2-S)

1) LGBTQIA2-S Indigenous Pride LA Project

The purpose of the Indigenous Pride LA: Voices to Faces project was to spread cultural awareness and education of healing practices that positively affect mental health among the Two-Spirit community. The project aimed to destigmatize mental health issues among Two-Spirit people by highlighting the diversity of the population and the need for culturally sensitive resources.

2) LGBTQIA2-S Black LGBTQ+ Network Project

The purpose of the Black LGBTQ+ Network Project was to identify the needs of Black LGBTQ+ individuals, while educating and empowering this community about the importance of mental health care to build awareness and connection. This project aimed to destigmatize mental health issues among Black LGBTQ+ people by highlighting the diversity of the population and the need for culturally sensitive resources.

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 T. 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 sister Health 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 competence in service planning, delivery and evaluation.

Examples of how the ESM accomplished these functions during CY 2020:

- Developing departmental policies related to cultural and linguistically competence.
  - The ESM developed LACDMH's Policy 200.09 "Culturally and Linguistically Inclusive Services"
- Ensuring inclusion of cultural and linguistic competence in key departmental documents such as the "LACDMH Strategic Plan, 2020-2030: Transforming the Los Angeles County Mental Health System"
- Leading 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
- Serving as departmental lead for the reporting of LACDMH's activities specific to Board Motions from the Los Angeles County Board of Supervisors
  - The ESM was responsible for completing monthly update reports on LACDMH's responsiveness during the acute phase of the COVID-19: "A Just and Equitable Response to Disparities Illuminated by the COVID-19 Pandemic"
- Developing and providing trainings related to cultural competence
  - Developed a new training focusing on cultural humility and implicit bias (from awareness to action) which is offered at various departmental venues and the community at large
- Collaborating with clinical programs in the training of future mental health professionals
  - The ESM provided clinical group supervisor to a group of five psychology doctoral students placed at North East Mental Health Center
- Providing oversight for the conduction of the LACDMH Cultural Competence Organizational Assessments
- Implementing projects that advance cultural and linguistic competence within the system of care
  - Implemented the LACDMH Speakers Bureau in collaboration with the Chief of Psychology
- 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 and participation in local and state cultural competence projects at various departmental venues
- Providing the technical assistance, education, and training necessary to fully integrate cultural competency into all the Department's operations
- Providing administrative oversight of the Cultural Competency Committee (CCC) activities
- Leading and/or participating in CCC ad hoc workgroups formed to draft recommendations for the inclusion of cultural competency into departmental functions
- Revising the cultural and linguistic competence content in the "Department of Mental Health Legal Entity Contract"
- 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 the Southern Region ESMs and representing LACDMH in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee

The most salient CY 2020 activities of the CCU directly under the oversight of the ESM include the following:

1. <u>Development and implementation of the LACDMH Speakers Bureau (SB)</u>

   This initiative was implemented in response to the COVID-19 pandemic and beyond as a joint effort between the Chief of Psychology Team and the Cultural Competency Unit. The Speakers Bureau functions as a specialized public communication, clinical and community intervention resource comprised of approximately 75 highly skilled, licensed mental health clinicians with extensive media and public-speaking experience. Its members are Subject Matter Experts (SME) who are culturally competent and linguistically certified to provide services and interventions in all threshold languages of Los Angeles County.

   Speakers Bureau members identify with the underserved communities served by LACDMH because they are active, engaged members of these communities and thus share their concerns. They are highly committed to serve our communities during these challenging times, above and beyond the demands of their usual work responsibilities. During its first year of operations, the Speakers Bureau assisted communities in navigating the complexities associated with access to competent care

and resources, in the midst of all the uncertainty, isolation, anxiety, depression, grief, sense of loss, unemployment and scarcity caused by the COVID-19 pandemic and social unrest. SB members collaborated with Community Based Organizations and their leadership to raise awareness and take action against violence toward underserved communities.

Services Offered by the Speakers Bureau

The Speakers Bureau members engage in a variety of internal and public-facing interventions that address the clinical, cultural and linguistic mental health needs of Los Angeles County communities. For example:

- Multi-lingual Town Halls
- Board of Supervisors press conferences and virtual conferences
- Cross-departmental collaborations, trainings, and workshops
- Community events sponsored or co-sponsored by LACDMH such as WE RISE and NAMI
- Print, radio and television media interviews
- Production of Public Service Announcements and mental health-related educational videos
- Presentations and trainings in the community (school district and colleges, libraries, and parks)
- Development of COVID-19 and other content materials for use within communities, LACDMH, and across other Health Departments
- Language translation of COVID-19 and other mental health materials
- Community-based consultation services
- Mental health support (COVID-19 and beyond) for Community-Based and Faith-Based Organizations

Feedback received from community members and organizations

- The Speaker Bureau is an awesome resource
- Very accommodating
- The signs and symptoms information taught what to watch for in ourselves, staff, coworkers and families as we cope with the pandemic and unrest
- Perfect timing and focus on wellbeing, just what we were looking for to help our members cope and balance life's challenges
- Great resources for the larger community
- Very important and valuable services

2. <u>Development and review of LACDMH's Policy and Procedure (P&P) pertinent to delivery of cultural and linguistic competent services</u>

This policy establishes guidelines for participation, implementation, and compliance with Federal and State regulations regarding cultural and linguistic competence. Developed by the ESM, P&P 200.09 became effective in September of 2019. The policy informs the system of care that culturally and linguistics appropriate 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 CLAS Standards 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.

3. LACDMH Cultural Competence Organizational Assessment Tool (CCOAT) Presentations

   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 inform future cultural and linguistic competence strategies to reduce mental health disparities. Toward the end of CY 2020, the CCU delivered virtual presentations to all Service Areas QICs, SALTs and other departmental venues. The CCU continues to utilize the outcomes of the organizational assessment and consultant recommendations to improve the Department's system of care in the area of cultural and linguistic competence.

4. 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.

5. Cultural Competence 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

      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.

   3) Development and delivery of Cultural Competence (CC), Cultural Humility and Implicit Bias Trainings

      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

6. External Quality Review Organization (EQRO) Review

   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.

7. 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.

III. Budgetary Allocations for Cultural Competence Activities, FY 19-20

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

- $34,149 for specialized foster care trainings
- $25,686 for juvenile justice trainings
- $11,855 for cultural-specific trainings focusing on underserved populations
- $30,015 for interpreter trainings
- $32,836 for Conferences sponsored by the Department and coordinated by the OAO-Training Unit

Language Translation and Interpreter Services

- $103,803.20 for language interpretation services, which allows consumers to participate in various departmental meetings and conferences
- $5,113.50 ASL interpretation services
- $3,892.50 CART Captioning interpretation services
- $15,931.86 Translation of documents services
- $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 projected budget allocations

Furthermore, a sizable amount of funding is dedicated for cultural competence-related activities under the MHSA Plans. The following table summarizes the projected MHSA-specific budget allocations for FYs 21-22 through 23-24:

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

TABLE 5: SUMMARY OF MHSA PLAN BUDGETARY ALLOCATIONS AND EXPENDITURES, FY 19-20

Programs	Funding
CSS Programs 1. Full Service Partnerships 2. Outpatient Care Services (former known as Recovery, Resilience and Integration) 3. Alternative Crisis Services 4. Planning Outreach & Engagement 5. Linkage Services 6. Housing	 $269.6 million $478.2 million $119.4 million $6.3 million $18.5 million $22.4 million
Total CSS Program Expenditures	**$971.4 million**
PEI Programs 1. Total Gross Expenditures - Suicide Prevention 2. Total Gross Expenditures - Stigma Discrimination Reduction Program 3. Total Gross Expenditures - Prevention 4. Total Gross Expenditures - Early Intervention	 $20.0 million $2.7 million $65.3 million $192.1 million
Total PEI Program Expenditures	**$280.1 million**
Total Gross Expenditures INN Programs	**$21.3 million**
Total Gross Expenditures WET Programs	**$14.8 million**

* Data Source: MHSA Three-Year Program and Expenditure Plan, FYs 21-22 through 23-24

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 their implementation.

TABLE 6: CROSSWALK OF LACDMH'S PRACTICES RELATED TO 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, P&P, providers 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 • 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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Development of paid employment opportunities for peers and persons with lived experience • Implementation of the Office of Discipline Chiefs for Nursing, Psychology and Social Services • Hiring of a LGBTQ+ Services Specialist • Expansion of the Mental Health Promoters Program from a Latino focus to other cultural and language groups: African American, AI/AN, EE/ME, LGBTQ and persons with physical disabilities • Implementation of the Community Ambassador Program
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 • LACDMH 24/7 Help Line • On-line Provider Directories translated into threshold languages • Translation of consent forms that require consumer signage in the threshold languages • The CCU's county wide coordination of language assistance services for consumers, family members, and community members to participate in stakeholder meetings and departmental events by the Cultural Competency Unit • Usage of posters at provider sites which inform the public of the availability of free of cost language assistance services
6. Availability of language assistance	7	• Monitoring the LACDMH 24/7 Help Line's language assistance operations • Hiring and retention of bilingual certified staff • Mechanisms for Contracted providers to establish contracts with language line vendors • Language accommodations via the CCU for consumers, family members and community members to participate in

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		LACDMH's Cultural Competency Committee, UsCC, SALT and other stakeholder meetings
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 • Addressing service quality issues reported by users
8. Easy to understand materials and signage	1, 3, and 7	• Translation of consent forms, program brochures and fliers in the threshold languages • Partnering with the community for the creation of brochures that are culturally meaningful and linguistically appropriate
9. CLAS goals, policies, and management accountability	1	• On-going evaluation of consumer satisfaction outcomes • Program-specific reporting on service utilization and strategies that address mental health disparities
10. Organizational assessments	3 and 8	• Monitoring the impact of cultural and language-specific outreach and engagement activities • Partnering with the community to identify capacity-building projects for underserved cultural communities • Conducting cultural competence assessments related to CCPR • Conducting program-based needs assessments • Conducting workforce/discipline – specific needs assessments • Conducting program outcome evaluations and reporting on the progress made in service accessibility, and improvements in penetration and retention rates
11. Demographic data	2, 4, and 8	• Compiling and reporting of the Los Angeles County demographics, consumer utilization data by ethnicity/race, age group, language, gender, and SA • Monitoring of consumer utilization data to identify emerging cultural and linguistic populations • Compiling and tracking of penetration rates, retention rates and mental health disparities • The ESM advocates and participates in data dashboard meetings to expand consumer demographical data (i.e., gender identity, physical disabilities and tribal affiliation)

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• The ESM connects with CCC and UsCCs to obtain their recommendations on LACDMH's efforts to expand consumer demographical information
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 • 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 consumer and family satisfaction with services received • Monitoring of beneficiary requests for change of provider • Monitoring the quality of services provided by the LACDMH 24/7 Help Line and contracted language lines

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

This space was intentionally left blank

Criterion 1 Appendix

1. Link to LACDMH policies and procedures

   https://secure2.compliancebridge.com/lacdmh/public/index.php?fuseaction=app.main&msg

2. Link to LACDMH Strategic Plan 2020-2030

   https://dmh.lacounty.gov/about/lacdmh-strategic-plan-2020-2030/

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

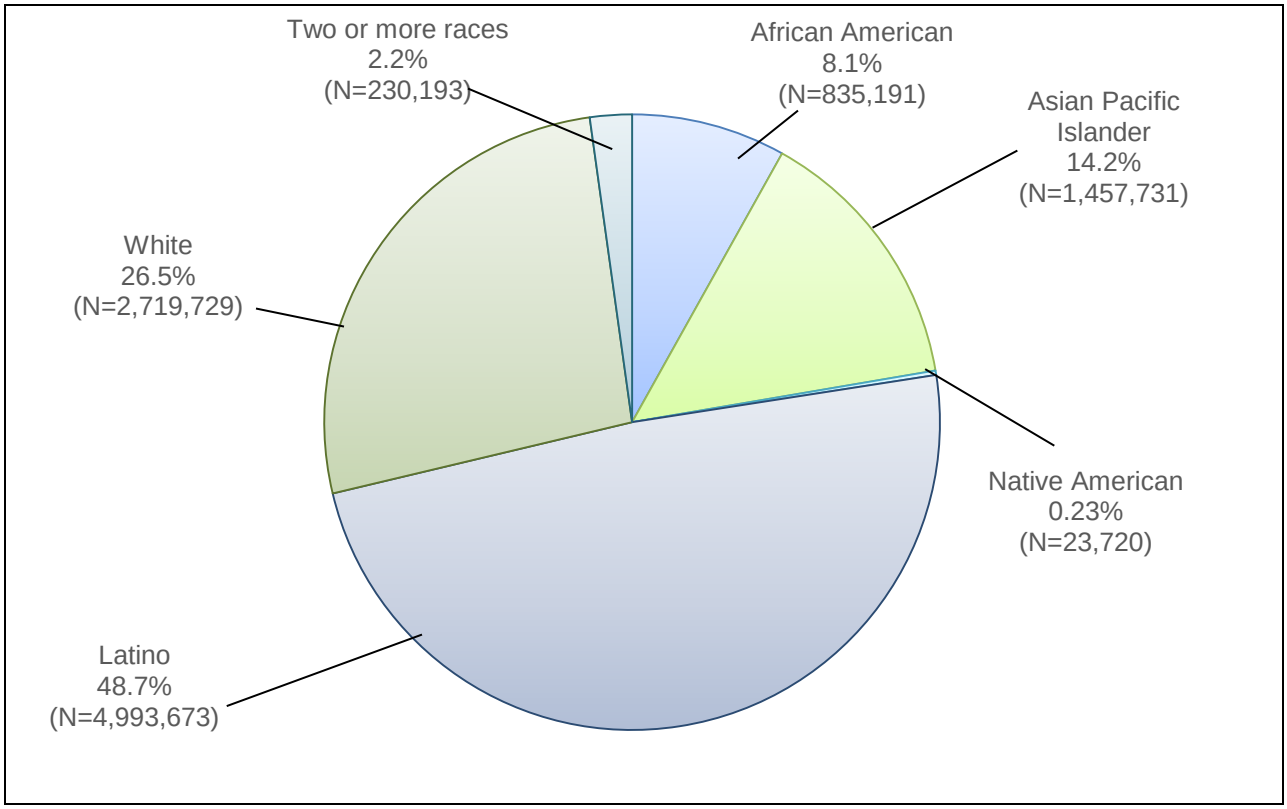
August 2021

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 2019 (N = 10,260,237)

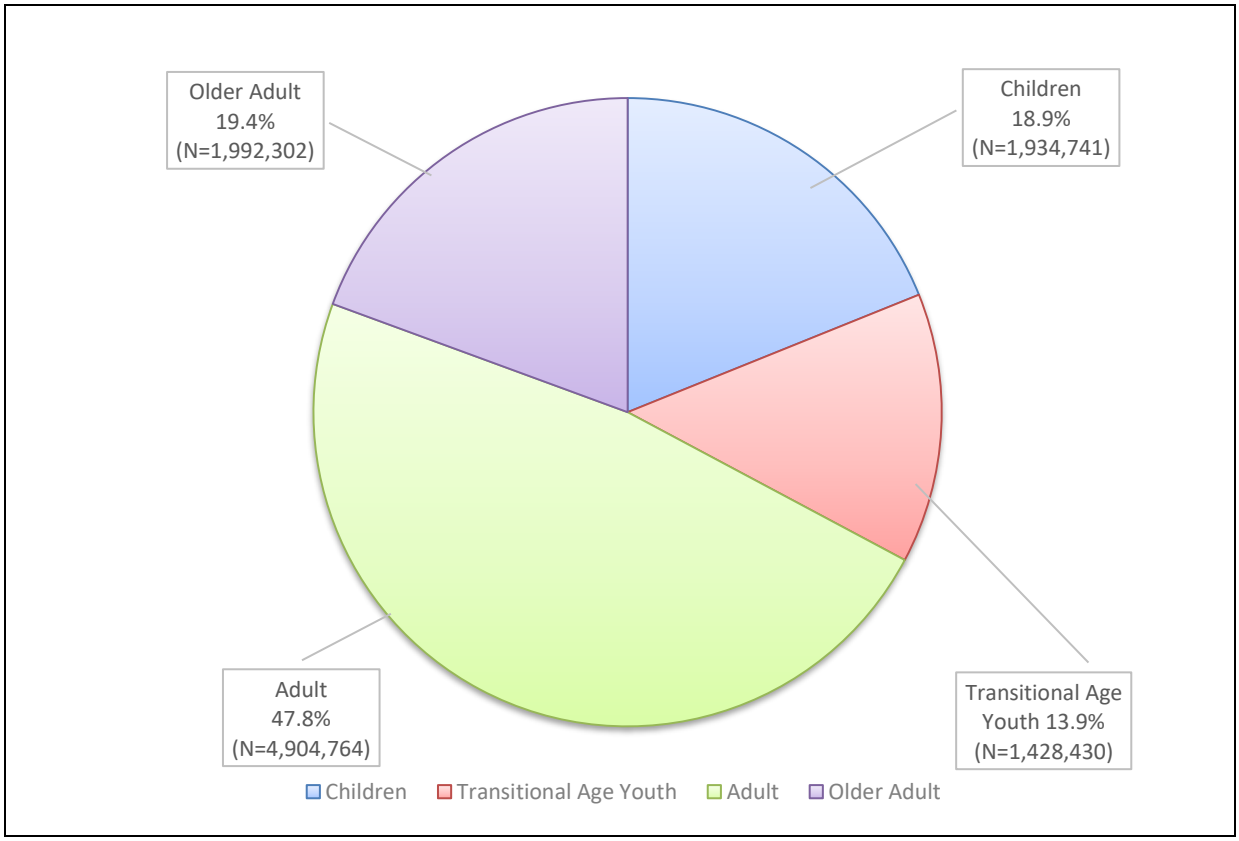


Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2020.

Figure 1 shows population by race/ethnicity. Latinos are the largest group at 48.7%, 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%.

This space was intentionally left blank

FIGURE 2: POPULATION BY AGE GROUP
CY 2019 (N = 10,260,237)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 20120.

Figure 2 shows population by age group. Adults make up the largest group at 47.8%, followed by Children at 18.9%, Older Adults at 19.4%, and Transition Age Youth (TAY) at 13.9%.

This space was intentionally left blank

TABLE 1: POPULATION BY RACE/ETHNICITY AND SERVICE AREA CY 2019

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	61,148	15,464	181,754	1,922	125,684	11,300	397,272
Percent	15.4%	3.9%	45.8%	**0.48%**	31.6%	2.8%	100.0%
SA 2	77,002	254,680	909,678	4,703	943,807	58,441	2,248,311
Percent	3.4%	11.3%	40.5%	0.21%	42.0%	2.6%	100.0%
SA 3	63,409	507,240	846,574	3,720	358,476	35,040	1,814,459
Percent	3.5%	**28.0%**	46.7%	0.21%	19.8%	1.9%	100.0%
SA 4	59,582	206,948	616,104	2,619	285,102	21,416	1,191,772
Percent	5.0%	17.4%	51.7%	0.22%	23.9%	1.8%	100.0%
SA 5	37,299	91,134	110,277	1,184	398,949	28,378	667,220
Percent	5.6%	13.7%	**16.5%**	0.18%	**59.8%**	**4.3%**	100.0%
SA 6	275,338	19,164	717,130	1,825	25,738	11,503	1,050,698
Percent	**26.2%**	**1.8%**	68.3%	**0.17%**	**2.4%**	**1.1%**	100.0%
SA 7	39,210	119,386	974,630	3,344	168,786	15,589	1,320,945
Percent	**3.0%**	9.0%	**73.8%**	0.25%	12.8%	1.2%	100.0%
SA 8	222,204	243,714	637,526	4,403	413,188	48,525	1,569,560
Percent	14.2%	15.5%	40.6%	0.28%	26.3%	3.1%	100.0%
Total	835,191	1,457,731	4,993,673	23,720	2,719,729	230,193	10,260,237
Percent	8.1%	14.2%	48.7%	0.23%	26.5%	2.2%	100.0%

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, 2020.

Differences by Race/Ethnicity

The highest percentage of African Americans was in SA 6 (26.2%) compared to SA 7 (3.0%) with the lowest percentage.

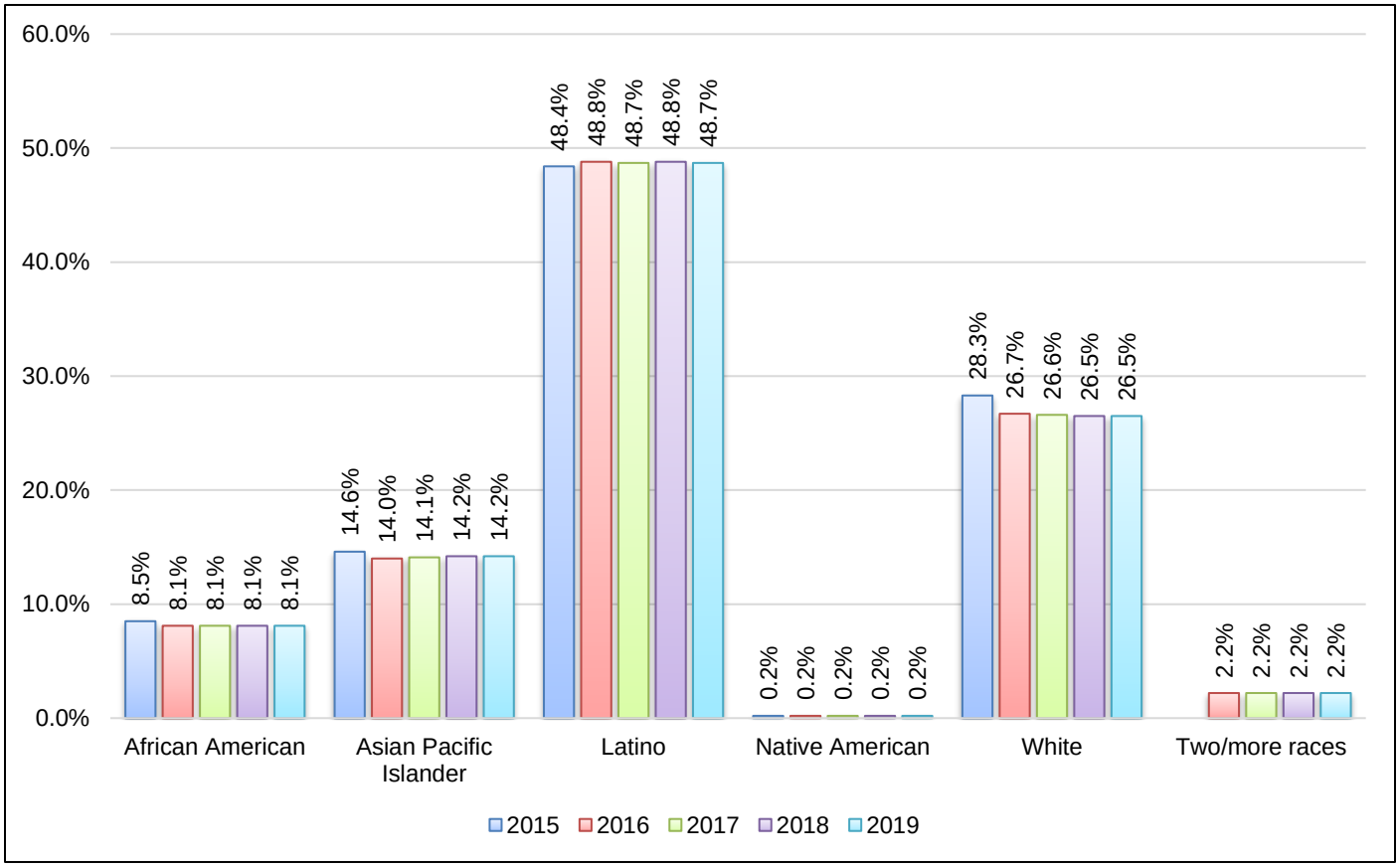
The highest percentage of Asian/Pacific Islanders was in SA 3 (28.0%) compared to SA 6 (1.8%) with the lowest percentage.

The highest percentage of Latinos was in SA 7 (73.8%) compared to SA 5 (16.5%) 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 2015–2019



Note: The "Two or More Races" ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2020.

The percentage of African Americans (AA) in the County has decreased by 0.4 percentage points (PP) over the past five years. AA represented 8.5% of the total population in CY 2015 and 8.1% of the population in CY 2019.

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 2015 and represented 14.2% in CY 2019.

The percentage of Latinos in Los Angeles County has increased by 0.3 PP over the past five years. Latinos represented 48.4% of the total population in CY 2015 and represented 48.7% in CY 2019.

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 2015` and in CY 2019.

The percentage of Whites in Los Angeles County has decreased by 1.8 PP over the past five years. Whites represented 28.3 of the total population in CY 2015 and represented 26.5% in CY 2019.

The percentage of Two or More Races in Los Angeles County remains the same over the past three years. Two or More Races category represent 2.2% of total population in CY 2019.

This space was intentionally left blank

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2019

Service Area (SA)	Age Group						
	0-18	**19-20**	**21-25**	**26-59**	**60-64**	**65+**	**Total**
SA1	104,022	13,206	34,450	176,405	24,364	44,825	397,272
Percent	26.2%	3.3%	8.7%	**44.4%**	6.1%	11.3%	100.0%
SA2	486,825	60,627	152,108	1,085,643	147,042	316,066	2,248,311
Percent	21.7%	2.7%	6.8%	48.3%	6.5%	14.1%	100.0%
SA3	390,614	54,138	131,937	837,009	119,711	281,050	1,814,459
Percent	21.5%	3.0%	7.3%	46.1%	**6.6%**	15.5%	100.0%
SA4	239,083	26,350	69,744	643,006	64,200	149,389	1,191,772
Percent	20.1%	**2.2%**	**5.9%**	**54.0%**	5.4%	12.5%	100.0%
SA5	119,662	23,038	40,973	334,647	41,382	107,518	667,220
Percent	**17.9%**	3.5%	6.1%	50.2%	6.2%	**16.1%**	100.0%
SA6	298,631	38,452	90,823	477,317	50,349	95,126	1,050,698
Percent	**28.4%**	**3.7%**	**8.6%**	45.4%	**4.8%**	**9.1%**	100.0%
SA7	329,651	40,947	103,494	610,331	72,824	163,698	1,320,945
Percent	25.0%	3.1%	7.8%	46.2%	5.5%	12.4%	100.0%
SA8	361,487	43,443	109,466	740,406	98,813	215,945	1,569,560
Percent	23.0%	2.8%	7.0%	47.2%	6.3%	13.8%	100.0%
Total	2,329,975	300,201	732,995	4,904,764	618,685	1,373,617	10,260,237
Percent	22.7%	2.9%	7.1%	47.8%	6.0%	13.4%	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, 2020.

Difference by Age Group

The highest percentage of individuals between 0 and 18 years old was in SA 6 (28.4%) 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.

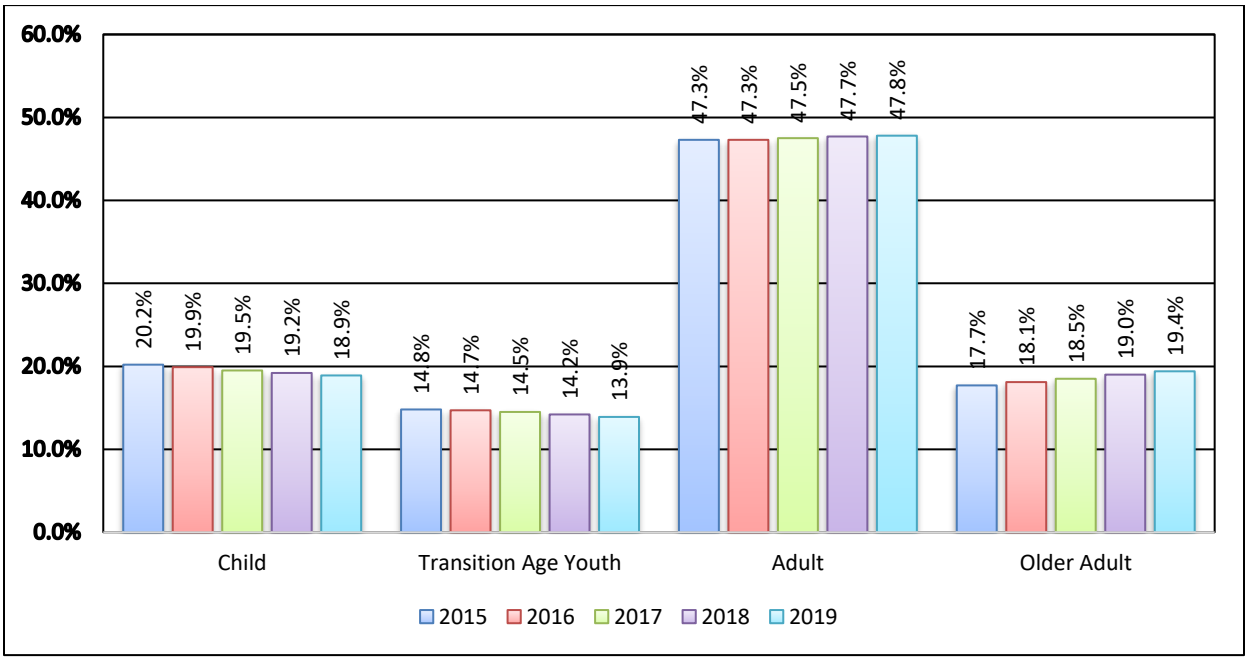
The highest percentage of individuals between 21 and 25 years old was in SA 6 (8.6%) compared to SA 5 (5.9%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (54.0%) compared to SA 1 (44.4%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 3 (6.6%) compared to SA 6 (4.8%) with the lowest percentage.

The highest percentage of individuals 65+ years old was in SA 5 (16.1%) compared to SA 6 (9.1%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT (PP) CHANGE BY AGE GROUP CY 2015–2019



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2020.

The percentage of Children in the County has decreased by 1.3 PP over the past five years. Children represented 20.2% of the total population in CY 2015 and 18.9% in CY 2019.

The percentage of Transition Age Youth (TAY) in the County has decreased by 0.9 PP over the past five years. TAY represented 14.8% of the total population in CY 2015 and 13.9% in CY 2019.

The percentage of Adults in the County increased by 0.5 PP over the past five years. Adults represented 47.3% of the total population in CY 2015 and 47.8% in CY 2019.

The percentage of Older Adults in the County has increased by 1.7 PP over the past five years. Older Adults represented 17.7% of the total population in CY 2015 and 19.4% in CY 2019.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2019

Service Area (SA)	Male	Female	Total
SA1	196,999	200,273	397,272
Percent	49.6%	50.4%	100.0%
SA2	1,111,884	1,136,427	2,248,311
Percent	49.5%	50.5%	100.0%
SA3	885,851	928,608	1,814,459
Percent	48.8%	51.2%	100.0%
SA4	611,826	579,946	1,191,772
Percent	**51.3%**	**48.7%**	100.0%
SA5	323,405	343,815	667,220
Percent	**48.5%**	**51.5%**	100.0%
SA6	512,487	538,211	1,050,698
Percent	48.8%	51.2%	100.0%
SA7	649,778	671,167	1,320,945
Percent	49.2%	50.8%	100.0%
SA8	767,827	801,733	1,569,560
Percent	48.9%	51.1%	100.0%
Total	5,060,057	5,200,180	10,260,237
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, 2020.

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 2019

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	17,237	2,552	47,915	485	23,435	2,386	94,011
Percent	18.3%	2.7%	51.0%	**0.52%**	24.9%	2.5%	100.0%
SA 2	14,246	34,531	213,960	755	120,161	7,496	391,148
Percent	3.6%	8.8%	54.7%	0.19%	30.7%	1.9%	100.0%
SA 3	10,610	84,594	172,577	631	42,430	4,100	314,941
Percent	3.4%	**26.9%**	54.8%	0.20%	13.5%	1.3%	100.0%
SA 4	13,002	47,399	186,766	775	48,465	3,833	300,239
Percent	4.3%	15.8%	62.2%	0.26%	16.1%	1.3%	100.0%
SA 5	4,221	11,698	13,440	113	40,243	2,665	72,380
Percent	5.8%	16.2%	**18.6%**	**0.16%**	**55.6%**	**3.7%**	100.0%
SA 6	90,494	6,870	271,691	746	7,571	3,247	380,619
Percent	**23.8%**	**1.8%**	71.4%	0.20%	**2.0%**	0.9%	100.0%
SA 7	7,161	15,442	224,871	681	22,255	1,824	272,234
Percent	**2.6%**	5.7%	**82.6%**	0.25%	8.2%	**0.7%**	100.0%
SA 8	56,495	35,021	165,865	853	43,613	6,823	308,670
Percent	18.3%	11.3%	53.7%	0.28%	14.1%	2.2%	100.0%
Total	213,465	238,106	1,297,085	5,038	348,173	32,374	2,134,242
Percent	10.1%	11.2%	60.8%	0.24%	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, 2020.

Differences by Race/Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (23.8%) compared to SA 7 (2.6%) 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 (26.9%) compared to SA 6 (1.8%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 11.2% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (82.6%) compared to SA 5 (18.6%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 60.8% self-identified as Latino.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.52%) compared to SA 5 (0.16%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 0.24% self-identified as NA.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (55.6%) compared to SA 6 (2.0%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 16.3% 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 (0.7%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 1.5% 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 2019

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	34,514	3,006	7,847	36,295	4,262	8,087	94,011
Percent	**36.7%**	3.2%	8.3%	38.6%	4.5%	8.6%	100.0%
SA2	118,776	10,814	27,831	173,332	18,571	41,824	391,148
Percent	30.4%	2.8%	7.1%	44.3%	4.7%	10.7%	100.0%
SA3	93,639	8,881	23,787	131,216	15,413	42,005	314,941
Percent	29.7%	2.8%	7.6%	41.7%	**4.9%**	**13.3%**	100.0%
SA4	87,776	6,568	18,877	141,585	12,649	32,784	300,239
Percent	29.2%	**2.2%**	**6.3%**	47.2%	4.2%	10.9%	100.0%
SA5	12,204	2,796	8,993	36,008	3,355	9,024	72,380
Percent	**16.9%**	**3.9%**	**12.4%**	**49.7%**	4.6%	12.5%	100.0%
SA6	154,301	12,246	31,845	144,762	14,028	23,437	380,619
Percent	40.5%	3.2%	8.4%	**38.0%**	**3.7%**	**6.2%**	100.0%
SA7	101,126	7,781	20,248	107,178	11,059	24,842	272,234
Percent	37.1%	2.9%	7.4%	39.4%	4.1%	9.1%	100.0%
SA8	104,735	8,823	22,837	129,738	13,691	28,846	308,670
Percent	33.9%	2.9%	7.4%	42.0%	4.4%	9.3%	100.0%
Total	707,071	60,915	162,265	900,114	93,028	210,849	2,134,242
Percent	33.1%	2.9%	7.6%	42.2%	4.4%	9.9%	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, 2020.

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 1 (36.7%) compared to SA 5 (16.9%) 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 (3.9%) compared to SA 4 (2.2%) 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 (12.4%) compared to SA 4 (6.3%) 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 (49.7%) compared to SA 6 (38.0%) 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 (4.9%) compared to SA 6 (3.7%) with the lowest percentage.

The highest percentage of individuals age 65 years old and overestimated to be living at or below 138% FPL was in SA 3 (13.3%) compared to SA 6 (6.2%) with the lowest percentage.

This space was intentionally left blank

TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2019

Service Area (SA)	Male	Female	Total
SA1	43,033	50,978	94,011
Percent	45.8%	54.2%	100.0%
SA2	180,988	210,160	391,148
Percent	46.3%	53.7%	100.0%
SA3	143,633	171,308	314,941
Percent	45.6%	54.4%	100.0%
SA4	141,378	158,861	300,239
Percent	**47.1%**	**52.9%**	100.0%
SA5	33,168	39,212	72,380
Percent	45.8%	54.2%	100.0%
SA6	174,204	206,415	380,619
Percent	45.8%	54.2%	100.0%
SA7	123,947	148,287	272,234
Percent	**45.5%**	**54.5%**	100.0%
SA8	141,159	167,511	308,670
Percent	45.7%	54.3%	100.0%
Total	981,510	1,152,732	2,134,242
Percent	46.0%	54.0%	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, 2020.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (47.1%) compared to SA 7(45.5%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 7 (54.5%) compared to SA 4 (52.9%) 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 2019

Service Area	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Other	Total
SA 1	576	396	64	124	57,839	155	191	26	228	51	31,280	513	245	2,111	93,799
Percent	0.61%	0.42%	0.07%	0.13%	**61.66%**	0.17%	0.20%	0.03%	0.24%	0.05%	**33.35%**	0.55%	0.26%	2.25%	100.00%
SA 2	5,314	40,595	95	501	120,048	7,671	3,768	726	3,268	6,756	187,233	6,942	2,130	4,581	389,628
Percent	1.36%	**10.42%**	0.02%	0.13%	**30.81%**	**1.97%**	**0.97%**	0.19%	0.84%	**1.73%**	**48.05%**	**1.78%**	**0.55%**	1.18%	100.00%
SA 3	2,651	2,035	743	15,112	90,409	387	2,941	23,794	23,401	199	134,843	3,971	9,644	3,101	313,231
Percent	0.85%	0.65%	0.24%	4.82%	**28.86%**	0.12%	0.94%	7.60%	7.47%	0.06%	43.05%	1.27%	3.08%	0.99%	100.00%
SA 4	1,538	5,414	494	3,108	76,944	1,220	1,063	1,230	6,384	4,559	169,722	5,106	922	3,326	281,030
Percent	0.55%	1.93%	0.18%	1.11%	**27.38%**	0.43%	0.38%	0.44%	2.27%	1.62%	60.39%	1.82%	0.33%	1.18%	100.00%
SA 5	1,376	393	70	300	42,651	5,484	1,497	1,413	3,115	1,147	11,769	471	352	2,280	72,318
Percent	1.90%	0.54%	0.10%	0.41%	**58.98%**	7.58%	2.07%	1.95%	4.31%	1.59%	16.27%	0.65%	0.49%	3.15%	100.00%
SA 6	482	78	98	967	98,779	347	2,744	512	2,181	91	270,186	336	337	4,211	381,349
Percent	0.13%	0.02%	0.03%	0.25%	**25.90%**	0.09%	0.72%	0.13%	0.57%	0.02%	70.85%	0.09%	0.09%	1.10%	100.00%
SA 7	1,995	700	387	855	59,491	118	2,744	1,090	1,997	149	195,337	2,608	899	2,879	271,249
Percent	0.74%	0.26%	0.14%	0.32%	21.93%	0.04%	1.01%	0.40%	0.74%	0.05%	72.01%	0.96%	0.33%	1.06%	100.00%
SA 8	2,616	351	5,075	84	125,328	601	3,225	534	3,294	377	154,009	4,566	2,176	5,557	307,793
Percent	0.85%	0.11%	1.65%	0.03%	**40.72%**	0.20%	1.05%	0.17%	1.07%	0.12%	50.04%	1.48%	0.71%	1.81%	100.00%
Total	16,548	49,962	7,026	21,051	671,489	15,983	18,173	29,325	43,868	13,329	1,154,379	24,513	16,705	28,046	2,110,397
Percent	0.78%	2.37%	0.33%	1.00%	31.82%	0.76%	0.86%	1.39%	2.08%	0.63%	54.70%	1.16%	0.79%	1.33%	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, 2020.

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 of 98.0% (N = 2,065,803) of the population (N = 2,110,397) living at or below 138% FPL spoke a LACDMH threshold language. Among these, 31.82% (N = 671,489) were English speaking, 54.7% were Spanish speaking (N = 1,154,379) and the remaining 13.5% spoke the other LACDMH threshold languages.

As applicable to LACDMH, below is a breakdown of the 138% FPL population's threshold languages:

SA 1 reported two (2) threshold languages: English (61.7%) and Spanish (33.4%).

SA 2 reported eight (8) threshold languages: Armenian (10.4%), English (30.8%), Farsi (2.0%), Korean (1.0%), Russian (1.7%), Spanish (48.1%), and Tagalog (1.8%).

SA 3 reported seven (7) threshold languages: Cantonese (4.8%), English (28.9%), Korean (0.9%), Mandarin (7.6%), Other Chinese (7.5%), Spanish (43.1) and Vietnamese (3.1%).

SA 4 reported seven (7) threshold languages: Armenian (1.9%), Cantonese (1.1%), English (27.4%), Korean (0.4%), Other Chinese (2.3%), Russian (1.6%), and Spanish (60.4%).

SA 5 reported three (3) threshold languages: English (59.0%), Farsi (7.6%), and Spanish (16.3%).

SA 6 reported two (2) threshold languages: English (25.9%) and Spanish (70.9%).

SA 7 reported three (3) threshold languages: English (22.0%), Korean (1.0%), and Spanish (72.0%).

SA 8 reported five (5) threshold languages: Cambodian (1.7%), English (40.7%), Korean (1.1%), Spanish (50.0%), and Vietnamese (0.7%).

This space was intentionally left blank

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 2019

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	3,051	299	7,762	227	4,054	1,253	16,646
Percent	18.3%	1.8%	46.6%	**1.36%**	24.4%	7.5%	100.0%
SA 2	2,521	4,040	34,662	352	20,788	3,935	66,299
Percent	3.8%	6.1%	52.3%	0.53%	31.4%	5.9%	100.0%
SA 3	1,878	9,897	27,957	294	709	2,152	42,889
Percent	4.4%	**23.1%**	65.2%	0.69%	**1.7%**	5.0%	100.0%
SA 4	2,301	5,546	30,256	362	8,384	2,012	48,862
Percent	4.7%	11.3%	61.9%	0.74%	17.2%	4.1%	100.0%
SA 5	747	1,369	2,177	53	6,962	1,399	12,707
Percent	5.9%	10.8%	**17.1%**	**0.41%**	**54.8%**	**11.0%**	100.0%
SA 6	16,017	804	44,014	348	1,310	1,705	64,198
Percent	**24.9%**	**1.3%**	68.6%	0.54%	2.0%	2.7%	100.0%
SA 7	1,268	1,807	36,429	318	3,850	958	44,629
Percent	**2.8%**	4.0%	**81.6%**	0.71%	8.6%	**2.1%**	100.0%
SA 8	10,000	4,097	26,870	399	7,545	3,582	52,493
Percent	19.0%	7.8%	51.2%	0.76%	14.4%	6.8%	100.0%
Total	37,783	27,858	210,128	2,353	60,234	16,997	355,353
Percent	10.6%	7.8%	59.1%	0.66%	17.0%	4.8%	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 2018 and CY 2019. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2020.

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 (25.0%) compared to SA 7 (2.8%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian/Pacific Islander (API) group was in SA 3 (23.1%) compared to SA 6 (1.3%) with the lowest percentage.

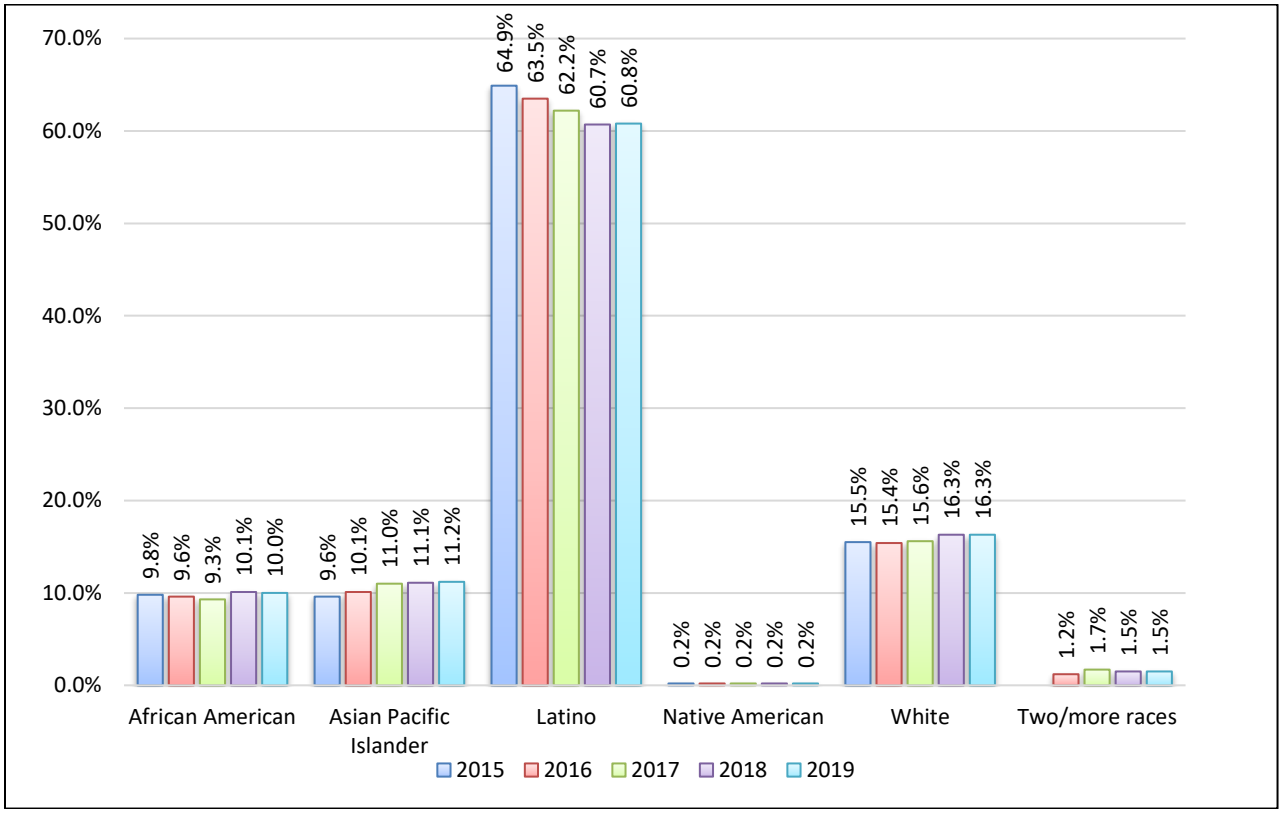
The highest rate of prevalence of SED and SMI among the Latino group was in SA 7 (81.6%) compared to SA 5 (17.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) group was in SA 1 (1.36%) compared to SA 5 (0.41%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White group was in SA 5 (54.8%) compared to SA 6 (1.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Two or More Races group was in SA 5 (11.0%) compared to SA 7 (2.1%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY CY 2015–2019



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2020.

The percentage of African Americans living at or below 138% FPL has increased by 0.2% from 9.8% in CY 2015 to 10.0% in CY 2019.

The percentage of Asian/Pacific Islanders (API) living at or below 138% FPL has increased by 1.6% from 9.6% in CY 2015 to 11.2% in CY 2019.

The percentage of Latinos living at or below 138% FPL has decreased by 4.1% from 64.9% in CY 2015 to 60.8% in CY 2019.

The percentage of Native Americans living at or below 138% FPL has remained unchanged at 0.2% from CY 2015 to CY 2019.

The percentage of Whites living at or below 138% FPL has increased by 0.8% from 15.5% in CY 2015 to 16.3% in CY 2019.

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 2019.

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 2019

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	7,766	962	2,833	4,900	413	283	17,157
Percent	45.3%	5.6%	16.5%	28.6%	2.4%	1.6%	100.0%
SA2	26,725	3,460	10,047	23,400	1,801	1,464	66,897
Percent	39.9%	5.2%	15.0%	35.0%	2.7%	2.2%	100.0%
SA3	21,069	2,842	8,587	17,714	1,495	1,470	53,177
Percent	39.6%	5.3%	16.1%	33.3%	**2.8%**	**2.8%**	100.0%
SA4	19,750	2,102	6,815	19,114	1,227	1,147	50,154
Percent	39.4%	**4.2%**	**13.6%**	38.1%	2.4%	2.3%	100.0%
SA5	2,746	895	3,246	4,861	325	316	12,389
Percent	**22.2%**	**7.2%**	**26.2%**	**39.2%**	2.6%	2.5%	100.0%
SA6	34,718	3,919	11,496	19,543	1,361	820	71,856
Percent	**48.3%**	5.5%	16.0%	**27.2%**	**1.9%**	**1.1%**	100.0%
SA7	22,753	2,490	7,310	14,469	1,073	869	48,964
Percent	46.5%	5.1%	14.9%	29.6%	2.2%	1.8%	100.0%
SA8	23,565	2,823	8,244	17,515	1,328	1,010	54,485
Percent	43.3%	5.2%	15.1%	32.1%	2.4%	1.9%	100.0%
Total	159,091	19,493	58,578	121,515	9,024	7,380	375,080
Percent	42.4%	5.2%	15.6%	32.4%	2.4%	2.0%	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 2018 and 2019. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2020.

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 (48.3%) compared to SA 5 (22.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 19-20 was in SA 5 (7.2%) compared to SA 4 (4.2%) with the lowest percentage.

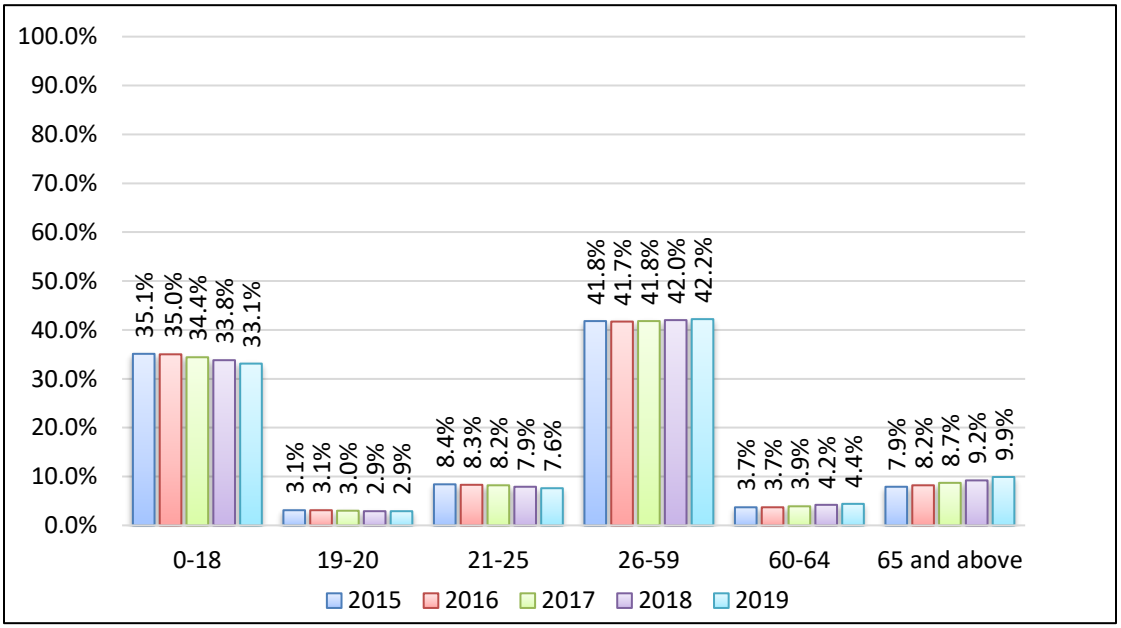
The highest rate of prevalence of SED and SMI in Age Group 21-25 was in SA 5 (26.2%) compared to SA 4 (13.6%) the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 26-59 was in SA 5 (39.2%) compared to SA 6 (27.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 60-64 was in SA 3 and SA (2.8%) compared to SA 6 (1.9%).

The highest rate of prevalence of SED and SMI in Age Group 65 and older was in SA 3 (2.8%) compared to SA 6 (1.1%) with the lowest percentage.

FIGURE 6: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2015–2019



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 2.0 PP from 35.1% in CY 2015 to 33.1% in CY 2019.

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 2015 and to 2.9% in CY 2019.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 0.8 PP from 8.4% in CY 2015 to 7.6% in CY 2019.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL increased by 0.4 PP from 41.8% in CY 2015 to 42.2% in CY 2019.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.7 PP from 3.7% in CY 2015 to 4.4% in CY 2019.

The percentage of individuals age 65 and older and estimated to be living at or below 138% FPL increased by 2.0 PP from 7.9% in CY 2015 to 9.9% in CY 2019.

TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA - CY 2019

Service Area (SA)	Male	Female	Total
SA1	5,379	9,788	15,167
Percent	35.5%	64.5%	100.0%
SA2	22,624	40,351	62,974
Percent	35.9%	64.1%	100.0%
SA3	17,954	32,891	50,845
Percent	35.3%	64.7%	100.0%
SA4	17,672	30,501	48,174
Percent	**36.7%**	**63.3%**	**100.0%**
SA5	4,146	7,529	11,675
Percent	35.5%	64.5%	100.0%
SA6	21,776	39,632	61,407
Percent	35.5%	64.5%	100.0%
SA7	15,493	28,471	43,964
Percent	**35.2%**	**64.8%**	100.0%
SA8	17,645	32,162	49,807
Percent	35.4%	64.6%	100.0%
Total	122,689	221,325	344,013
Percent	35.7%	64.3%	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 2018 and CY 2019. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2020.

Differences by Gender

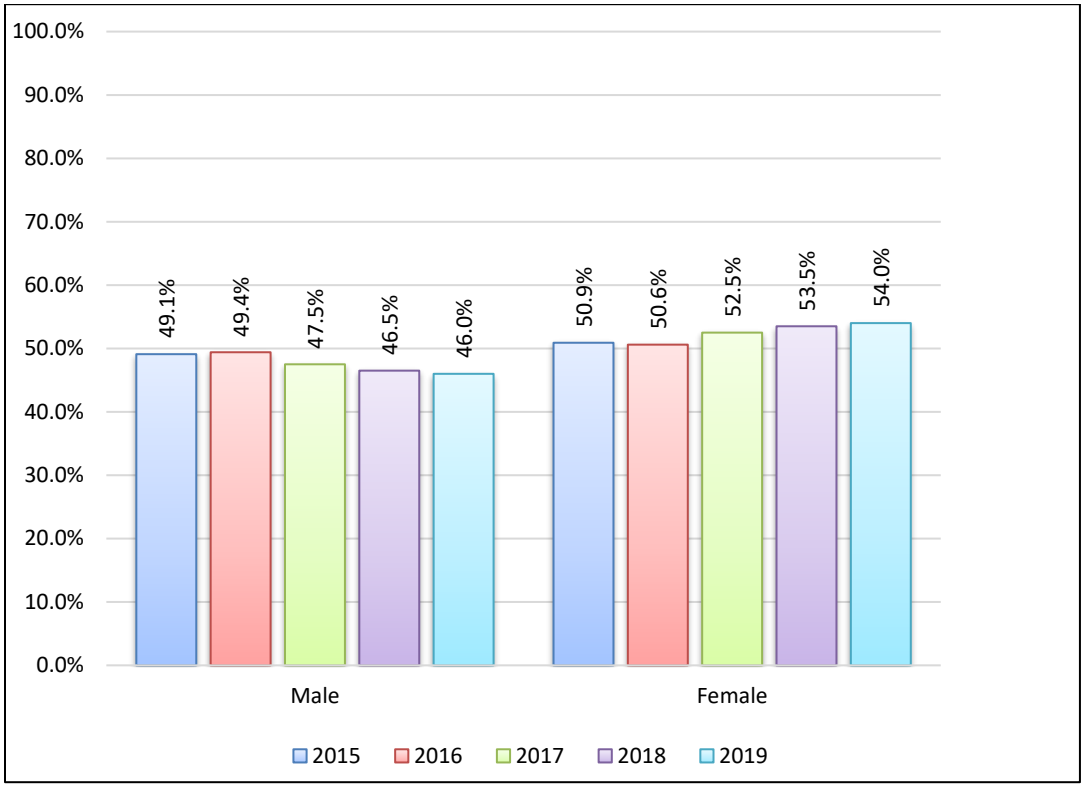
Table 10 compares the prevalence of SED and SMI for population living at or below 138% FPL for Males and Females.

The highest rate of prevalence of SED and SMI among Males was in SA 4 (36.7%) compared to SA 7 (35.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 7 (64.8%) compared to SA 4 (63.3%) with the lowest percentage.

This space was intentionally left blank

FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2015–2019



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2020.

The percentage of Males living at or below 138% FPL decreased by 3.1% PP from 49.1% in CY 2015 to 46.0% in CY 2019.

The percentage of Females living at or below 138% FPL increased by 3.1% from 50.9% in CY 2015 to 54.0% in CY 2019.

This space was intentionally left blank

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	8,295	546	16,833	114	5,626	31,413
Percent	26.4%	1.7%	53.6%	0.36%	17.9%	100.0%
SA 2	5,228	6,644	65,310	251	39,729	117,163
Percent	4.5%	5.7%	55.7%	0.21%	33.9%	100.0%
SA 3	4,105	20,650	55,038	197	9,908	89,898
Percent	4.6%	**23.0%**	61.2%	0.22%	11.0%	100.0%
SA 4	5,436	7,893	48,220	355	11,102	73,007
Percent	7.4%	10.8%	66.0%	**0.49%**	15.2%	100.0%
SA 5	2,306	956	4,961	71	6,822	15,116
Percent	15.3%	6.3%	**32.8%**	0.47%	**45.1%**	100.0%
SA 6	27,525	752	72,910	180	2,544	103,911
Percent	**26.5%**	**0.7%**	70.2%	**0.17%**	**2.4%**	100.0%
SA 7	2,570	3,473	45,143	183	5,877	57,246
Percent	**4.5%**	6.1%	**78.9%**	0.32%	10.3%	100.0%
SA 8	17,727	6,771	45,670	279	9,591	80,038
Percent	22.1%	8.5%	57.1%	0.35%	12.0%	100.0%
Total	73,193	47,685	377,449	1,629	91,199	591,155
Percent	12.4%	8.1%	63.8%	0.28%	15.4%	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 2018 and CY 2019. 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 (26.5%) compared to SA 2 and SA 7 (4.5%) with the lowest percentage.

The highest prevalence of SED and SMI in the Asian/Pacific Islander (API) group was in SA 3 (23.0%) compared to SA 6 (0.7%) with the lowest percentage.

The highest prevalence of SED and SMI in the Latino group was in SA 7 (78.9%) compared to SA 5 (32.8%) 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 (0.2%) with the lowest percentage.

The highest prevalence of SED and SMI in the White group was in SA 5 (45.1%) compared to SA 6 (2.4%) with the lowest percentage.

This space was intentionally left blank

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	21,297	1,928	4,970	9,749	954	448	39,346
Percent	**54.1%**	**4.9%**	12.6%	**24.8%**	**2.4%**	**1.1%**	100.0%
SA 2	65,412	6,026	16,433	40,897	5,192	3,671	137,631
Percent	47.5%	4.4%	**11.9%**	29.7%	3.8%	2.7%	100.0%
SA 3	57,078	5,349	14,260	32,571	4,275	3,080	116,612
Percent	48.9%	4.6%	12.2%	27.9%	3.7%	2.6%	100.0%
SA 4	37,433	3,584	10,611	28,154	3,450	2,484	85,717
Percent	43.7%	4.2%	12.4%	32.8%	4.0%	2.9%	100.0%
SA 5	6528	691	2306	6700	791	569	17586
Percent	**37.1%**	**3.9%**	**13.1%**	**38.1%**	**4.5%**	**3.2%**	100.0%
SA 6	69,178	6,015	15,707	33,108	3,476	1,708	129,192
Percent	53.5%	4.7%	12.2%	25.6%	2.7%	1.3%	100.0%
SA 7	54,281	4,872	12,491	26,082	2,928	1,955	102,609
Percent	52.9%	4.7%	12.2%	25.4%	2.9%	1.9%	100.0%
SA 8	50,760	4,661	12,960	28,581	3,260	1,853	102,075
Percent	49.7%	4.6%	12.7%	28.0%	3.2%	1.8%	100.0%
Total	361,968	33,125	12,960	205,842	24,326	15,770	653,990
Percent	55.3%	5.1%	2.0%	31.5%	3.7%	2.4%	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 2018 and CY 2019. Due to rounding, some estimated totals and percentages may not total 100%. Data Source: State MEDS File, March 2018.

Differences by Age Group

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

The highest prevalence of SED and SMI in Age Group 0-18 was in SA 1 (54.1%) compared to SA 5 (37.1%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 19-20 was in SA 1 (4.9%) compared to SA 5 (3.9%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 21-25 was in SA 5 (13.1%) compared to SA 2 (11.9%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 26-59 was in SA 5 (38.1%) compared to SA 1 (24.8%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 60-64 was in SA 5 (4.5%) compared to SA 1 (2.4%) with the lowest percentage.

The highest prevalence of SED and SMI in Age Group 65 and older was in SA 5 (3.2%) compared to SA 1 (1.1%) 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	13,195	19,166	32,362
Percent	40.8%	59.2%	100.0%
SA 2	51,498	74,861	126,359
Percent	40.8%	59.2%	100.0%
SA 3	42,916	62,782	105,698
Percent	40.6%	59.4%	100.0%
SA 4	33,967	46,916	80,883
Percent	42.0%	58.0%	100.0%
SA 5	7,354	10,006	17,360
Percent	**42.4%**	**57.6%**	100.0%
SA 6	43,850	64,385	108,234
Percent	40.5%	59.5%	100.0%
SA 7	35,154	53,147	88,301
Percent	**39.8%**	**60.2%**	100.0%
SA 8	36,225	52,761	88,986
Percent	40.7%	59.3%	100.0%
Total	264,158	384,025	648,184
Percent	40.8%	59.2%	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 2018 and CY 2019. 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 (42.4%) compared to SA 7 (39.8%) with the lowest percentage.

The highest prevalence of SED and SMI among Females was in SA 7 (60.2%) compared to SA 5 (57.6%) with the lowest percentage.

This space was intentionally left blank

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 19–20

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	Two or More Races	Unknown	White	Total
SA 1	7,245	209	6,531	140	1,063	2,211	4,415	21,814
Percent	33.2%	**1.0%**	29.9%	0.64%	**4.9%**	**10.1%**	20.2%	100.0%
SA 2	4,018	1,579	22,156	145	1,469	10,211	12,557	52,135
Percent	7.7%	3.0%	42.5%	**0.28%**	2.8%	19.6%	24.1%	100.0%
SA 3	3,519	2,971	15,655	215	869	17,111	5,331	45,671
Percent	7.7%	**6.5%**	34.3%	0.47%	1.9%	**37.5%**	11.7%	100.0%
SA 4	6,545	2,336	17,468	268	795	8,202	5,627	41,241
Percent	15.9%	5.7%	42.4%	0.65%	1.9%	19.9%	13.6%	100.0%
SA 5	2,009	386	2,173	53	344	2,585	3,821	11,371
Percent	17.7%	3.4%	**19.1%**	0.47%	3.0%	22.7%	**33.6%**	100.0%
SA 6	20,102	608	22,601	754	836	10,703	2,664	58,268
Percent	**34.5%**	**1.0%**	38.8%	**1.29%**	**1.4%**	18.4%	**4.6%**	100.0%
SA 7	2,019	951	20,329	244	940	12,789	3,120	40,392
Percent	**5.0%**	2.4%	**50.3%**	0.60%	2.3%	31.7%	7.7%	100.0%
SA 8	11,786	2,345	15,067	287	1,369	9,236	6,509	46,599
Percent	25.3%	5.0%	32.3%	0.62%	2.9%	19.8%	14.0%	100.0%
Total	35,573	8,599	81,902	1,361	5,059	48,881	30,086	211,461
Percent	16.8%	4.1%	38.7%	0.64%	2.4%	23.1%	14.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes State N = 3,988. Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, April 2021.

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 (34.5%) as compared to SA 7 (5.0%) with the lowest percentage.

The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (6.5%) as compared to SA 1 and SA 6 (1.0%) with the lowest percentage.

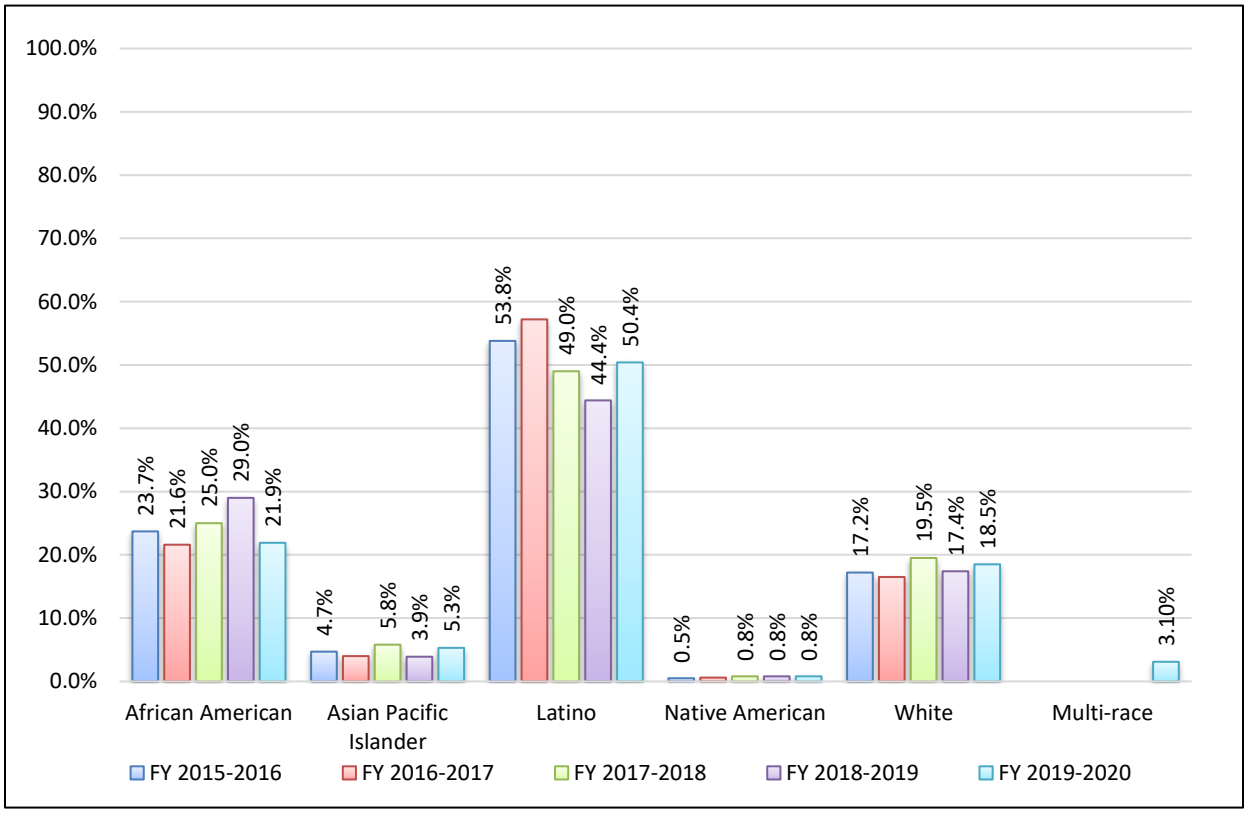
The highest percentage of Latino consumers served in outpatient programs was in SA 7 (50.3%) as compared to SA 5 (19.1%) with the lowest percentage.

The highest percentage of Native American consumers served in outpatient programs was in SA 6 (1.29%) as compared to SA 2 (0.28%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (33.6%) as compared to SA 6 (4.6%) with the lowest percentage.

The highest percentage of Two or More Races served in outpatient programs was in SA 1 (4.9%) as compared to SA 6 (1.4%) with the lowest percentage.

FIGURE 8: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY FY 15–16 TO FY 19–20



Data Source: LACDMH, IS-IBHIS, April 2021

The percentage of African Americans (AA) served in outpatient programs decreased by 1.8% from 23.7% to 21.9% between FY 15-16 and FY 19-20.

The percentage of Asian/Pacific Islanders (API) served in outpatient programs increased by 0.6% from 4.7% to 5.3% between FY 15-16 and FY 19-20.

The percentage of Latinos served in outpatient programs decreased by 3.4% from 53.8% to 50.4% between FY 15-16 and FY 19-20.

The percentage of Native Americans (NA) served in outpatient programs increased by 0.3% from 0.5% to 0.8% from FY 15-16 and FY 19-20.

The percentage of Whites served in outpatient programs increased by 1.3% from 17.2% to 18.5% between FY 15-16 and FY 19-20.

The percentage of Two or More Races served in outpatient programs was 3.1% for FY 19-20.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP AND SERVICE AREA FY 19–20

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA1	9,189	3,655	7,592	1,378	21,814
Percent	**42.1%**	16.8%	34.8%	**6.3%**	100.0%
SA2	16,876	10,959	19,266	5,034	52,135
Percent	32.4%	21.0%	37.0%	9.7%	100.0%
SA3	17,357	10,952	14,215	3,147	45,671
Percent	38.0%	**24.0%**	31.1%	6.9%	100.0%
SA4	11,399	7,339	17,548	4,955	41,241
Percent	27.6%	17.8%	42.5%	12.0%	100.0%
SA5	2,160	1,710	5,832	1,669	11,371
Percent	**19.0%**	**15.0%**	**51.3%**	**14.7%**	100.0%
SA6	20,612	11,322	21,549	4,784	58,267
Percent	35.4%	19.4%	37.0%	8.2%	100.0%
SA7	16,606	8,889	12,196	2,701	40,392
Percent	41.1%	22.0%	**30.2%**	6.7%	100.0%
SA8	15,385	8,457	18,165	4,591	46,598
Percent	33.0%	18.1%	39.0%	9.9%	100.0%
Total	67,250	40,057	83,740	22,412	213,459
Percent	31.5%	18.8%	39.2%	10.5%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Table excludes Out of County N = 3,988.Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, April 2021.

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 1 (42.1%) compared to SA 5 (19.0%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 3 (24.0%) when compared to SA 5 (15.0%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (51.3%) compared to SA 7 (30.2%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (14.7%) compared to SA 1 (6.3%) with the lowest percentage.

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

Service Area (SA)	Male	Female	Transgender (F to M)	Transgender (M to F)	Unknown	Total
SA1	10,766	11,022	17	5	4	21,814
Percent	49.4%	50.5%	**0.08%**	0.02%	0.02%	100.0%
SA2	25,606	26,462	36	25	6	52,135
Percent	**49.1%**	**50.8%**	0.07%	0.05%	**0.01%**	100.0%
SA3	22,870	22,760	17	16	8	45,671
Percent	50.1%	49.8%	**0.04%**	0.04%	0.02%	100.0%
SA4	21,968	19,192	32	42	7	41,241
Percent	**53.3%**	**46.5%**	**0.08%**	**0.10%**	0.02%	100.0%
SA5	5,805	5,548	7	4	7	11,371
Percent	51.1%	48.8%	0.06%	0.04%	**0.06%**	100.0%
SA6	29,589	28,593	31	38	17	58,268
Percent	50.8%	49.1%	0.05%	0.07%	0.03%	100.0%
SA7	19,958	20,401	20	6	7	40,392
Percent	49.4%	50.5%	0.05%	**0.01%**	0.02%	100.0%
SA8	23,335	23,170	39	36	19	46,599
Percent	50.1%	49.7%	**0.08%**	0.08%	0.04%	100.0%
Total	105,244	107,918	133	116	50	213,461
Percent	49.3%	50.6%	0.06%	0.05%	0.02%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Table excludes Out of County N = 3,988. Data Source: LACDMH-IS-IBHIS, April 2021.

Differences by Gender

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

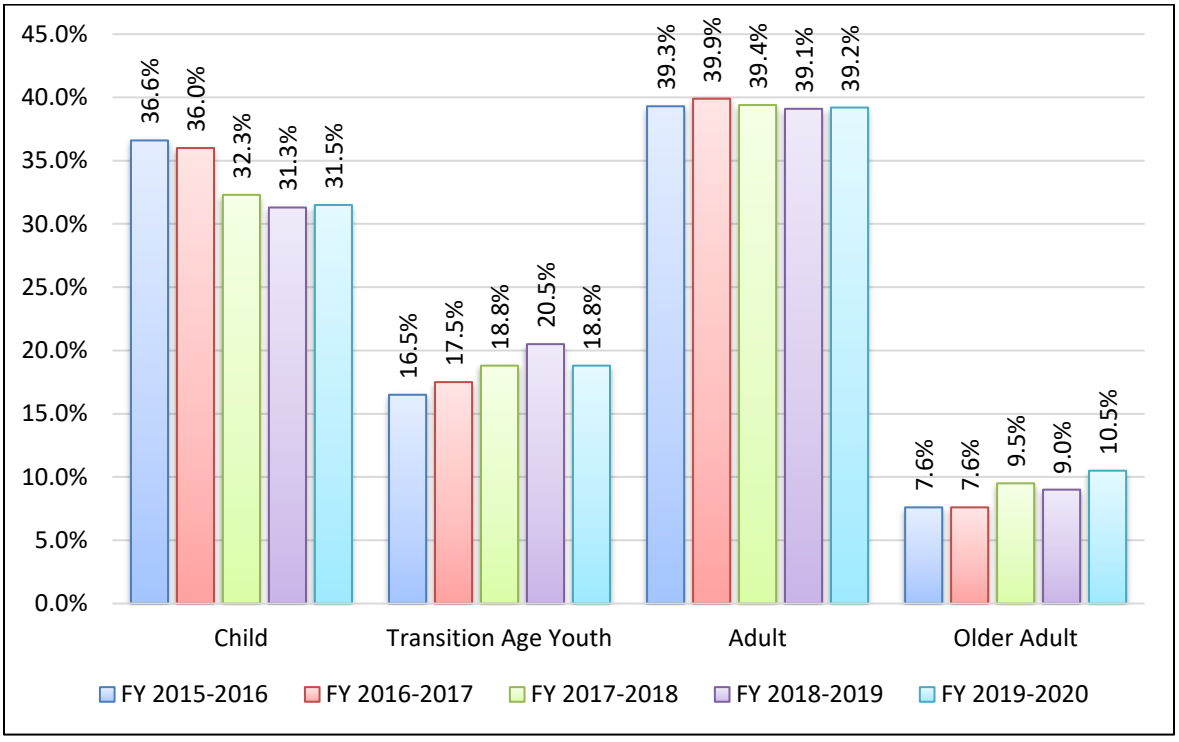
The highest percentage of Males served in outpatient programs was in SA 4 (53.3%) compared to SA 2 (49.1%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 2 (50.8%) compared to SA 4 (46.5%) with the lowest percentage.

The highest percentage of Transgender (F to M) persons served in outpatient programs was in SA 2, SA 4, and SA 8 (0.1%) compared to SA 3 (0.04%).

The highest percentage of Transgender (M to F) persons served in outpatient programs was in SA 4 (0.1%) compared to SA 7 (0.01%).

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP - FY 15–16 TO FY 19–20



Data Source: LACDMH, IS-IBHIS, April 2021.

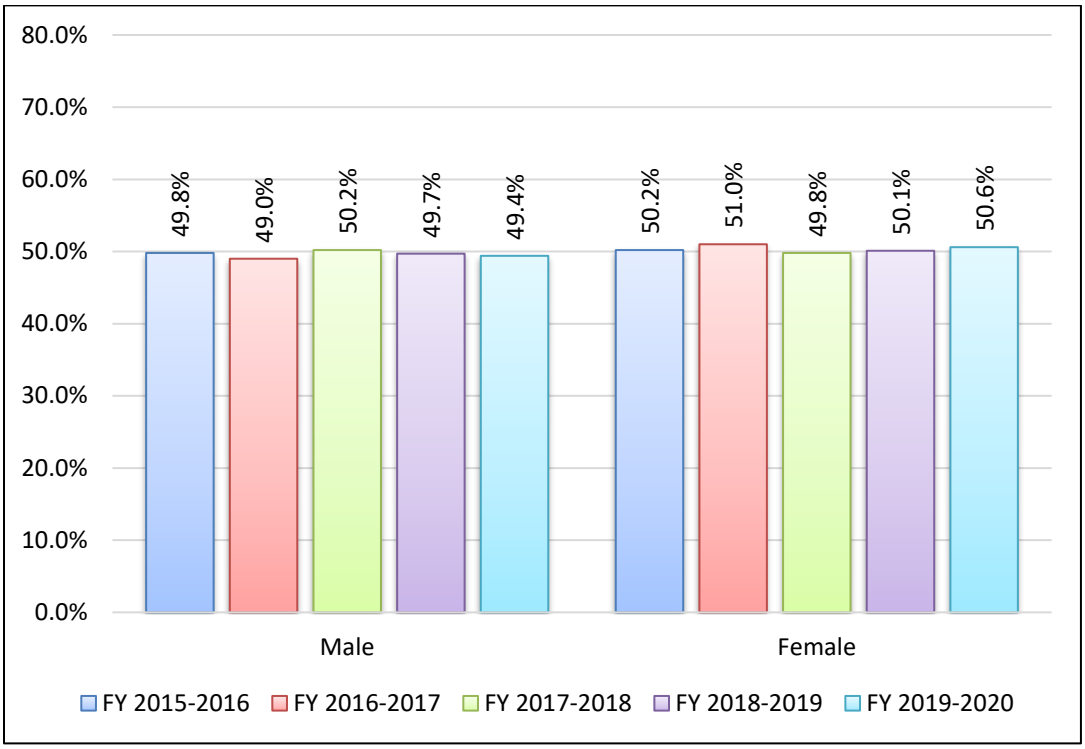
The percentage of Children served in outpatient programs decreased by 5.1% from 36.6% to 31.5% between FY 15-16 and FY 19-20.

The percentage of TAY served in outpatient programs increased by 2.3% from 16.5% to 18.8% between FY 15-16 and FY 19-20.

The percentage of Adults served in outpatient programs decreased by 0.1% from 39.3% to 39.2% between FY 15-16 and FY 19-20.

The percentage of Older Adults served in outpatient programs increased by 2.9% from 7.6% to 10.5% between FY 15-16 and FY 19-20.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER - FY 15–16 TO FY 19–20



Data Source: LACDMH, IS-IBHIS, April 2021.

The percentage of Males in outpatient programs decreased by 0.4% from 49.8% to 49.4% between FY 15-16 and FY 19-20.

The percentage of Females served in outpatient programs increased by 0.4% from 50.2% to 50.6% between FY 15-16 and FY 19-20.

This space was intentionally left blank

TABLE 21: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE - FY 19–20

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Non-Threshold Languages	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	7	15	3	0	19,981	7	0	1	0	3	6	1,448	4	1	21,476
Percent	0.03%	0.07%	0.01%	0.00%	93.04%	0.03%	0.00%	0.00%	0.00%	0.01%	0.03%	6.74%	0.02%	0.00%	100.00%
SA 2	110	1,456	23	7	40,826	575	123	11	15	8	292	6,933	94	67	50,540
Percent	0.20%	2.90%	0.00%	0.00%	80.80%	1.10%	0.24%	0.02%	0.03%	0.02%	0.60%	13.70%	0.20%	0.10%	100.00%
SA 3	27	62	78	571	35,002	17	101	601	93	10	5	7,075	42	459	44,143
Percent	0.10%	0.10%	0.20%	1.30%	79.30%	0.00%	0.23%	1.40%	0.20%	0.00%	0.00%	16.00%	0.10%	1.00%	100.00%
SA 4	11	198	67	93	31,059	47	626	44	16	6	189	6,952	85	75	39,468
Percent	0.00%	0.50%	0.20%	0.20%	78.70%	0.10%	1.59%	0.11%	0.04%	0.02%	0.50%	17.60%	0.20%	0.20%	100.00%
SA 5	12	6	0	2	9,901	154	29	4	4	1	36	649	4	7	10,809
Percent	0.10%	0.10%	0.00%	0.00%	91.60%	1.40%	0.27%	0.04%	0.04%	0.01%	0.30%	6.00%	0.00%	0.10%	100.00%
SA 6	7	7	17	17	47,222	9	67	15	1	10	5	9,260	10	26	56,673
Percent	0.01%	0.01%	0.03%	0.03%	83.32%	0.02%	0.12%	0.03%	0.00%	0.02%	0.01%	16.34%	0.02%	0.05%	100.00%
SA 7	19	18	94	22	30,561	3	52	31	19	2	3	8,440	25	29	39,318
Percent	0.05%	0.05%	0.24%	0.06%	77.73%	0.01%	0.13%	0.08%	0.05%	0.01%	0.01%	21.47%	0.06%	0.07%	100.00%
SA 8	17	15	557	16	37,982	7	99	23	7	4	5	6,166	73	117	45,088
Percent	0.04%	0.03%	1.24%	0.04%	84.24%	0.02%	0.22%	0.05%	0.02%	0.01%	0.01%	13.68%	0.16%	0.26%	100.00%
Total	162	1,333	794	610	**166,476**	661	895	580	123	34	393	**32,970**	270	617	205,918
Percent	0.10%	0.60%	0.40%	0.30%	80.80%	0.30%	0.40%	0.30%	0.10%	0.00%	0.20%	16.00%	0.10%	0.30%	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. Table excludes Out of County N = 3,672. A total of 1,183 consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 23. Another 1,468 consumers had primary languages that were “Unknown”. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, April 2021.

Table 21 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 166,476 (80.8%) English speaking consumers were served followed by 32,970 (16.0%) Spanish speaking consumers. The remaining 6,438 (3.2%) consumers served spoke other LACDMH threshold languages. A total 39,442 (16.4%) of the consumers served reported a primary language other than English.

SA 1 (93.0 %) had the highest percentage of English speaking consumers, as compared to SA 7 (77.7%) 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 (21.5%) and the lowest percentage was in SA 5 (6.0%).

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

- SA 1: Spanish (6.7%)
- SA 2: Armenian (2.9%), Farsi (1.1%), Russian (0.6%), Spanish (13.7%), Tagalog (0.2%), and Vietnamese (0.1%)
- SA 3: Cantonese (1.3%), Korean (0.2%), Mandarin (1.4%), Spanish (16.1%), and Vietnamese (1.0%)
- SA 4: Armenian (0.5%), Cantonese (0.2%), Korean (1.6%), Other Chinese (0.1%), Russian (0.5%), Spanish (17.6%), and Tagalog (0.2%)
- SA 5: Farsi (1.4%) and Spanish (6.0%)
- SA 6: Spanish (16.3%)
- SA 7: Korean (0.1%) and Spanish (21.5%)
- SA 8: Cambodian (1.2%), Korean (0.2%), Spanish (13.7%), 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 2019 and consumers served in FY 19-20. The needs assessment section further analyzes the demographic distribution of the outpatient consumers served in the County Service Areas for FY 19-20 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 22: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED AFRICAN AMERICAN POPULATION WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	8,295	4,766	-3,529
SA 2	5,228	2,468	-2,760
SA 3	4,105	2,103	-2,002
SA 4	5,436	4,501	-935
SA 5	2,306	1,192	-1,114
SA 6	27,525	13,330	-14,195
SA 7	2,570	1,300	-1,270
SA 8	17,727	7,913	-9,814
Total	73,192	37,573	-35,619

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 African American (AA) consumers, the greatest disparity was in SA 6 with an estimated 14,195 (unduplicated) individuals in need of services. The least disparity was in SA 4 with an estimated 935 (unduplicated) individuals served beyond the estimated need for services. Overall, at the county level, there was an estimated unmet service need for 35,619 Medi-Cal Enrolled AA individuals as the number of unduplicated consumers served was 35,573 while the estimated Medi-Cal Enrolled Population with SED and SMI was 73,192.

This space was intentionally left blank

TABLE 23: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ASIAN/PACIFIC ISLANDER POPULATION WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	546	150	-396
SA 2	6,644	1,156	-5,488
SA 3	20,650	2,244	-18,406
SA 4	7,893	1,790	-6,103
SA 5	956	262	-694
SA 6	752	382	-370
SA 7	3,473	721	-2,752
SA 8	6,771	1,894	-4,877
Total	47,685	8,599	-39,086

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 Asian/Pacific Islander (API) consumers, the greatest disparity was in SA 3 with an estimated 18,406 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated 370 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 39,086 Medi-Cal Enrolled API individuals as the number of unduplicated consumers served was 8,599 while the estimated Medi-Cal Enrolled Population with SED and SMI was 47,685.

This space was intentionally left blank

TABLE 24: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED LATINO POPULATION WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	16,833	4,276	-12,557
SA 2	65,310	14,556	-50,754
SA 3	55,038	10,299	-44,739
SA 4	48,220	12,224	-35,996
SA 5	4,961	1,360	-3,601
SA 6	72,910	14,605	-58,305
SA 7	45,143	13,995	-31,148
SA 8	45,670	10,587	-35,083
Total	354,085	81,902	-272,183

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 Latino consumers, the greatest disparity was in SA 6 with an estimated 58,305 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 3,601 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 272,183 Medi-Cal Enrolled Latino individuals as the number of unduplicated consumers served was 81,902 while the estimated Medi-Cal Enrolled Population with SED and SMI was 354,085.

This space was intentionally left blank

TABLE 25: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED NATIVE AMERICAN POPULATION WITH SED AND SMI BY SERVICE AREA
FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	150	98	-52
SA 2	332	108	-224
SA 3	260	142	-118
SA 4	469	176	-293
SA 5	93	34	-59
SA 6	239	440	(+)201
SA 7	242	166	-76
SA 8	369	197	-172
Total	2,154	1,361	-793

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 Native American consumers, the greatest disparity was in SA 4 with an estimated 293 (unduplicated) individuals in need of services. The least disparity was in SA 1 with an estimated 52 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 793 Medi-Cal Enrolled Native American individuals as the number of unduplicated consumers served was 1,361 while the estimated Medi-Cal Enrolled Population with SED and SMI was 2,154.

This space was intentionally left blank

TABLE 26: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED WHITE POPULATION WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	5,626	2,983	-2,643
SA 2	39,729	8,807	-30,922
SA 3	9,908	3,492	-6,416
SA 4	11,102	3,905	-7,197
SA 5	6,822	2,522	-4,300
SA 6	2,544	1,577	-967
SA 7	5,877	2,118	-3,759
SA 8	9,591	4,682	-4,909
Total	91,199	30,086	-61,113

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

Table 26 shows that among the Outpatient White consumers, the greatest disparity was in SA 2 with an estimated 30,922 (unduplicated) individuals in need of services. The least disparity was in SA 6 with an estimated 967 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 61,113 Medi-Cal Enrolled White individuals as the number of unduplicated consumers served was 30,086 while the estimated Medi-Cal Enrolled Population with SED and SMI was 91,199.

This space was intentionally left blank

Disparity by Language

TABLE 27: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED POPULATION WITH SED AND SMI BY LANGUAGE ESTIMATED FY 19–20

Language	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
Arabic	1,081	167	-914
Armenian	13,142	1,274	-11,868
Cambodian	1,541	694	-847
Cantonese	7,823	594	-7,229
English	356,987	180,722	-176,265
Farsi	2,769	620	-2,149
Korean	6,310	819	-5,491
Mandarin	8,591	559	-8,032
Other Chinese	847	133	-714
Russian	2,344	407	-1,937
Spanish	236,761	35,304	-201,457
Tagalog	1,950	295	-1,655
Vietnamese	5,397	567	-4,830
Total	645,543	222,155	-423,388

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 27 shows that among the Outpatient consumers in Los Angeles County, the threshold language with the greatest disparity was Spanish with an estimated 176,265 (unduplicated) Spanish speaking individuals in need of services. The least disparity was Other Chinese with an estimated 714 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need based on language for 423,388 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 645,543.

Disparity by Age Group

TABLE 28: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED CHILDREN (0-15) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	25,495	4,929	-20,566
SA 2	77,710	10,344	-67,366
SA 3	67,426	10,817	-56,609
SA 4	44,584	7,535	-37,049
SA 5	7,719	1,266	-6,453
SA 6	83,501	12,079	-71,422
SA 7	64,838	10,603	-54,235
SA 8	60,855	9,677	-51,178
Total	432,128	67,250	-364,878

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 Children consumers, the greatest disparity was in SA 6 with an estimated 71,422 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 6,453 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 364,878 Medi-Cal Enrolled individuals as the number of unduplicated Children consumers served was 67,250 while the estimated Medi-Cal Enrolled Population with SED and SMI was 432,128.

This space was intentionally left blank

TABLE 29: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED TAY (16-25) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	9,429	2,325	-7,104
SA 2	30,500	6,875	-23,625
SA 3	26,912	6,731	-20,181
SA 4	18,542	4,820	-13,722
SA 5	3,731	1,034	-2,697
SA 6	29,508	6,974	-22,534
SA 7	23,942	5,732	-18,210
SA 8	23,430	5,566	-17,864
Total	165,994	40,057	-125,937

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 TAY consumers, the greatest disparity was in SA 2 with an estimated 23,625 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,697 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 125,937 Medi-Cal Enrolled individuals as the number of unduplicated TAY consumers served was 40,057 while the estimated Medi-Cal Enrolled Population with SED and SMI was 165,994.

This space was intentionally left blank

TABLE 30: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED ADULTS (26-59) ESTIMATED WITH SED AND SMI BY SERVICE AREA - FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	9,749	5,984	-3,765
SA 2	40,897	13,707	-27,190
SA 3	32,571	10,396	-22,175
SA 4	28,154	12,715	-15,439
SA 5	6,700	3,711	-2,989
SA 6	33,108	15,089	-18,019
SA 7	26,082	8,798	-17,284
SA 8	28,581	13,340	-15,241
Total	205,842	83,740	-122,102

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 Adult consumers, the greatest disparity was in SA 2 with an estimated 27,190 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 2,989 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 122,102 Medi-Cal Enrolled individuals as the number of unduplicated Adult consumers served was 83,740 while the estimated Medi-Cal Enrolled Population with SED and SMI was 205,842.

This space was intentionally left blank

TABLE 31: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED OLDER ADULTS (60+) ESTIMATED WITH SED AND SMI BY SERVICE AREA FY 19–20

Service Area (SA)	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	SA Total Disparity
SA 1	1,151	1,174	(+)23
SA 2	8,285	4,003	-4,282
SA 3	6,916	2,558	-4,358
SA 4	5,579	3,867	-1,712
SA 5	1,279	1,213	-66
SA 6	4,317	3,653	-664
SA 7	4,483	2,138	-2,345
SA 8	4,460	3,806	-654
Total	36,470	22,412	-14,058

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 Older Adult consumers, the greatest disparity was in SA 3 with an estimated 4,358 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 66 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 14,058 Medi-Cal Enrolled individuals as the number of unduplicated Older Adult consumers served was 22,412 while the estimated Medi-Cal Enrolled Population with SED and SMI was 36,470.

This space was intentionally left blank

Disparity by Gender

TABLE 32: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY GENDER ESTIMATED WITH SED AND SMI AND SERVICE AREA FY 19–20

	Male			Female		
Service Area (SA)	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	13,195	6,923	-6,272	19,166	7,470	-11,696
SA 2	51,498	16,805	-34,693	74,861	18,082	-56,779
SA 3	42,916	14,962	-27,954	62,782	15,511	-47,271
SA 4	33,967	15,161	-18,806	46,916	13,711	-33,205
SA 5	7,354	3,679	-3,675	10,006	3,532	-6,474
SA 6	43,850	18,648	-25,202	64,385	19,098	-45,287
SA 7	35,154	13,279	-21,875	53,147	13,969	-39,178
SA 8	36,225	15,787	-20,438	52,761	16,545	-36,216
Total	264,159	105,244	-158,915	384,024	107,918	-276,106

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 32 shows that among the Outpatient Male consumers, the greatest disparity was in SA 2 with an estimated 34,693 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 3,675 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 158,915 Medi-Cal Enrolled individuals as the number of unduplicated Male consumers served was 105,244 while the estimated Medi-Cal Enrolled Population with SED and SMI was 264,159.

Among the Outpatient Female consumers, the greatest disparity was in SA 2 with an estimated 56,779 (unduplicated) individuals in need of services. The least disparity was in SA 5 with an estimated 6,474 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 276,106 Medi-Cal Enrolled individuals as the number of unduplicated Female consumers served was 107,918 while the estimated Medi-Cal Enrolled Population with SED and SMI was 384,024.

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

A. This section summarizes the 138% of poverty by Race/Ethnicity, Language, Age Group, and Gender.
B. This section also provides a trend analysis of the data as described in A.

TABLE 33: ESTIMATED COUNTYWIDE TOTAL POPULATION BY RACE/ETHNICITY TREND FOR CY 2016, CY 2017, AND CY 2018

Race/Ethnicity	Countywide Estimated Total Population					
	2017		2018		2019	
	N	%	N	%	N	%
African American	870,728	8.1%	835,568	8.1%	835,191	8.1%
Asian /Pacific Islander	1,505,337	14.1%	1,454,863	14.2%	1,457,731	14.2%
Latino	5,003,461	48.7%	5,011,365	48.8%	4,993,673	48.7%
Native American	18,345	0.2%	23,716	0.2%	23,720	0.2%
White	2,874,777	26.6%	2,723,137	26.5%	2,719,729	26.5%
Two or More Races	227,125	2.2%	230,184	2.2%	230,193	2.2%
Total	10,272,648	100.0%	10,278,834	100.0%	10,260,237	100.0%

The African American population decreased by 35,537 between CY 2017 and CY 2019, from 870,728 to 835,191 (percent remained the same at 8.1% of the total population.) The African American population decreased by 377 between CY 2018 and CY 2019, from 835,568 to 835,191 (percent remained the same at 8.1% of the total population.)

The Asian/Pacific Islander population decreased by 47,606 between CY 2017 and CY 2019, from 1,505,337 to 1,457,731 (percent increased by 0.1% from 14.1% to 14.2% of the total population.) The Asian/Pacific Islander population decreased by 2,868 between CY 2018 and CY 2019, from 1,454,863 to 1,457,731 (percent remained the same at 14.2% of the total population.)

The Latino population decreased by 9,788 between CY 2017 and CY 2019, from 5,003,461 to 4,993,673 (percent remained the same at 48.7% of the total population.) The Latino population decreased by 17,692 between CY 2018 and CY 2019, from 55,011,365 to 4,993,673 (deceased by 0.1% from 48.8% to 48.7% of the total population.)

The Native American population increased by 5,375 between CY 2017 and CY 2019, from 18,345 to 23,720 (percent remained at 0.2% of the total population.) The Native American population increased from four (4.0) between CY 2018 and CY 2019, from 23,716 to 23,720 (percent remained the same at 0.2% of the total population.)

The White population decreased by 155,048 between CY 2017 and CY 2019, from 2,874,777 to 2,719,729 (percent decreased by 0.1% from 26.6% to 26.5% of the total population.) The White population decreased by 3,408 between CY 2018 and CY 2019, from 2,723,137 to 2,719,729 (percent remained the same at 26.5% of the total population.)

The Two or More Races population increased by 3,068 from CY 2017 and CY 2019 from 227,125 to 230,193 (percent remained the same at 2.2% of the total population). The Two or More Races population increased by nine (9.0) from CY 2018 and CY 2019 from 230,184 to 230,193 (percent remained the same at 2.2% of the total population.)

TABLE 34: 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)					
	2017		2018		2019	
	N	%	N	%	N	%
African American	230,552	9.3%	228,375	10.1%	213,465	10.0%
Asian/Pacific Islander	274,213	11.0%	249,736	11.1%	238,106	11.2%
Latino	1,548,943	62.3%	1,368,985	60.7%	1,297,085	60.8%
Native American	4,637	0.2%	5,255	0.2%	5,038	0.2%
White	386,832	15.6%	368,507	16.3%	348,173	16.3%
Two or More Races	41,803	1.7%	33,208	1.5%	32,374	1.5%
Total	2,486,980	100.0%	2,254,066	100.0%	2,134,242	100.0%

The African American population living at or below 138% FPL decreased by 17,087 between CY 2017 and CY 2019, from 230,552 to 213,465 (percent increased by 0.7% from 9.3% to 10.0% of the total 138% FPL population.) The African American population decreased by 14,910 between CY 2018 and CY 2019, from 228,375 to 213,465 (percent decreased 0.1% from 10.1 to 10.0 of the total 138% FPL population.)

The Asian/Pacific Islander population living at or below 138% FPL decreased by 36,107 between CY 2017 and CY 2019, from 274,213 to 238,106 (percent increased by 0.2% from 11.0% to 11.2% of the total 138% FPL population.) The Asian/Pacific Islander population decreased by 11,630 between CY 2018 and CY 2019, from 249,736 to 238,106 (percent increased by 0.1% from 11.1% to 11.2% of the total 138% FPL population.)

The Latino population living at or below 138% FPL decreased by 251,858 between CY 2017 and CY 2019, from 1,548,943 to 1,297,085 (percent decreased by 1.5% from 62.3% to 60.8% of the total 138% FPL population). The Latino population decreased by 71,900 between CY 2018 and CY 2019, from 1,368,985 to 1,297,085 (percent increased by 0.7% from 60.7% to 60.8% of the total 138% FPL population).

The Native American population living at or below 138% FPL increased by 401 between CY 2017 and CY 2019, from 4,637 to 5,038 (percent remained the same at 0.2% of the total 138% FPL population.) The Native American population decreased by 217 between CY 2018 and CY 2019, from 5,255 to 5,038 (remaining at 0.2% of the total 138% FPL population.)

The White population living at or below 138% FPL decreased by 38,659 between CY 2017 and CY 2019, from 386,832 to 348,173 (percent increased by 0.7 from 15.6% to 16.3% of the total 138% FPL population.) The White population decreased by 20,334 between CY 2018 and CY 2019, from 368,507 to 348,173 (percent remained the same at 16.3% of the total 138% FPL population.)

The Two or More Races population decreased by 9,429 from CY 2017 and CY 2019 from 41,803 to 32,374 (percent decreased by 0.2% from 1.7% to 1.5% of the total population.) The Two or More Races population decreased by 834 from CY 2018 and CY 2019 from 33,208 to 32,374 (percent remained the same at 1.5% of the total population.)

TABLE 35: ESTIMATED COUNTYWIDE TOTAL POPULATION BY AGE GROUP TREND FOR CY 2017, CY 2018, AND CY 2019

Age Group	Countywide Estimated Total Population					
	2017		2018		2019	
	N	%	N	%	N	%
0-18	2,422,597	23.6%	2,380,526	23.2%	2,329,975	22.7%
19-20	307,906	3.0%	304,749	3.0%	300,201	2.9%
21-25	765,972	7.5%	747,746	7.3%	732,995	7.1%
26-59	4,879,498	47.5%	4,897,871	47.7%	4,904,764	47.8%
60-64	580,677	5.7%	600,998	5.8%	618,685	6.0%
65 and older	1,315,998	12.8%	1,346,944	13.1%	1,373,617	13.4%
Total	10,272,648	100.0%	10,278,834	100.0%	10,260,237	100.0%

The Age Group 0-18 decreased by 92,622 between CY 2017 and CY 2019, from 2,422,597 to 2,329,975 (percent decreased by 0.9 from 23.6% to 22.7%). The Age Group 0-18 decreased by 50,551 between CY 2018 and CY 2019, from 2,380,526 to 2,329,975 (percent decreased by 0.5% from 23.2% to 22.7%).

The Age Group 19-20 decreased by 7,705 between CY 2017 and CY 2019, from 307,906 to 300,201 (percent decreased by 0.1% from 3.0% to 2.9%). The Age Group 19-20 decreased by 4,548 between CY 2018 and CY 2019, from 304,749 to 300,201 (percent decreased by 0.1% from 3.0% to 2.9%).

The Age Group 21-25 decreased by 32,977 between CY 2017 and CY 2019, from 765,972 to 732,995 (percent decreased by 0.4% from 7.5% to 7.1%). The Age Group 21-25 decreased by 14,751 between CY 2018 and CY 2019, from 747,746 to 732,995 (percent decreased by 0.2% from 7.3% to 7.1%).

The Age Group 26-59 increased by 25,266 between CY 2017 and CY 2019, from 4,879,498 to 4,904,764 (percent increased by 0.3% from 47.5% to 47.8%). The Age Group 26-59 increased by 6,893 between CY 2018 and CY 2019, from 4,897,871 to 4,904,764 (percent increased by 0.1% from 47.7% to 47.8%).

The Age Group 60-64 increased by 38,008 between CY 2017 and CY 2019, from 580,677 to 618,685 (percent increased by 0.3% from 5.7% to 6.0%). The Age Group 60-64 population increased by 17,687 between CY 2018 and CY 2019, from 600,998 to 618,685 (percent increased by 0.2% from 5.8% to 6.0%).

The Age Group 65 and older increased by 57,619 between CY 2017 and CY 2019, from 1,315,998 to 1,373,617 (percent increased by 0.6% from 12.8% to 13.4%). The Age Group 65 and older increased by 26,673 between CY 2018 and CY 2019, from 1,346,944 to 1,373,617 (percent increased by 0.3% from 13.1% to 13.4%).

TABLE 36: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP TREND FOR CY 2017, CY 2018, AND CY 2019

Age Group	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2017		2018		2019	
	N	%	N	%	N	%
0-18	856,137	34.4%	760,978	33.8%	707,071	33.1%
19-20	74,939	3.0%	66,182	2.9%	60,915	2.9%
21-25	203,071	8.2%	177,416	7.9%	162,265	7.6%
26-59	1,038,947	41.8%	947,137	42.0%	900,114	42.2%
60-64	97,941	3.9%	93,912	4.2%	93,028	4.4%
65 and older	215,945	8.7%	208,441	9.2%	210,849	9.9%
Total	2,486,980	100.0%	2,254,066	100.0%	2,134,242	100.0%

Table 36 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 149,066 between CY 2017 and CY 2019, from 856,137 to 707,071 (percent decreased by 1.3% from 33.4% to 33.1%

of the total 138% FPL population.) The Age Group 0-18 living at or below 138% FPL decreased by 53,907 between CY 2018 and CY 2019, from 760,978 to 707,071 (percent decreased by 0.7% from 33.8% 33.1%).

The Age Group 19-20 living at or below 138% FPL decreased by 14,024 between CY 2017 and CY 2019, from 74,939 to 60,915 (percent decreased by 0.1% from 3.0% to 2.9% of the total 138% FPL population.) The Age Group 19-20 living at or below 138% FPL decreased by 5,267 between CY 2018 and CY 2019, from 66,182 to 60,915 (percent remained the same at 2.9%).

The Age Group 21-25 living at or below 138% FPL decreased by 40,806 between CY 2017 and CY 2019, from 203,071 to 162,265 (percent decreased by 0.6% from 8.2% to 7.6% of the total 138% FPL population.) The Age Group 21-25 living at or below 138% FPL decreased by 15,151 between CY 2018 and CY 2019, from 177,416 to 162,265 (percent decreased by 0.3% from 7.9% to 7.6%).

The Age Group 26-59 living at or below 138% FPL decreased by 138,833 between CY 2017 and CY 2019, from 1,038,947 to 900,114 (percent increased by 0.4% from 41.8% to 42.2% of the total 138% FPL population.) The Age Group 26-59 living at or below 138% FPL decreased by 47,023 between CY 2018 and CY 2019, from 947,137 to 900,114 (percent increased by 0.2% from 42.0% to 42.2%).

The Age Group 60-64 living at or below 138% FPL decreased by 4,913 between CY 2017 and CY 2019, from 97,941 to 93,028 (percent increased by 0.5% from 3.9% to 4.4% of the total 138% FPL population.) The Age Group 60-64 living at or below 138% FPL decreased by 884 between CY 2018 and CY 2019, from 93,912 to 93,028 (percent increased by 0.2% from 4.2% to 4.4%).

The Age Group 65 and older living at or below 138% FPL decreased by 5,096 between CY 2017 and CY 2019, from 215,945 to 210,849 (percent increased by 1.2% from 8.7% to 9.2% of the total 138% FPL population.) The Age Group 65 and older living at or below 138% FPL increased by 2,408 between CY 2018 and CY 2019, from 208,441 to 210,849 (percent increased by 0.7% from 9.2% to 0.7%).

This space was intentionally left blank

TABLE 37: ESTIMATED COUNTYWIDE TOTAL POPULATION BY GENDER TREND FOR CY 2017, CY 2018, AND CY 2019

Gender	Countywide Estimated Total Population					
	2017		2018		2019	
	N	%	N	%	N	%
Male	5,067,041	49.3%	5,067,739	49.3%	5,060,057	49.3%
Female	5,205,607	50.7%	5,211,095	50.7%	5,200,180	50.7%
Total	10,272,648	100.0%	10,278,834	100.0%	10,260,237	100.0%

Table 37 presents the estimated countywide total population by gender for CY 2017, CY 2018, and CY 2019.

The Male population decreased by 6,984 between CY 2017 and CY 2019, from 5,067,041 to 5,060,057 (percent remained the same at 49.3%). The Male population increased by 7,682 between CY 2018 and CY 2019 from 5,067,739 to 5,060,057 (percent remained the same at 49.3%).

The Female population decreased by 5,427 between CY 2017 and CY 2019, from 5,205,607 to 5,200,180 (percent remained the same at 50.7%). The Female population decreased by 10,915 between CY 2018 and CY 2019, from 5,211,095 to 5,200,180 (percent remained the same at 50.7%).

TABLE 38: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER TREND FOR CY 2017, CY 2018, AND CY 2019

Gender	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2017		2018		2019	
	N	%	N	%	N	%
Male	1,181,627	47.5%	1,048,535	46.5%	981,510	46.0%
Female	1,305,353	52.5%	1,205,531	53.5%	1,152,732	54.0%
Total	2,486,980	100.0%	2,254,066	100.0%	2,134,242	100.0%

Table 38 presents the estimated total population living at or below 138% FPL by gender for CY 2017, CY 2018, and CY 2019.

The Male population living at or below 138% FPL decreased by 200,117 between CY 2017 and CY 2019, from 1,181,627 to 981,510 (percent decreased by 1.5% from 47.5% to 46.0%). The Male population living at or below 138% FPL decreased by 67,025

between CY 2018 and CY 2019, from 1,048,535 to 981,510 (percent decreased by 0.5% from 46.5% to 46.0%).

The Female population living at or below 138% FPL decreased by 152,621 between CY 2017 and CY 2019, from 1,305,353 to 1,152,732 (percent increased by 1.5% from 52.5% to 54.0%). The Female population living at or below 138% FPL decreased by 52,799 between CY 2018 and CY 2019, from 1,205,531 to 1,152,732 (percent increased by 0.5% from to 53.5% to 54.0%).

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 39: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA - FY 19–20

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Multi-race	Total
SA 1	4,590	154	4,476	99	3,047	748	13,114
Percent	35.0%	**1.2%**	34.1%	0.75%	23.2%	**5.7%**	100.0%
SA 2	2,512	1,168	15,380	104	8,670	1,010	28,844
Percent	8.7%	4.0%	53.3%	**0.36%**	30.1%	3.5%	100.0%
SA 3	1,660	2,013	9,698	138	3,181	555	17,245
Percent	9.6%	**11.7%**	56.2%	0.80%	18.4%	3.2%	100.0%
SA 4	4,414	1,633	15,380	177	3,664	519	25,787
Percent	17.1%	6.3%	59.6%	0.69%	14.2%	2.0%	100.0%
SA 5	1,238	276	1,484	35	2,680	253	5,966
Percent	20.8%	4.6%	**24.9%**	0.59%	**44.9%**	4.2%	100.0%
SA 6	12,704	400	14,073	412	1,634	520	29,743
Percent	**42.7%**	1.3%	47.3%	**1.39%**	**5.5%**	**1.7%**	100.0%
SA 7	1,169	689	12,152	156	1,918	570	16,654
Percent	**7.0%**	4.1%	**73.0%**	0.94%	11.5%	3.4%	100.0%
SA8	7,502	1,888	10,046	186	4,547	923	25,092
Percent	29.9%	7.5%	40.0%	0.74%	18.1%	3.7%	100.0%
Total	26,440	6,625	55,924	920	22,199	3,728	115,836
Percent	22.83%	5.72%	48.28%	0.79%	19.16%	3.22%	100.00%

Note: Table excludes 'Unknown' (N=29,653) across the SAs. Total reflects unduplicated count of consumers served with the SAs. Data Source: LACDMH-IS Database, April 2021.

Differences by Race/Ethnicity

The highest percentage of African American MHSA consumers served in outpatient programs was in SA 6 (42.7%) compared to SA 7 (7.0%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander (API) MHSA consumers served in outpatient programs was in SA 3 (11.7%) compared to SA 1 (1.2%) with the lowest percentage.
The highest percentage of Latino MHSA consumers served in outpatient programs was in SA 7 (73.0%) compared to SA 5 (24.9%) with the lowest percentage.

The highest percentage of Native American MHSA consumers served in outpatient programs was in SA 6 (1.4%) compared to SA 2 (0.4%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (44.9%) compared to SA 6 (5.5%) with the lowest percentage.

TABLE 40: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 19–20

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	4,676	2,289	6,265	1,223	14,453
Percent	32.4%	15.8%	43.3%	8.5%	100.0%
SA 2	10,699	7,003	13,281	3,732	34,715
Percent	30.8%	20.2%	38.3%	10.8%	100.0%
SA 3	10,095	6,191	8,700	2,147	27,133
Percent	**37.2%**	**22.8%**	**32.1%**	7.9%	100.0%
SA 4	6,581	4,596	11,887	3,449	26,513
Percent	24.8%	17.3%	44.8%	13.0%	100.0%
SA 5	1,280	1,121	3,869	1,208	7,478
Percent	**17.1%**	**15.0%**	**51.7%**	**16.2%**	100.0%
SA 6	11,208	6,819	14,524	3,464	36,015
Percent	31.1%	18.9%	40.3%	9.6%	100.0%
SA 7	8,803	5,179	8,154	1,885	24,021
Percent	36.6%	21.6%	33.9%	**7.8%**	100.0%
SA 8	8,868	5,275	12,981	3,642	30,766
Percent	28.8%	17.1%	42.2%	11.8%	100.0%
Total	39,652	25,879	62,415	17,542	145,488
Percent	27.3%	17.8%	42.9%	12.1%	100.0%

Note: Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS Database, April 2021

Differences by Age Group

The highest percentage of Children MHSA consumers 0-15 years old was in SA 3 (37.2%) compared with SA 5 (17.1%) with the lowest percentage.

The highest percentage of TAY MHSA consumers 16-25 years old was in SA 3 (22.8%) compared with SA5 (15.0%) with the lowest percentage.

The highest percentage of Adult MHSA consumers 26-59 years old was in SA 5 (51.7%) compared with SA 3 (32.1%) with the lowest percentage.

The highest percentage of Older Adult MHSA consumers 60 years old and over was in SA 5 (16.2%) compared with SA 7 (7.8%) with the lowest percentage.

TABLE 41: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA - FY 19–20

Service Area (SA)	Male	Female	Total
SA 1	6,799	7,632	14,431
Percent	**47.1%**	**52.9%**	100.0%
SA 2	16,512	18,159	34,671
Percent	47.6%	52.4%	100.0%
SA 3	13,114	13,996	27,110
Percent	48.4%	51.6%	100.0%
SA 4	13,796	12,651	26,447
Percent	**52.2%**	**47.8%**	100.0%
SA 5	3,760	3,708	7,468
Percent	50.3%	49.7%	100.0%
SA 6	17,646	18,315	35,961
Percent	49.1%	50.9%	100.0%
SA 7	11,536	12,466	24,002
Percent	48.1%	51.9%	100.0%
SA 8	14,739	15,963	30,702
Percent	48.0%	52.0%	100.0%
Total	69,751	75,518	145,269
Percent	48.0%	52.0%	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, April 2021.

Differences by Gender

The highest percentage of Male MHSA consumers served in outpatient programs was SA 4 (52.2%) compared with SA 1 (47.1%) with the lowest percentage.

The highest percentage of Female MHSA consumers served in outpatient programs was SA 1 (52.9%) compared with SA 4 (47.8%) with the lowest percentage.

This space was intentionally left blank

TABLE 42: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY THRESHOLD LANGUAGE AND SERVICE AREA FY 19–20

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	4	13	2	0	13,189	6	0	1	0	5	1,027	4	1	14,252
Percent	0.03%	0.09%	0.01%	0.00%	**92.54%**	0.04%	0.00%	0.01%	0.00%	0.04%	**7.21%**	0.03%	0.01%	100.0%
SA 2	81	965	21	5	27,214	504	82	8	8	107	4,934	75	41	34,045
Percent	0.24%	**2.83%**	0.06%	0.01%	**79.94%**	**1.48%**	**0.24%**	0.02%	0.02%	**0.31%**	**14.49%**	**0.22%**	**0.12%**	100.0%
SA 3	19	29	54	423	20,176	9	75	444	58	2	4,806	26	271	26,392
Percent	0.07%	0.11%	0.20%	**1.60%**	**76.45%**	0.03%	**0.28%**	**1.68%**	0.22%	0.01%	**18.21%**	0.10%	**1.03%**	100.0%
SA 4	10	157	42	51	20,161	34	463	33	8	67	4,684	69	35	25,814
Percent	0.04%	**0.61%**	0.16%	**0.20%**	**78.10%**	0.13%	**1.79%**	0.13%	**0.03%**	**0.26%**	**18.15%**	0.27%	0.14%	100.0%
SA 5	11	4	0	2	6,594	123	20	4	0	17	471	3	3	7,252
Percent	0.15%	0.06%	0.00%	0.03%	**90.93%**	**1.70%**	0.28%	0.06%	0.00%	0.23%	**6.49%**	0.04%	0.04%	100.0%
SA 6	4	3	15	8	29,104	9	47	6	0	3	6,049	6	8	35,262
Percent	0.01%	0.01%	0.04%	0.02%	**82.54%**	0.03%	0.13%	0.02%	0.00%	0.01%	**17.15%**	0.02%	0.02%	100.0%
SA 7	13	7	85	11	18,213	3	35	22	13	3	5,203	19	23	23,650
Percent	0.05%	0.03%	0.36%	0.05%	**77.01%**	0.01%	**0.15%**	0.09%	0.05%	0.01%	**22.00%**	0.08%	0.10%	100.0%
SA 8	13	10	544	12	24,930	5	85	18	6	4	4,265	62	106	30,060
Percent	0.04%	0.03%	**1.81%**	0.04%	**82.93%**	0.02%	**0.28%**	0.06%	0.02%	0.01%	**14.19%**	0.21%	**0.35%**	100.0%
Total	129	957	733	435	112,298	580	685	428	80	181	22,670	223	421	139,820
Percent	0.09%	0.68%	0.52%	0.31%	80.32%	0.41%	0.49%	0.31%	0.06%	0.13%	16.21%	0.16%	0.30%	100.0%

Note: Total reflects unduplicated count of consumers served. Data Source: LACDMH3-IS Database, April 2021.

Table 42 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 80.3% followed by Spanish at 16.2% 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 (92.5%) and Spanish (7.2%).

SA 2 has seven (7) threshold languages: Armenian (2.8%), English (80%), Farsi (1.5%), Korean (0.2%), Russian (0.3%), Spanish (14.5%), Tagalog (0.2%) and Vietnamese (0.1%).

SA 3 has six (6) threshold languages: Cantonese (1.6%), English (76.5%), Korean (0.3%), Mandarin (1.7%), Spanish (18.2%), and Vietnamese (1.0%).

SA 4 has seven (7) threshold languages: Armenian (0.6%), Cantonese (0.2%), English (78.1%), Korean (1.8%), Other Chinese (0.03%), Russian (0.3%), Spanish (18.2%).

SA 5 has three (3) threshold languages: English (91%), Farsi (1.7%), and Spanish (6.5%).

SA 6 has two (2) threshold languages: English (82.5%) and Spanish (17.2%).

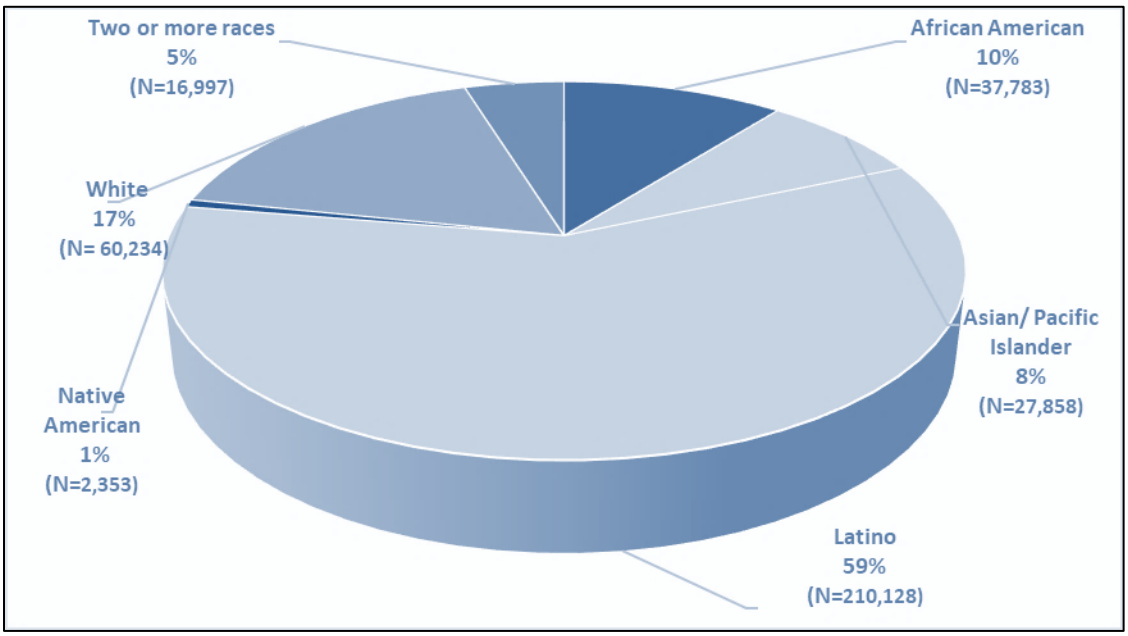
SA 7 has three (3) threshold languages: English (77.0%) and Spanish (22.0%).

SA 8 has five (5) threshold languages: Cambodian (1.8%), English (83%), Korean (0.3%), Spanish (14.2%) and Vietnamese (0.4%).

This space was intentionally left blank

Analysis of Disparities

FIGURE 11: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2019

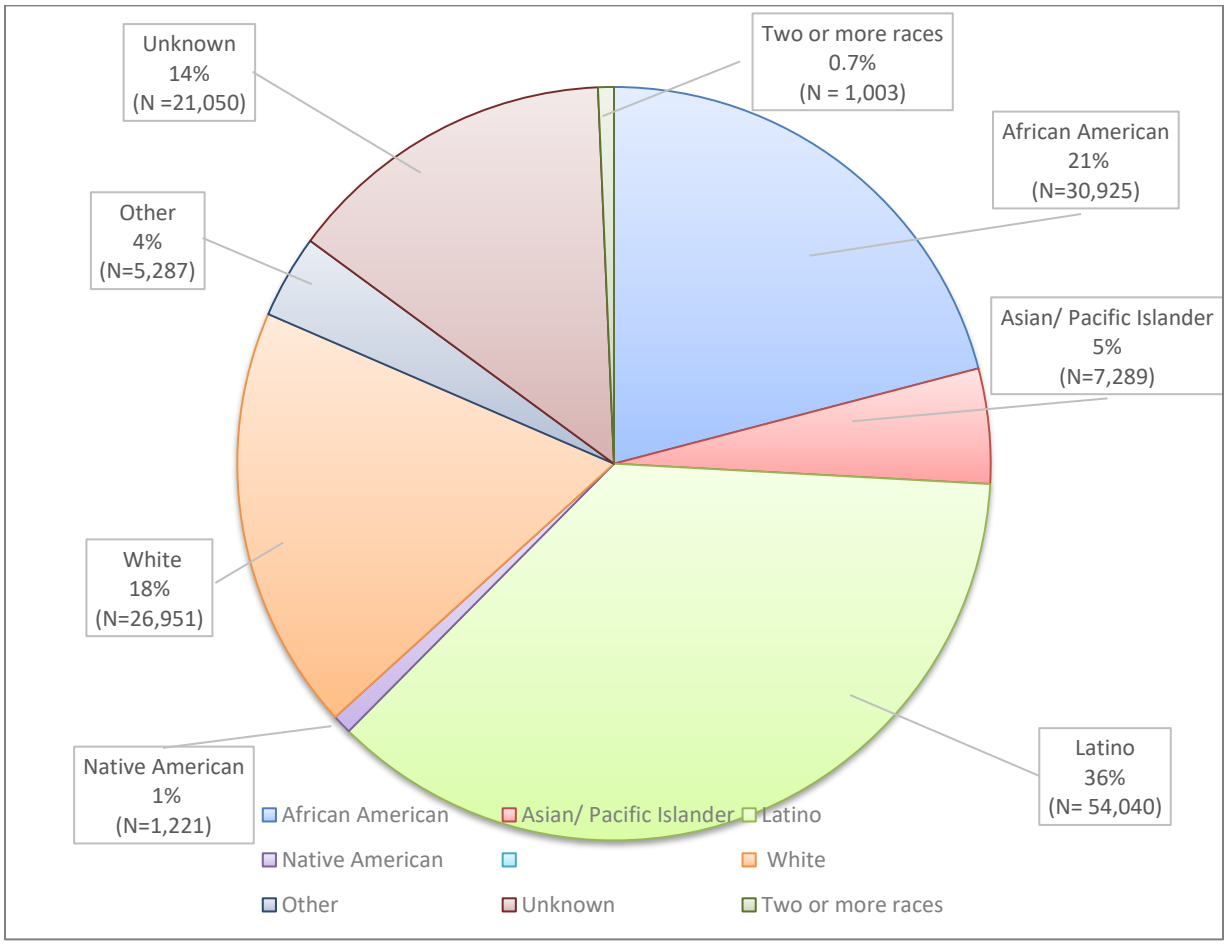


Estimated prevalence of mental illness by Race/Ethnicity for Los Angeles County is provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2018 and CY 2019.
Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2020.

Figure 11 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.

This space was intentionally left blank

FIGURE 12: CSS CONSUMER POPULATION BY RACE/ETHNICITY
FY 19–20



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 21-22.

Figure 12 shows the CSS enrolled population by Race/Ethnicity. Latinos are the largest group at 37%, followed by African Americans at 21%, Whites at 18%, Asian/Pacific Islanders at 5%, Native Americans at 1.0%, Two or More Races at 1%, and Unknown/Not specified Race/Ethnicity at 14%.

Figures 11 and 12 indicate the following:

African Americans constitute 11% of the population in need of services at or below 138% FPL and constitute 21% of the CSS consumers.

Asian/Pacific Islanders constitute 8% of the population in need of services at or below 138% FPL and constitute 5% of the CSS consumers.

Latinos constitute 59% of the population in need of services at or below 138% FPL and constitute 37% of the CSS consumers.

Native Americans constitute 1% of the population in need of services at or below 138% FPL and constitute 1.3% of the CSS consumers.

Whites constitute 17% of the population in need of services at or below 138% FPL and constitute 18% of the CSS consumers.

Two or more races constitute 5% of the population in need of services at or below 138% FPL and constitute 0.7% of CSS consumers.

FIGURE 13: NEEDS ASSESSMENT SUMMARY FOR CSS PROGRAMS: PERCENTAGE FOR THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES COMPARED WITH PERCENTAGE OF CONSUMERS SERVED BY CSS PROGRAMS BY RACE/ETHNICITY
FY 19–20

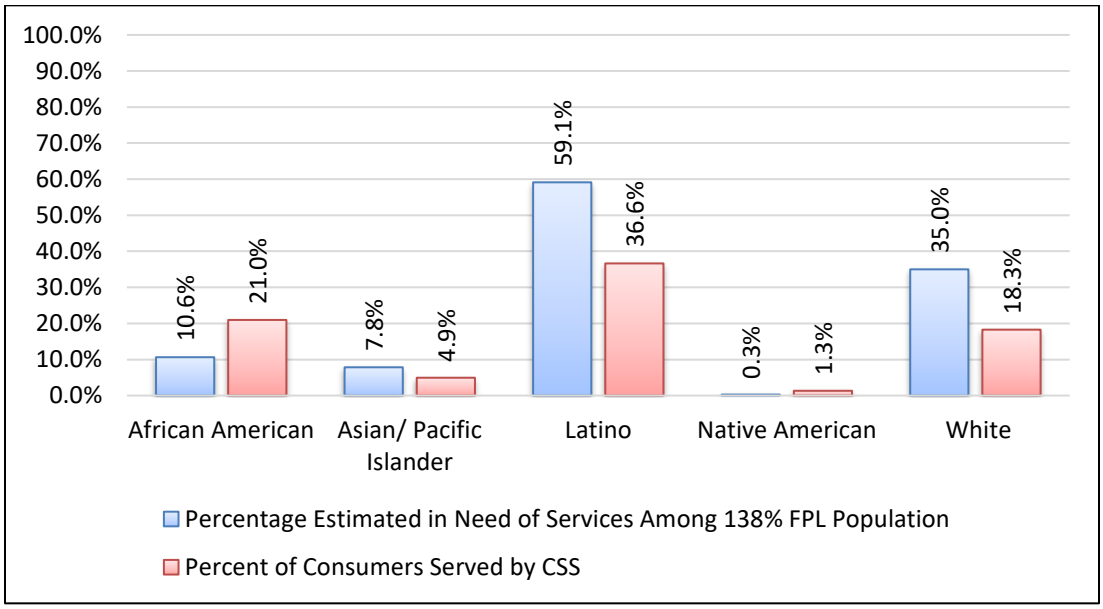


Figure 13 compares the information in Figures 10 and 11.

The percentage of African Americans receiving CSS services was the highest at 21.0% when compared with their population at or below 138%, FPL estimated in need of services at 10.6%.

The percentage of Asian/Pacific Islanders receiving CSS services was 5.0% when compared with their population at or below 138%, FPL estimated in need of services at 7.8%.

The percentage of Latinos receiving CSS services was 36.6% when compared to their population at or below 138%, FPL estimated in need of services at 59.1%.

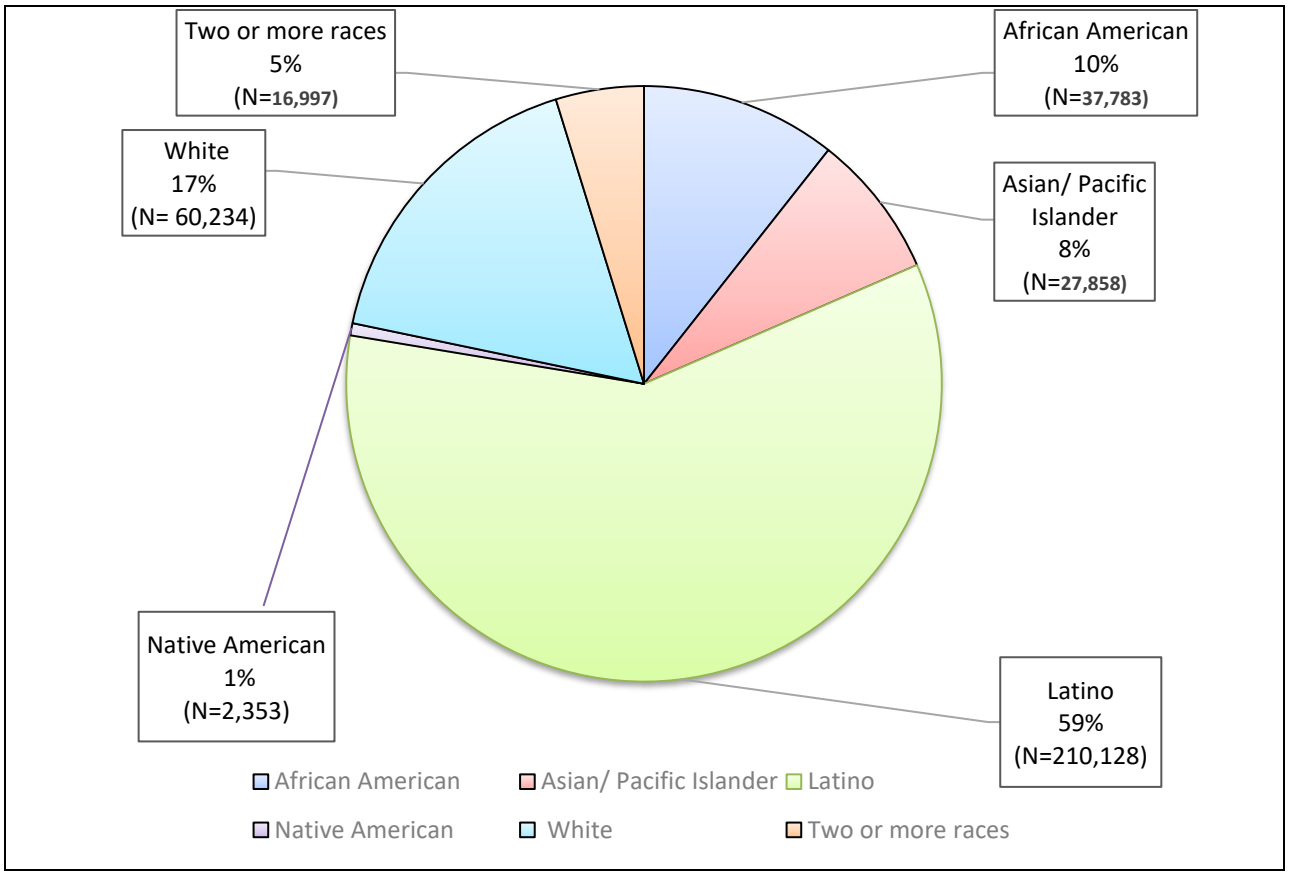
The percentage of Native Americans receiving CSS services was 1.3% when compared with their population of Native Americans at or below 138%, FPL estimated in need of services at 0.3%.

The percentage of Whites receiving CSS services was 18.3% when compared with their population at or below 138%, FPL estimated in need of services at 35.0%.

The percentage of Two or More Races receiving CSS services was 0.7% when compared with their population at or below 138%, FPL estimated in need of services at 4.8%.

Prevention and Early Intervention (PEI) Plan

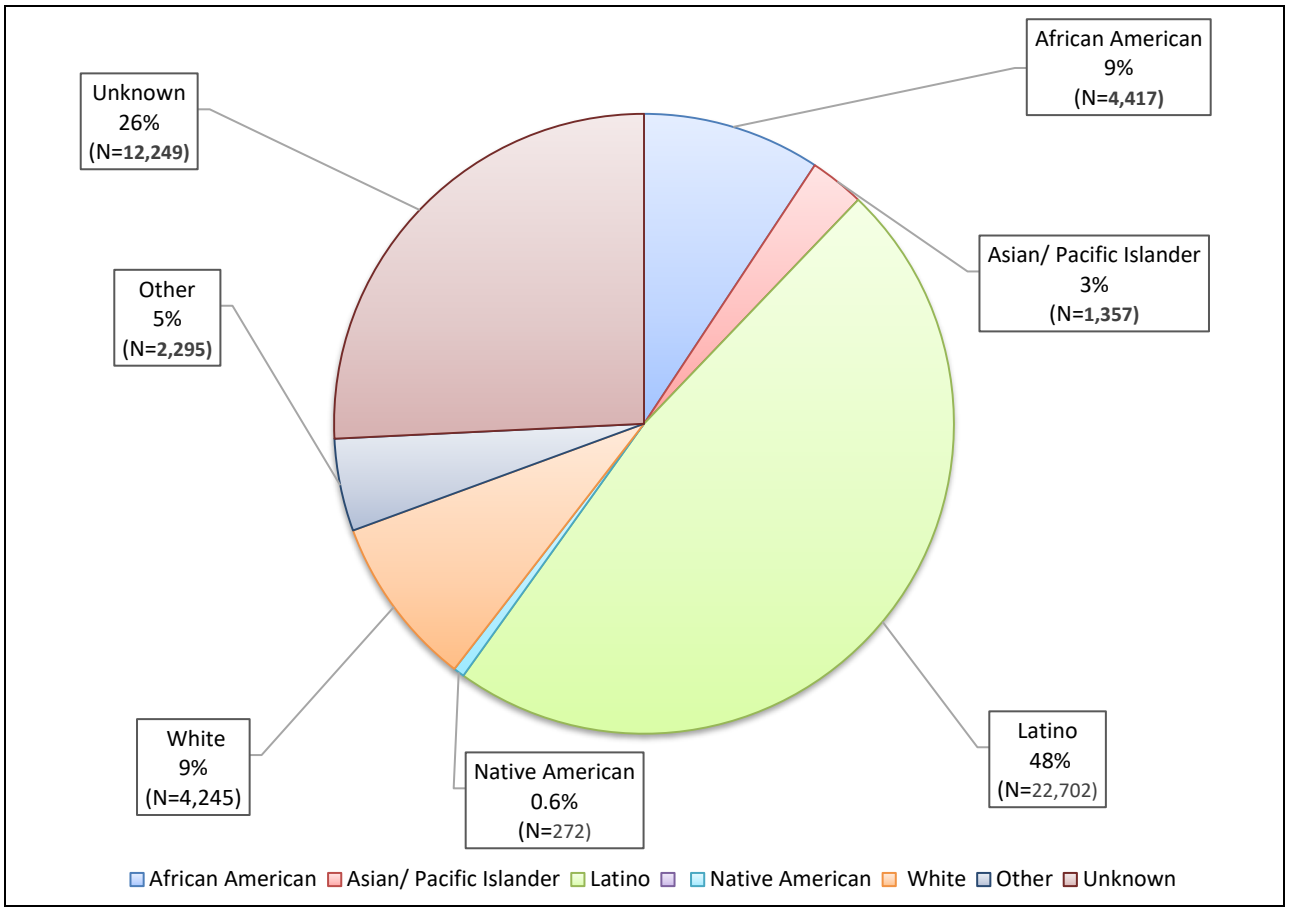
FIGURE 14: ESTIMATED POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2019



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 2018 and CY 2019. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2020.

Figure 14 shows the estimated population at or below or 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 15: PEI CONSUMER POPULATION BY RACE/ETHNICITY FY 19-20



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2021-22.

Figure 15 shows the PEI enrolled population by Race/Ethnicity. Latinos are the largest group at 48.0%, followed by African Americans at 9.0%, Whites at 9.0%, Asian/Pacific Islanders at 3.0%, and Native Americans at 0.3%.

Figures 14 and 15 indicate the following:

African Americans constitute 9.0% of the population in need of services at or below 138% FPL and constitute 9.8% of the PEI consumers.

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

Latinos constitute 48.0% of the population in need of services at or below 138% FPL and constitute 47.8% of the PEI consumers.

Native Americans constitute 0.6% of the population in need of services at or below 138% FPL and constitute 0.6% of the PEI consumers.

Whites constitute 9.0% of the population in need of services at or below 138% FPL and constitute 9.0% of the PEI consumers.

FIGURE 16: 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 19-20

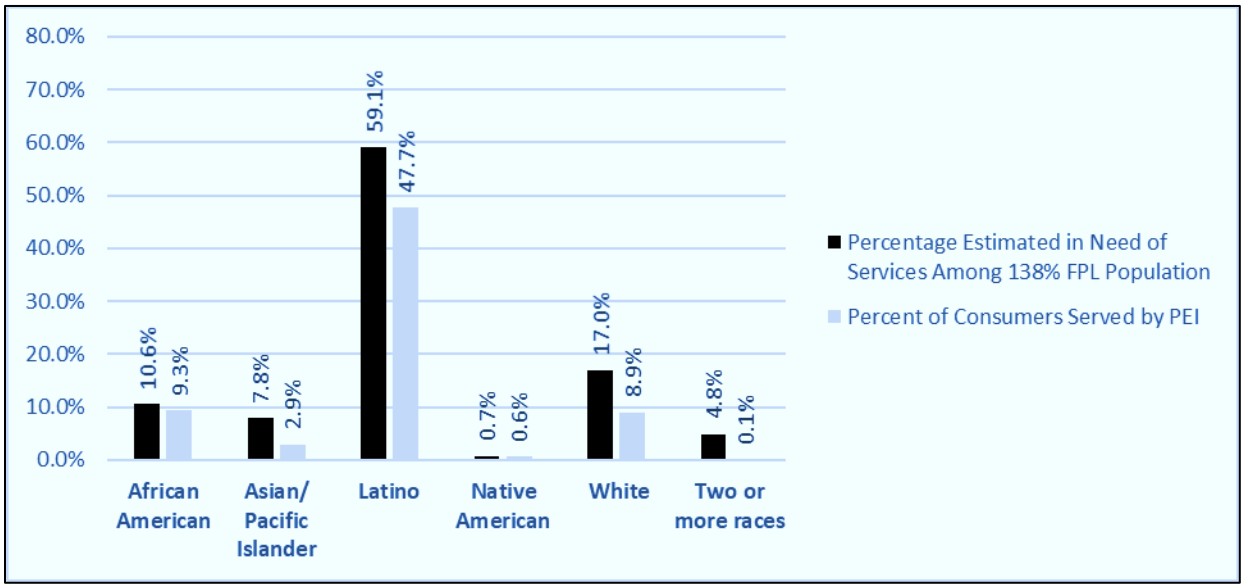


Figure 16 compares the information in Figures 14 and 15.

The percentage of African Americans receiving PEI services was 9.3% when compared with their population at or below 138% FPL estimated in need of services at 10.6%.

The percentage of Asian/Pacific Islanders receiving PEI services was 2.9% when compared with their population at or below 138% FPL estimated in need of services at 7.8%.
The percentage of Latinos receiving PEI services was the highest at 47.7% when compared to their population at or below 138% FPL estimated in need of services at 59.1%.

The percentage of Native Americans receiving PEI services was 0.6% 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 8.9% when compared with their population at or below 138% FPL estimated in need of services at 35.0%.

The percentage of Two or More Races receiving PEI services was 0.1% when compared with their population at or below 138% FPL estimated in need of services at 5%.

This space was intentionally left blank

.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 3

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

August 2021

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

Based on FY 19-20 data, the LACDMH target populations with mental health disparities by Service Area (SA) include the following:

Medi-Cal population

By ethnicity

- African American in SAs 1, 2, 3, 4, 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, 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 SAs 3 and 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, 4, 5, 6, 7 and 8

By gender

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

II. Identified disparities within the CCPR target populations

A. Community Services and Support (CSS) Plan

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

By ethnicity

- African American in SAs 1, 2, 3, 4, 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, 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 SAs 3 and 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, 4, 5, 6, 7 and 8

By gender

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

B. 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

C. 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

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

LACDMH has implemented multiple strategies to reduce disparities. Many of them are grounded in the CSS, WET, and PEI plans. Additionally, LACDMH has implemented the following strategies to reduce mental health disparities; eliminate stigma; increase equity in service delivery; and promote hope, wellness, recovery and resiliency:

1. Collaboration with faith-based and other trusted community entities/groups
2. Development and translation of public informing materials that address mental health education
3. 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)
4. Community education to increase mental health awareness and decrease stigma
5. Consultation to gatekeepers
6. Countywide Full Service Partnership (FSP) Networks to increase linguistic/cultural access
7. Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery
8. Designation and tracking ethnic targets for FSP
9. Evidence-Based Practices (EBPs)/ Community-Defined Evidence Practices
    a. (CDEs) for ethnic populations
10. Field-based services
11. Flexibility in FSP enrollment such as allowing “those living with family” to qualify as “at-risk of homelessness”
12. Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health
13. Implementation of capacity-building projects based on the specific needs of targeted groups via the Underserved Cultural Communities subcommittees (UsCC)
14. Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services
15. Implementation of new technologies to enhance the Department’s service delivery
16. Augmentation of mental health service accessibility to underserved populations
17. Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings

18. Integrated Supportive Services
19. Interagency Collaboration
20. Investments in learning (e.g., Innovation Plan)
21. Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts
22. Integration of physical health, mental health, and substance use services
23. Programs that target specific ethnic and language groups
24. Provider communication and support
25. School-based services
26. Trainings/case consultation
27. Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing
28. Utilization of the workforce's responses to cultural competence organizational assessments, surveys, and focus groups to address knowledge gaps and support advancements in cultural competence
29. Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity
30. COVID-19 responsiveness at clinical and administrative program level

    Examples:
    - Partnerships for special community events such as Salazar Park Holiday Event and Supervisor Hilda Solis' Drive-Thru Food Drive/Resource Fair
    - Collaboration with Community-Based Organizations in hosting drive thru events to distribute common hygiene products and personal protective equipment
    - Dissemination of community resources for basic needs such as food, shelter, and COVID-19 testing sites
    - Providing mental health support to community members and Faith-Based Organizations
    - Creation of virtually-run safe spaces to share the impact of the pandemic and ways of coping
    - Efforts to inform the community about COVID-19 myths and fraudulent activities targeting most vulnerable community members
    - Countywide telehealth enhancements
    - Implementation of LACDMH Speakers Bureau to support the community as a whole in a culturally and linguistically relevant manner
    - Mobilization of Mental Health Promotores to provide virtual presentations in the community settings such as shelters
    - Peers providing support to consumers regarding mental health services and challenges related to the pandemic
    - Expansion of Mental Health Promotores program to underserved communities

The following chart summarizes the endorsement of above-mentioned strategies to reduce disparities by Program.

.

	NAME OF PROGRAM/ACTIVITY	1. Outreach and Engagement	2. Community Education	3. Multi-lingual Materials	4. Faith-Based Collaboration	5. School-based services	6. Field-Based Services	7. Specific Ethnic/Language Group	8. FSP-Ethnic Targets	9. FSP-Enrollment Flexibility	10. FSP-Countywide Networks	11. Integrated Supportive Services	12. Co-location of Services	13. Interagency Collaboration	14. Consultation to Gatekeepers	15. Trainings/Case Consultation	16. Provider Communication/Support	17. Multi-Cultural Staff Development	18. EBPs/CDEs for Ethnic Population	19. Investments in Learning	20. Community Partnerships	21. Policies & Procedures	22. New Technologies	23. Service Accessibility	24. Integration of Services	25. Committees & Taskforces	26. COVID-19 Responses
1)	CalWORKs	X	X	X	X		X						X	X		X	X	X	X			X	X	X	X		
2)	Community Ambassador Network (CAN)	X	X													X					X			X			X
3)	DMH/DHS Collaboration Program	X	X	X	X			X					X	X	X	X	X	X				X	X	X	X		
4)	Health Neighborhoods	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X
5)	DMH Help Line														X							X	X	X			X
6)	HOME Teams	X	X	X	X		X					X	X	X	X	X	X	X			X	X		X	X		X
7)	Katie A	X	X	X	X	X	X					X	X	X	X	X	X	X				X	X	X	X	X	X
8)	Maternal Mental Health	X	X	X	X		X	X				X	X	X	X	X	X	X	X		X	X	X	X	X	X	X
9)	Men's Community Reintegration	X		X	X									X		X		X	X		X	X	X		X		X
10)	Outreach & Engagement (O&E)	X	X	X	X									X			X				X						
11)	Preventing Homelessness & Promoting Health	X		X	X		X					X	X	X	X	X	X	X	X			X	X	X	X	X	X
12)	Prevention Early Intervention (Older Adults)	X	X	X	X									X													

	NAME OF PROGRAM/ACTIVITY	1. Outreach and Engagement	2. Community Education	3. Multi-lingual Materials	4. Faith-Based Collaboration	5. School-based services	6. Field-Based Services	7. Specific Ethnic/Language Group	8. FSP-Ethnic Targets	9. FSP-Enrollment Flexibility	10. FSP-Countywide Networks	11. Integrated Supportive Services	12. Co-location of Services	13. Interagency Collaboration	14. Consultation to Gatekeepers	15. Trainings/Case Consultation	16. Provider Communication/Support	17. Multi-Cultural Staff Development	18. EBPs/CDEs for Ethnic Population	19. Investments in Learning	20. Community Partnerships	21. Policies & Procedures	22. New Technologies	23. Service Accessibility	24. Integration of Services	25. Committees & Taskforces	26. COVID-19 Responses
13)	Promotores de Salud	X	X	X	X	X	X	X						X	X	X	X	X	X	X	X	X	X	X	X		X
14)	Service Extenders	X	X	X				X								X		X			X			X	X		
15)	Spanish Support Groups	X	X	X	X	X	X							X		X	X	X	X		X		X	X	X	X	X
16)	TAY Drop-in Centers	X	X	X															X					X			
17)	TAY Navigation Team	X	X		X		X					X	X	X	X	X		X				X	X	X	X	X	X
18)	Telemental Health Program													X				X			X	X	X	X			X
19)	Underserved Cultural Communities (UsCC), MHSA	X	X	X	X		X	X	X	X	X		X	X	X	X	X	X		X	X			X	X	X	
20)	Veterans	X	X	X	X	X	X	X				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
21)	Wellness Outreach Workers Program	X	X	X																							
22)	WET/ Trainings	X	X	X	X		X	X					X			X		X						X	X		
23)	Whole Person Care	X	X	X	X		X	X				X	X	X	X	X	X	X	X	X	X		X	X	X	X	X
24)	Women's Community Reintegration	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

The section below presents detailed information on LACDMH programs that focus on various aspects of diversity and cultural competence. Each featured program contains

- A brief description of scope and purpose
- Data on consumers served
- Strategies and objectives to reduce disparities
- Impact on the cultural and linguistic competence of the system of care

Given the significant amount of technical terms used by each program, a glossary of acronyms has been developed to guide the reading of this information.
(See Attachment 1: Acronyms)

Note: This particular content organization incorporates sections IV. "Additional Strategies/ Objectives/Actions" and V. "Planning and Monitoring of Identified Strategies/Objectives/ Actions/Timeliness to Reduce Mental Health Disparities" of the CCPR structure for Criterion 3.

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

The DMH/DHS Collaboration Program is a MHSA PEI-funded program in which DMH staff are located on a full-time basis within the DHS Ambulatory Care Network (ACN), working alongside the medical providers in the Primary Care or Family Medicine clinics. DMH staff provides short-term, early intervention, specialty mental health services in health settings thereby improving accessibility. The program ensures collaboration between the mental health and health care providers in the co-management of individuals referred by primary care providers to DMH staff.

The DMH/DHS Collaboration Program has contributed to LACDMH's provision of culturally and linguistically competent services. For example, DMH clinicians provide and deliver culturally and linguistically appropriate services to consumers where possible, and where not, the staff are comfortable using the Language Line for triage and linkage. Based on staffing capacity of DMH/DHS staff, project specific to language and cultural needs of diverse communities are implemented. Community-informing brochures in English, Spanish, and Chinese have been developed and published.

The DMH/DHS Collaboration Program also increases access to mental health services and eliminates disparities by specifically bringing early intervention of mental health services into primary care settings. This practice ensures early identification and treatment of mental health conditions before they increase in severity. Seeking treatment in a traditional mental health clinic is often stigmatizing for members of culturally diverse backgrounds. Due to fear of stigmatization, individuals in need of services may not seek them in a timely manner, or may wait until their symptoms are debilitating, thus requiring a more intensive approach. The role of the primary care providers in endorsing mental health interventions is essential and can increase comfort and follow-up.

DMH/DHS COLLABORATION		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) MLK site held Diabetes groups and Cancer Support groups jointly with DHS medical providers in Spanish	These groups are held twice monthly with good attendance (10-15 participants)	Anecdotal feedback by participants and DHS medical team is that the group provides an efficient, effective way to address the medical/social/mental health needs of members.
2) A Wellness Education group for the Chinese consumers at the Roybal site, designed by the clinician and Medical Case Worker, provides non-stigmatizing outreach to the community	The group is held biannually. The PHQ-4/PHQ-9 is administered and reviewed to identify the participants' mental health needs. Prevention or treatment services are offered to attendees as appropriate.	The group is conducted in Mandarin and Cantonese, and offers 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 continues to be positive. The DHS PCPs are becoming aware of the group and make referrals to it. The group is offered biannually on an ongoing basis.
3) The Collaboration sites across the DHS Ambulatory Care Network (ACN) are involved in DHS's implementation of a Behavioral Health Integration model in their primary care settings	This model helps patients access to a complement of mental health and support resources, along with appropriate referrals and linkage, at their primary care location. The Collaboration has actively participated in designing the workflows and referral/treatment logic so that services are value-added and non-redundant.	Phase two (2) launch of the Behavioral Health Integration (BHI) to the whole ACN happened in October 2020. Ongoing modifications are being made to workflows with regular input by the Collaboration team.
4) At the Mid Valley site, the clinician is co-facilitating a disease management group focusing on Diabetes. The group alternates weekly in English and Spanish	Launched in July 2019, the group was well publicized to the patient population. Initial attendance was low but consistent (5-10/session)	Strategies for improving registration and attendance numbers were in discussion in January 2020. The group was suspended in March due to the pandemic.
5) At the High Desert site, the team is part of an effort to increase access to mental health services by perinatal women by creating a new cross-referral workflow between DHS Women's Health medical providers, the Collaboration Program team, and two (2) Directly Operated LACDMH clinics with staff	Launched in November 2019, the effort was supported with monthly calls involving all providers to address workflow issues.	Women's Clinic providers report that this pathway is a "relief" due to being able to link their perinatal patients with mental health services on a reliable basis. The workflow has minimal issues that are easily resolved due to the clear communication lines that have been established.

DMH/DHS COLLABORATION		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
trained in providing maternal mental health services		
6) A new program site at Curtis Tucker Health Center, the DPH clinic, had been in the works for four (4) years. This site is the first collaboration across all three (3) Health Departments	The clinician and clerk were identified. The office was prepared in accordance with Medi-Cal certification standards. Due to ongoing construction and renovations by DPH and DHS, then the Public Health Emergency, the site launch was delayed.	The site launch was completed August 2020.

CONSUMERS SERVED BY DMH/DHS COLLABORATION FY 19-20

Program/ Activity	**# Consumers Served by Race/Ethnicity**							**Gender**				
	White	Multi-racial	African American	Latino/ Latinx	API	American Indian	Other (Unreported)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported
DMH/DHS Collaboration El Monte CHC	19	7	6	145	11		44	231		1		
DMH/DHS Collaboration Roybal CHC	26	8	28	201	11		44	317				1
DMH/DHS Collaboration Long Beach	11	6	18	72	3		4	113	1			
DMH/DHS Collaboration Mid Valley	45	2	18	128	7		28	228				
DMH/DHS Collaboration MLK OPC	12	5	66	155	2	1	73	314				
DMH/DHS Collaboration Lomita	24	2	25	104	10		23	188				

CalWORKs

CalWORKs recipients are eligible to receive Specialized Supportive Services as part of their Welfare-to-Work plan in order to assist them in removing barriers to employment and moving on to self-sufficiency. Specialized Supportive Services include domestic violence services, substance use disorder counseling, and mental health treatment. CalWORKs participants are all Medi-Cal recipients. However, Medi-Cal is not billed for CalWORKs participants who are receiving mental health services as part of their Welfare-to-Work

plan. Further, they are not required to meet medical necessity to receive mental health services funded by CalWORKs.

Mental health services for CalWORKs participants include:

- Crisis Intervention
- Individual and family assessment and treatment
- Individual, group, and collateral treatment services
- Specialized vocational assessments
- Supported Employment – Individual Placement and Support
- Life skills support groups
- Parenting effectiveness
- Medication management
- Case management, brokerage, linkage and advocacy
- Rehabilitation, support, vocational rehabilitation and employment services
- Home visits
- Community outreach

CalWORKs' community outreach is done via educational presentations in local DPSS offices where potential CalWORKs consumers may be present as well as churches, community centers, community colleges, and other local social service agencies. The goal of these outreach activities is to provide education on CalWORKs mental health services available to the community. Outreach activities are also conducted with potential employers in the community to provide education and awareness regarding the abilities of CalWORKs consumers. This is done to facilitate employment opportunities.

The CalWORKs Program Administration maintains the responsibility of ensuring all agencies provide culturally competent mental health services for the CalWORKs participants. Also, CalWORKs providers conduct outreach and education activities within their Service Areas and communities to educate potential CalWORKs participants about the availability of mental health services to address their barriers to gainful employment and self-sufficiency.

CalWORKs		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Multi-lingual and multi-cultural case management and clinical staff throughout the CalWORKs program.	DPSS staff who make referrals to LACDMH Directly Operated and Contracted clinics have continuously updated listings of all clinics and their language capabilities to ensure that participants are appropriately referred if a specific language need is identified. Languages spoken include: • Arabic	DPSS provides childcare funding as part of a participant's Welfare-to-Work plan. Additionally, some LACDMH Directly Operated and Contracted clinics provide child watch services or children's socialization groups while their parents are participating in their own mental health services.

CalWORKs		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	• Armenian • Cantonese • English • Farsi • Hebrew • Hindi • Japanese • Khmer • Korean • Laotian • Mandarin • Portuguese • Punjabi • Russian • Samoan • Spanish • Tagalog • Urdu • Vietnamese	CalWORKs Program Administration monitors accessibility of culturally competent mental health services for CalWORKs participants.

Health Neighborhoods (HN)
Health Neighborhoods is a collaboration of community partners working to build thriving communities in underserved areas through prevention, improved coordination, and strong support networks that utilize the Community Change and Integrated Service Delivery models. Health Neighborhood coalitions continue to expand and diversify their existing networks to improve coordination, collaboration, and effective use of resources to support residents and address existing health inequities prioritized by community members.

To meet the specific needs of a defined community, place-based Health Neighborhoods must remain organic in nature with a shared leadership and commitment by the three Health Departments and community stakeholders. Each Health Neighborhood develops an annual Action Plan that outlines specific issues to be addressed along with an annual budget. As Health Neighborhoods identify needed resources or barriers to attain their goals, the Operations Committee leverages resources among the Health Departments.

Health Neighborhood contribute to LACDMH's provision of culturally and linguistically competent services by creating and sustaining 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 Health Neighborhoods is to create and sustain a collaboration of community partners working to build thriving

communities in underserved areas through prevention, improved coordination, and strong support networks.

Health Neighborhoods increase access to mental health services and eliminate disparities by making meetings open to diverse communities. Health Neighborhood attendees are encouraged to share meeting information with other community members to encourage involvement. Projects and activities focus on outreaching to the diverse populations within each Health Neighborhood. Providers and networks collaborate on community projects that vary racially, ethnically, and culturally and bring their expertise to connect/reach those diverse groups. This type of collaboration greatly contributes to the Department's mission of culturally and linguistically appropriate services.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) AV Self Care Forum and Appreciation Event	Implemented	92 attendees were able to gain insight to three (3) or more self-care techniques and various activities including mindfulness and deep breathing.
2) Maternal Health Training	Implemented	Provided one (1) training on maternal mental health to community partners and agencies. 32 participants were presented and gained knowledge and skills to use in practice.
3) Interfaith and Mental Health Conference	Implemented	65 attendees attended from various religious denominations, which were able to collaborate and link services for mental health to their congregation members.
4) Wellness Minute Give Away,	Implemented	Provided 500 community members with mental health resources including hygiene kits. Community members included African American, Latino/Latinx, White, Families, Children, and LGBTQ+.
5) Day of Giving Event	Implemented	Provided services to 250 Community members that included African American, Latino/Latinx, White, Families, Children, and LGBTQ+ with food, clothing, groceries, health and mental health resources.
6) Food Delivery Services during COVID-19 in partnership with AVPH	Implemented	Provided food resources to over 100 Community members that included Senior Citizens, African American, Latino/Latinx, White, Families, Children, and LGBTQ+.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
7) Unity Block Party in Collaboration with Youth Build	Implemented	Provided over 100 youth ages 10-18 with mental health and food resources. Youth were African American, Latino/Latinx, White, and LGBTQ+ populations.
8) Suicide Prevention Training	Implemented	Provided 250 youth 6th to 8th grades, with awareness information and prevention of suicide. Youth were African American, Latino/Latinx, White, and LGBTQ+ populations.
9) AV Resource and Community Fair	Implemented	Provided mental health, wellness, and food services for over 2000 community members. Clinical services were provided including case management and intakes.
10) Living Through the Pandemic Support Group	Implemented	Provided on-going mental health and social support to over 100 community members in response to the COVID-19 pandemic. Community members included African American, Latino/Latinx, White, Seniors, Grandparents, and LGBTQ+ populations.
11) Monthly Collaborative Health Neighborhood Meetings with all partners, as to stay informed with available community services and resources.	Ongoing on a monthly basis.	Ongoing meetings per month.
12) Outreach events in the community (virtual during COVID-19 pandemic)	Ongoing, as Health Neighborhood partners work together to provide outreach for the community.	Ongoing outreach, primarily virtual due to COVID-19 pandemic.
13) Utilizing the One Degree platform to collaborate and offer the community information on various available services (mental health, substance use, medical, etc.)	Ongoing sharing of resources.	Ongoing at this time. One Degree is available for all community members and partners to find local resources.
14) Presentation to Probation Pomona Valley Community Advisory Committee to describe Services in SA 3 and Health Neighborhoods	Completed: August 15, 2019	The presentations are effective in getting the word out about mental health services in SA 3 and about the El Monte and East San Gabriel Valley (ESGV) Health Neighborhoods.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
15) Participation in the Azusa Pacific University Mental Health Symposium to describe LACDMH Services and provide additional information about San Gabriel Valley (SGV) Health Neighborhoods and resources within Health Neighborhoods	Completed: September 16, 2019	The presentations are effective in getting the word out about mental health services in SA 3 and about the El Monte and ESGV Health Neighborhoods. Connected with providers who resulted in participating in future Health Neighborhood meetings.
16) Coffee and Conversation group at West Covina Library to discuss mental health, services, and resources within the county and Health Neighborhoods.	Completed: March 25, 2020 (ongoing group that was placed on hold due to COVID-19)	Patrons from the library had an opportunity to share, connect and learn about services in the SGV area.
17) SGV Health Neighborhoods partnered with Los Angeles County DCFS and planned 3D Family Jam Resource event. Health neighborhood providers provided resources and educated providers/community members of services in SA3	Completed: September 7, 2020	Health Neighborhood partners were able to connect with approximately 400 families in the SGV and provide information and resources.
18) Initiation of the SGV Maternal Mental Health Workgroup, an extension of the Health Neighborhoods.	Ongoing: Webinar 1: SGV Maternal Mental Health (October 22, 2020) Webinar 2: Screening of "Dark Side of the Full Moon (March 10, 2021)	SGV Maternal Mental Health Workgroup meets monthly to address the needs in the SGV area, to provide education, and connect with resources.
19) Presentation at the Baldwin Park Unified School District Summer Support meeting to describe LACDMH services in SA 3 and connect/inform providers about Health Neighborhoods	Completed: May 27, 2020	Presentations are effective in getting the word out about mental health services in SA 3 and about the El Monte and ESGV Health Neighborhoods.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
20) Collaboration with the SGV African American Infant Maternal Mortality and the SGV Community Action Team (CAT)	Ongoing	Provide information on SGV Health Neighborhoods and SGV Maternal Mental Health Workgroup. Collaboration is effective in educating providers and community members on mental health services. This resulted in participants joining the SGV Maternal Mental Health workgroup.
21) Park Therapy: Using non-traditional activities to provide an access point to connect the community to MH and Health services. Collaborate with LACDMH Contracted providers, County Parks and Rec, Promotores, and DPH. Two (2) of the providers, UMMA Community and Wellness have contracts with DMH to provide services to the underserved culture communities (African/African American and Latino/Latinx). Activities include: Healthy Cooking, Stress Reductions, Promotores Presentations, Yoga, Physical Health Screenings, mobile game truck and Art Therapy.	This is an ongoing collaboration in hopes to continue to recruit additional providers to help support. There was a pause in the event due to the March Safer at Home orders.	We have monthly meetings to address the needs in the community at the parks and the services each provider has available. Each provider provides feedback on the number of participants they connected to their agency for services. The activities with non-traditional services had highest level of attendance.
22) His Sheltering Arms Thanksgiving Community Dinner: The South Los Angeles Health Neighborhood (SLAHN) assisted to provide a hot meal, food to prepare a Thanksgiving meal, and resources to the women in the shelter as well as those in the community.	This event occurred on Tuesday, November 19, 2019.	With this event, more than 50 community members were provided a meal. They used a passport to visit the resource booths to obtain the bagged Thanksgiving items.
23) Weekly Day of Dignity event: This event is a collaboration with Mt. Tabor Missionary Baptist Church, DMH, Los Angeles Homeless Services Authority (LAHSA), HOPICS, Project 180, Child Support Services, LAVA Mae Mobile Showers, Mobile Medical	This is an ongoing event that occurs every Wednesday from 9AM-1PM. There was a pause in participation in March 2020 due to the Safer-at-Home orders.	This event is headed by Ms. Bernice of Mt. Tabor MBC. Periodically she would inform the group of the number of individuals in the program who were successfully housed. This team approach appears to be a great way to build rapport with unhoused community to connect them with services.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Truck and other partners. The purpose of this event is to provide services to unhoused community members in South Los Angeles. Mental health resources and assistance were provided to unhoused members experiencing mental health conditions.		
24) Community Walk and Backpack Giveaway: This event was a collaboration with Supervisor District two (2) office, Southside Coalition of Community Health, Special Needs Network, and County Parks and Rec. LACDMH assisted with creating a Wellness area with resources and activities for the community. LACDMH also received support from the consumers who volunteered for this event.	This event occurred in August 2019.	This appeared to be an effective event to reach out to the community for a day of family fun, education about resources in the community, and school supplies for the youth. Due to effective marketing, this event was highly attended by those in the South Los Angeles Area.
25) The Southeast Los Angeles Health Neighborhood (SELA) and Clergy Roundtable members met monthly and shared vital information that provided strategies on outreach efforts to unserved and underserved populations within SA 7 communities, to educate and empower residents, decrease stigma and fear of mental health issues, and promote self-care. SELA-Every 2nd Tuesday of the month Clergy Roundtable-Every 4th Tuesday of the month Clergy Breakfast-Quarterly	Staff continued to conduct outreach to community-based organizations, places of worship, school districts, and other health and mental health entities in efforts to grow and expand the not just the Health Neighborhood but other SA 7 collaborative as well	The SELA Health Neighborhood added an additional 11 community partners. • Senior Helping Hands Foundation • Latino Family Coalition • Bienestar Family Counseling • Tree People • HCA Health Care • The Green Foundation • Kaiser Health Care • You are RAD Foundation • Blue Anthem • Aunt Bertha
26) SALT 7, SELA, Clergy Roundtable, Town Hall	The event was the first Town Hall held in Service Area 7. Plans are to continue holding Town Hall meetings at	The event was attended by over 300 community residents. Participants met DMH leadership and expressed their concerns and provided feedback on mental health service needs.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	a minimum, once a year	
27) The Department of Mental Health SA 7 Administration co-sponsored a Día de los Muertos event in South Gate Park, bringing together SELA partners and Clergy Roundtable to host resource tables, promoting services offered as well as linkage if needed.	LACDMH will continue to participate in community events to promote services offered by various agencies throughout the Southeast Los Angeles communities thus enhancing the overall wellness of community residents.	It was estimated that approximately 1,000 community members walked through the various events, activities and vendor tables as reported by South Gate City Hall.
28) SA 7 Administration in collaboration with SELA and other community service agencies participated in bringing together two Job Fairs in the City of Santa Fe Springs and in the City of Downey. Potential employers, trade schools, colleges and universities were aware that many job fair attendees would be consumers of mental health services and those that participated offered their full support in helping enhance the lives of those we serve	The job fairs will be a continuous event. The Job Fair was planned for 2020, however postponed due to COVID-19	City of Santa Fe Springs Job Fair Vendors: 86 Total Number of attendees: 120 City of Downey Hope and Wellness Job Fair Vendors: 100 Total Number of attendees: 240 Post survey results showed that well over 80 percent of those who participated in the survey indicated satisfaction with the events, Four (4) people obtained employment Two (2) enrolled in Trade schools
29) The Department of Mental Health, Service Area 7 was invited to participate in the 74th Annual City of South Gate Christmas Parade. Mr. Manuel Rosas, the District Chief, and Countywide Activity Fund (CAF) members were invited to participate	Both health and mental health service providers hosted resource tables offering community residents information and if needed possible linkage to services.	As reported by the City of South Gate, approximately 30,000 people lined the streets and walked through the maze of activities, events and resource tables.
30) Outreach to homeless individuals were held at the Sagrada Familia Church in Huntington Park, CA., twice a month providing information and linkage to mental health and housing services	Seven (7) events conducted.	210 community members were served.

HEALTH NEIGHBORHOODS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
31) Continued collaboration with St. Joseph's Catholic Church and the surrounding organizations	Active	Streamlined to needed services

CONSUMERS SERVED BY HN
FY 19-20

Program/ Activity	**# Consumers Served by Race/Ethnicity**												**Languages used by Staff in service provision**
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/ Gender Fluid	Not reported	
Interfaith and Mental Health Conference	10	10	10	20	15								English, Spanish and Vietnamese
Wellness Minute Give Away	75	45	171	190	10	9							English, Spanish and Vietnamese
Day of Giving Event	39	10	88	106	5	2							English, Spanish and Vietnamese
Food Delivery Services During COVID-19 in partnership with AVPH	12	5	35	55	1								English, Spanish and Vietnamese
Unity Block Party in Collaboration with YouthBuild	20	5	36	40	3						4		English and Spanish
Suicide Prevention	47	15	99	82	5						2		English and Spanish
AV Resource and Community Fair	408	109	667	754	29	11			6	5	11		English and Spanish
Living Through the Pandemic Support Group	22	11	29	32	2	1			1		2		English and Spanish
AV Self Care Forum and	15	5	22	33	5	2			2		0		English and Spanish

Program/ Activity	# Consumers Served by Race/Ethnicity												Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/ Gender Fluid	Not reported	
Appreciation Event													
Maternal Health Training	7	3	10	11	1								English
SA2	x	x	x	x				x	x	x	x	x	English and Spanish
SA3								x				x	English, Spanish, Mandarin, and Cantonese
SA4								x				x	English, Spanish, Mandarin, and Cantonese
SA5	x	x		x	x			x	x	x	x	x	English, Spanish, Mandarin, and Cantonese
SA6		x	x	x				x				x	English and Spanish
SA7	x	x	x	x	x	x		x				x	English and Spanish
SA8	x	x	x	x	x	x		x				x	English, Spanish, Mandarin, and Cantonese
Countywide	x	x	x	x	x	x		x	x	x	x	x	English and Spanish

LIST OF HEALTH NEIGHBORHOODS (HN) ACROSS SERVICE AREAS

HEALTH NEIGHBORHOODS	
Service Area (SA)	**Name**
SA 1	• Antelope Valley
SA 2	• Northeast San Fernando Valley • Panorama City/Van Nuys

HEALTH NEIGHBORHOODS	
Service Area (SA)	**Name**
SA 3	• El Monte • East San Gabriel Valley
SA 4	• Hollywood • Boyle Heights
SA 5	• Palms/Mar Vista Intergenerational • Venice/Marina Del Rey • Pico/Robertson
SA 6	• South Los Angeles
SA 7	• East Los Angeles
SA 8	• Long Beach • Hawthorne

Note: Virtual meetings in all SAs during the COVID-19 pandemic

HOME Teams

The HOME program provides field-based outreach, engagement, support and treatment to individuals with severe and persistent mental illness who are experiencing unsheltered homelessness. Services are provided by addressing basic needs; conducting clinical assessments; providing street psychiatry and linkage to appropriate services including mental health, substance use and housing.

The HOME program's activities are in line with LACDMH's provision of culturally and linguistically competent services by providing consumers with services in their preferred language for communication. The team makes every effort to address consumers' concerns regarding the ability to communicate effectively with their provider. The team also engages with various types of community-based supports that consumers desire involved in their recovery process.

The purpose of this program is to engage consumers in the community who would not otherwise seek services and to reduce as many barriers as possible. The HOME Program provides mental health services, healthcare, food, and other resources in the community wherever they are able to connect with consumers.

HOME TEAMS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Collaboration with DHS and DPH in creating programs and groups to attend to all of consumer's needs that are consistent with their culture/identity	In progress	

HOME TEAMS		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
2) Outreach with community partners to facilitate COVID-19 testing and vaccinations	In progress	Data being pulled by community partners
3) Partnering with places of worship to offer meals, showers, and services	In progress	Documentation in medical records
4) Providing four (4)-part series training on cultural competency and humility to all program staff	Planning began in June 2020 with Los Angeles Homeless Services Authority (LAHSA) and Department of Health Services Partners. Curriculum finalized in August 2020 training in progress currently final session to be delivered May 20, 2021	

This space was intentionally left blank

CONSUMERS SERVED BY HOME PROGRAM
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Total	Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	TOTAL	
7701A	75	6	107	69	5	2	70	181	151	1	1	0	334	English, Spanish, and Unknown
7917A	16	5	195	48	4	1	63	176	156	0	0	0	332	English and Unknown
7921A	133	18	71	169	15	8	138	300	250	1	1	0	552	Unknown
7922A	130	13	64	81	7	2	99	220	174	1	1	0	396	English, Spanish, Samoan, and Unknown
7924A	50	2	48	51	1	1	50	112	90	0	1	0	203	English, Spanish, and Unknown
7929A	57	6	19	118	2	6	53	132	129	0	0	0	261	Unknown
7933A	40	5	55	19	1	0	13	64	69	0	0	0	133	Unknown
7934A	97	5	54	19	7	1	30	121	89	0	1	2	213	Unknown
7935A	19	1	17	5	1	0	8	31	20	0	0	0	51	English and Unknown

Katie A.

LACDMH, in collaboration with Los Angeles County Department of Children and Family Service (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, Early and Periodic Screening, Diagnostic, and Treatment Services (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 twenty (20) DCFS regional offices. Cases are triaged based on acuity and linked to Directly Operated and Contracted children's mental health providers.

Key program components include:

- Wraparound Program
- Family Preservation
- Intensive Field Capable Clinical Services (IFCCS)
- Intensive Services Foster Care (ISFC)
- Multidisciplinary Assessment Teams (MAT)

The County continues implementation of the Integrated Core Practice Model (ICPM) as well as Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) consistent with the California Department of Health Care Services Medi-Cal Manual for these services.

Based on Assembly Bill 1997, Continuum of Care Reform (CCR) requires the expansion of culturally relevant, trauma-informed, developmentally appropriate, and medically necessary specialty and non-specialty mental health services to all children and youth involved with the Department of Children and Family Services (DCFS) and the Department of Probation (Probation). In addition, AB 1997 requires Local Mental Health Plans (LMHPs) to contract with agencies transitioning from group homes to Short-Term Residential Therapeutic Programs (STRTPs) and Foster Family Agencies (FFAs) delivering Intensive Services Foster Care (ISFC) and the new Therapeutic Foster Care (TFC) specialty mental health services (SMHS). As a result, LACDMH will be establishing new Short Doyle/Medi-Cal contracts with new Legal Entity (LE) providers within Los Angeles County.

These projects/activities contribute to LACDMH's provision of culturally and linguistically competent services by delivering interventions in ways that increase accessibility for children/youth and families. Discussing with and training providers on information that may increase their cultural and linguistic competency have the potential to increase the trust within their therapeutic relationship. This, in turn, has the potential for children/youth and families to feel better seen and understood and more likely for them to remain in a collaborative relationship to work on their mental health goals. LACDMH, through collaboration with County partners, ensure- that the CCR legislation continues to be implemented in Los Angeles County. This in turn ensures that the Specialty Mental Health Services continue to be available to all Child Welfare youth and that services are delivered in a culturally relevant manner. They also have contributed to increasing access to mental health services and eliminating disparities by providing psychoeducation to referral portals, providers, and DCFS partners with the intention to minimize administrative delays.

LACDMH, in collaboration with its County partners, is working to make sure that there is access to mental health services for Child Welfare youth in all areas of Los Angeles County including underserved areas such as SA 6 and the Antelope Valley. Through monitoring and training of providers, LACDMH works to provide services that are culturally relevant, trauma-informed, and ensures linguistic needs are met for all Child Welfare youth.

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Multidisciplinary Assessment Team (MAT) Trainings: • MAT/Child and Family Team (CFT) Integration Roll Out ICPM and CFT Trainings	• Aligned with the roll out of the MAT/CFT process in SA1, SA2, SA5, and SA6, these trainings were provided to MAT agencies servicing the Lancaster, Palmdale, Santa Clarita, Chatsworth, Van Nuys, West LA, Compton, and Wateridge North DCFS regional offices.	• Qualitative outcomes were tracked through regularly held feedback sessions throughout the MAT/CFT implementation process. Quantitative outcomes were tracked jointly by LACDMH and DCFS countywide MAT staff.
• 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	• The MAT 101 and the MAT/CFT 101 training is provided to new MAT assessors across all eight (8) Service Areas (SA) as needed. Additionally, new assessors are trained on the ICPM and the current policies and procedures of the MAT program. Trainings are held within the SA and are coordinated with the Service Area LACDMH staff and DCFS MAT staff members when new MAT assessors have been hired by Contracted MAT providers. Typically, such trainings occur eight (8) to ten (10) times per fiscal year.	• 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.
• Birth – five (0-5) Training on Trauma, developmentally and culturally–informed components in clinical assessments and case conceptualization	• This training was developed for MAT assessors and Birth to five (0-5) treatment providers across the system in order to increase capacity for service provision to young children involved in the Child Welfare system.	• The trainings continued to be provided to MAT staff and MAT contractors being trained throughout the course of FY 19-20.
• Routine announcements to agencies about available LACDMH trainings on cultural humility and those that incorporate cultural competency (e.g., Culturally Co-occurring Developmental Disabilities, Sensitive Practices, Commercial Sexual Exploitation of Children 101, LGBTQ+ TAY Safe and Welcoming Environment, and	• Agency staff attend trainings through this announcement process.	

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Substance Use/Dual Diagnosis trainings)		
2) Wraparound Wraparound is an integrated, community-based, intensive services program intended for children and youth who are experiencing serious emotional and behavioral problems. The Wraparound program continues to follow the Wraparound Practice Principles which include: Family Voice and Choice; Team–based; Collaboration; Community-based; Culturally Competent; Individualized; Strength based; Natural Supports; Persistent; Outcome-based 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 Children's Intensive Service Review (CISR) provides an in-depth case-based review of frontline mental health practice as well as the provision of culturally competent services. The CISR uses a combination of record review, interviews, and observations regarding children and families involved with the child welfare system receiving intensive mental health services.	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 individual needs of the children and families served. **Trainings** In response to the nationwide Stay at Home order trainings transitioned to online forums to ensure that training opportunities continue to be made accessible to all Wraparound team members, supervisors, and administrative staff. Trainings included: *Creating Effective Teams; Understanding My Role as a Member of a Team training.* • During FY 19-20, 64 participants attended this training, which focuses on the stages of teaming and understanding how cultural differences affect communication styles. *Family Crisis and Safety Planning training.* • During FY 19-20, 134 participants attended this training, which focuses on having participants explore how culture influences safety planning and crisis intervention when working with families of	Wraparound Administration continuously oversees the provision of mental health services delivered to its participants by ensuring that services are culturally congruent with the individual needs of each child or youth and family. **Findings** • The CISR's found that there is a continued need for ongoing trainings as they relate to cultural competency and trauma-informed practice. • Through the expansion of Case Rate Services and Supports (CRSS) funds, items such as, but not limited to, groceries, laptops, tablets, phones, utility bills, rent, school supplies, and cleaning supplies were made available to families to assist in accessing their educational, vocational, and mental health needs.

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Wraparound Providers received a one-time additional Case Rate Services and Supports (CRSS) funding in an effort to meet the housing, personal, vocational and program/socialization needs of the children, youth and families served as a result of the COVID-19 pandemic.	diverse backgrounds and experiences. *Principles of Teaming, Wraparound Roles Definition and Skills training* • During FY 19-20, 231 participants attended this training, which focuses on the exploration of the Wraparound team members' roles and includes activities that demonstrate the use of a trauma-informed lens with consideration given to culture by each Wraparound team member. *Utilizing a Trauma-Informed Lens in Wraparound training.* • During FY 19-20, 153 participants attended this training, which focuses on increasing participants' knowledge on trauma-informed care by understanding the different types of trauma, overlapping diagnoses, and application of trauma-informed and culturally congruent strategies important to working in the child welfare system. • Wraparound completed 61 Children Intensive Service Reviews (CISR) from July 2019 to March 2020.	
3) Intensive Services Foster Care (ISFC): Pre-Match consultations incorporate culture as one of the elements discussed/considered at the time of matching youth with Resource Families and planning services	• Agencies are considering ethnicity, language, local community, age, and experience with systems and mental health challenges when matching youth to Resource Families and treatment staff.	• 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 included the incorporation of biological

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Routine announcements to agencies about available trainings on cultural humility and those that incorporate cultural competency (e.g., 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)	• Agency staff attended trainings through this announcement process. • Several agencies recruited Resource Parents who wished to work with special populations youth and matched youth with these homes for services.	family as well as community of origin members in services.
Provider Roundtable meetings schedule time for agencies to share information with one another about upcoming trainings and information obtained from trainings they attended. This included topics such as developmental disabilities, Commercial Sexual Exploitation of Children (CSEC), and LGBTQ populations	• Providers 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 was offered as needed and includes discussion and support for the provision of culturally competent engagement and services. This was especially crucial during post-placement follow-ups and during placement preservation meetings.	• Clinical consultation was provided to support improvement with culturally appropriate services (e.g., culture of family violence and substance abuse, gang culture).	
Intensive Services Foster Care Program (ISFC) Outreach in the community. ISFC Foster Family Agencies (FFA) outreach to faith-based communities to recruit Resource Parents for ISFC. Some ISFC agencies trained, certified, and supported ISFC Resource Parents who were monolingual in Spanish or bilingual in English and Spanish. Spanish speaking youth are able to receive services in Spanish.	• ISFC agencies continued to recruit and train staff and Resource Parents to provide care and services to youth in Spanish.	

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
4) Family Preservation (FP): ICPM Trainings that incorporate the element of Cultural Humility Family Preservation 101	• Multiple ICPM trainings were offered to FP LACDMH staff this fiscal year. • The Family Preservation 101 training was provided to all of the LACDMH and Lead Agencies across all eight (8) Service Areas. This training incorporated the ICPM into the program. The in-home outreach counselors and clinicians were trained on the ICPM and the current policies and procedures of the Family Preservation program, highlighted cultural competence and provided service providers with strategies to strengthening cultural inclusion in the FP program. Trainings were held within each Service Area and were coordinated with the Service Area FP Liaison, the DCFS FP staff members, and the Community Based Organizations contracted by DCFS to provide services to FP. Typically, such training occurs four (4) to six (6) times per fiscal year.	• 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 was completed during each of the trainings and provided to the DCFS Family Preservation Program Monitors. Qualitative outcomes such as timely access to services, coordination and teaming conducted, strengths, and cultural considerations and humility are monitored during the FP survey visits conducted one (1) time a year at each LACDMH provider site.
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 LGBTQ+ populations.	• Providers shared information on topics such as developmental disabilities, CSEC, and LGBTQ populations and trainings available through their agencies or community partners.	
Routine announcements to agencies about available LACDMH trainings on cultural humility and those that incorporate cultural competency (e.g., Culturally Co-occurring Developmental Disabilities, Sensitive Practices, Commercial Sexual Exploitation of	• Agency staff attend trainings through this announcement process. • Clinical consultation has been provided to support improvement with culturally appropriate services (e.g., Co-occurring Developmental	

KATIE A.		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Children 101, LGBTQ+ TAY Safe and Welcoming Environment, and Substance Use/Dual Diagnosis) trainings	Disabilities, culture of family violence and substance abuse, gang culture).	
5) 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 was to incorporate a coordinated child and family team approach into service delivery and minimize psychiatric hospitalizations, placement disruptions, and out-of-home placements. This was achieved by engaging and assessing children and their families' strengths and underlying needs through a trauma informed lens and cultural awareness. Routine announcements to agencies about available LACDMH trainings on cultural humility and those that incorporate cultural competency (e.g., Culturally Co-occurring Developmental Disabilities, Sensitive Practices, Commercial Sexual Exploitation of Children 101, LGBTQ+ TAY Safe and Welcoming Environment, and Substance Use/Dual Diagnosis) trainings. 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 LGBTQ+ populations.	• The IFCCS program continued to provide culturally and linguistically competent services by ensuring that services were provided in the families' preferred language. Target populations were consistently met every fiscal year. • Several agencies offered specialized treatment services to meet the needs of special populations youth. • Agency staff attended trainings through this announcement process. • Clinical consultation was provided to support improvement with culturally appropriate services (e.g., Co-occurring Developmental Disabilities, culture of family violence and substance abuse, gang culture) • Providers shared information on topics such as developmental disabilities, CSEC, and LGBTQ populations and trainings available through their agencies or community partners.	• The Children's Intensive Service Review (CISR) process continued to be implemented to evaluate the IFCCS Program. The purpose of the evaluation process was to ensure that IFCCS staff are adhering to the principles of the Integrated Core Practice Model and consistently providing high quality mental health services to children and youth intensive needs. • The IFCCS providers were scored on the following performance indicators: Engagement, Teaming, Assessment and Understanding, and Intervention Adequacy. 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 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.

Maternal Mental Health (MMH)
This program provides specialized mental health services tailored to address the unique experiences that parenthood presents. MMH is designed to support families who may be currently pregnant, plan to become pregnant, or post-partum, typically up to a year after child birth. Services are tailored to meet specific cultural competency. For example, MMH has groups that target specific groups of women (i.e., African American support group, Teen Parent support group).

MMH has contributed to LACDMH's provision of culturally and linguistically competent services by providing services which are geared towards women, family units and individuals in reproductive age. MMH also provides services to underserved populations such as African American, Latino and Latinx, and LGBTQ+. Services are provided in all County threshold languages, with the most prevalent language being English and Spanish.

MMH is a community-based program and the goal is to have groups, services and events in the community to increase accessibility, decrease mental health stigma and encourage participant's willingness to engage in services. Services are provided in person and virtually to increase accessibility.

MATERNAL MENTAL HEALTH		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) The Village- African American (AA) Support Group	Implemented	Group attendance and self-tracking and monitoring number of consumers served. Monitoring with PHQ-9 and/or GAD-7
2) Operational Motherhood Support Group	Implemented	Group attendance and self-tracking and monitoring number of consumers served. Monitoring with PHQ-9 and/or GAD-7
3) Teen Parenting- Targets consumers between ages 18 and 21	Implemented	Group attendance and self-tracking and monitoring number of consumers served
4) Lactation Support for mothers	Implemented	Attendance to treatment and consumers ability to nurse or be comfortable with the outcome
5) Reproductive Psychiatry and Full Nurse Assessment and Screening for MMH	Implemented	Group attendance and self-tracking and monitoring number of consumers served. Monitoring PHQ-9 and/or GAD-7
6) Due to CDC recommendations for COVID-19, all MMH	Implemented	Implemented all groups and services via telehealth

MATERNAL MENTAL HEALTH		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
services became telehealth, outreached		
7) Miscarriage, stillborn and Infant Loss and Pregnancy after Loss	Planning Development	In planning phase
8) Maternal Health Training – To providers in all Service Areas	Implemented	Implemented several trainings on Maternal Health in various service areas and to several MH providers. Certificates provided to participants
9) Collaboration with Black Infant Health	Implemented	DMH provided four (4) presentations on maternal health to community providers and partners. Participants were able to increase knowledge about maternal health disparities in the African American community.
10) Collaboration with Antelope Valley (AV) African American Infant and Maternal Mortality (AAIMM) Community Action Teams (CAT)	Implemented	DMH supported six (6) events for AA women (i.e., Black baby shower, May is mental Health Month, Black Mother's Day in LA, Black Birthing Stories, outreach to community members etc.)

This space was intentionally left blank

CONSUMERS SERVED BY MME
FY 19-20

Program/Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
The Village- African American Support Group			48					48-50					English and Spanish
Operational Motherhood Support Group	11	4	27	45				86			1		English and Spanish
Teen Parenting Targets clients between ages 18-21 years old				6-8									English and Spanish
Lactation Support for mothers	2		1	2									English and Spanish
Reproductive Psychiatry Full Nurse Assessment and Screening for MMH	26		37	32									English and Spanish
Maternal Mental Health Trainings to Providers	29	7	28	17		3					3		English and Spanish
Collaboration with Black Infant Health			39							1	1		English and Spanish
Collaboration with AV AAIMM CAT			43								2		

My Health Los Angeles (MHLA) Behavioral Health Expansion Project

DHS developed the MHLA program in 2014 in response to a Board of Supervisors directive to fill a gap in health care access in Los Angeles County. MHLA participants receive primary medical care at contracted Community Partner (CP) clinics throughout Los Angeles County. They can also receive dental services at selected CP sites. When needed, participants receive specialty, inpatient, emergency and urgent care at Los Angeles County DHS facilities. To be eligible for MHLA, participants must be Los Angeles County residents, ages 26 and older, and not eligible for publicly-funded health care coverage programs such as full-scope Medi-Cal. MHLA participants must also have a household income at or below 138% Federal Poverty Level.

In 2015, planning began at LACDMH to partner with Federally Qualified Health Centers (FQHC) to provide early intervention/preventive mental health treatment to underserved, uninsured community members. Over time, and in response to the 2018 Board of Supervisors motion, the project shifted and LACDMH partnered with MHLA to add a new

mental health prevention benefit for participants. MHLA, LACDMH, the Community Clinic Association of Los Angeles County, and CPs collaborated to create the MHLA Mental Health Behavioral Health Expansion Project. This project is designed to help build protective factors and reduce risk factors associated with the onset of serious mental illness. Under the program, 52 CPs are responsible for screening MHLA participants and providing them with prevention services.

The Community Partner clinics responsible to deliver prevention services are embedded in the targeted communities, which is pertinent to providing culturally and linguistically competent services. Furthermore, the MHLA program has contributed to increasing access to mental health services and reducing disparities. DPH estimates that over 8% of County adults have depression and 11% are at risk for developing major depression. These conditions, when left untreated, can have a devastating impact on the consumers as well as on their family and friends. Yet, many of county residents who do not have Medi-Cal or other health insurance have very limited options to receive mental health services for lower-level acuity problems like depression and anxiety. Many of My Health LA members are dependent upon “charity” mental health care from community-based organizations. The County examines options for providing access to mental health services for My Health LA members and has taken great steps in the past several years to build on the Affordable Care Act and the Drug Medi-Cal Waiver in order to enhance the services for over four (4) million Medi-Cal beneficiaries. The MHLA Behavioral Health Expansion Project is a first effort by LACDMH to use MHSA Prevention funding to offer preventive mental health intervention to uninsured and underserved communities.

Jail Transition and Linkage Services

Jail Transition and Linkage Services 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. 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. These services aim to prevent release to the streets, thus alleviating the revolving door of incarceration and unnecessary emergency/acute psychiatric inpatient services. According to the outcomes data for FY 19-20, 2,555 consumers received the Jail Transition and Linkage Services.

Men’s Community Reintegration Program (MCRP)

The Men's Community Reintegration Program (MCRP) serves adult males ages 18 years and older, who are returning to the community after incarceration. The focal population is adult male consumers with moderate to high criminogenic risk factors, along with co-occurring disorders and other conditions, who are returning to the community, including men who conditionally-released to the program by the courts. MCRP uses an evidence-based model to identify the unique needs of this population and provide specialty behavioral health services aimed at addressing criminogenic risk factors that place consumers at risk for re-offending and recidivism.

MCRP has contributed to LACDMH's provision of culturally and linguistically competent services by increasing awareness and knowledge of the unique interventions needed to work effectively with this population. Additionally, frequent specialized trainings offerings develop the necessary skills of the MCRP staff to conduct assessments and provide effective treatment interventions.

In addition to providing specialty designed treatment services, MCRP staff engage in successful coordination with jail/prison staff, courts, probation/parole officers, and public defenders. Staff provide progress reports to court and must often transport and accompany consumers to court. To identify consumers most in need of the services offered by MCRP and who can be appropriately served by the program, MCRP staff use a structured, evidence-based assessment tool to identify criminogenic risk factors and the level of risk.

MEN'S COMMUNITY REINTEGRATION PROGRAM		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) COVID-19 Responsiveness: Services were transitioned to phone and videoconference (VSEE) platform so that consumers could continue being served during the pandemic, while optimizing safety for them and staff alike. • Consumers eligible to receive free phones through available programs were assisted with doing so. Consumers who could not utilize phone or video for services, or otherwise needed to be seen in-person, were still assisted with services in-person using Personal Protective Equipment (PPE) and observing physical distancing. • Consumers without PPE were provided with PPE for in-person contact, and clinic signage alerted visitors to the PPE and physical distancing guidelines.	Implemented	Implemented
2) Forensically focused trainings: These trainings focused on building skill set for clinical assessments and development of effective treatment for the forensic population	Implemented	Implemented

CONSUMERS SERVED BY MCRP
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
Men's Community Reintegration Program (7995)	37	11	89	75	2	3	45	M (245) F (17)	0	0	Unknown	0	English, Spanish, and Unknown

Women's Community Reintegration Program (WCRP)

The mission of the Women's Community Reintegration (WCRP) program is to empower women with hope, alternatives, and skills for a better tomorrow. The main goal is to assist women who have been incarcerated to reintegrate and become successful members of their communities. Women's Community Reintegration Program (WCRP) is a field-based program offered throughout Los Angeles County.

WCRP activities/projects increase access to mental health services by improving sensitivity and responsiveness to the target population they serve and fostering a deeper level of trust by consumers. Consumers feel safe with the WCRP staff and many consumers have been with WCRP for over seven (7) years. In addition, they continue to hire diverse staff with linguistic capabilities such as American Sign Language.

Six (6) Teams of the WCRP are mostly comprised of one Community Health Worker with lived experience, some with incarcerated lived experience; one to two (1-2) clinicians (licensed or waivered); and several medical caseworkers. WCRP is planning to address cultural and linguistic competent service delivery, reduction of disparities, access to mental health services by continuing Trauma Informed Care, LGBTQ+ trainings and consultations, along with mandatory implicit bias trainings annually.

The WCRP program has contributed to making services culturally and linguistically accessible to the communities by training staff to use effective communication skills during individual contact with consumers such as using open-ended questions vs. closed-ended questions, practicing social etiquette by researching the target population being served, avoiding slangs, speaking slowly, and keeping simple conversation.

WOMEN'S COMMUNITY REINTEGRATION PROGRAM		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Celebrating traditional national holidays, festivals, and food	On going	Positive feedback from staff and better understanding of consumer needs.
2) Understanding the unique needs of forensic population by visiting the jails	On going	Positive feedback from staff and better understanding of consumer needs.
3) Guest Speakers	Held during Community Meeting with consumers and staff in 2019.	Positive feedback from staff and better understanding of consumer needs.
4) Consultation with the LACDMH LGBTQ specialist.	On going	The LGBTQ specialist attends all staff general meetings twice a month. When clinicians need support to effectively serve LGBTQ consumers, they can consult with the specialist.
5) Acknowledgement of the Black History Month during all staff meetings	Completed	Two (2) times a month historical information was provided to all staff during meetings inclusive of fun quizzes with prizes. Games and prizes initiated to reflect on the history and historical figures each week of the month.

CONSUMERS SERVED BY WCRP
FY 19-20

Program /Activity	**# Consumers Served by Race/Ethnicity**							**Gender**					**Total**	**Languages used by Staff in service provision**
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	TOTAL	
WCRP	14%	3%	50%	22%	1.5%	1.2%		M (13%) F (86%)	.2%	.2%	.1%			English, Spanish, Russian, Portuguese, Korean, Armenian

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

One of the cornerstones of MHSA is to empower underrepresented ethnic populations. In June 2007, LACDMH established the Under Represented Ethnic Populations (UREP) to develop a stakeholder platform for historically underserved ethnic and cultural communities in Los Angeles County. Subcommittees were established to work closely with the various underrepresented/ underserved ethnic and cultural populations in order to address their individual needs. In 2017, the UREP became the Underserved Cultural Communities (UsCC) after the incorporation of two (2) additional subcommittees implemented by the Cultural Competency Unit (CCU) in collaboration with the Cultural Competency Committee (CCC).

UsCC Subcommittees include:

- Black and African Heritage
- American Indian/Alaska Native
- Asian Pacific Islander
- ACCESS for All (formerly known as Deaf, Hard of Hearing, Blind, and Physical Disabilities)
- Eastern European/Middle Eastern
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two-Spirit (LGBTQIA2-S)

Each UsCC subcommittee is allotted one-time funding totaling $200,000 per fiscal year to focus on CSS-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. Project proposals are created and submitted via a participatory and consensus-based approach.

Intended Outcomes:

- Increase mental health awareness to all communities within the Los Angeles County
- Identify and address disparities amongst target populations
- Reduce stigma discrimination by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contract providers

In FY 19-20, Service Area outreach staff attended multiple events with 58,375 participants. The population consisted of the community at large from UsCCs. Staff disseminated mental health information at job fairs, Veteran events, colleges, libraries, community events and activities at local senior centers

Observance of the COVID-19 physical distancing measures directly impacted the implementation of UsCC capacity building projects, which had to be completed utilizing different virtual platforms. An overview of each UsCC subcommittee's projects for FY 19-20 is provided in the following table.

UsCC	
Project	**Project Outcomes**
Black and African Heritage *Community Agents of Change Network Project* The purpose of the project was to spread mental health awareness, education, and community resources to African American community members who reside in SA 6 - South L.A. and SA 8 - South Bay. This project aimed to educate and empower the African American community about the importance of mental health care to build awareness and community connections by training community members to become Community Agents of Change Educators (CACE). Additionally, this project had a goal of increasing community member involvement in the LACDMH stakeholder process. This project involved two (2) components: 1) The facilitation of community stakeholder focus groups helped with the development of a culturally responsive outreach and engagement curriculum; the recruitment of community members and volunteers; and the training of community members who reside in SAs 6 and 8 to become CACE 2) CACEs conduct grassroots level community mental health presentations and/or one to one (1 to 1) outreach and engagement supportive activities.	Twelve (12) CACEs were trained to deliver community mental health presentations. • Twenty-two (22) community mental health presentations were successfully completed • 408 community members have been educated about basic mental health education and accessibility to services in Los Angeles County • Eight (8) additional community presentations were completed in the month of February 2021 • This project was completed on February 28, 2021

UsCC	
Project	**Project Outcomes**
African American Youth Community Ambassador Network Project The purpose of the project was to educate and empower Black youth about the importance of mental health care to build awareness and community connections. This project increased mental health awareness through educational workshops, the arts (dance, music, drama, poetry, etc.) and other outreach and engagement activities that are culturally sensitive to this community. This project targeted SA 1 African American youth ages 12-25. This project involved two (2) components: 1) The facilitation of community stakeholder focus groups that helped with the development of a culturally responsive outreach and engagement curriculum targeting African American youth ages 12 and older, as well as the recruitment of Black youth ages 18-25 years, who were trained to conduct the outreach and engagement activities 2) The trained African American presenters conducted grassroots level community mental health presentations through educational workshops, the arts and or other cultural relevant activities.	Seven (7) Black youth were recruited and trained to conduct virtual community mental health presentations. • Twenty (20) community mental health presentations were conducted by the youth • 273 Black youth, ages 12-25 participated in virtual community mental health presentations

UsCC	
Project	**Project Outcomes**

American Indian/Alaska Native (AI/AN)
 	
AI/AN Community Symposiums Project
The purpose of the Community Symposiums project was to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing.
 	
Attendees of the Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by community members. In total, five (5) symposiums were held on the following dates:
• 2019 – Sept 28, Oct 12, Nov 9
• 2020 – Jan 11, Feb 8
 	
Symposium topics included:
• Traditional ways of healing
• Indigenous education
• Art and music as medicine
• Suicide prevention and harm reduction
• Historical trauma to intergenerational resilience
	A total of 339 participants attended the Community Symposiums.
	• Two hundred (200) pre/posts tests were conducted and collected
	• Overall, participants reported an increase in knowledge from the pre-test to the post-test regarding:
	  ○ The mental health challenges experienced by the AI/AN community (15.75% increase)
	  ○ Traditional forms of healing for this population (10% increase)
	• This project was completed on April 30, 2020.

UsCC	
Project	**Project Outcomes**

AI/AN Educational Public Service Announcement (PSA) Project
A media consultant was contracted to produce five (5) 60-second PSAs.
 	
• The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting)
 	
• Production/filming
 	
• Post-production (editing, voice-over, and delivery)
	A total of five (5) PSAs were developed:
	• The consultant conducted focus groups with AI/AN community members to determine the subject matter of the PSAs
	
	• The five (5) PSAs covered the following topics:
	  ○ AI/AN UsCC subcommittee (75-seconds)
	  ○ American Indian Counseling Center (30-seconds)
	  ○ The Dark Cave (75-seconds)
	  ○ Trust Umbrella (60-seconds)
	  ○ The Invisible Man (105-seconds)
	
	• All five (5) PSAs were uploaded to the LACDMH website and YouTube pages and are being used as a tool to promote mental health education and services accessibility targeting the AI/AN community
	
	• This project was completed on May 31, 2020.

UsCC	
Project	**Project Outcomes**

AI/AN Video Showcase Project
A media consultant was contracted to produce a Video Showcase project that included two (2) videos:
 	
• The first video was a 12-minute video highlighting the American Indian Counseling Center (AICC), a LACDMH Directly-Operated clinic providing services to the AI/AN community
 	
• This video was developed with the intent to be played in the clinic and to provide viewers with information on
  ○ How to access services
  ○ What the process of accessing services may involve
  ○ What services can be provided including intake, case management, medication management, substance abuse counseling, housing resources, etc.
 	
• The second video was a five (5)-minute video highlighting AICC, as well as other providers serving the AI/AN community
 	
• This video was developed with the intent to be played on social media platforms
  ○ The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting)
  ○ Production/filming
  ○ Post-production (editing, voice-over, and delivery)
	The consultant partnered with AI/AN community members to develop the concepts for the two (2) videos and attended AI/AN gatherings to capture additional footage.
	
	• Upon completion, both videos were uploaded to the LACDMH website and YouTube pages and is being used as a tool to promote mental health education and services accessibility targeting the AI/AN community
	
	• This project was completed on February 28, 2020

UsCC	
Project	**Project Outcomes**

AI/AN Mental Health Conference
One of the recommendations of the AI/AN UsCC subcommittee was to plan and coordinate the 2019 AI/AN Native Mental Health Conference: "Native Health & Resilience." The conference took place on November 12, 2019.
 	
• The goals of the conference included:
  ○ Inform participants of mental health issues unique to the AI/AN community
  ○ Improve participants' ability to recognize when to refer an AI/AN community member for mental health services
  ○ Provide participants with useful information on available mental health resources for AI/AN community members
  ○ Improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers
 	
• A survey was handed out to all participants at the start of the conference
 	
• A total of 97 completed surveys were received from the 207 individuals who attended the conference
	A total of 97 completed surveys were received from the 207 individuals who attended the conference.
	
	The feedback revealed:
	
	• 96% agreed or strongly agreed that the conference made them more aware about the mental health issues unique to the AI/AN community
	
	• 78% agreed or strongly agreed that the conference improved their ability to recognize when to refer an AI/AN community member for mental health services
	
	• 92% agreed or strongly agreed that they received useful information on mental health resources for AI/AN community members
	
	• 85% agreed or strongly agreed that the conference improved their ability to provide culturally appropriate mental health treatment to AI/AN consumers

UsCC	
Project	**Project Outcomes**
Asian Pacific Islander (API) *API Families – Supporting through Recovery* This project aimed to increase awareness about mental health related struggles that API consumers and their family members experience to decrease mental health related stigma and encourage early access of services. • The overarching goal of this project was to develop a Mental Health Informational Booklet specifically designed for API family members and friends to understand the scope of mental illness, address their fears and questions, and offer suggestions on how to care for and assist their loved ones • The booklet, was developed with input gathered from focus groups with API family members, API support groups and mental health providers who serve the API community were conducted • The goal was to better understand the challenges and identify effective strategies to help support and guide API family members in their efforts to support themselves and their loved one who is suffering from mental illness • Once developed, the booklet was translated into five (5) API languages (specifically Khmer, Simplified Chinese, Korean, Tagalog, and Vietnamese) and distributed to clinics and community-based agencies that serve API consumers and family members.	• Eleven (11) focus groups were conducted to gather qualitative and quantitative data to develop the API Mental Health Informational Booklet • Eighty-three (83) community members participated in the focus groups • Participants consisted of family members and providers who spoke different API languages and represented different API groups • Due to physical distance guidelines, the completion of this project was delayed. This project was completed February 28, 2021 • The completed API Mental Health Informational Booklet was released in spring 2021. Copies of the booklet were printed and distributed among community members. It was made available digitally to all community non-profit organizations countywide that serve the API community

UsCC	
Project	**Project Outcomes**
API – Sharing Tea, Sharing Hope This project aimed to increase awareness about mental health to decrease mental health related stigma and encourage early access of services within the API community. • The focus of this project was to conduct mental health outreach to the API community using a mobile teacart service, and/or online virtual tea salons via Zoom • Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various outreach events with the goal of engaging them in discussions about mental health and providing information on mental health issues and services • Through sharing of tea, the goal was to create a space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma and gaps in mental health service delivery in the various API communities • The following API communities were targeted for this project: o Cambodian (Khmer) o Chinese (Mandarin or Cantonese) o Filipino (Tagalog) o Vietnamese o Korean • The outreach events focused on areas across the County with large concentrations of API community members	• Five (5) community members were trained to become "Community Listeners." • Once trained, the Community Listeners were required to conduct the community mental health presentations targeting five (5) different API groups • Ten (10) community mental health presentations were completed • Eight (8) out of ten (10) presentations were conducted using a virtual platform due to the COVID-19 social distance guidelines • This project is still in process and outcomes will be shared once completed

UsCC	
Project	**Project Outcomes**
ACCESS for All (formerly known as Deaf, Hard of Hearing, Blind, and Physical Disabilities) *PSA Development Project* This project consisted of collaborating with a media consultant to develop the concept and produce a 30-second PSA targeting the Deaf, Hard of Hearing, Blind, Physically Disabled communities throughout the County. The goal of the PSA was to promote mental health services, increase awareness, reduce stigma, and increase the capacity of public mental health system.	The 30-second PSA was developed in collaboration with community members, cultural brokers, and individuals with lived-experience. • Members of the ACCESS for All subcommittee were showcased in the PSA to increase mental health awareness
Deaf, Hard of Hearing, Blind, and Physical Disabilities Peer-to-Peer Network The Peer-to-Peer Network Project aimed to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community members into advocacy and activism around mental health issues that are affecting their community. • Community members with lived experience were trained to become Community Advocates and Activists around issues related to mental health • They were given the responsibility to conduct community presentations regarding mental health and mental health resources	Twenty-six (26) community members were trained to become Mental Health Advocates and Activists. Due to the pandemic, twenty-three (23) members dropped out of the project and only three (3) were available for the virtually community presentations. As a result, the trainer and one (1) community member facilitated the presentation. • Eleven (11) virtual community presentations were conducted • Due to physical distance guidelines and issues related to accessibility to internet services and devices, only twenty-eight (28) community members participated

UsCC	
Project	**Project Outcomes**
Deaf, Hard of Hearing, Blind, and Physical Disabilities Clinical Mental Health Training A mental health training specifically addressing the mental health needs and treatment modalities pertaining to the Deaf, Hard of Hearing, Blind, and Physically disabled community was made available for licensed clinical staff at LACDMH Directly-Operated clinics and Contracted providers. • This project aimed to provide mental health clinicians with an opportunity to be trained on identifying and treating the unique mental health needs and challenges faced by this community • The consultant was responsible for developing the training curriculum and facilitating the one-day clinical trainings that were conducted using a virtual platform due to social distance guidelines	Focus groups were conducted to develop the curriculum for the Clinical Mental Health training. • Seven (7) Clinical Mental Health trainings have been conducted • Two (2) trainings were done in-person • Five (5) were conducted using a virtual platform due to social distance guidelines • This project is still in process and outcomes will be shared once completed

UsCC	
Project	**Project Outcomes**

Eastern European/Middle Eastern
 	
Parenting Seminars for the Arabic Speaking Community Project
The project was designed to increase knowledge about effective parenting practices and accessibility to mental health services for Arabic speaking community members.
 	
• Twelve (12) parenting seminars were conducted at different locations countywide
 	
The goal of the project was to conduct the parenting seminars, and to provide mental health linkage and referral information pertaining to the services offered by LACDMH.
	Twelve (12) parenting seminars were conducted countywide.
	• One hundred eighty-one (181) community members participated in the parenting seminars
	• The pre and post survey indicated that the participants in the Parenting seminars reported:
	  ○ 90% of respondents gained a greater understanding of the signs and symptoms of mental illnesses
	  ○ 95% of respondents gained a solid understanding of how to seek mental health services from LACDMH
	
	• Qualitative feedback received from participants suggests success in the intended program outcomes
	• It was clear that these services made a tangible difference at many locations, evidenced by the desire of the community to sustain services not previously offered or sustained and to expand them with other psychoeducational opportunities and classes
	• Utilizing and implementing culturally competent promotion/prevention and treatment/intervention education at various seminar locations such as mosques, Muslim Community Organizations, universities, etc. Community members, who did not share their personal challenges previously, participate in both community wellness programs (promotion/prevention) and consumer counseling services (treatment/intervention)

UsCC	
Project	**Project Outcomes**
The Armenian Mental Health Show Project The Armenian Mental Health Television Show was developed to help increase knowledge and awareness about mental health issues and treatment modalities and services available for the Armenian community. The local Armenian-Russian Television Network (ARTN) was contracted to produce, direct, host and broadcast the weekly mental health show in the Armenian language.	Thirty-four (34) half-hour (1/2 Hour) episodes presenting various mental health topics were produced and aired on ARTN from June to September 2019. • There are more than 200,000 Armenians who reside in Southern California who were given the opportunity to learn about mental illness and how it affects their community from the comfort of their own home • The show focused on educating the Armenian community about various mental health conditions, therapeutic modalities, and services accessibility in the County • Based on the TV ratings, the mental health show had great success within the Armenian community • Based on the feedback provided by viewers, Armenian community members felt that the show was engaging, culturally relevant, and overall, it increased their knowledge about mental health issues, available resources, and helped to decrease mental health stigma • The qualitative data demonstrated that there is an increase in community awareness and education pertaining to mental illness and services that are offered by LACDMH

UsCC	
Project	**Project Outcomes**

The Russian and Farsi Speaking Mental Health Theatrical Performances Project
This project was developed for the purpose of increasing mental health access and reducing disparities for the Russian and Farsi speaking communities.
 	
A local non-profit organization specializing in serving the Farsi and Russian communities was contracted to develop and implement a theatrical play with an emphasis on mental health.
 	
The goal of this project included:
• To increase mental health awareness and education among the targeted cultural groups
• To promote mental health services that are offered by LACDMH
	• A Table Read and a Virtual Play replaced the live theatrical performances as a result of the pandemic
	• It was conducted a total of eight (8) times using a virtual platform
	• It aired in three different languages:
	  ○ English
	  ○ Farsi
	  ○ Russian
	• Over 100 community members participated
	• The pre and post surveys demonstrated that there was a significant shift in the participants' beliefs and knowledge about mental health issues
	• The qualitative feedback demonstrated that community members' perception about mental health was changed and they became more open to talk about this "highly stigmatized" topic

UsCC	
Project	**Project Outcomes**

Latino
 	
The Latino Comic Book Project – Cómics Que Curan (Comics that Heal)
The Latino Comic Book Project was developed to engage Latino Transition Age Youth (TAY) in a dialogue about mental health awareness and education.
• Latino TAY, ages 16-25 were recruited countywide to participate in creating their own 2-page comic about their mental health struggles and experiences
• At the start of the project, they were provided with education about mental health issues and resources and were introduced to the art of comic book writing. The youth were provided with training and technical assistance during the writing-process and once completed; the comics were then complied into an anthology featuring the 2-page comics of each participating youth
• The overarching goal of this project was to display stories written by Latino Youth in a Comic book. The comic book was used as an outreach tool to educate the community about the mental health issues that Latino youth are experiencing and initiate a community dialogue about their mental health needs and the services that they need
• Due to social distance guidelines, a virtual community culmination event was conducted, which included using Eventbrite as the digital registration platform for event attendees, and Google Meet as the web-based platform for individuals to view the unveiling of the artwork installation on the two (2) aforementioned bus shelters, the display of all published comics featured in both "Comics que Curan" anthology (Volume 1), and a Question and Answer (Q&A) session with all of the workshop participants
	• Twelve (12) Latino TAY participated in this project
	• Eleven (11) short stories were featured in the Comic Book
	• Forty (40) community members participated in the virtual culmination/award ceremony. The community event was done virtually, which affected the number of community members who participated
	• Seventeen (17) pre and post surveys were submitted, and the feedback demonstrated the following:
	  ○ The majority of the participants recommended the implementation of similar programs/projects to be continually offered for underserved communities
	  ○ The majority of the Latino TAY Youth who participated in the project reported that the workshop series allowed them to be open and speak up about their mental health struggles and that it would also help adults around them better understand their experience of mental illness and struggles without feeling ashamed
	  ○ All survey respondents reported having a better understanding of mental illness affecting Latino youth and mental health in general

UsCC	
Project	**Project Outcomes**

The Latino Mental Health Stigma Reduction Community Theater Project - "De Sabios y Locos Todos Tenemos un Poco"
 	
This project was developed to increase awareness and education about mental health issues in the Latino community. Through this theatrical play, the community gained an inside look into the world of those who suffer from a mental health condition.
 	
In addition, the Latino community was educated on how to access mental health services and understand some of the cultural biases associated with suffering from a mental health condition. The play was conducted in the Spanish language.
	Sixteen (16) theatrical presentations were conducted in all Service Areas countywide.
	• Three (3) presentations were delivered in-person at local churches and parks
	• The vendor transitioned the remaining thirteen (13) in-person theatrical plays into virtual platform
	• At the end of each theatrical presentation, there was a 30-minute live Q&A segment led by Dr. Ana Nogales, who is a well-known Spanish speaking Clinical Psychologist in the Los Angeles area:
	  ○ On the average, twenty (20) community members engaged in the Q&A segment
	  ○ This effort created an opportunity to educate the community and decrease mental health stigma
	• More than 280 community members have attended either the in-person or virtual theatrical play
	• This project was completed February 28, 2021.

UsCC	
Project	**Project Outcomes**
Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two-Spirit (LGBTQI2-S) *LGBTQIA2-S Indigenous Pride LA Project* The purpose of the Indigenous Pride L.A.: Voices to Faces project was to spread cultural awareness and education of healing practices that positively affect mental health among the Two-Spirit community. • The project aimed to destigmatize mental health issues among Two-Spirit people by highlighting the diversity of the population and the need for culturally sensitive resources • The consultant recruited six (6) Two-Spirit community members into a Community Collaborative to discuss mental health and identify the specific needs of the Two-Spirit community • Following the Community Collaborative, the consultant developed a curriculum to be utilized during five (5) Health and Wellness Workshops	• The consultant transitioned the Community Collaborative meetings to a virtual platform and conducted six (6) meetings of the Community Collaborative via Zoom during June and July 2020 • The curriculum was finalized, and the Health and Wellness Workshops were completed January 30, 2021 and February 6, 2021.

UsCC	
Project	**Project Outcomes**
LGBTQIA2-S Black LGBTQ+ Network Project The purpose of the Black LGBTQ+ Network Project was to identify the needs of Black LGBTQ+ individuals, while educating and empowering this community about the importance of mental health care to build awareness and connection. • This project aimed to destigmatize mental health issues among Black LGBTQ+ people by highlighting the diversity of the population and the need for culturally sensitive resources. • The consultant recruited twelve (12) community members into a Community Collaborative to develop a survey to be administered to Black LGBTQ+ people to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. • Survey results were compiled to produce a White Paper to address the mental health needs of the Black LGBTQ+ community and provide recommendations as to how LACDMH can engage this population as part of the MHSA stakeholder process, as well as incorporate services to target this population.	• The consultant transitioned the Community Collaborative meetings to a virtual platform and conducted eight (8) meetings of the Community Collaborative as of December 31, 2020 • In total, 150 surveys were collected with the goal of 250 surveys

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 SAs
- 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

The following table shows the examples of O & E activities across all eight (8) SAs for FY 19-20.

O & E SAMPLE ACTIVITIES
ACROSS ALL EIGHT (8) SERVICE AREAS

SERVICE AREA 1		
Month-CY	**Event**	**Number of Participants**
Jul-19	Vendorization Outreach & Engagement (Oasis, Holiday Inn, Palmdale Country club, elegant affairs, oxford inn, & Spring Hill Suites)	9
Jul-19	Parks After Dark (PAD) - George Lane Park	100
Jul-19	Clergy Roundtable Meeting for Faith Based Community	15
Aug-19	L.A CARE Back to School Event	1,259
Aug-19	Total deliverance Church Back to School	250
Aug-19	Connect Day	55
Aug-19	Sage Middle School Back to School Event	2,000
Aug-19	Veterans " Stand Down" Event	120
Aug-19	San Joaquin Valley College Resource Event	108
Sep-19	Antelope Valley Youth Build	100
Sep-19	TAYstock	100
Sep-19	Senior Network Event	120
Oct-19	Antelope Valley Community Resource Event	2,000
Oct-19	Desert Vineyard H.O.P.E Event	42
Nov-19	Making Appropriate Choices Suicide Prevention Presentation	500
Nov-19	DCFS- Palmdale Meeting Faith Based	15
Dec-19	Antelope Valley Connect Day	40
Dec-19	Tri-Valley Adoption/Foster Meeting	15
Jan-20	Antelope Valley YouthBuild	75
Jan-20	DCFS Community Faith Based Meeting	25
Jan-20	Snow Daze Event	120
Feb-20	AVPH Community Event	45
Feb-20	Clergy Roundtable Meeting for Faith Based Community	37
Feb-20	Uplift youth Event	75

Feb-20	The Source Event	25
Feb-20	The HOPE Church/"Talking to Myself" for Faith Based Community	50
Mar-20	Connect Day	30
Apr-20	Av Senior Center Event	5
Apr-20	DCSF Collaborations	22
Apr-20	W.E.D.O. (Children Center of Antelope Valley)	27
Apr-20	Terra Mobile Home Park Event	100
May-20	Various Faith-based organizations	17
May-20	Wellness Drive-thru giveaway event	250
Jun-20	Health Neighborhoods	50
Jun-20	AV Child and Family Wellbeing Event	37
Jun-20	Virtual Resource Fairs	137
Jun-20	Suicide Prevention 101	35
Jun-20	Clergy Round Table	10
SERVICE AREA 2		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Olive View Expansion Community meeting	60
Jul-19	Calvary Baptists Church Mental Health Awareness Event	30
Jul-19	Health Neighborhood	26
Jul-19	Clergy Roundtable	8
Aug-19	National Night Out with San Fernando Police Department	300
Aug-19	Wat Thai Temple Health Fair	100
Aug-19	Healing Through Arts Event	20
Aug-19	Panorama City Best Start meeting	45
Aug-19	Mental Health and Faith Symposium Event	80
Sep-19	Resource Booth at Grant High School	80
Sep-19	Community Health and Safety Resource Fair	150
Sep-19	COC Homecoming Event	100

Oct-19	Power 106 Radio Station Event at Burbank High School	100
Oct-19	FundaMental Change - Mental Health and Immigration Community Event	17
Nov-19	Panorama High School Día De Los Muertos Event Booth	100
Nov-19	Providence Health Ministry	18
Nov-19	San Fernando Valley Thanksgiving Event	400
Dec-19	Community Event at San Fernando Valley Refugee Children Center	125
Jan-20	El Nido's Alliance United Meeting	35
Jan-20	Vida y Salud Community Event	80
Feb-20	Trauma Informed Learning Resource Fair	56
Feb-20	Healing Through Arts Event	25
Mar-20	SA2 Clergy Luncheon	60
Apr-20	Santa Clarita Valley Suicide Prevention Meeting	19
May-20	Northeast Valley Best Start Community Meeting (virtual)	45
SERVICE AREA 3		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Parks After Dark-Pamela Park	17
Jul-19	Back to School Stay in School Resource Fair	39
Jul-19	SGV Faith Based Breakfast	43
Jul-19	West Covina Library (multiple monthly visits)	6
Jul-19	SPIRITT: School is Cool Event	39
Aug-19	Rowland Heights Night Out Event	53
Aug-19	Azusa Care's Cyber Bullying Seminar	31
Sep-19	2019 Los Angeles County Day Expo	118
Sep-19	3D Family Jam	331
Sep-19	Power 106 Event at Citrus College	32
Sep-19	Rosemead Adult School Resource Fair	25
Sep-19	49 AD's Emergency Preparedness Resource Fair	74
Oct-19	A Day Without Hunger	62

Oct-19	Power 106 Event at Pasadena City College	51
Oct-19	SA3 Interfaith Roundtable	10
Oct-19	25th Annual Asian American Mental Health Conference	89
Oct-19	Latino Heritage Month at Azusa City Library	25
Oct-19	2019 El Monte Community Alliance at Mountain View High School Event	146
Oct-19	MILES Conference Booth	118
Oct-19	Adelante Young Men's Conference	82
Nov-19	Human Trafficking Awareness Event	133
Nov-19	Harvest Feast	6
Dec-19	Parks After Dark at Valley Dale Park	57
Dec-19	Rimgrove Park Event	110
Dec-19	Steinmetz Park Hacienda Heights	63
Jan-20	HIV Health Fair Valley Dale	8
Jan-20	Planned Parent Hood Open House	12
Feb-20	Basset Park Winter Shelter	5
Feb-20	San Gabriel Valley Town Hall: Get Facts on the Novel Virus	25
Feb-20	West Covina Library Hosting of Coffee and Conversation	46
SERVICE AREA 4		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Interfaith Clergy Meeting	10
Jul-19	Health Neighborhood	18
Jul-19	Service Area Leadership Team (SALT) 4 / Town Hall	250
Aug-19	Boyle Heights Health Neighborhood – Immigration Outreach Know Your Rights presentation at Garcia Park	135
Sep-19	Roosevelt High School Outreach Event	62
Sep-19	Marshall High School Outreach Event	75
Oct-19	National Alliance on Mental Illness (NAMI) Walk	434
Oct-19	LACC Community Resource and Job Fair	186
Oct-19	Cal-State Los Angeles Wellness Fair	124

Oct-19	KTOWN HOPE Anti Bullying Resource Fair	53
Nov-19	Care Harbor Outreach Event	152
Nov-19	Young Nak Church Wellness Fair	155
Nov-19	SOURCE Event at Edendale Library	25
Dec-19	Day of Giving Event SA4	266
Dec-19	Las Manañitas at Olvera Street	250
Dec-19	LACC Community Resource and Job Fair	62
Jan-20	Ketchum YMCA Downtown Investing in Youth Fair	31
Feb-20	SOURCE Event at Edendale Library	42
Feb-20	Esperanza Immigrant Rights Project Community Fair	51
Feb-20	Midtown Connect Day Event	11
Feb-20	SOURCE Event at Los Angeles Central Library	54
Mar-20	Kidneys Quest Foundation O&E event	51
Mar-20	Self Help Graphics Wellness Event	11
SERVICE AREA 5		
Month-CY	**Description/Name**	**Number of Participants**
Jul-19	SALT Meeting	40
Jul-19	Health Neighborhood/Faith Based	20
Jul-19	Library O&E	5
Jul-19	Mar-Vista Gardens Outreach	9
Aug-19	Peoples First Aid	18
Oct-19	SA 5 All Faith Quarterly Breakfast	25
Oct-19	Venice High School Event	70
Oct-19	West Los Angeles College	45
Nov-19	Thanksgiving Dinner at Mar-Vista Public Housing	35
Jan-20	Westside Mental Health Network	15
Jan-20	Consumers: Social Skill Building at Edelman Adult Clinic	35
Jan-20	Service Area 5 Town Hall	300

Feb-20	Supporting Consumers with Eating Disorders	35
SERVICE AREA 6		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Summer Night Lights - Green Meadows	37
Jul-19	Compton Pride Festival	99
Jul-19	Summer Night Lights - Ross Snyder	122
Jul-19	Summer Night Lights - 109th Recreational Center	29
Jul-19	Parks After Dark - Ted Watkins Memorial Park	132
Jul-19	Teen Talk at Healing Center	10
Jul-19	Summer Night Lights - A. Sutton	27
Jul-19	Parks After Dark - Athens Park	54
Jul-19	Symposium Building Bridges for Youth Wellbeing	58
Jul-19	Dodgers RBI - Athens Park	172
Aug-19	14th Annual Back to School	353
Aug-19	Summer Night Lights - Van Ness	56
Aug-19	Community resource and Fellowship Event	45
Aug-19	Annual Reproductive Justice Event	52
Aug-19	Animo Mae Jemison Middle School Back to School	117
Aug-19	Community Block Part and Resource Fair	86
Sep-19	Back to School Night at George Washington Prep.	29
Sep-19	Disaster Preparedness Fair	102
Sep-19	Fall Friday Nights at Green Meadows Recreation Ctr.	82
Sep-19	Community Resource Fair at Tessie Cleveland	161
Sep-19	Animo Mae Jemison Middle School Fall Carnival	44
Sep-19	Fall Friday Nights at 109th St. Recreation Center	66
Oct-19	Taste of Soul	428
Oct-19	Mental Health Awareness Week “Purpose is Power Fall Campus Tour 2019 at Compton College	38
Oct-19	Mental Health Awareness Week “Purpose is Power Fall Campus Tour Crenshaw High	50

Oct-19	Our annual High School Night at Ánimo Mae Jemison Charter Middle School	46
Nov-19	Purpose is Power HS& CC Tour 2019_O&E: Dorsey High School	167
Nov-19	Plan, Purpose, and Pursue" to help a younger generation of men to become	103
Nov-19	LA Care Harbor Event /Three-day event	900+
Nov-19	27th Annual Thanksgiving Dinner Celebration" at His Sheltering Arms	83
Dec-19	Angel City Health Celebration and Resource Fair/Fun	587
Jan-20	28th Annual Empowerment Congress Summit	123
Jan-20	Breaking the Chains Community Festival	165
Mar-20	SLA Health Neighborhood Meeting	22
SERVICE AREA 7		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Health Neighborhoods	11
Jul-19	Clergy Roundtable	10
Jul-19	Parks After Dark - City Terrace	40
Jul-19	Parks After Dark - Obregon	100
Jul-19	Parks After Dark - Adventure	15
Jul-19	Holydale Library Reopening	150
Jul-19	Parks After Dark - Sorensen	30
Jul-19	Parks After Dark - Saybrook	100
Aug-19	Parks After Dark - Salazar	120
Aug-19	Parks After Dark - Amigo Park	70
Aug-19	Walnut Park Nature Park	120
Aug-19	National Night Out City of Norwalk	100
Aug-19	YMCA Maywood Back to School	80
Aug-19	Linda Sanchez Senior Fair	50
Aug-19	Landlord/Tenant's rights Workshop	45
Sep-19	Cerritos College Resource Event	55

Sep-19	Resource Fair Back to School	45
Sep-19	Southgate Career Expo	55
Sep-19	La Mirada Senior Center	75
Sep-19	CASA Youth Build	50
Oct-19	CONNECT Event Downey New Hope Christian Center	55
Oct-19	Family Health Center Bell Gardens Breast Cancer Awareness	25
Oct-19	Power 106 Family Fair	200
Oct-19	Service Area 7 Town Hall	300
Oct-19	Norwalk High School Outreach Event	180
Nov-19	City of Bell Health Fair	50
Nov-19	Hilda Solis Turkey Giveaway	50
Nov-19	South Gate Día de los Muertos Celebration	250
Nov-19	Hamasaki Health Resource Fair	65
Dec-19	Winter Wonder Land-Walnut Park	80
Dec-19	Winter Wonder Land - Whittier	110
Dec-19	Winter Wonder Land - City Terrace	40
Jan-20	SOURCE day East L.A Library	25
SERVICE AREA 8		
Month-CY	**Name of Event**	**Number of Participants**
Jul-19	Community Events (3)	450
Jul-19	Park Events (7)	521
Jul-19	Clergy Meeting	35
Jul-19	Dodger Event	200
Aug-19	Park Event	40
Aug-19	Resource Fairs (4)	470
Aug-19	Dodger Day	250
Aug-19	Power 106 Radio Station Event	50
Sep-19	Resource Fairs (5)	520

Sep-19	St. Gregory's Episcopal Church Christmas	10
Sep-19	Pastor's in Inglewood Christmas	10
Oct-19	Women's Health Conference	200
Oct-19	City of Long Beach Resource Fair	150
Oct-19	College Medical Center Presentation	25
Nov-19	Harbor Regional Center Resource Event	150
Nov-19	Health Fair	200
Nov-19	LA Care Family Resource Center	200
Nov-19	SBCC Collaboration	75
Nov-19	St. Gregory's Episcopal Church Turkey Giveaway	69
Feb-20	CCEJ 29th Annual Interfaith Intercultural Breakfast	200
Feb-20	Black Men Health Fair/ Resource Fair	150
Mar-20	Long Beach Unity Festival	200

Prevention and Early Intervention

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

- Prevention
- Early Intervention
- Stigma and Discrimination Reduction
- Suicide Prevention

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 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 to:

- Raise 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
- Build organizational and community capacity to promote wellbeing and resiliency and to recognize and respond to trauma and mental health needs
- Build bridges to mental health care when it is requested
- Ensure that requested services are being delivered and achieving intended impact.

CONSUMERS SERVED THROUGH PEI
FY 19-20

PREVENTION AND EARLY INTERVENTION	
Consumers Served	**New Consumers Served**
47,602 consumers received a direct mental health service: • 65% of the consumers are children • 19% of the consumers are TAY • 45% of the consumers are Latino • 9% of the consumers are African American • 8% of the consumers are White • 2% of the consumers are Asian • 74% have a primary language of English • 22% have a primary language of Spanish	26,381 new consumers receiving PEI services countywide: with no previous MHSA service • 44% of the new consumers are Latino • 8% of the new consumers are African American • 8% of the new consumers are White • 74% have a primary language of English • 22% have a primary language of Spanish

CONSUMERS SERVED THROUGH PEI BY SERVICE AREA
FY 19-20

Service Area (SA)	Number of Consumers Served	Number of New Consumers Served
SA 1	3,410	2,990
SA 2	7,596	5,840
SA 3	8,494	6,414
SA 4	6,329	5.388
SA 5	1,828	1,685
SA 6	6,049	5,163
SA 7	6,720	5,892
SA 8	7,923	6,846

Prevention Early Intervention (Older Adults)
The Older Adult population in Los Angeles County is ethnically and racially diverse. It is estimated that by 2030 the Older Adult population, ages 60 and older, will increase to about 3 million. LACDMH has a well-established Prevention & Early Intervention for Older Adults, which includes the Anti-Stigma & Discrimination (ASD) team. The program's aim is to increase awareness of mental health and wellness for Older Adults, particularly in underserved and underrepresented communities. To promote healthy aging communities, it is imperative to increase quality of life by addressing the physical health and mental health needs of Older Adults. Keeping this in mind, the

ASD created the Older Adult Mental Wellness Series as an outreach and engagement strategy that is culturally sensitive and linguistically appropriate. This series encompasses psycho-educational presentations related to mental wellbeing.

To address cultural competence, reduce linguistic barriers, and improve access to care for Older Adults, these presentations have been translated and delivered in various threshold languages. For example, these presentations have been translated and offered in Spanish and Farsi to address the needs of the Spanish-speaking and Farsi-speaking community. In addition, to accommodate and address the language needs of the API community in delivering these presentations, ASD staff collaborated with Special Services for Groups SILVER, which is a division of Special Services for Groups (SSG) for Older Adults, to deliver the presentations in requested API languages.

Due to the COVID-19 pandemic demands such as physical distancing, self-quarantine, closure of senior centers, public gathering restrictions, limited access to community rooms at senior housing facilities, and other safety related factors, these presentations were pivoted and limited to virtual platforms (e.g., MS TEAMS and Zoom) during the last quarter of FY 19-20. Despite these challenges, the Older Adult Anti Stigma and Discrimination Team participated in 212 events and outreached to more than 2,639 County residents. Staff outreached to Senior Centers, Senior Housing Facilities, Faith-Based Organizations, and other agencies to provide Older Adults-focused presentations which were delivered with cultural sensitivity in English, Spanish, Farsi, ASL, Korean, Russian, and Mandarin.

PREVENTION EARLY INTERVENTION (OLDER ADULTS)		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Community Presentations: These community presentations were presented in the following languages: English; ASL; Spanish; Korean; Farsi; Mandarin; Russian Presentations at Various Settings: Community Centers; Senior Centers; Senior Housing; Other (Library, Church, City Hall); Resource Fairs and Meet and Greet Events	Topics of Presentations: Bullying; Depression and Anxiety; Good Sleep; Grief and Loss; Health, Wellness and Wholeness; Healthy Aging Bingo; Hoarding; Holiday Blues; Isolation; Late Life Transitions; Medication Management; Preserving Your Memory; Resiliency; Elder Financial Exploitation: Impact on Mental Health; Stress Management; Substance Use;	<u>Countywide Presentations:</u> SA1: 4 SA5: 13 SA2: 47 SA6: 38 SA3: 6 SA7: 36 SA4: 38 SA8: 30

PREVENTION EARLY INTERVENTION (OLDER ADULTS)		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	Emotional Intelligence; Mindfulness and Meditation	

ANTI STIGMA AND DISCRIMINATION PRESENTATIONS BY SERVICE AREA FY 19-20

Service Area (SA)	Location	Number of Presentations
SA 1	Antelope Valley	4
SA 2	San Fernando Valley	47
SA 3	San Gabriel Valley	6
SA 4	LA Metro Area	38
SA 5	West LA Area	13
SA 6	South LA Area	38
SA 7	East LA Area	36
SA 8	South Bay Area	30

The staff is racially/ethnically diverse (African American, Latino, Persian and Caucasian) and represents different age groups. Collectively, they amount to a significant range of cultural expertise. The program's plans for service delivery include the following:

a) Outreach and engagement efforts through community presentations, resource fairs, and meet-and-greet events
b) Roll-out the "Good Balance" a newly-developed presentation
c) Develop more presentation topics related to Older Adults
d) Enhance the virtual platform presentations and, when safe and indicated, return to face-to-face mode of presenting
e) Develop a library of video-taped psychoeducational presentations
f) Develop new presentation topics related to Older Adults, "What is Your Passion?"
g) Collaborate with other providers to increase language capacity and outreach in other languages

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.

EVIDENCE BASED PRACTICES (EBP)
FY 19-20

Early Intervention EBP	Descriptions
Aggression Replacement Training (ART) Children (ages 5-12) Skill Streaming Only Children (ages 12-15) TAY (ages 16-17) Unique Consumers Served: 37 Gender: 62% Male, 38% Female Ethnicity: 38% Latino, 14% African American, 43% Unreported, 5% Multiple Races	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) Unique Consumers Served: 231 Gender: 57% Male, 43% Female Ethnicity: 64% Latino, 9% African American, 1% Asian, 1% White, 23% Unreported, 1% Native Hawaiian/Pacific Islander, 1% Multiple Races	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.
Brief Strategic Family Therapy (BSFT) Children (ages 10-15) TAY (ages 16-18)) Unique Consumers Served: 5 Gender: 60% Male, 40% Female Ethnicity: 40% Latino, 40% Unreported, 20% 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 Consumers Served: 38 Gender: 68% Male, 32% Female Ethnicity: 55% Latino, 21%: Unreported, 11% White, 5% Asian, 3% Multiple Races, 5% Native Hawaiian/Pacific Islander	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.

Early Intervention EBP	Descriptions
Child-Parent Psychotherapy (CPP) Young Children (ages 0-6) Unique Consumers Served: 1,579 Gender: 53% Male, 47% Female Ethnicity: 45% Latino, 12% African American, 1% Asian, 9% White, 28% Unreported, 5% Multiple Races	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.
Crisis Oriented Recovery Services (CORS) Children TAY Adults Older Adults Unique Consumers Served: 134 Gender: 37% Male, 63% Female Ethnicity: 43% Latino, 4% African American, 3% Asian, 8% White, 33% Unreported, 9% Multiple Races	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 Consumers Served: 120 Gender: 33% Male, 66% Female, 1% Female to Male Ethnicity: 32% Latino, 2% African American, 62% Unreported, 2% White, 2% Multiple Races	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 Consumers Served: 153 Gender: 26% Male, 73% Female, 1% Female to Male Ethnicity: 30% Latino, 11% African American, 3% Asian, 32% White, 14% Unreported, 2% Native Hawaiian/Pacific Islander, 8% Multiple Races	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.
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, Post Traumatic Stress Disorder (PTSD), and combat operational issues. FOCUS believes that poor communication skills and combat operational stress leads to distortions in thinking and

Early Intervention EBP	Descriptions
Unique Consumers Served: 127 Gender: 53% Male, 47% Female Ethnicity: 27% Latino, 1% African American, 1% Asian, 7% White, 60% Unreported, 1% Native Hawaiian/Pacific Islander, 3% Multiple Races	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.
Functional Family Therapy (FFT) Children (ages 11-15) TAY (ages 16-18) Unique Consumers Served: 58 Gender: 60% Male, 40% Female Ethnicity: 60% Latino, 9% African American, 7% White, 12% Multiple Races, 2% Native Hawaiian/Pacific Islander, 10% Unreported	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.
Group Cognitive Behavioral Therapy for Major Depression (Group CBT) TAY (ages 18-25) Adults Older Adults Unique Consumers Served: 23 Gender: 22% Male, 78% Female Ethnicity: 44% Latino, 13% African American, 4% Asian, 18% White, 17% Unreported, 4% Native Hawaiian/Pacific Islander	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 Consumers Served: 153 Gender: 73% Male, 27% Female Ethnicity: 74% Latino, 2% African American, 1% Asian, 4% White, 16% Unreported, 3% Multiple Races	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 Unique Consumers Served: 9,906 Gender: 31% Male, 69% Female Ethnicity: 48% Latino, 7% African American, 2% Asian, 16% White, 21% Unreported, 1% Native Hawaiian/Pacific Islander, 5% Multiple Races	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.

Early Intervention EBP	Descriptions
Interpersonal Psychotherapy for Depression (IPT) Children (ages 9-15) TAY Adults Older Adults Unique Consumers Served: 1,703 Gender: 31% Male, 69% Female Ethnicity: 40% Latino, 5% African American, 3% Asian, 5% White, 43% Unreported, 1% Native Hawaiian/Pacific Islander, 3% Multiple Races	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 Consumers Served: 21 Gender: 62% Male, 38% Female Ethnicity: 62% Latino, 9% African American, 29% Unreported	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 Consumers Served: 16,099 Gender: 52% Male, 48% Female Ethnicity: 47% Latino, 7% African American, 1% Asian, 6% White, 36% Unreported, 3% Multiple Races	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 Consumers Served: 629 Gender: 28% Male, 72% Female Ethnicity: 66% Latino, 9% African American, 2% Asian, 10% White, 7% Unreported, 2% Native Hawaiian/Pacific Islander, 4% Multiple Races	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.
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

Early Intervention EBP	Descriptions
Unique Consumers Served: 4 Gender: 100% Male Ethnicity: 100% Unreported	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 Consumers Served: 1,661 Gender: 48% Male, 52% Female Ethnicity: 62% Latino, 12% African American, 1% Asian, 9% White, 7% Unreported, 1% Native Hawaiian/Pacific Islander, 8% Multiple Races	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 Consumers Served: 1,377 Gender: 65% Male, 35% Female Ethnicity: 45% Latino, 9% African American, 32% Unreported, 8% White, 6% Multiple Races	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 Consumers Served: 24 Gender: 25% Male, 75% Female Ethnicity: 63% Latino, 4% African American, 21% White, 4% Multiple Races, 8% Unreported	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 consumers who are experiencing short- term challenges that may be temporarily impacting their ability to function normally. This intervention model is particularly designed for Older Adults who have diagnoses of dysthymia or mild depression who are experiencing early signs of mental illness.
Program to Encourage Active Rewarding Lives for Seniors (PEARLS) Older Adults Unique Consumers Served: 8 Gender: 100% Female Ethnicity: 13% Latino, 37% Asian, 12% White, 25% African American, 13% Unreported	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)	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.

Early Intervention EBP	Descriptions
Adults Older Adults Directly Operated Clinics Only Unique Consumers Served: 23 Gender: 22% Male, 78% Female Ethnicity: 48% Latino, 13% African American, 13% Unreported, 13% White, 9% Native Hawaiian/Pacific Islander, 4% Multiple Races	Individual therapy is designed to help consumers 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 Consumers Served: 9 Gender: 44% Male, 56% Female Ethnicity: 45% Latino, 22% African American, 11% White, 22% Multiple Races	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 Consumers Served: 2,108 Gender: 36% Male, 64% Female Ethnicity: 47% Latino, 6% African American, 3% Asian, 11% White, 29% Unreported, 1% Native Hawaiian/Pacific Islander, 3% Multiple Races	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.
Strengthening Families (SF) Children (ages 3-15) TAY (ages 16-18) Unique Consumers Served: 18 Gender: 56% Male, 44% Female Ethnicity: 39% Latino, 11% White, 50% Unreported	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 Consumers Served: 4,517 Gender: 41% Male, 59% Female Ethnicity: 50% Latino, 8% African American, 6% White, 30% Unreported, 1% Native Hawaiian/Pacific Islander, 5% Multiple Races	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.

Early Intervention EBP	Descriptions
Triple P Positive Parenting Program (Triple P) Young Children (ages 0-5) Children (ages 6-15) TAY (age 16) Unique Consumers Served: 475 Gender: 67% Male, 33% Female Ethnicity: 49% Latino, 4% African American, 3% Asian, 6% White, 5% Multiple Races, 33% Unreported	Triple P is intended for the prevention and early intervention of social, emotional and behavioral problems in childhood, the prevention of child maltreatment, and the strengthening of parenting and parental confidence. Levels Two and Three, which focus on preventive mental health activities, are being implemented through community- based organizations. Levels Four and Five, which are early interventions parenting and teen modules, are being implemented by LACDMH Directly Operated and contract agencies.
UCLA Ties Transition Model (UCLA TTM) Young Children (ages 0-5) Children (ages 6-12) Unique Consumers Served: 23 Gender: 57% Male, 43% Female Ethnicity: 17% Latino, 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).

Note: some age groups show the specific age(s) consumers served

EBP OUTCOMES SINCE 2009 THROUGH JUNE 2020

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
ART	3,432	42%	24% Improvement in mental health functioning
AF-CBT	1,618	52%	50% Improvement in mental health functioning 53% Reduction in symptoms related to posttraumatic stress
BFST	203	63%	48% Improvement in mental health functioning 50% Reduction in behavioral problems
Caring for Our Families	733	67%	23% Improvement in mental health functioning 30% Reduction in disruptive behaviors
CAPPS	202	43%	30% Improvement in mental health functioning 60% Reduction in prodromal symptoms
CPP	6,695	47%	53% Improvement in mental health functioning 19% Reduction in child's mental health functioning following a traumatic event
CBITS	130	71%	30% Improvement in mental health functioning

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
			28% Reduction in symptoms related to posttraumatic stress
CORS	4,125	60%	27% Improvement in mental health functioning
DBT	219	66%	28% Improvement in mental health functioning
DTQI	1,210	65%	48% Improvement in mental health functioning 55% Reduction in symptoms related to depression
FOCUS	640	70%	40% Improvement in mental health functioning 50% Improvement in family functioning
FFT	1,713	66%	29% Improvement in mental health functioning
Group CBT	1,139	42%	20% Improvement in mental health functioning 42% Reduction in symptoms related to depression
IY	2,843	64%	27% Improvement in mental health functioning 35% Reduction in disruptive behaviors
Individual CBT	Anxiety: 3,099 Depression: 6,807 Trauma: 936	Anxiety: 45% Depression: 44% Trauma: 47%	Anxiety 37% Improvement in mental health functioning 63% Reduction in symptoms related to anxiety Depression 35% Improvement in mental health functioning 50% Reduction in symptoms related to depression Trauma 44% Improvement in mental health functioning 61% Reduction in symptoms related to posttraumatic stress
IPT	7,576	50%	31% Improvement in mental health functioning 50% Reduction in symptoms related to depression
LIFE	431	65%	36% Improvement in mental health functioning 50% Reduction in disruptive behaviors
MAP	63,003	54%	46% Improvement in mental health functioning 43% Reduction in disruptive behaviors 55% Reduction in symptoms related to depression 44% Reduction in symptoms related to anxiety 50% Reducing symptoms related to posttraumatic stress

Early Intervention EBP	Number of Treatment Cycles	Percent Reported Completing the EBP	Mental Health
MHIP	Anxiety: 2,280 Depression: 5,981 Trauma: 297	Anxiety: 38% Depression: 34% Trauma: 29%	Anxiety 58% Reduction in symptoms related to anxiety Depression 60% Reduction in symptoms related to depression Trauma 24% Reduction in symptoms associated with exposure to trauma
MDFT	77	89%	25% Improvement in mental health functioning
MST	126	73%	46% Improvement in mental health functioning
PCIT	4,364	40%	58% Improvement in mental health functioning 53% Reduction in disruptive behaviors
PST	395	62%	28% Improvement in mental health functioning 45% Reduction in symptoms related to depression
PEARLS	165	48%	26% Improvement in mental health functioning 45% Reduction in symptoms related to depression
PATHS	747	33%	37% Improvement in mental health functioning 33% Reduction in disruptive behaviors
RPP	247	71%	9% Improvement in mental health functioning 15% Reduction in disruptive behaviors
SS	20,546	40%	36% Improvement in mental health functioning 31% Reducing symptoms related to posttraumatic stress
TF-CBT	24,532	54%	48% Improvement in mental health functioning 51% Reducing symptoms related to posttraumatic stress
Triple P	6,280	60%	42% Improvement in mental health functioning 47% Reduction in disruptive behaviors

Source: Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan, FY 21-22 through FY 23-24

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.

LACDMH partners with several county and city agencies, such as the Los Angeles County Departments of Parks and Recreation, Department of Children and Family Services (DCFS), DPH, 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 400,000 public contacts in FY 19-20. Other partner programs served about 50,000 people combined in FY 19-20.

The COVID-19 pandemic impacted the planned delivery of prevention services. Some programs were able to adapt by providing services virtually while others were not able to continue providing services under physical distancing and other safety guidelines. The following are examples of the Prevention activities for FY 19-20.

Children's Health Outreach, Enrollment, Utilization, and Retention (CHOEUR)
DPH's Children's Health Outreach Initiatives (CHOI) program administers the CHOEUR services to uninsured children, families, and individuals in the County who may be eligible for Medi-Cal, Covered California, My Health LA, and other low-cost health coverage programs. CHOEUR contractors utilize various techniques for outreach and enrollment for health coverage, provide individual assessments of health coverage eligibility, utilize various strategies to reduce barriers to health coverage enrollment and utilization of benefits, and implement strategies to support health coverage retention. CHOEUR services contractors incorporate an additional screening for mental health, while providing comprehensive and coordinated health coverage outreach, enrollment, utilization, and retention services to children and families. CHOUER staff outreached to 41,667 persons in FY 19-20. Out of this number, they helped 14,342 with benefit establishment applications and verified enrollment. Another accomplishment involved troubleshooting assistance to over 25,000 individuals.

CHOEUR CONSUMER DEMOGRAPHICS
FY 19-20

Count (n = 20,838)	
Primary Language	
Arabic	18
Armenian	12
Cambodian	67

Count (n = 20,838)	
Ethnicity	
Latina or Latino as follows:	14,522
Caribbean	22
Central American	2,946

Count (n = 20,838)	
English	6,694
Farsi	9
Korean	5
Other Chinese	469
Russian	25
Spanish	10,518
Tagalog	77
Vietnamese	253
Other	996
Declined to answer	1,695
Age	
0-15	3,822
16-25	3,669
26-59	10,776
Older than 60	2,012
Declined to answer	559
Gender Assigned at Birth	
Male	7,499
Female	11,235
Declined to answer	2,104
Current Gender Identity	
Male	5,825
Female	9,550
Transgender	19
Genderqueer	19
Questioning or unsure	16
Another gender identity	14
Declined to answer	5,488

Count (n = 20,838)	
Mexican/Mexican American/Chicano	8,711
Puerto Rican	26
South American	220
Other	2,590
Non-Latina or Non-Latino as follows:	6,316
African	312
Asian Indian/South Asian	260
Cambodian	105
Chinese	484
Eastern European	34
European	44
Filipino	392
Japanese	81
Korean	30
Middle Eastern	86
Vietnamese	288
Others	1,178
More than one ethnicity	150
Declined to answer	2,872
Sexual Orientation	
Gay or Lesbian	74
Heterosexual/Straight	14,044
Queer	6
Questioning or Unsure	2
Declined to answer	6,712
Race	
American Indian	17
Asian	2,147

Count (n = 20,838)	
Disability	
No	14,779
Yes	11,105
Difficulty Seeing	53
Difficulty Hearing	34
Mental Domain	95
Physical/Mobility Domain	147
Chronic Health Condition	569
Other	379
Declined to answer	5,046

Count (n = 20,838)	
Black/African American	396
Native Hawaiian or other Pacific Islander	29
White	7,491
More than one race	133
Declined to answer	10,625
Veteran Status	
Yes	114
No	14,206
Declined	6,518

Library Child, Family and Community Prevention Programs

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 (4) primary target populations residing in underserved communities experiencing adversity:

- Young children and their parents/caregivers
- School-aged children
- TAY
- 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 19-20

Library Program	Deliverable
School Readiness Smarty Pants Story Time	37,000 children and adult caregiver contacts
Triple P	8,358 consultations
Afterschool Programs	45,169 youth attended
Summer Discovery Program	18,853 child and parent attended
STEAM/MAKMO	Nearly 30,000 attended

Home Visitation Program (HVP)

HVP expansion encompasses three (3) home visiting programs: Healthy Families America (HFA), Parents as Teachers (PAT), and Nurse Family Partnership (NFP). Program goals include 1) augment traditionally-delivered HVP services by integrating mental health and protective factor screenings, 2) decrease risk factors and 3) increase protective factors. HVP enhances the skills of home visitors who serve high-risk, low-income, pregnant women, or parents/caregivers with children between the ages of zero and five.

The skills of HVP home visitors are enhanced through trainings that assist them in recognizing mental illness risk factors and when to refer for mental health services. The HVP uses the following indicators to measure outcomes: social connections, parental/caregiver knowledge of child development, self-sufficiency, risky behaviors, birth outcomes, child development inclusive of kindergarten readiness, and parental and familial resiliency. In addition, to determine a correlation between services and improvement in screening scores, NFP created a cohort of mothers whose progress was tracked during FY 19-20. The scores for women in this group decreased during the 12 months in services, showing a decrease in anxiety and depressive symptoms.

HVP CONSUMER DEMOGRAPHICS
FY 19-20

Count (n = 2,015)			**Count (n = 2,015)**	
Primary Language			**Ethnicity**	
	Armenian	1	*Latina or Latino as follows:*	1,471
	Cambodian	11	Caribbean	8
	Cantonese	11	Central American	271
	English	1,269	Mexican/Mexican American/Chicano	977
	Spanish	676	Puerto Rican	11
	Tagalog	2	South American	20
	Vietnamese	1	Other	179
	Declined to answer	44	*Non-Latina or Non-Latino as follows:*	622
Age			African	67
	0-15	17	Asian Indian/South Asian	14
	16-25	979	Cambodian	11
	26-59	1,008	Chinese	12
	Declined to answer	11	Eastern European	7

Count (n = 2,015)	
Gender Assigned at Birth	
Male	24
Female	1,343
Declined to answer	648
Current Gender Identity	
Male	24
Female	1,343
Transgender	10
Genderqueer	3
Questioning or unsure	1
Another gender identity	21
Declined to answer	613
Disability	
No	1,507
Yes	449
Difficulty Seeing	2
Difficulty Hearing	4
Mental Domain	83
Physical/Mobility Domain	3
Chronic Health Condition	202
Other	247
Declined to answer	59

Count (n = 2,015)	
European	15
Filipino	23
Japanese	2
Korean	5
Middle Eastern	14
Vietnamese	2
Others	178
More than one ethnicity	44
Declined to answer	233
Race	
American Indian	12
Asian	81
Black/African American	260
Native Hawaiian or other Pacific Islander	5
White	766
More than one race	54
Other	834
Declined to answer	3
Veteran Status	
Yes	31
No	1,919
Declined to answer	65

Preventing Homelessness and Promoting Health

Prevent Homelessness Promote Health $(PH)^2$ is a joint program between LACDMH and Health Services Housing for Health. $(PH)^2$ works with adults and families countywide to address risk factors and build skills that support the maintenance of permanent and stable housing.

This program has contributed to LACDMH's provision of culturally and linguistically competent services and increased access to mental health services by raising awareness regarding the needs of culturally-diverse communities impacted by homelessness and strategically addressing those needs.

PREVENTING HOMELESSNESS AND PROMOTING HEALTH		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Establishing and maintaining data collection tools that illustrate language and cultural needs	Data is up to date and currently moving from Excel to IBHIS	Data indicated a need for Spanish speaking clinicians. Two (2) were hired.
2) Establishing a HELP line to give support and assistance to Integrated Case Management Services (ICMS) providers	A schedule of phone hours was established and provided to ICMS as well as Housing For Health	HELP line was not utilized as frequently, and this service is no longer being offered. More direct assistance is being provided.
3) Weekly COVID-19 collaborative learning calls were attended by PH staff.	In progress: every 2nd and 4th Tuesday from 9:30 AM to 10:30 AM	These collaborative calls take place with all outreach teams from Los Angeles Homeless Services Authority (LAHSA), DHS, and DMH. Topics for training include safety, cultural humility, grief and loss, LGBTQ, Women's Health and Maternal Psychiatry, and other specific target populations needing street outreach teams.
4) Consultation and telepsychiatry with HOME Team resident psychiatrist	Ability to consult with a resident psychiatrist for consumers with emergent psychiatric need and in the process of being linked to MHS or if psychiatric evaluation was several weeks out.	Consultation line was underutilized. The few consumers who could benefit from this service had difficulties connecting with the telehealth services even when a clinician was present to assist.
5) DHS Learning Webinar	Ability to consult with ICMS providers and DHS nurse practitioners to explore urgent needs within the permanent supportive sites to address risk factors perpetuating barriers to the participants'	The collaborative calls take place biweekly with DHS Housing for Health ICMS team members and DMH Prevent Homelessness Promote Health.

PREVENTING HOMELESSNESS AND PROMOTING HEALTH		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	ability to access care (i.e., complex health related problems, active substance use disorder, mental illness)	

CONSUMERS SERVED BY (PH[2])
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
Prevent Homelessness Promote Health	12	0	11	11	0	1	5	M (19) F (20)	0	1	0	0	English / Spanish

Prevention and Aftercare (P&A)

This program serves children residing in Los Angeles County who are either at risk of entering, currently-involved with DCFS, or have exited the child welfare system. All children and families receive services specifically-tailored to meet their needs via one or more of the following:

- Community activities, events, and workshops that outreach and engage the family, increase financial literacy, raise awareness of resources that meet basic needs, increase access and utilization of supports and services
- Case navigation: case management services that assess participant needs, provide coaching and empowerment, provide direct linkage and referrals, help participants set goals, allow for skill building, and/or provide economic development

During FY 19-20, P&A agencies administered the Protective Factors Survey (PFS) at enrollment and surveyed 3,157 participants. Not all cases were assessed at termination due to attrition. The table below presents the average scores for the PFS at enrollment and termination, as well as the percent change. Families demonstrated an increase in protective factors including parental resilience, social connections, knowledge of parenting and child development, social and emotional competence of

children, concrete support in times of need, family economic opportunity, and social/emotional competence of adults.

P&A PROTECTIVE FACTORS AT ENROLLMENT AND TERMINATION FY 19-20

Protective Factor Assessed	Average Initial Score	Average Final Score	Pre-Post Percent Change
Parental Resilience	5.33	5.74	8%
Social Connections	5.32	5.81	9%
Concrete Support in Times of Need	3.61	4.43	23%
Knowledge of Parenting and Child Development	4.10	4.33	6%
Social and Emotional Competence of Children	6.24	6.37	2%
Family Economic Opportunity/Development	4.99	5.35	7%
Social and Emotional Competence of Adults	5.90	6.19	5%
Overall PFS Average	5.07	5.46	8%

During FY 19-20, P&A agencies held a total of 436 one-time events, with an estimated total attendance of over 12,000. These events ranged from one-time workshops to larger community events. A total of 4,492 surveys were collected. 90% of the participants reported being able to connect with others, 80% reported learning something new about themselves or their family, 88% reported learning about resources that would be useful to themselves or their family, and 86% reported learning tips, tools, and resources to strengthen their own or their family's Wellbeing.

Veterans Peer Access Network (VPAN)

The mission of VPAN is to provide a high quality, coordinated network of care that is easily accessible for Los Angeles County service members, veterans, and their families through an enduring, world-class VPAN that will deploy trained Veteran and Military Family Peers throughout Los Angeles County to connect veterans and their families to critical resources including housing, mental health care, substance use treatment, job placement and legal services. VPAN started in early 2020 and engaged 340 veteran consumers from March to June 2020. This program engaged many more veterans in 2021.

Led by veterans for veterans, VPAN helps veterans and their families navigate often complicated systems so that they can receive the services they deserve. The

first-ever community-driven support network serving veterans and their families in the U.S., VPAN connects County departments, non-profits, the Veterans Administration and Los Angeles City programs. The network embodies the #YouMatter ideal – that veterans deserve hope, Wellbeing and a greater quality of life as valued members of the community.

VPAN placed trained Veteran Peers on the ground in Los Angeles County communities to assist in connecting Veterans to the services they need as they transition out of the military.

VPAN serves:

- All Veterans and military family members of every age countywide
- No specific criteria for time in service, service era or discharge status
- Regardless of VA disability rating
- No specific or exclusionary criteria for level of need/care
- No income level requirements

VPAN identifies disparities and provides culturally and linguistically competent services to veterans residing within Los Angeles County. Many veterans do not feel comfortable engaging with non-veteran providers as they tend to use a different style of communication. The program recruited staff who are veterans or family members of veterans to ensure shared lived experience in engagement with the Los Angeles Veteran community.

The VPAN Veteran Support Line provides coverage from 9:00 am – 9:00 pm. The VPAN staff immediately creates referrals for mental health services as needed and responds to referrals within two or three (2-3) days. The program has contributed to increasing access to mental health services and reducing disparities by utilizing a low barrier approach with minimal eligibility criteria for veterans and their families.

VETERANS PEER ACCESS NETWORK		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) VPAN Veteran Support Line	June 2020 - On going	Increased numbers of calls from veterans looking for emotional support and resources
2) Rapidly housing veterans into temporary shelters at the start of the COVID-19 pandemic	March 2020 - On going	Veterans were matched and placed in permanent housing
3) Suicide Prevention Efforts	November 2019 - On going	A study by the Coroner's Office, Department of Veterans Affairs and LACDMH found that veterans are

VETERANS PEER ACCESS NETWORK		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
		four (4) times more likely to die by suicide than non-veterans.

CONSUMERS SERVED BY VPAN
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
VPAN Veteran Support Line*							215					215	English, Spanish, Mandarin
Rapid Housing	6		5	2		1	19	M (31) F (2)					English
Suicide Prevention Coordinator	7	1	1	4			8 (Unknown)	M (19) F (1)					English

**Gender and race data not collected on the VPAN Veteran Support Line*

Veterans Service Navigators

The focus of this program is to engage veterans and their families to identify currently available services, including supports and services tailored to the particular cultural, ethnic, age and gender identity of those seeking assistance. Staff are veterans who understand the culture of the veterans and their families. Staff ensures successful linkage to services and that veterans and family members receive the help they need. The Navigators engage in joint planning efforts with community partners, including veteran's groups, veteran's administration, community-based organizations, other County departments, intradepartmental staff, schools, health service programs, faith-based organizations, self-help and advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services available to veterans within and outside the mental health system. Staff assists the veterans and their families by promoting awareness of mental health issues and work towards de-stigmatizing seeking help.

In FY 19-20, Military and Veterans Affairs Navigators participated in forty-three (43) community outreach events providing benefits information to include healthcare and mental health referrals to Department of Veterans Affairs (VA) Clinics, Veterans

Centers, West Los Angeles, and Long Beach VA. All Veteran Service Navigators (including but not limited to LACDMH sponsored) assisted 14,476 veterans with making nearly 31,500 claims, including almost 300 for mental health treatment. There were 394 indigent referrals, 1,025 female veterans, 292 homeless veterans, and 48 incarcerated veterans served by the program.

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 19-20, 940 persons were screened. Questions were asked to gauge concrete supports, parental resilience, and social connections during the initial screening. Of those screened, over two-thirds reported that they have others who will listen when they need to talk about problems or if there is a crisis. Over one quarter 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 DPH are collaboratively working to determine tools to evaluate the program's effectiveness and intended outcomes.

SUD-TIPS CONSUMER DEMOGRAPHICS
FY 19-20

Count (n = 940)	
Primary Language	
Armenian	3
English	760
Russian	3
Spanish	156
Declined to answer	16
Age	
15-25	191
26-35	435
36 and older	314
Declined to answer	16
Gender Assigned at Birth	
Male	340
Female	578
Declined to answer	22
Current Gender Identity	
Male	577
Female	342
Genderqueer	1

Count (n = 940)	
Ethnicity	
Latina or Latino as follows:	
Central American	47
Mexican/Mexican American/Chicano	482
Puerto Rican	4
South American	16
Non-Latina or Non-Latino as follows:	
African	42
Asian Indian/South Asian	4
Eastern European	9
European	28
Filipino	3
Middle Eastern	6
Other	216
More than one ethnicity	35
Declined to answer	48
Race	
American Indian or Alaska Native	5
Asian	5
Black or African-American	101

Count (n = 940)	
Another gender identity	2
Declined to answer	18
Veteran Status	
No	940
Disability	
No	940

Count (n = 940)	
Native Hawaiian or other Pacific Islander	9
White	394
Other	331
More than one race	52
Declined to answer	43

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

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 Wellbeing, 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 participants, 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 fifteen (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
  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. The YDD Summit did not occur in 2020 due to COVID-19

- Youth Development Services (YDS)
  Intensive case management is provided to youth identified and referred through law enforcement through contracted community-based partners. 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. In FY 19-20, the YDS MBK providers expanded from 10 to 24 school sites, serving 381 students.

- YDD Training and Technical Assistance
  The YDD Training and Technical Assistance involves the education, training, and technical assistance necessary to provide Y-Intensive Case Management Services and ensure the success of the YDD Program.

YDS MBK CONSUMER DEMOGRAPHICS
FY 19-20

Count (n = 381)	
Primary Language	
English	182
Spanish	19
Declined to answer	180
Age	
0-15	218
16-25	160
Declined to answer	3
Current Gender Identity	
Male	150
Female	62
Genderqueer	1
Declined to answer	168
Disability	
No	149
Yes	34
Difficulty Seeing	3

Count (n = 381)	
Ethnicity	
Latina or Latino as follows:	
Central American	8
Mexican/Mexican American/Chicano	86
South American	5
Other Latino	10
Non-Latina or Non-Latino as follows:	
African	13
Asian Indian/South Asian	2
Middle Eastern	1
Other Non-Latino	35
Declined to answer	221
Race	
American Indian or Alaska Native	2
Black or African-American	89
Native Hawaiian or other Pacific Islander	3
White	16
Other	169
More than one race	7
Declined to answer	95

Count (n = 381)	
Difficulty Hearing	1
Mental Disability	14
Chronic Health Condition	12
Another Type of Disability	4
Declined to Answer	198

Count (n = 381)	
Sexual Orientation	
Gay or Lesbian	3
Heterosexual/Straight	178
Bisexual	11
Declined to Answer	220

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22

Prevention and Community Outreach Services

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

- 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 communities

COS affords an avenue for the LACDMH PEI network to provide services such as education and information to individuals who are not formal consumers of the mental health system and providers who are outside the county mental health system. Often, individuals as well as their parents, family, and caregivers do not seek traditional clinic-based services due to a multitude of factors. Community outreach is a key component in initiating and providing effective and supportive mental health services. Most programs are not evidence-based practices, nonetheless, they have significant data and research indicating their effectiveness.

In previous years, LACDMH in collaboration with the RAND Corporation, developed questionnaires that asked individuals to report on general wellness as well as risk and protective factors. For each consumer group (adult, parent, youth), pre and post surveys were administered at the start and end of the prevention activity they participated in.

In FY 19-20, LACDMH suspended the use of the instrument created by the RAND Corporation to collect outcomes for COS programs. LACDMH is making changes to the data collection protocol for Prevention programs funded by the MHSA PEI. These changes were proposed after consulting with subject matter experts based on input from the stakeholders asking to reduce the burden of collecting additional measures while still ensuring data satisfies PEI evaluation regulations.

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 one (1), three (3), four (4), or six (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.
Child Help 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 two to four (2-4) 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:

Prevention Program	Descriptions
	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 (5) -session parent involvement program that teaches parents of children ages nine to fourteen (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.
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 consumers 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 six to eight (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

Prevention Program	Descriptions
	from a wide spectrum of socioeconomic, educational, cultural and geographical background.
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 five years old, school-aged children five to 11 (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.
Peacebuilders 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 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,

Prevention Program	Descriptions
	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.
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 ten (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.

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

Stigma and Discrimination Reduction (SDR)

The purpose of Stigma and Discrimination Reduction (SDR) is to reduce and eliminate barriers that prevent individuals from utilizing mental health services by prioritizing information and knowledge on early signs and symptoms of mental illness through consumer-focused, family support and education and community advocacy strategies. Core strategies have been identified to reduce stigma and discrimination, increase access to mental health services, and reduce the need for more intensive mental health services in the future. 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 consumer and family education and empowerment.

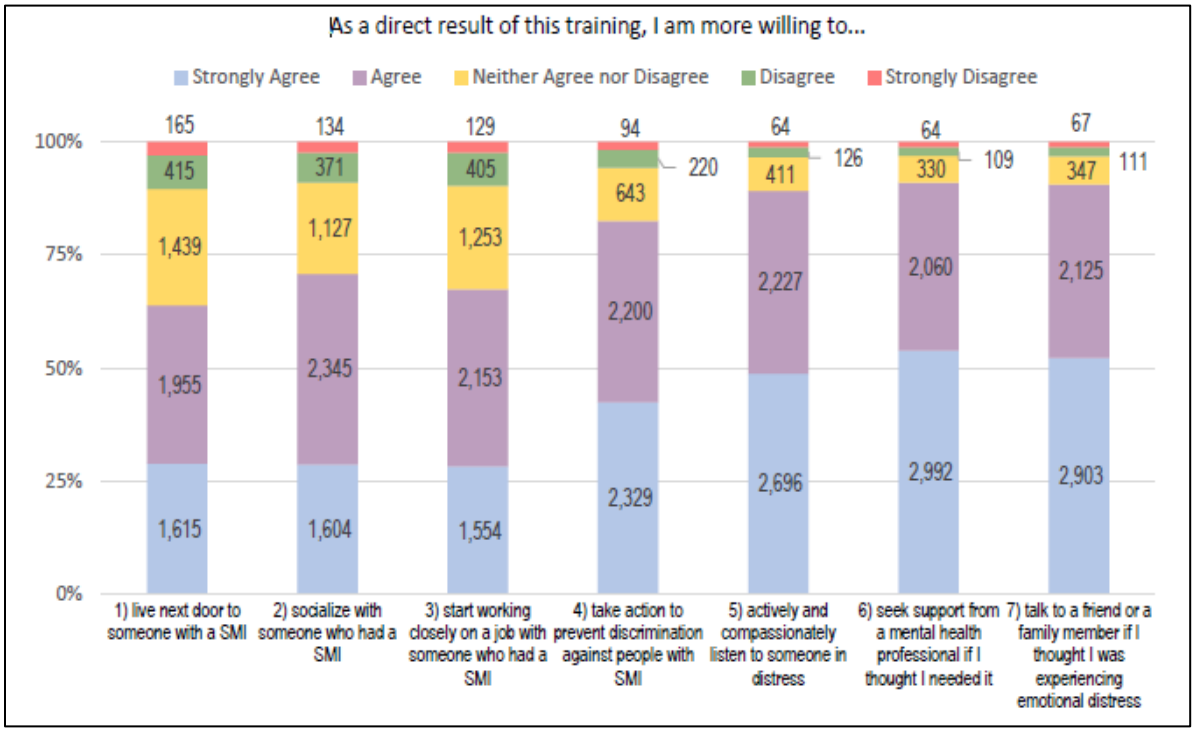
Outcomes for Stigma and Discrimination Reduction (DSR)

SDR trainings are intended to decrease stigma and discrimination against individuals who have a mental health condition and increase knowledge about the topic of mental health. To determine the effectiveness of its SDR trainings, Los Angeles County uses a post-training survey that assesses the impact of trainings on participants' knowledge about stigma towards persons with mental illness as well as their attitudes and behavior toward persons with mental illness. In addition, the survey measures training quality and demographics.

The following graph shows the results of data analyses performed on the 5,968 SDR surveys administered to assess the effectiveness of SDR trainings that were conducted during FY 19-20. The SDR survey was made available all threshold languages as well as Hmong. However, only Spanish (5,166) and English (781) language surveys were received from training participants. The high percentage of Spanish surveys received is noteworthy as it suggests SDR trainings were successfully reaching the monolingual Spanish-speaking participants. This success is due primarily to the Promotores de Salud Program, which primarily serves monolingual Spanish-speaking individuals.

This space was intentionally left blank

CHANGES IN BEHAVIORS AFTER SDR TRAINING

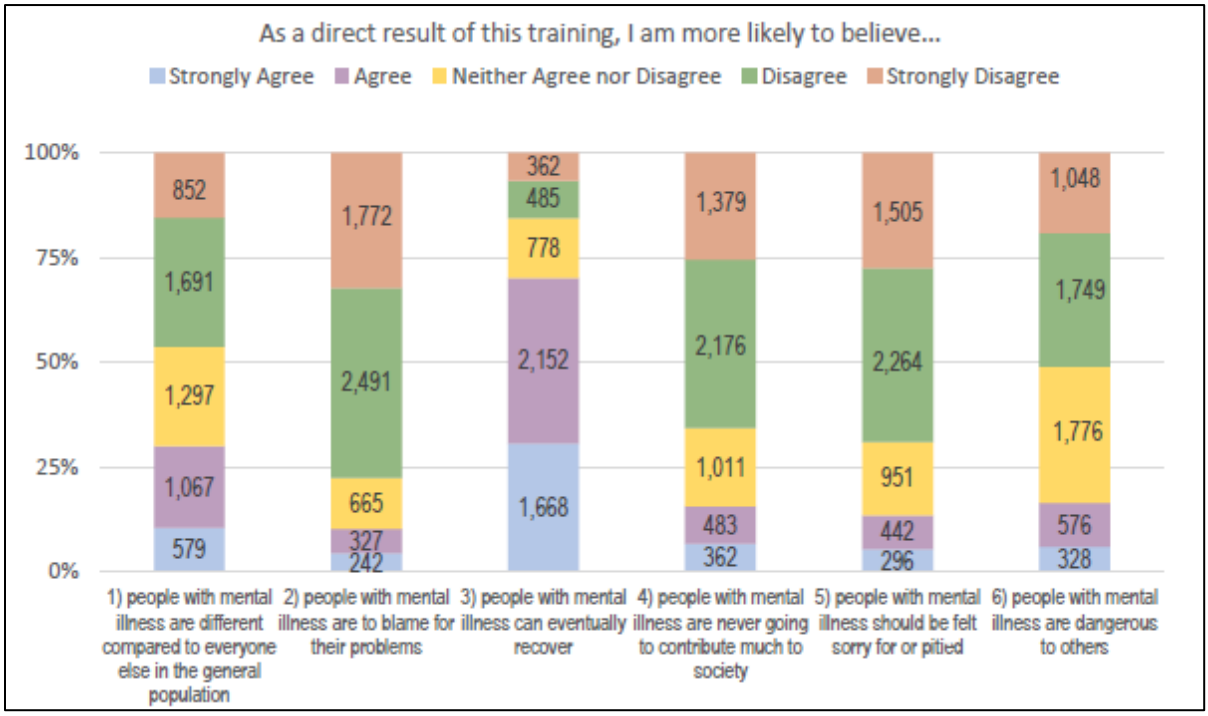


The figure of "Changes in Behaviors" above shows the impact of SDR trainings on participants' willingness to engage in behaviors that support persons with mental illness. Item ratings are: *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, and Strongly Disagree*. Agreeing suggests the participant believes the training positively influenced their future behavior (e.g., willingness to advocate for a person who has a mental illness).
Results suggest participants believed the trainings: 1) decreased the likelihood of discriminating against persons with mental illness; 2) increased the likelihood of acting in support of individuals who have a mental illness; and 3) greatly increased the likelihood of seeking support for themselves in times of need.

Across all items, at least 64% of participants agreed the training had a positive influence in regards to:

- Item 6: A high of 91% agreeing (37%) or strongly agreeing (54%) the training increased willingness to "*seek support from a mental health professional if I thought I needed it*"
- Item 7: A high of 91% agreeing (38%) or strongly agreeing (52%) the training increased willingness to "*talk to a friend or a family member if I thought I was experiencing emotional distress.*"

CHANGES IN KNOWLEDGE AND BELIEFS



The figure above shows change in knowledge and beliefs as a result of attending an SDR training. Items were rated from *Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, to Strongly Disagree*. Items rated as Disagree or Strongly Agree suggest the participant believes training had a positive influence (e.g., decreasing the belief that "mentally ill people are dangerous"). Items rated as Agree or Strongly Agree are indicative of 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, most participants agreed the trainings had a positive influence. Specifically:

- Item 1: 52% of the participants either disagreed (34%) or strongly disagreed (18%) that the training increased their likelihood of believing that "*people with mental illness are different compared to everyone else in the general population."*
- Item 2: 79% of the participants disagreed (47%) or strongly disagreed (32%) that the training increased their likelihood of believing that "*people with mental illness are to blame for their problems.*"

This space was intentionally left blank

SURVEY DEMOGRAPHICS (n = 5,968)
FY 19-20

Description	Demographics	
Sex at Birth	Female: 72% Male: 11%	Declined to answer: 17%
Gender Identity	Female: 72% Male: 11%	Declined to answer: 16%
Sexual Orientation	Heterosexual or Straight: 61% Another sexual orientation: 1%	Declined to answer: 36%
Ethnicity	Mexican/Mexican-American/ Chicano: 55% Central American: 12% European: 2%	Other: 11% Declined to answer: 19%
Veteran Status	Yes: 1% No: 75%	Declined to answer: 24%
Age Groups	Children (0-15): 1% TAY (16-25): 7% Adult (26-59): 64%	Older Adults (60+): 9% Declined to answer: 19%
Disability	Yes: 6% No: 71%	Declined to answer: 23%
Primary Language	English: 11% Spanish: 64%	Other: 4% Declined to answer: 21%
Race	White: 37% Black or African American: 2% Asian: 2%	More than one race: 2% Other: 31% Declined to answer: 26%

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

Promotores de Salud Mental

The Promotores de Salud Mental Program focuses on educating mental health issues, removing barriers, and providing resources. The program merges a community leadership, and/or peer-to-peer approach with support and guidance from LACDMH clinical staff. Community Health Workers who once served as Promotores and/or peer advocates provide mentorship, share knowledge and lived experiences to further support Promotores de Salud Mental.

The Promoters are primarily paraprofessional members of the communities, and prior to the COVID-19 “Safer at Home Orders”, they delivered face-to-face mental health workshops and resources within their neighborhoods. Since April 2020, most workshops have been delivered via online platforms. Promotores possess a high degree of passion and commitment to helping others and have a profound

desire to improve their communities. They have served as leaders in peer support networks, health centers and other community organizations. Many have lived experience or have cared for family members with mental health conditions thus they possess a unique understanding and skill set to help and support residents of their communities.

The Promotores have contributed to LACDMH's provision of culturally and linguistically competent services by reducing stigma and educating communities on mental health issues by:

- Normalizing the experience of living with a mental health condition through shared life experience
- Supporting community residents in examining their thoughts and feelings about mental health issues by using self-reflection and appropriate self-disclosure
- Educating communities and inform them about the signs and symptoms of mental health conditions and the impact of COVID-19 on mental and emotional health
- Delivering presentations address the impact of social determinants of health, such as neighborhood and physical environment, socioeconomic status, and social support networks
- Assisting community residents in accessing mental health care
- Helping targeted communities identify culturally appropriate and geographically accessible resources, and linking residents to a wide range of services as appropriate
- Connecting community members to formal and informal service settings, making referrals to settings such as support groups, women's centers, regional centers, Head Start, USC Wellness, community-based organizations, and mental health programs, in accordance to the needs and the preferences of persons being served

Promotores increase access to mental health services and reduce disparities by supporting residents while they face cultural, linguistic and economic barriers. This means that significant mental health problems can be addressed sooner and possibly be prevented from becoming worse with time. The program provides culturally responsive and grass-roots mental health outreach, engagement and education to communities that may feel unseen, marginalized, or otherwise disconnected from mental health resources. The following table summarizes the Promotores projects and activities for FY 19-20.

This space was intentionally left blank

PROMOTORES DE SALUD MENTAL		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Mental health awareness workshops to Spanish-speaking communities across all eight (8) SAs	• Workshops covered thirteen (13) different topics including Depression, Anxiety, Childhood related disorders, Stress due to Immigration and Mental Health-related Stigma	• In FY 19-20, 5,731 workshops were conducted • 57,171 community residents • 128 of these workshops were conducted virtually
Collaboration with UCLA Latino Neuropsychiatric Center of Excellence (HNCE) to develop new training content to address the mental health effects of COVID-19	• LACDMH Promotores program worked with UCLA HNCE to develop new trainings started in April 2020 • Promotores and program staff restructured their efforts in response to pandemic closures, initiating telework, COVID-19-related training and virtual presentations	• A total of 128 virtual presentations, including fifty (50) “COVID 19 & Stress” workshops were conducted from April through June 2020
Collaboration with LACDPH to raise community awareness about Exide and lead paint in primarily Spanish-speaking underrepresented communities affected by the disaster	• Promotores informed communities affected by Exide and lead paint about the contamination and offered families resources, health education information, and health screening referrals	• Promotores provided a total of 1,119 hours of outreach in FY 19-20 • Continued to assist with outreach for the lead abatement programs in FY 20-21
Deliver linguistically and culturally relevant referrals and linkages	• Promotores provided linguistically and culturally relevant referrals and linked residents to formal and informal services and resources including support groups, mental health clinics, legal aid, substance use treatment, flu shots, food banks, rental assistance and COVID-19 testing	• In FY 19-20, a total of 1,345 referrals were documented
Provide outreach at community-based events such as health and resource fairs	• Promotores provided outreach at health and resource fairs including Care Harbor in November 2020 where medical, dental and other health services were provided to homeless and at-risk populations • Promotores from across the county organized a team effort to connect with participants at this event and provided mental health and other resources to	• Promotores conducted outreach at Care Harbor and 802 other health and resource events

PROMOTORES DE SALUD MENTAL		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	helpparticipants and health professionals with Spanish-English translation	
Provide staffing and support at homeless shelters	• Beginning in April 2020, Promotores provided staffing and support at homeless shelters during the COVID-19 pandemic • Promotores provided information on LACDMH's 24/7 Help Line, distributed mental health related brochures, and provided mental health support to community members and staff	• Promotores staffed shelters for a total of 3,061 hours from April through June 2020
Implement a countywide Promotores conference	• The first Countywide Promotores conference was held August 23, 2019 in Huntington Park, CA Promotores presented all workshops at this event • Topics included eliminating stigma, empowering communities, recognizing mental health symptoms and understanding self-care • Community partners set up tables to display and share their information and resources	• Three hundred (300) participants attended this one-day event, including twelve (12) community partners • Participants reported being highly satisfied with the conference overall, and goals of emphasizing hope in the cultural values in communities and providing educational workshops and resources were achieved

Support Groups in Spanish and Latino and Latinx Community Outreach Project

The mission of the project is to create a safe space where participants feel safe to share common life experiences and provide each other with encouragement, information about available resources, and emotional support. The structure of the groups and other culturally sensitive activities in the program allow participants to engage in personal exploration, emotional expression, and problem solving. Support groups and art activities serve as vehicles to create a sense of community, develop companionship, discover hidden artistic talents, and reduce stigma associated to mental illness.

This program utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to the communities. For example:

- Offering psychoeducational materials in Spanish, inspired by the needs and strengths of consumers and the community
- Running twenty (20) Spanish support groups with culturally relevant activities

- Offering activities facilitated by Peers within mental health clinics. Peers or "Compañeros de camino" (in Spanish) are incorporated into leadership teams and provide valuable assistance to others. As mental health consumers, peers maintain an active connection to their clinic or mental health center. Consequently, they are excellent liaisons for group members who require encouragement to get to the clinic, as well as for consumers who are advanced in their recovery and need to take new steps to reintegrate into everyday life
- Having Support Groups strategically located within organizations trusted by the Latino/Latinx community such as churches, and hospitals. These groups attract high-risk participants who are not accessing mental health services due to stigma or lack of information
- Mobilizing the expression of the cultural protective factors of the Latino and Latinx community, such as music, culinary culture, familism and the celebration of cultural events. Engaging in these activities provides participants a unique opportunity to display and develop their skills while bonding with other consumers over shared experiences of wellness and recovery. LACDMH staff has designed curriculums and an implementation process for four (4) trainings related to art and mental health:
  - Theater training which aims to help participants express and regulate their emotions, develop skills, improve communication skills and body expressions, and increase awareness to combat stigma
  - Painting training: painting has a healing power and allows for a creative outlet for repressed emotions and helps individuals appreciate their self-worth
  - Arts and Crafts training: the act of building artistic objects or decorations helps participants feel empowered and creative, develop new skills, and feel useful
  - Music training: music and songs influence the emotion and can refresh moods. It also stimulates the creative sensibilities, the mind, and helps liberate from suffering or isolation

SUPPORT GROUPS IN SPANISH AND LATINO AND LATINX COMMUNITY OUTREACH		
Projects/Activities/Strategies	**Status / Progress**	**Monitoring / Outcomes / Findings**
1) Support Groups in Spanish	The support groups that were offered face to face, prior to the pandemic, are being offered via telephone (participants connect to a conference call line provided by LACDMH). The groups are facilitated by LACDMH volunteers with lived experience (consumers, family, and community members) including sixteen (16) Wellness Outreach Workers.	Participants have reported their appreciation for these groups as they provide a safe space and support network amid the physical distancing regulations.

SUPPORT GROUPS IN SPANISH AND LATINO AND LATINX COMMUNITY OUTREACH		
Projects/Activities/Strategies	**Status / Progress**	**Monitoring / Outcomes / Findings**
1) Community Empowerment and Mental Health Training	Twelve (12)-week classes were provided for members of the Support Group leadership teams to participate in community outreach and empowerment actions.	Graduates participated in community outreach tasks and established collaboration with other local agencies.
2) Latino/Latinx Community Outreach through the Arts Project	Weekly classes facilitated by art teachers were offered including arts & crafts, painting, music, and theater.	Participants displayed their final products during cultural events throughout the year.
3) Leadership and Support Groups Facilitator's Training	This twelve (12)-week training was offered to individuals interested in becoming support group facilitators.	Graduates from this training reinforced leadership teams and facilitated the opening of new support groups in the community.
4) End of Year Celebration	The main purpose of this event was to celebrate the graduation of those who completed the trainings and to thank and highlight the achievements of the existing support group facilitators throughout the year.	Approximately 100 individuals participated in this community event and to celebrate their individual and collective achievements.
5) Support Networks During Times of Crisis Bulletins	Two (2) volumes of the bulletins were distributed to group participants at the beginning of the COVID-19 pandemic.	Provided information about available resources and messages of encouragement, hope, and motivation Promoted resiliency and mental health through motivational stories identified by participants Shared art projects that participants completed during the pandemic

This program increases access to mental health services and contributes to reducing disparities by engaging and training mental health consumers who are linguistically and culturally diverse. When necessary, peers accompany members to the clinics or help them get connected to the services that they need. Spanish speaking Peers bring

significant help to new members and to consumers who have been in the system for many years. They motivate others to take steps, starting with the idea that “if he/she can succeed then I could do it too.”

To achieve the program’s objectives, the current staff makes an enormous effort to assure that twenty (20) support groups are running effectively. The program needs to hire two (2) experienced, bilingual, and culturally sensitive Community Health Workers. The addition of two (2) staff members will help solidify and eventually expand the project to other areas of the county. The leadership teams are made-up of volunteers, in some cases with more than 12 years of unconditional and sacrificial collaboration. Most veterans and talented members of leadership team were encouraged to apply for the Promoters position, so that the services can be expanded.

The plans for projects that will address culturally and linguistically competent service, reduction of disparities, and access to mental health services include:

- Expanding the services provided by the Community Education Programs by utilizing licensed clinicians to provide direct clinical services to the targeted population
- Developing a Web page with information about the activities and locations of the support group
- Continuing to provide virtual support groups, which benefit especially people with disabilities or those who live in remote places

Wellness Outreach Workers (WOW) Program

This program is run by volunteers with lived experience who provide peer support at Directly Operated programs. They work with the treatment teams to assist consumers on their path to wellbeing and recovery. The purpose of the WOW is to provide ongoing peer support for wellness and recovery to vulnerable adult consumers. WOW facilitate community reintegration and educate consumers, families, and community members about mental health care through culturally-sensitive treatment options.

The WOW program utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible for persons served. Accomplishments for FY 19-20 include:

- A total of seventy-three (73) new consumers with lived experience were trained as WOW volunteers for their clinics
- Eighty-three (83) WOW volunteers served at over fifteen (15) Directly Operated LACDMH programs providing peer support in Spanish, Chinese, Tagalog, Vietnamese, Khmer, Korean, French, Greek and Russian to provide culturally and linguistically accessible services
- A total number of 8,120 volunteer days were provided in the Directly Operated clinics from July 2019 to June 2020

Wellness Outreach Workers (WOW) Program		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Bimonthly WOW meetings	During FY 19-20, WOW program continued to support current WOW volunteers placed in LACDMH Directly Operated Wellness centers to improve access to mental health services and provide peer- to-peer support. Bimonthly meetings were held on 8/13/2019, 10/29/2019, and 2/11/2020.	Forty to fifty-five (40-55) WOW volunteers attended the bimonthly meetings. The meeting agenda addresses areas of diversity as well as strengthen supportive service skills in working with adult consumers.
2) WOW program trainings for newly recruited peers	A total of 73 new consumers with lived experienced were trained as WOW volunteers. The two (2) day training curriculum included an overview of the WOW program, advocacy and problem solving, confidentiality, eight (8) dimensions of wellness, how to start support groups, community reintegration, housing, health, employment, co-occurring disorders and benefits.	Seventy-three (73) individuals completed the two (2) days WOW training. LACDMH Directly Operated wellness programs provide opportunities for volunteers to serve as WOW volunteers at their clinics. WOW trainings were offered on 8/28/19 - 8/29/19; and 2/25/20 - 2/26/20.

The WOW Program's projects and activities have contributed to LACDMH's provision of culturally and linguistically competent services by building a network of culturally and racially diverse volunteers. During FY 19-20, there were forty-five (45) WOW volunteers representing multiple ethnic backgrounds, cultural groups, and language capabilities in Spanish, Korean, Tagalog, Chinese, Japanese, Vietnamese, Khmer, Russian, French, and Greek. They provided information on resources to the community while creating a welcoming environment at clinics, and helping visitors navigate services. Additionally, WOW volunteers provided peer-to-peer support by facilitating groups at clinic sites or the community, and helping community members link to services, resources, and events. In addition, they were involved in the treatment teams to offer the peer perspective.

WOW volunteers have increased access to mental health services and help reduce disparities by sharing their lived experience. They are consumer who have advanced in their own recovery journey and are committed to sharing their lived experience to promote recovery in others. They also assist in navigating the mental health system, facilitate groups, and provide linkage to community services. WOW volunteers make a culturally and ethnically diverse group that includes Latinos, African Americans, Russian, Korean, Vietnamese, Cambodian, Chinese, Filipinos, and Greek. Additionally, the LGBTQ is represented in the WOW program. The WOW supervisor and Program Heads refer consumers to the trainings facilitated by WOW volunteers. A database containing information on all trained WOW volunteers is utilized to match their linguistic and cultural expertise to the needs of clinics. From July 2019 to June 2020, there were eighty-three (83) active WOW volunteers placed in Directly Operated programs.

The WOW program's future plans will address culturally and linguistically competent service delivery, reduction of disparities, and access to mental health services including the following:

- Provide resource information to the community
- Improve access to mental health services by
  - Fostering a welcoming environment at the clinic
  - Helping visitors navigate services
- Provide peer-to-peer support by
  - Facilitating groups at the clinics or community
  - Providing linkage to community services, resources, and events
- Bring peer's perspective to treatment teams
- Promote hope and trust, enhancing the Wellbeing, quality of life, and resilience among consumer recipients

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 (SPN), with support from LACDMH, has developed a strategic plan for suicide prevention to guide 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 Wellbeing 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 LYP 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.

During FY 19-20, LYP provided direct clinical services, outreach, and education to forty (40) unduplicated consumers and their families with funding through the LACDMH contract. These consumers are those who have no other coverage for mental health services. They represent four (4) percent of the total LYP program population (n = 1010). The outcomes focus on this subgroup. A range of clinical presentations were noted in this group. While the majority of consumers continue to present with either a depressive or anxiety related disorder, neurodevelopmental, trauma related, and substance use disorders were also common diagnoses. Although one (1) suicide attempt and twenty-four (24) psychiatric hospitalizations were reported during FY 19-20, only twelve (12) of the hospitalizations and one (1) attempted suicide occurred within this LACDMH funded subgroup. Fortunately, and as in other program years, there were no completed suicides.

Outreach, education, and clinical services were provided at twenty-seven (27) schools and throughout the community. Program staff are trained in eight (8) different EBPs. Administrative staff focused much of their feedback on the program's pivot to COVID-19 related activities, as well as lessons learned over the program's long history. They are proud of the passage in the U.S. House of Representative of H.R. 1109, the Mental Health Services for Students Act, which is based on LYP's program design. The bill is authored by Congresswoman Grace F. Napolitano, who is a strong supporter of Pacific Clinic's LYP since its inception.

24/7 Crisis Hotline

During FY 19-20, the 24/7 Suicide Prevention Crisis Line responded to a total of 133,837 calls, chats, and texts originating from Los Angeles County, including Spanish-language crisis hotline services to 12,588 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 19-20

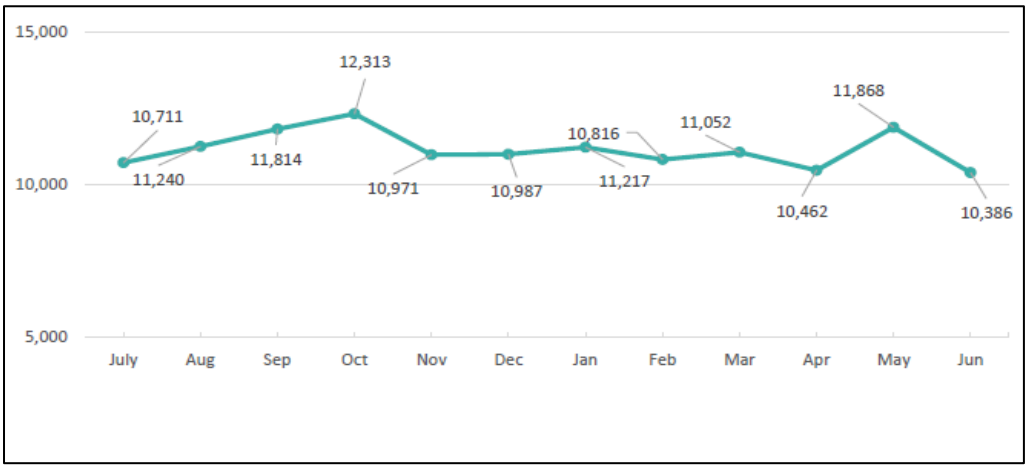
Description	Number of Call
Total Calls	112,878
Total Chats	20,949
Total Texts	10
Total*	133,837

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

TOTAL CALLS BY LANGUAGE, FY 19-20

Language	Number of Calls
Korean	85
Spanish	12,588
English	100,205
Total	112,878

CALL, CHAT, AND TEXT VOLUME BY MONTH, FY 19-20



CALLS AND CHATS BY RACE/ETHNICITY - FY 19-20

Ethnicity	Calls (n = 46,850)	Chats (n = 19,339)
White	37%	59%
Latino	35%	13%

Ethnicity	Calls (n = 46,850)	Chats (n = 19,339)
Black/African American	10%	11%
Asian	9%	7%
Native American	1%	1%
Pacific Islander	1%	0%
Other Race	8%	0%

CALLS AND CHATS BY AGE GROUPS - FY 19-20

Age Groups	Calls (n = 57,690)	Chats (n = 20,437)
5 to 14	6%	18%
15 to 24	37%	52%
25 to 34	26%	19%
35 to 44	12%	6%
45 to 54	8%	3%
55 to 64	7%	1%
65 to 74	3%	1%
75 to 84	1%	0%
85 and up	0%	0%

CALLS AND CHATS BY SUICIDE RISK ASSESSMENT FY 19-20

Suicide Assessment	Calls	Chats
History of psychiatric diagnosis	42%	37%
Prior suicide attempt	26%	28%
Substance use - current or prior	16%	6%
Suicide survivor	8%	4%
Access to gun	3%	4%

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
FY 19-20

Suicide Risk Status	Calls (n = 40,712)	Chats (n = 5,750)
Low Risk	49%	49%
Low-Moderate Risk	25%	21%
Moderate Risk	13%	15%
High-Moderate Risk	5%	6%
High Risk	8%	8%
Attempt in Progress	1%	0%

Note: 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.
(See Attachment 2**: **Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24 for more details).

School Threat Assessment and Response Team (START)
In FY 19-20, START provided 5,102 services to 809 individuals at either suicidal or homicidal risk: 168 open 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. Clinicians triaged and determined their active status: consultation only, limited follow-up for cases that posed no threat, received services from other mental health providers, declined START services, or active follow-up identifying as open cases.

In FY 19-20, 147 male cases and 21 female cases were opened, and 101 of those were between the ages of 0-15; 55 were between the ages of 16-25; 12 were between the ages of 25-59. English was the language spoken by most consumers (148) followed by Spanish (17). Close to half of the open cases were identified as Latino at 46%. The consumers identified as white (23%) was the second largest ethnic group and African Americans/Blacks were third at 15%. To meet the consumers' cultural needs, one third of START clinicians are Spanish speaking.

The reported outcomes for FY 19-20 were based on a combination of assessment tools, collateral information, clinical observation, and other reliable sources. The three (3) 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 (3) 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.

The following table summarizes changes in high suicidal risk and moderate suicidal risk groups. Seventeen (17) consumers (10.12%) were referred to the START Program with high suicidal risk and dropped to one (1) consumer (0.60%) as the START services progressed. Twenty (20) consumers (11.90%) presented moderate suicidal risk in the initial contacts and decreased to fifteen (15) consumers (8.93%) with the START interventions. In terms of the low suicidal risk level group, 131 consumers (77.98%) increased to 152 (90.47%) after they continued to receive interventions from the START program.

CHANGE OF SUICIDAL RISK LEVELS
BETWEEN INITIAL AND MOST RECENT CONTACTS
FY 19-20

Risk Level	Initial Suicidal Risk Level	Most Recent Suicidal Risk Level
High	17 (10.12%)	1 (0.60%)
Moderate	20 (11.90%)	15 (8.93%)
Low	131 (77.98%)	152 (90.47%)
Early Dropout	0 (0.00%)	0 (0.00%)
Total	168	168

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

In FY 19-20, the consumer counts also dropped in both high and moderate violent risk groups with the START interventions.

- Twelve (12) consumers (7.14%) were rated as high violent risk in the beginning of the service period and decreased to three (3) consumers (1.79%) throughout the service cycles
- Seventy (70) consumers (41.67%) presented moderate violent risk in the initial contacts and declined to twenty-four (24) consumers (14.29%) as the services continued
- As for the low violent risk group, 86 consumers (51.19%) increased to 135 (80.35%) after they remained in the START Program
- No most recent (or last reported) violent risk levels were reported for six (3.57%) consumers due to early dropout

CHANGE OF VIOLENT RISK LEVELS
BETWEEN INITIAL AND MOST RECENT CONTACTS
FY 19-20

Risk Level	Initial Violent Risk Level	Most Recent Violent Risk Level
High	12 (7.14 %)	3 (1.79%)
Moderate	70 (41.67%)	24 (14.29%)
Low	86 (51.19%)	135 (80.35%)
Early Dropout	0 (0.00%)	6 (3.57%)
Total	168 (100%)	168 (100%)

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

Furthermore, the START program provided 68 trainings to 3,823 attendees. Training topics included bullying, de-escalation of violent behaviors, targeted school violence, orientation to START services, suicide prevention, mental health awareness, and outreach. 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.

Outpatient Care Services (Formerly Recovery, Resilience, and Reintegration)

Outpatient Care Services, formerly known as Recovery, Resilience and Reintegration (RRR), provides a broad array of integrated community-based, clinic-based and Wellbeing services and a recovery-focused supportive system of care services to all age groups. A continuum of care is critical for consumers to receive the care they need, when they need it, in the most appropriate setting to meet their needs.

The goal is for consumers to achieve their recovery goals to reintegrate successfully into the community. An array of services designed to meet the mental health needs of individuals in different stages of recovery. Each program provides each consumer with a combination of one or more of the core components to meet the consumer's individual needs. These services meet the needs of all age groups. While there may be some minor differences in the specific services provided to each population, there is more commonality across age groups than differences. All age groups have access to

assessments, traditional mental health services, crisis intervention, case management and medication support. The intensity, location (community/field or office/clinic) and duration of the service(s) will depend on the individualized need of each consumer and will likely change over time. While most consumers will hopefully move from more intensive to less intensive services, some consumers may need more intensive services for periods of time due to a variety of factors. These factors include, but are not limited to, the emergence or exacerbation of a severe mental illness, non-adherence to treatment recommendations, a substance use disorder, exposure to trauma or violence or external psychosocial stressors, such as housing, employment, relationship or legal problems.

In response to the COVID-19 pandemic, LACDMH made immediate modifications to standard clinical operations in order to reduce risk, support the staff, and maintain the health and safety of the consumers, staff, and communities. To reduce risk, one of the first steps taken was to reduce the footprint in LACDMH programs. The bulk of staff was transitioned to telework and provided most services via telehealth. In-person services were also maintained for essential/urgent/emergent needs (e.g., vulnerable populations, crises, FSP consumers, 51/50 evaluations, consumers without access to technology), and developed ways to adapt and monitor clinical practice in the context of telework. Additionally, the technology solutions were identified for workforce to provide care consistent with the modifications made to clinical practice during the pandemic. Consumers and staff had to adjust to a largely virtual world, and training was needed to prepare both consumers and staff. To prevent any gaps in service, LACDMH quickly mobilized resources including: the distribution of personal protective equipment; creating psychiatry hubs that could reach across the County from any location; the capacity for clinical pharmacy refills that could be done without in-person contact; and providing equipment needed for mental health services including vehicles, laptops, and phones.

Below are the examples of clinic services during the pandemic.

- Peer volunteers implemented a Warm Line for the consumers of the clinic who were having a difficult time
- Virtual groups implemented to help consumers stay connected with one another and the clinic
- Virtual celebrations to boost consumer and staff morale
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion
- Checking in with every consumer on the entire case load of each clinic

Intended Outcomes

The aim of the Outpatient Care Services is to help consumers and families to accomplishing the following:

- Securing a safe place to live
- Forming healthy relationships
- Being able to access to public assistance when necessary
- Weathering crises successfully
- Using their time in a meaningful way
- Having the best possible physical health

Key Activities

- Clinical services (individual, group, and family therapy; crisis resolution/intervention; evidence-based treatments; medication management and support; outreach and engagement screenings and assessments to determine the level of functioning and impairment; case management)
- Non-clinical services (peer support; family education and support; linkage to primary care; housing services; vocational and pre-vocational services)

DATA FOR CONSUMERS SERVED THROUGH OUTPATIENT PROGRAMS FY 19-20

Age Group	Number of Unique Consumers Served	Average Cost per Consumer
Children, Ages 0-15	25,549	$5,603
TAY, Ages 16-25	17,971	$4,313
Adults, Ages 26-59	57,620	$3,249
Older Adults, Ages 60+	14,934	$3,344

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

TAY Probation Camps

LACDMH staff provides MHSA-funded services to youth in camps operated by the Los Angeles County Probation Department, including youth with Serious Emotional Disturbance (SED)/Serious Mental Illness (SMI). LACDMH staff and contract providers are co-located in these camps along with Probation, DHS Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education (LACOE). This inter-departmental team provides coordinated care to the youth housed at the camps.

Youth housed in the camps receive an array of mental health services, including assessments; individual group, and family therapy; medication support; and aftercare and transition services. These services are individually tailored to meet the needs of each youth, including co-occurring disorders and trauma. Interventions include evidence-based practices such as Aggression Replacement Training, Adapted Dialectical Behavior Therapy and Seeking Safety. MHSA funding has made it possible for youth to be housed in a broader array of camps and still receive psychotropic medications.

TAY Drop-In Centers

TAY Drop-In Centers are designed to be entry points to the mental health system for SED and Severe and Persistently Mentally Ill (SPMI) TAY, ages 16-25, who may be homeless or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. The complex trauma may manifest in TAY's inability to maintain relationships, keep jobs, or stay in

school, often putting them at risk of unemployment, school drop-outs, incarceration, and homelessness. Without early intervention, TAY are at risk of experiencing mental disorders that may impair their daily activities and functioning. Drop-In Centers have a strong emphasis on outreaching TAY who are difficult to engage and would otherwise remain unserved, by linking TAY to a range of resources that promote stability and self-sufficiency. Drop-In Centers operate daily including evenings and some weekends. TAY Drop-In Centers also contribute to LACDMH's provision of culturally and linguistically competent services by contracting providers who have similar cultural and linguistic backgrounds to those consumers being served.

Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can connect them to the services and supports they need. They also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, mailing address, and a safe inside place to rest. Generally, these centers are operated during regular business hours.

CONSUMERS SERVED BY TAY DROP-IN CENTERS
FY 19-20

Program /Activity	**# Consumers Served by Race/Ethnicity**							**Gender**					**Language used by Staff in service provision**
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
Drop-In Centers (all)	259	201	748	676	37	26	56	1037/ 714			98	79	English, Spanish, Vietnamese, Armenian, Korean, American Sign Language

This space was intentionally left blank

TAY DROP-IN CENTER LOCATIONS

Service Area	Agency	Address
SA 1	Penny Lane Centers Yellow Submarine	43520 Division Street Lancaster, CA 93535
SA 2	The Village Family Services TVFS TAY Drop-In Center	6801 Coldwater Canyon Boulevard North Hollywood, CA 91606
SA 3	Pacific Clinics Hope Drop-In Center	13001 Ramona Boulevard Irwindale, CA 91706
SA 4	Los Angeles LGBT Center Youth Center on Highland	1220 N. Highland Avenue Los Angeles, CA 90038
SA 5	Daniel's Place Step-Up on Second Street, Inc.	1619 Santa Monica Boulevard Santa Monica, CA 90405
SA 6	Good Seed Church of God in Christ, Inc. Good Seed Youth Drop-in Center	2814 W. MLK Jr., Boulevard Los Angeles, CA 90008
SA 7	Penny Lane Centers With A Little Help from My Friends	5628 E. Slauson Avenue Commerce, CA 90040
SA 8	Good Seed Church of God in Christ, Inc. Good Seed on Pine Youth Drop-In Center	1230 Pine Avenue Long Beach, CA 90813

Source: Mental Health Services Act (MHSA) Three Year Program and Expenditure Plan, FY 21-22 through FY 23-24

TAY Navigation Team

The TAY Navigation Team is a field-based team comprised of clinicians, medical case workers who serve in the role of Housing Specialists, a Substance Use Counselor, and a Community Health Worker who work with TAY, ages 16-25, countywide. Each service area has one (1) clinician and one (1) housing specialist assigned. The team assists youth, often homeless, through the various human services systems to link to mental health, housing, and other essential services. The staff also provide clinical consultations to the County departments and organizations while outreaching and engaging TAY that are referred.

A key role for TAY staff is in the Enhanced Emergency Shelter Program (EESP). These shelters are located in SAs 4 and 6 and provide 60-day shelter for TAY who are between 18-25 years old. The EESP offers a warm, clean and safe place to sleep, hygiene facilities, hot meals and case management services. Each youth in the EESPs is assigned to one of the clinicians and housing specialists to work with the youth and refer to needed mental health support as well as a more permanent housing plan, and employment resources.

The team and the EESP's main point of entry is through the TAY Gatekeeper. The Gatekeeper covers the gatekeeping line Monday-Friday, from 8 am-5 pm and screens calls from youth, their loved ones, or interested community members for services to TAY.

The TAY Navigation Team has contributed to LACDMH's provision of culturally and linguistically competent services by engaging in community outreach to the TAY

population. The staff is varied racially, ethnically, and culturally, and this broadens the services they can provide. Staff consult with each other on difficult cases or questions requiring cultural expertise. The staff, including supervisors, also provide consultation to the EESP shelter staff on cultural issues that may arise among youth in the shelters, and this is due to the trusting relationship that has been developed over the years. This type of collaboration greatly contributes to the Department's mission of culturally and linguistically appropriate services.

The team's primary mission is to serve homeless TAY by linking them to housing and mental health resources. Furthermore, the team enhances the overall long-term functioning of TAY consumers in the community, beyond the time they are in the EESP program. The O&E activities mentioned above are all designed to specifically identify the TAY population and increase their knowledge and access to the services.

TAY NAVIGATION TEAM		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) The creation of a new, youth-oriented flyer advertising the Enhanced Emergency Shelter Program and Gatekeeper phone number for outreach and engagement	Completed in April 2020.	This flyer has been disseminated during trainings and on the LACDMH website to broaden knowledge around EESPs and their criteria, as well as the Gatekeeper phone line.
2) Expanded coverage of Gatekeeper Desk to include clinicians to better assess for mental health concerns as well as cultural needs and concerns	Started in May 2020 and continues.	This expansion has led to better screening and placement of youth in EESPs, particularly for those who are LGBTQ+.
3) Presentations to Service Area CES meetings and Impact meetings to describe TAY Navigation Team and EESP and its criteria	The program manager or supervisor, along w/one (1) clinician and one (1) housing specialist have presented throughout the County, starting with SA1 on 3/11/2020.	The presentations are effective in getting the word out about the services of the team and the TAY shelters, and these will continue and expand in the next fiscal year.
4) Facilitate learning from the Departmental resources such as the Speakers Bureau and LGBTQIA2-S UsCC subcommittee	ongoing	LGBTQIA2-S experts from the Speakers Bureau and the UsCC subcommittee provided relevant information to the team and advocate for equity.

TAY NAVIGATION TEAM		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
5) Staff participation in monthly countywide Los Angeles Performance Partnership Pilot (LAP3) meetings in the various service areas	ongoing	These meetings enable TAY staff to provide information on the team and the TAY shelters, as well as gather information on disparities within each SA and ways to address.
6) Due to COVID-19 restrictions, use of County cell phones to telephone and allow for FaceTime with consumers	This strategy was implemented in April 2020 and is ongoing.	Use of these tools has been effective in connecting with consumers during this time, although not all youth have phones or prefer to use their minutes for interaction with staff.

CONSUMERS SERVED BY TAY NAVIGATION TEAM
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
EESP housing	49	5	200	139	8	0	137	M (431) F (64)	Transgender (38)			4	English/ Spanish

Older Adult Training

The Older Adult Training Program addresses the training needs of existing mental health professionals and community partners by providing the following training topics: field safety, elder abuse, documentation, co-occurring disorders, hoarding, geriatric psychiatry, gero-psychiatry fellowship, service extenders and evidence-based practices. The achievements/highlights for FY 19-20 include:

- Older Adult Consultation Medical Doctor's (OACT-MD) Series: This was training and consultation for psychiatrists, nurse practitioners, nurses and mental health clinicians to improve the accessibility and quality of mental health services for Older Adults
- Community Diversion and Re-Entry Program for Seniors (CDRP) Training and Consultation Series: This training and consultation series, as part of the Older Adult Training & Consultation 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 and consultation were designed to upgrade the training knowledge base and skills of all mental health staff through case presentation and consultation

- Older Adult Legal Issues/Elder Law Trainings and Consultation: As part of ongoing multi-disciplinary Older Adult Consultation team trainings, the following information was provided: training and Elder Law consultation; curriculum training development and coordination on Elder Law for LACDMH and LACDMH-Contracted clinical and non-clinical staff on best practices for working with Older Adult populations
- Public Speaking Club Graduate Curriculum: Speaker Club graduate programs were provided for consumers who successfully completed public speaking curriculum to enhance and practice their skills. These took place on the 3rd Friday of every month throughout the fiscal year once a month
- Speaker Club Workshop Training Curriculum: This 7-week training session course provided peers with tools and skills to educate the community and advocate for hope, wellness, and recovery
- Recognizing and Responding to Suicide Risk (RRSR): This is an interactive training for mental health clinicians desiring to acquire competency-based skills for working with consumers who are at risk for suicide. The RRSR training model is based on a set of 24 core clinical competencies developed by a task force of clinical experts collaborating with the American Association of Suicidology (AAS) and the Suicide Prevention Resource Center
- Seeking Safety Training: This training provides an overview of Seeking Safety, an evidenced-based treatment for trauma and/or substance abuse. Topics included in the training:
  - Background on trauma and substance abuse (rates, presentation, models and stages of treatment, clinical challenges)
  - Implementation of Seeking Safety (overview, evidence base)
  - Assessment tools and community resources are also addressed
  - The training will allow participants to be able to implement Seeking Safety in their setting.
- 18th Annual Collaboration in Geriatric Mental Health Care - Technology & Mental Health Care of Older Adults: In collaboration with Los Angeles Care Health Plan, LACDMH hosted the 18th Annual Collaboration in Geriatric Psychiatry breakfast. The new name reflects the focus on collaboration among multiple agencies and among multiple disciplines working together for the mental health care of older individuals. With the advent of national, state, and local directives to integrate health and mental healthcare, and especially with the establishment of the Medi-Cal managed health and mental health plans, this year's training will highlight how technology can improve social isolation and morbidity of individuals and how technology can be effectively used by providers
- Medical Legal Pre-Elective, Part I: The purpose of this training is to educate participants on cognitive screening tests, elements of decision-making and legal reporting for geriatric patients who require evaluation for conservatorship, testamentary capacity, undue influence, and other issues that involve geriatric law

- Medical Legal Elective, Part II - Direct and Cross Examination: The training educates mental health participants on strategies for expert witness court testimony specific to Older Adults with cognitive impairments. This training prepared medical doctors and psychologists on ethnically diverse older adult cases with practiced simulated direct and cross examination situations
- Medical Legal Elective, Part III - Simulated Trails: The training educates mental health participants on strategies for expert witness court testimony specific to Older Adults with cognitive impairments. The training described the evolution of mock trials and involves a simulated actual case, including practicing attorneys, and an experienced judge in a condensed version of a trial
- Problem Solving Treatment (PST): PST is a brief intervention and offers experiential activities to enhance clinical skills thereby supporting the model's effectiveness
- The Use of Cognitive Screening Measures- the Mini Mental State Exam (MMSE): The purpose of this training is to provide an overview of a cognitive screening tool as well as hands on-experience using MMSE
- Older Adult Sexual Assault: The Rape Treatment Center (RTC) at the UCLA Medical Center in Santa Monica provided a training on sexual assault and rape, with a specific focus on the older adult population. The training addresses the following topics: prevalence of sexual assault in the U.S., including factors that contribute to Older Adults heightened risk of sexual assault; victim impact, including common presentations; the influence of rape culture and intersectionality on issues of sexual violence; how to support a survivor, RTC services and how to refer to RTC
- Advanced Issues in Grief and Loss: This training addresses areas related to grief and loss in children and adults, such as issues faced by adults exiting the criminal justice system, homeless adults, and immigrants facing unresolved grief over the loss of loved ones and their homes, among other factors. Cultural factors impacting the grief and loss process is addressed throughout this training, since culture plays a critical role in dealing with grief and loss. Finally, the training also focuses on ways to effectively work with adults across the life span facing complicated grief and loss.

Older Adult (OA) Service Extenders (SE) Program

Service Extenders are volunteers who have been specially trained to provide highly sensitive and culturally appropriate supportive services to Older Adults. They work with the treatment team and provide added support and advocacy as part of the multi-disciplinary team. Service Extenders may assist in providing friendly visits to isolated Older Adults, assisting in community reintegration, and providing hope and support in the recovery process.

Service Extenders may be peers who are recovering from a mental illness, family members who have experience with an Older Adult loved one with a mental illness, or other qualified individuals interested in providing services as a part of an interdisciplinary team and receiving supervision from a professional clinical staff.

According to the Los Angeles County-Data Notebook for California Behavioral Health Boards and Commissions, the major language groups or communities with greatest need for mental health outreach include Cambodian/Khmer, Vietnamese, and Korean. To address the need to improve access and utilization of mental health services in the API population, the Outpatient Services Division collaborated with its mental health provider network. Six (6) Service Extenders provided services in API languages during FY 19-20.

Older Adult (OA) Service Extenders (SE) Program		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Quarterly Service Extender meetings	Cultural competence is an important aspect of trainings and discussions during quarterly meetings. Service Extenders share their experiences of working with consumers from diverse cultural backgrounds and receive feedback from facilitators and their peers. Meetings were held on 9/23/20, 12/9/20, and 3/9/20.	Service Extender quarterly meetings are well-attended by Service Extenders. The meeting agenda is carefully designed to support Service Extenders and enhance their skills of working with diverse Older Adults in Los Angeles County.
2) Training opportunities for the Service Extenders	Service Extenders are regularly invited to relevant training opportunities to enhance their knowledge and capacity to promote health, Wellbeing, and access to underserved, unserved and inappropriately served populations. The program manager and designated staff inform Service Extenders upon receipt of these trainings and as needed, assist and support Service Extenders to participate.	Service Extenders have been invited to attend the following trainings: Orientation for Promotores; 18th Annual Collaboration in Geriatric Mental Health Care; Webinar for Community Health Worker, A Day in the Life of Community Health Workers; Recovery and Older Adults; Digital Health Literacy Training by Painted Brain

The Outpatient Services Division administrative team has contributed to LACDMH's provision of culturally and linguistically competent services by continuously outreaching to Older Adult LACDMH programs and mental health providers and considering their cultural needs to identify appropriate placement for Older Adult Service Extenders. During FY 19-20, the Outpatient Services Division had forty-two (42) Service Extenders representing multiple ethnic backgrounds, cultural groups, and language capabilities. Additionally, having Service Extenders who speak the consumers' languages facilitates the establishment of rapport, connection, and trust. This can enhance access and encourage consumers to remain in the services they need and to feel supported. Service Extenders, who are often peers in recovery, inspire other consumers through their personal journeys and help them navigate the

mental health system. LACDMH Older Adult consumers are a culturally diverse group. To provide them with culturally sensitive and appropriate services, the efforts are made to recruit the Service Extenders from different cultural backgrounds. For example, they include Latinos, African Americans, Armenians, Russians, Iranians, Chinese, and Filipinos. In FY 19-20, the Service Extenders' language capacity included: English, Spanish, Farsi, Armenian, Russian, Indonesian, Mandarin, and American Sign Language. As of FY 19-20, forty-two (42) Service Extenders are working in the Contracted and Directly Operated clinics.

The Outpatient Services Division continuously collaborates with the Program Managers at LACDMH, Directly Operated clinics/programs, and other LACDMH Contracted providers to identify appropriate placements for Service Extenders based on the need of the programs.

The Outpatient Services Division plans for service delivery including the following:

- Continue to recruit additional Service Extenders from diverse ethnic and cultural communities
- Continue to train Service Extenders to assist in providing mental wellness presentations with cultural considerations
- Train Service Extenders to co-facilitate support groups
- Train Service Extenders in the secure virtual platforms (VSEE) to assist with the delivering of services
- Recruit new volunteers to participate in the Service Extenders Training Academy. Depending on the recovery from the COVID-19 pandemic, the recruitment process is expected to resume for FY 20-21.
- Expand the number of volunteers for the Service Extenders program to address other cultural and language needs of the community since this is an essential part of the recruitment process.

Telemental Health and Consultation

The goal of Telemental Health (TMH) program is to provide psychiatric services to the areas of Los Angeles County that are in need of psychiatrists. The TMH program provides the services only in LACDMH outpatient clinics across all eight (8) Service Areas and prioritizes geographical areas that are the hardest to reach. TMH services serves consumers who have equipment installed in their homes (i.e., computers or smart phones) which allows them to interact with psychiatrists without going to a clinic. The overall goal of the TMH program is to use technology in order to improve care, access to care, treatment adherence and outcomes, and consumer satisfaction.

The TMH program provides psychiatric medication evaluation and management (E+M) services, also called Medication Support Services by Medi-Cal, for LACDMH clinics throughout the Los Angeles County. TMH services are provided by thirteen (13) psychiatrists who work part-time at their LACDMH provider sites of employment and part-time in the TMH program. These include the following:

1. Initial Medication Assessments, conducted 'face-to-face' or via video teleconference, are usually lengthy; aimed at deriving a detailed history in order

to obtain an accurate and complete diagnostic picture that anchors the prescription of psychotropic medications for the unique client. In addition, the assessment aids in establishing how the medications prescribed support the client-generated goals of treatment.

2. Comprehensive Medication Services are conducted 'face-to-face' or via video teleconference and aim at expanding the initial medication assessment or adult initial assessment or focusing on a new and emergent problem. These services enhance medical decision making of moderate complexity and may result in changes in medications prescribed or in the adjustment of medication dosages by the psychiatrist or nurse practitioner.
3. Brief Medication Visits are conducted either 'face-to-face', video teleconference, or by telephone with the client or with a collateral whom the client has granted consent; they require only a brief history or problem-focus that is of low to moderate complexity, including the evaluation of safety and effectiveness of medications with straightforward decision making regarding renewal or simple dosage adjustments in a stable client by a physician or a Mental Health Counselor Registered Nurse if no medications are changed.
4. Clients of a Directly Operated LACDMH clinic may see psychiatrists remotely. They have the option for in person or remote appointments.
5. Psychiatric medication consultation services are also provided remotely to several DHS clinics throughout Los Angeles County via the DMH/DHS Collaboration Program.

The above services are provided to clients in remote locations using video teleconferencing. Video teleconferencing allows the members of this mental health staff to communicate with the clients in a completely confidential manner and, most importantly, with real time audio and high-definition visual resolution.

The Telemental Health and Consultation Team (TMHCT) provides medication review, medication counseling/education and prescriptions as permitted by their licensure with documentation in the medical record of each client. Prescriptions are sent through the EMR. There will be no dispensing or storing of medication at the unit site. The TMHCT is comprised of one (1) supervising psychiatrist, one (1) full-time psychiatrist, one (1) mental health counselor registered nurse and one (1) patient financial service worker. This team also strategizes all aspects of training and deployment of telemental health psychiatrists.

The TMH program assigns psychiatrists to provide remote telepsychiatry coverage of clinics throughout Los Angeles County based upon data. The data that is used to determine need is the caseload for psychiatrists located in each clinic. Because there are geographic disparities in the physical location of psychiatrists that lead to disparities in caseload per psychiatrist (i.e., clinics that are underserved by psychiatrists have larger caseloads), the TMH program helps to improve access to psychiatric treatment in underserved regions of Los Angeles County.

The TMH program increases access to mental health services and works on reducing disparities. The goal is to increase access to psychiatric medication services

throughout the County, especially targeting geographically underserved areas. By using telepsychiatry, LACDMH is able to overcome the geographic barrier to care in certain areas of Los Angeles County experiencing a shortage of psychiatrists such as the Antelope Valley.

TELEMENTAL HEALTH AND CONSULTATION		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Distribution of part-time telemental health psychiatrists to work remotely in order to improve access to care in underserved areas	Implemented	Caseloads are improving in regions where out psychiatrists have been deployed
2) Expansion of psychiatric care accessibility after hours and on weekends via telepsychiatry visits	Implemented	Clients are being seen via telepsychiatry in several locations after the physical clinic is closed
3) Implementation of the Psychiatry Registry to improve accessibility to medication support services	Implemented	Four (4) psychiatrists are members of the registry. LACDMH deploys these independent contracted psychiatrists to sites experiencing shortages in medication support services
4) Countywide Training for psychiatrists on delivery of telemental health services via virtual platforms	Completed. Approximately ten (10) bi-weekly trainings were provided to LACDMH psychiatrists	Approximately 200 psychiatrists were trained and supported during their process of learning how to provide telemental health services
5) VSEE Telehealth Champions for Community Health Workers and Peers	Completed	Approximately twenty (20) Community Health Workers and peers were trained on how to assist clients and clinic staff in effectively operating virtual platforms for telemental health services

CONSUMERS SERVED BY TMH PROGRAM
FY 19-20 (N = 287)

Program/ Project/ Activity	Number of Consumers Served by Ethnicity and Gender								
TMH	White	Black/ African American	Latino/ Latino	Asian	American Indian/ Alaska Native	Multi	Native Hawaiian/ Pacific Islander	Middle Eastern	Unreported
	47 (16.5%)	80 (28.1%)	84 (29.5%)	16 (5.6%)	2 (0.7%)	12 (4.2%)	4 (1.4%)	3 (1.1%)	39 (13.7%)
	Gender								
	Female: 157 (54.7%) Male: 130 (45.3%)								
	Languages of Staff								
	English Farsi French								

Spirituality

LACDMH recognizes that many persons 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)

The goals of this Council include: increase the integration of spirituality and mental health messages and resources; increase community awareness of mental health and access to care; and decrease stigma by convening diverse faith community leaders, information sharing, and participation in collaborative projects.

LACDMH staff review published data from mental health and public health, on racial, socio-economic, geographic, and other disparities, to plan FBAC activities. Furthermore, staff conducts needs assessment and opinion surveys of FBAC participants. Survey findings help the FBAC Executive Board and staff plan and prioritize activities.

FBAC has contributed to LADCMH's provision of culturally and linguistically competent services by including culturally and linguistically diverse participants and communities. An average of 36 (ranging from 30 to 46) diverse faith community leaders, serving in congregations throughout Los Angeles County, participated in the Faith-Based Advocacy Council monthly meetings during the year. Meetings were held in-person, at Holman United Methodist Church in South Los Angeles, from July 2019 through March 2020. Meetings were held online, in adherence with COVID-19 physical distancing protocols, from April through June 2020. Meetings were held in English with simultaneous interpretation provided in Korean and Spanish. To support participants with accurate and helpful information during the pandemic, a message containing multilingual mental health, public health, and community resource

information was emailed to FBAC participants every Friday, from mid-March through June 30, 2020.

FBAC monthly meetings, clergy self-care eventst, and weekly messages increase access to care and reduce disparities by increasing awareness and decreasing the stigma of seeking mental health services in congregations, families, and communities. Six (6) months of the year were dedicated to studying and discussing the *Spiritual Self-Care Manual and Toolkit: Empowering People on their Recovery and Wellness Journey.* LACDMH previously produced this 182-page manual in English and translated it into Korean and Spanish. FBAC participants used it in their pastoral counseling to facilitate spiritual self-care groups in their congregations. FBAC is staffed part-time by an administrative team (Health Program Analysts and clerical staff) with linguistic capabilities in English, Spanish, and Cantonese.

Additionally, FBAC sponsored the Clergy Self-Care Event in February 2020. The event was well-represented by clergy, faith leaders and the faith-based liaisons from all Service Areas which had a strong turnout with a total of 78 participants. Virtually all participants completed and submitted an evaluation at the close of the event. Overall, the evaluation showed that all the participants were very satisfied with the event.
(See Attachment 3*: Clergy Self-Care Event Evaluation Summary Report for more details*.)

FBAC EVENTS FOR FY 19-20

Events	Participation
July 2019 "Intergenerational Spread of Trauma and Innovations 2; Religious Pluralism and Resilient Communities; Integrating Spirituality and Psychology; and History and Focus of Muslim Progressives."	46 participants
August 2019 "Partnering with Faith Communities to Address Mental Health Crisis in the Justice System; and Faith Organizations and Families for Foster Children"	37 participants
October 2019 "A Safe Place for Youth in Venice"	33 participants
November 2019 "Suicide Prevention in Los Angeles County"	35 participants
December 2019 "Training on Responding to an Opioid Overdose with Naloxone (Narcan)" Clare/Matrix Foundation	27 participants

Events	Participation
January 2, 2020 "*Spiritual Self-Care Manual and Toolkit: Empowering People for their Recovery and Wellness Journey" (Toolkit)* Introduction, and monthly series facilitated by *Toolkit* author Charles Suhayda, PhD, MD Session One: Orientation to the Spirituality Group	30 participants
February 6, 2020 *Toolkit*, Session Two: Understanding the Whole Person "2020 Census: Be Counted, Los Angeles County!" presentation by Marcha Stevenson, County of Los Angeles Chief Executive Office	30 participants
February 11, 2020 "Gathering of Clergy and Faith Communities to Explore Spirituality and Self-Care: Finding Your Sacred Space in a Demanding World" at The California Endowment	78 participants
March 5, 2020 *Toolki*t, Session Three: Coping with Life's Challenges "Whole Person Pastoral Care and the Gift of Presence," presentation by Adrienne Hament, LCSW	30 participants
April 2, 2020 *Toolkit*, Session Four: The Spirituality of Hope, Love, Compassion, Faith, and Service	37 participants
May 7, 2020 *Toolkit*, Session Five: Connectedness and Healthy Relationships	45 participants
June 4, 2020 *Toolkit,* Session Six and Series Closing: Establishing Spiritual Self-Care Goals, Self-Help Group and Spiritual Practices	39 participants

Partnership with Stakeholders: YourDMH

The purpose of YourDMH is to produce community-driven stakeholder priorities that provide feedback to guide LACDMH in the development of its Departmental Action Plan. This Action Plan, an extension of LACDMH's Strategic Plan, is congruent with high-level organizational changes that LACDMH is pursuing to create new partnerships and improve services including all necessary policies, program designs, information technology supports and quality monitoring activities. Mental Health Services Act (MHSA)-specific activities, including the development of the Three-Year Plan, Annual Updates, and Innovation Programs, are drawn from this broader Action Plan. YourDMH creates a community driven platform for the voice of stakeholders who are consumers and family members of consumers, community members, cultural brokers, representatives of

community grassroots organizations, etc. to provide advisement and guidance to the Department.

Service Area Leadership Teams (SALT)
For the purposes of planning and operation, Los Angeles County is divided into eight (8) Service Areas. Each Service Area has a Service Area Leadership Team (SALT – formerly known as Service Area Leadership Team/SALT). Each SALT functions as a local forum of consumers, families, service providers and community representatives to provide LACDMH with information, advice and recommendations regarding:

- Functioning of local service systems
- Mental health service needs of their geographic area
- Most effective/efficient use of available resources
- Maintenance of two-way communication between LACDMH and various groups and geographic communities

For the SALT, close captioning services, Spanish and other language accommodations are provided during monthly meetings across each Service Area. The values of the SALT include:

- Collaboration: LACDMH and its stakeholders work together toward common goals by partnering with the whole community, including culturally isolated groups and marginalized community members, through sharing knowledge and building consensus
- Dedication: LACDMH and its stakeholders work towards improving the lives of consumers and diverse communities
- Transparency: LACDMH and its stakeholders openly convey their ideas, decisions, and outcomes to ensure trust throughout all levels of operation
- Communication: LACDMH and its stakeholders ensure information is communicated, shared, and used in a mindful and meaningful manner to increase engagement, transparency, and trust
- Integrity: LACDMH and its stakeholders conduct themselves professionally according to the highest ethical standards
- Respect: LACDMH and its stakeholders recognize the uniqueness of every individual, including cultural differences, and treat all people in a way that affirms their personal worth and dignity
- Accountability: LACDMH and its stakeholders take responsibility for the choices made and their outcomes
- Quality and Excellence: LACDMH and its stakeholders embrace the highest personal, organizational, professional, and clinical standards and commit to achieving those standards by continually improving every aspect of their performance

Whole Person Care (WPC) Intensive Service Recipient and Kin through Peer (ISR/KTP)
The WPC-ISR/KTP Program is a field-based and focuses on serving adults who have severe and persistent mental health condition, including co-occurring substance use disorders. Consumers eligible for the program must be Medi-Cal-eligible, reside in Los

Angeles County, and have had at least two (2) psychiatric inpatient hospitalizations within the last 12 months.

The program provides a range of supportive services that prevent unnecessary psychiatric inpatient hospitalization by providing emotional support and referral to community agencies. Supportive services include:

- Crisis support services
- Service navigation
- Benefits establishment
- Linkage to mental health
- Health care
- Substance use interventions
- Assistance with emergency food, clothing, purchase of personal hygiene items, and household goods
- Linkage to housing resources, social services, educational and employment services
- Legal assistance
- Transportation

The KTP Program provides ongoing support from a peer substituting as a family to provide a surrogate "kin" function for consumers that need longer-term social help through Community Health Workers (CHW) who can provide long-term kinship and serve as a surrogate family. The CHWs focus on intense relationship-building and long-term sustainable community reintegration to preserve healthy wellbeing.

The WPC-ISR and KTP program contributes to LACDMH's provision of culturally and linguistically competent services by providing specialized outreach and engagement activities for disengaged and marginalized residents of Los Angeles County. Many of them face needs related to living with a mental health condition, substance use, and homelessness. The peer workforce has successfully worked with these hard-to-engaged populations and linked them to appropriate services. Utilizing the peer-to-peer approach and linguistically matching staff to consumers have not only increased access to mental health services but also reduced disparities. Referrals are assigned to staff who have matching linguistic and cultural backgrounds to connect and build relationships for ongoing services quickly.

During FY 19-20, the program was drastically affected by COVID-19 given that it relies on working relationships with hospitals and the ability to first engage and enroll participants while they are hospitalized. As a result of the pandemic, very few hospitals allowed WPC staff to enter the facility to engage and enroll individuals. Some staff continued to outreach to in-person and the program continued to receive referrals from many hospitals.

CONSUMERS SERVED BY WHOLE PERSON CARE
FY 19-20

Program/ Activity	# Consumers Served by Race/Ethnicity							Gender					Languages used by Staff in service provision
	White	Multiracial	African American	Latino/ Latinx	API	American Indian	Other (Specify)	M/F	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
WPC	488	13	493	686	59	12	79 (Unknown)	1,799	19			13	

Alternative Crisis Services

Alternative Crisis Services (ACS) provides a comprehensive range of services and supports persons experiencing mental health conditions. Services are designed to provide alternatives to emergency room care, acute inpatient hospitalization and institutional care, reduce homelessness, and prevent incarceration. These programs are essential to crisis intervention and stabilization, service integration, and linkage to community-based programs (e.g., FSP and Assertive Community Treatment programs, housing alternatives, and treatment for co-occurring substance abuse). ACS serves individuals 18 years of age and older from all racial/ethnic, cultural and linguistic backgrounds.

In CY 2019, Countywide Resource Management integrated with the Managed Care Division and changed its name to the Intensive Care Division. It remains responsible for overall administrative, clinical, integrative, and fiscal aspects of programs that serve the most severely ill individuals with mental illness. This includes planning, developing, and implementing urgent care centers and enriched residential programs for these specialized populations. Additionally, the division coordinates functions to maximize the flow of consumers between various levels of care and community-based mental health services and supports. ACS's key activities include:

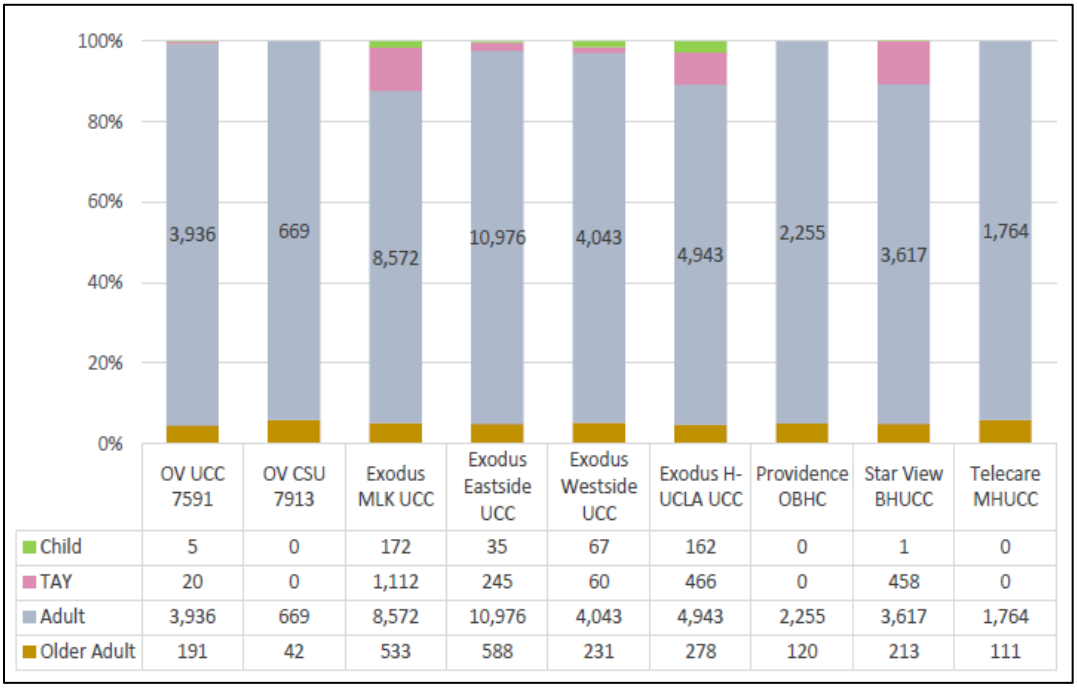
- Divert consumers as appropriate to mental health urgent cares
- Divert consumers as appropriate to Crisis Residential Treatment programs
- Utilize mental health clinician teams in the field as Alternatives to Crisis Response

Psychiatric Urgent Care Centers (UCC)

Psychiatric UCC 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, seven days a week. UCC provide case management for individuals experiencing psychological distress and/or psychiatric crisis. UCC services, including integrated services for co-occurring disorders, are focused on stabilization and linkage to recovery-oriented community-based resources. Consumers are permitted to stay in

the UCC chair 23 hours and 59 minutes that are licensed by the California Department of Health Care Services. The following graphs provide an overview of FY 19-20 outcomes of the eight (8) UCC.

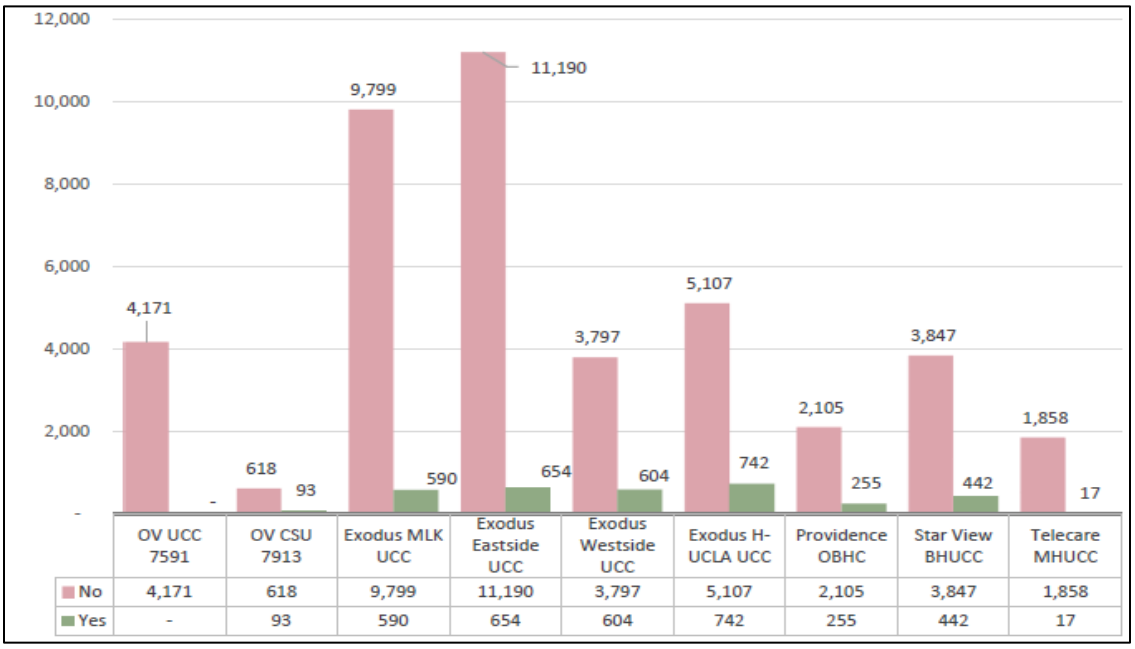
UCC NEW ADMISSIONS BY AGE GROUP, FY 19-20



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
Child	5	0	172	35	67	162	0	1	0
TAY	20	0	1,112	245	60	466	0	458	0
Adult	3,936	669	8,572	10,976	4,043	4,943	2,255	3,617	1,764
Older Adult	191	42	533	588	231	278	120	213	111

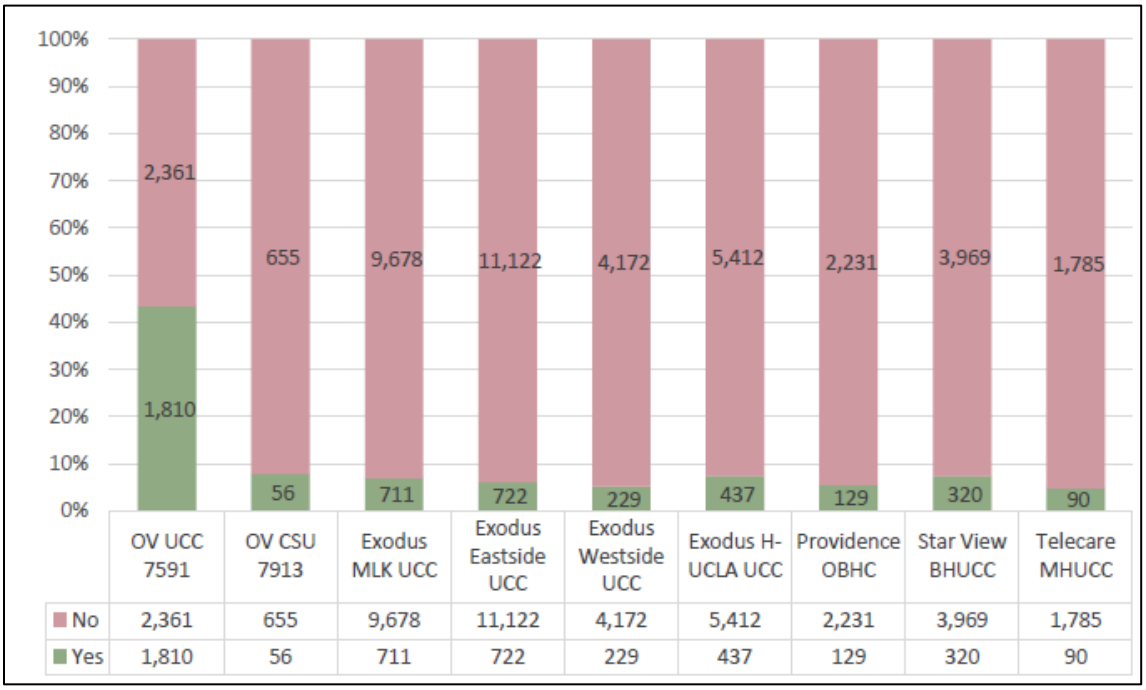
This space was intentionally left blank

CONSUMERS WITH A PSYCHIATRIC EMERGENCY ASSESSMENT WITHIN 30 DAYS OF AN UCC ASSESSMENT, FY 19-20



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	4,171	618	9,799	11,190	3,797	5,107	2,105	3,847	1,858
Yes	-	93	590	654	604	742	255	442	17

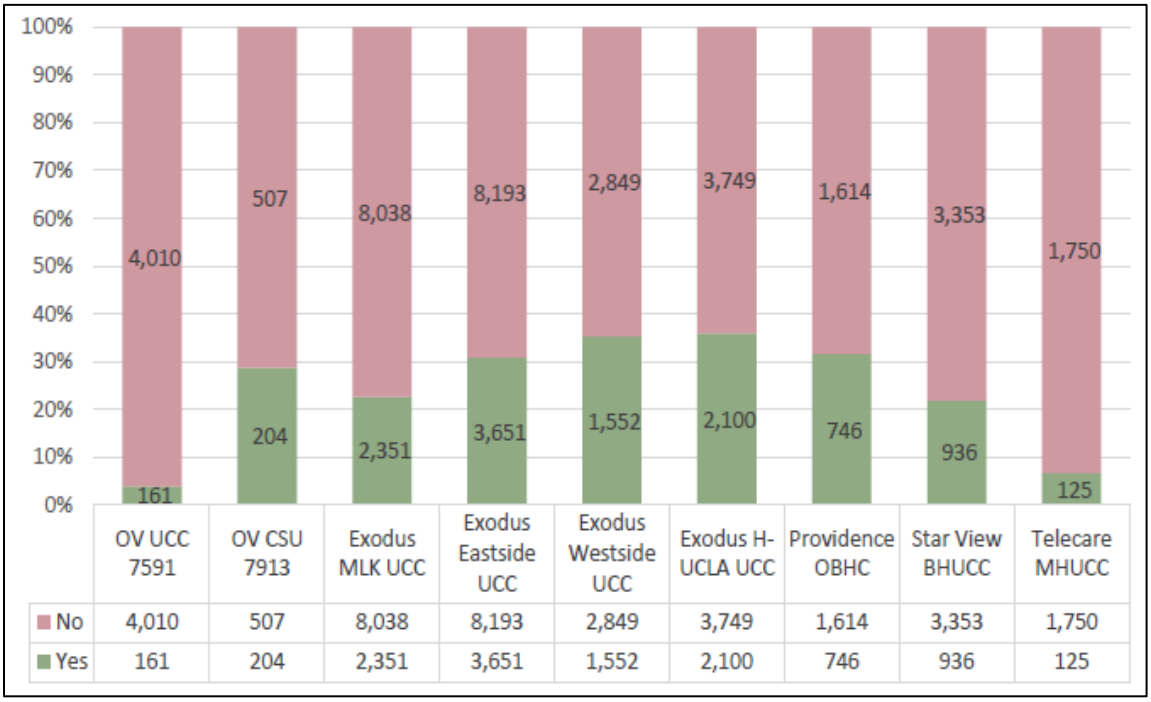
CONSUMERS RETURNING TO UCC WITHIN 30 DAYS OF PRIOR UCC VISIT, FY 19-20



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	2,361	655	9,678	11,122	4,172	5,412	2,231	3,969	1,785
Yes	1,810	56	711	722	229	437	129	320	90

CONSUMERS WHO WERE HOMELESS UPON ADMISSION TO UCCS

FY 19-20



	OV UCC 7591	OV CSU 7913	Exodus MLK UCC	Exodus Eastside UCC	Exodus Westside UCC	Exodus H-UCLA UCC	Providence OBHC	Star View BHUCC	Telecare MHUCC
No	4,010	507	8,038	8,193	2,849	3,749	1,614	3,353	1,750
Yes	161	204	2,351	3,651	1,552	2,100	746	936	125

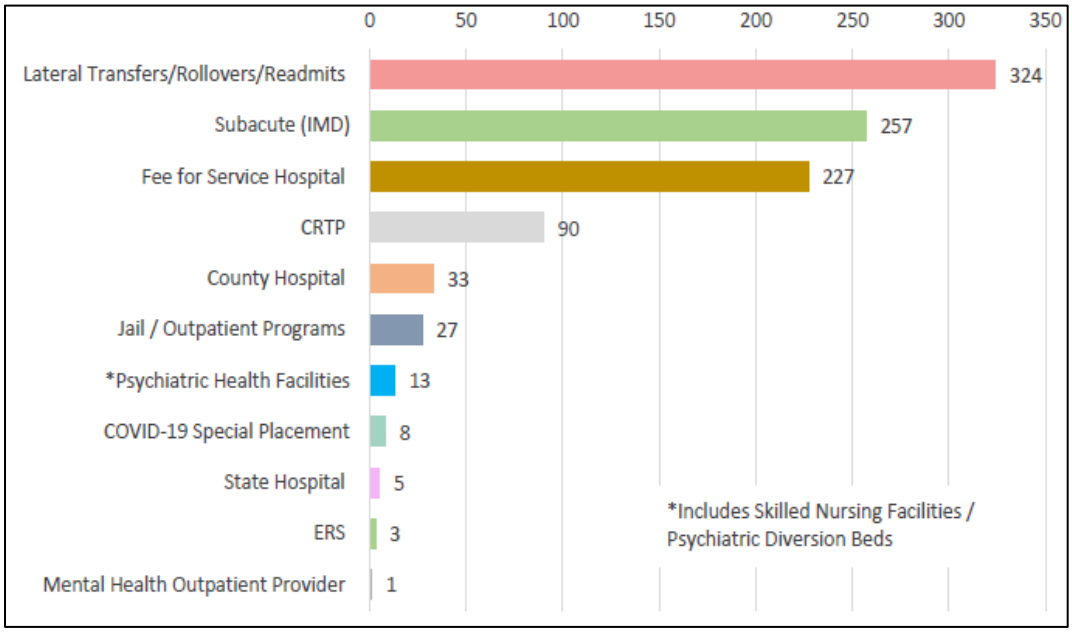
Source: Mental Health Services Act-Three Year (MHSA) Program & Expenditure Plan, FY 21-22 through 23-24.

Enriched Residential Services (ERS)

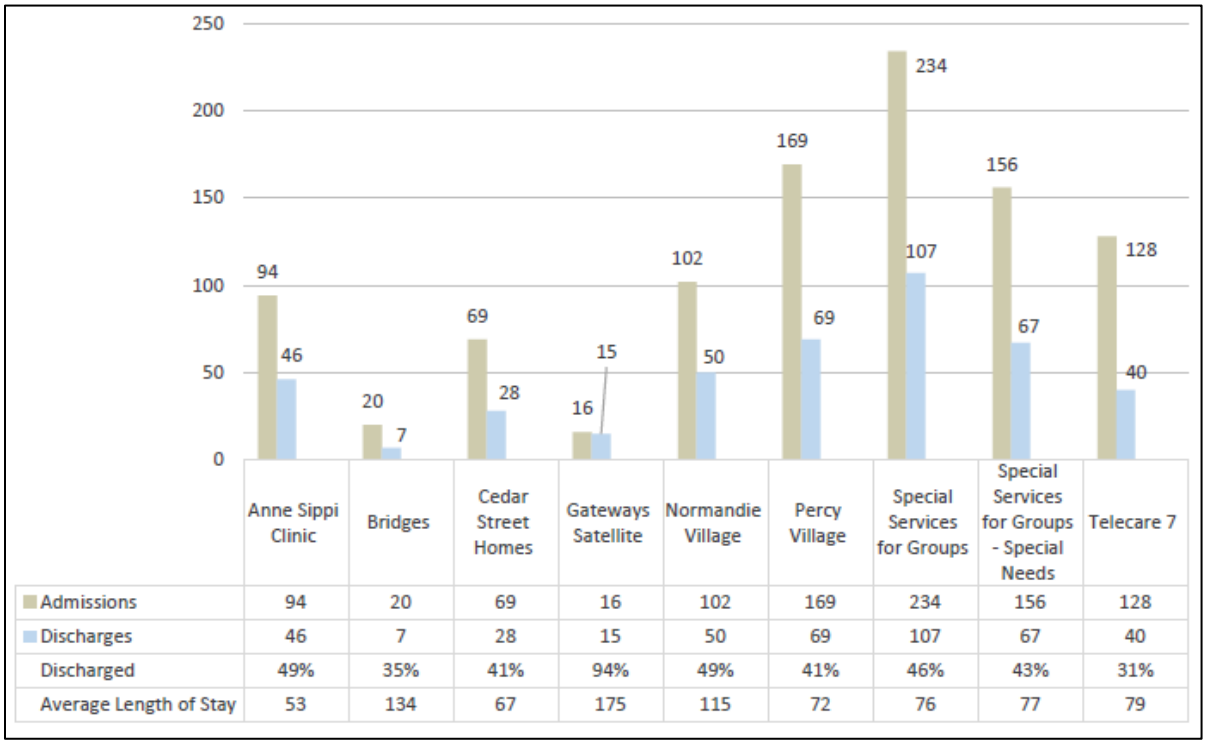
ERS is designed to provide supportive on-site mental health services at selected licensed Adult Residential Facilities, and in some instances, assisted living, congregate housing or other independent living situations. The program also assists consumers transitioning from acute inpatient and institutional settings to the community by providing intensive mental health, substance abuse treatment and supportive services. The following graphs provide an overview of FY 19-20 outcomes of the nine (9) ERS facilities.

This space was intentionally left blank

SOURCE OF CONSUMER REFERRALS FOR ERS ADMISSIONS (n = 988) FY 19-20

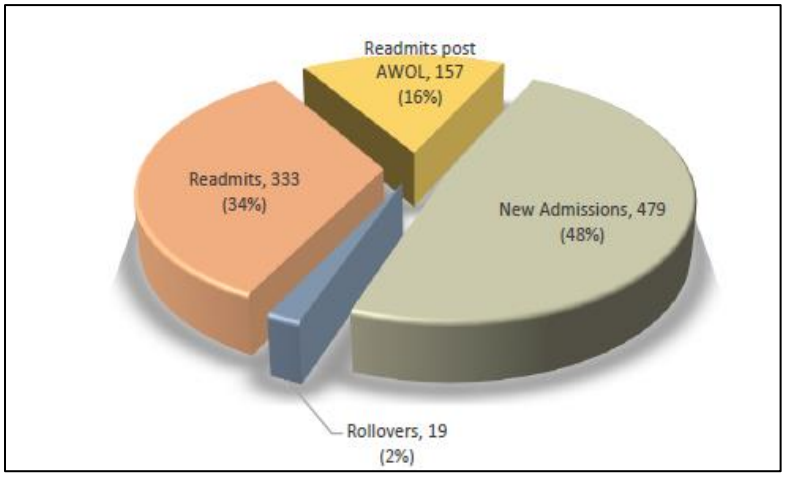


CONSUMER ADMISSION AND DISCHARGE RATES TO ERS FACILITIES FY 19-20 (Admission n = 988; Discharge n = 429)



	Anne Sippi Clinic	Bridges	Cedar Street Homes	Gateways Satellite	Normandie Village	Percy Village	Special Services for Groups	Special Services for Groups - Special Needs	Telecare 7
Admissions	94	20	69	16	102	169	234	156	128
Discharges	46	7	28	15	50	69	107	67	40
Discharged	49%	35%	41%	94%	49%	41%	46%	43%	31%
Average Length of Stay	53	134	67	175	115	72	76	77	79

CONSUMER ADMISSION TYPES TO ERS FACILITIES (n = 988)
FY 19-20



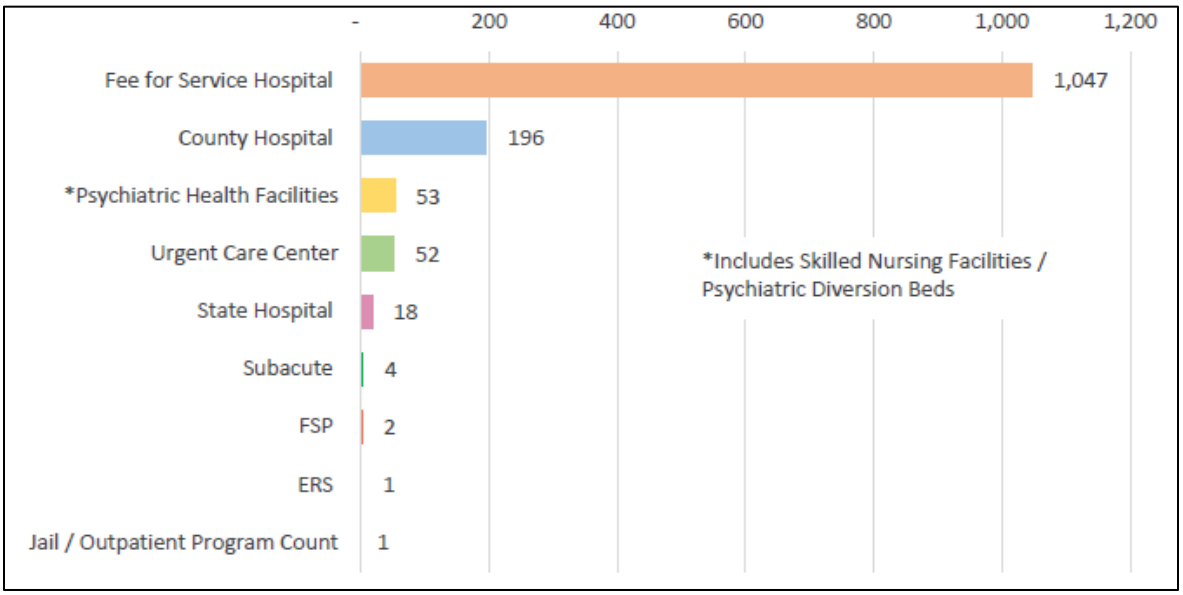
Note: Admission types include consumers who newly admit into a facility for the current fiscal year (New Admissions); readmit into the same facility as result of an absence (Readmits or Readmits post AWOL); (3) transfer internally to a higher or lower level of care (Lateral Transfers); and (4) change bed type, such as from indigent to Medi-Cal (Rollovers).

Crisis Residential Treatment Programs (CRTP)

CRTPs are designed to provide short-term, intensive, and supportive services in a home-like environment through an active social rehabilitation program that is certified by the California Department of Health Services and licensed by the California Department of Social Services, Community Care Licensing Division. These services are designed to improve the lives and adaptive functioning of persons served by the CRTP Program. Persons admitted to a CRTP receive an array of services including:

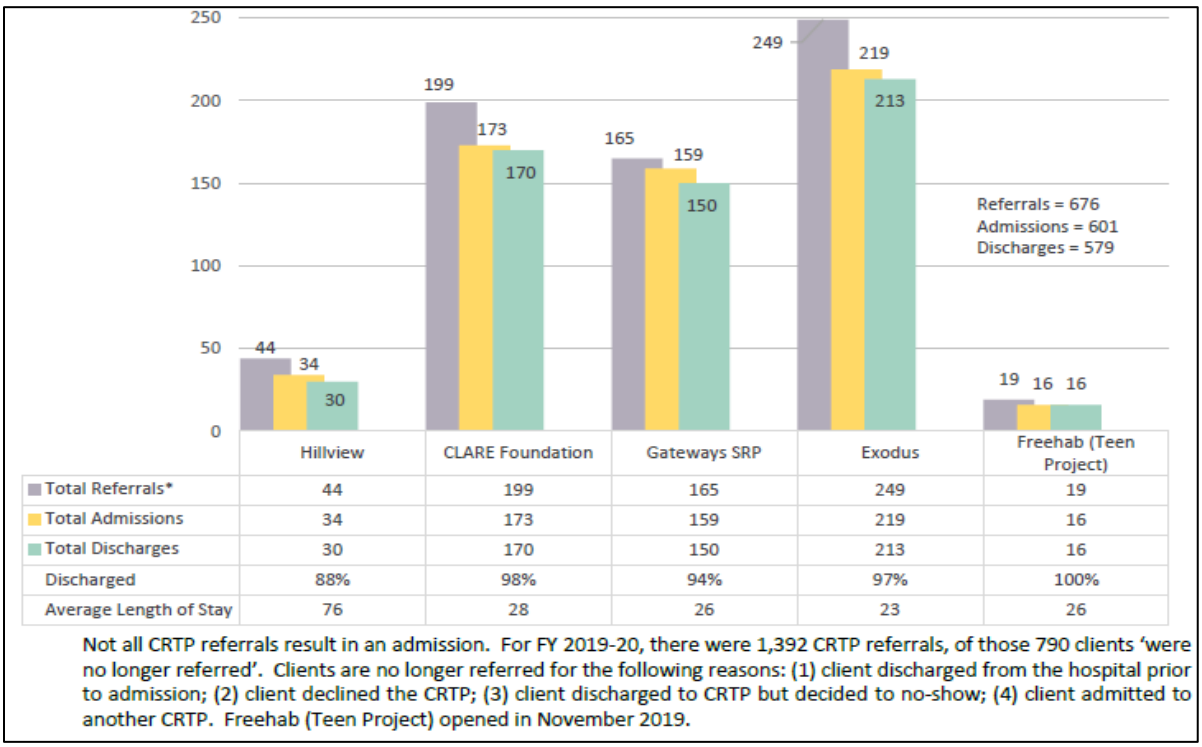
- Self-help skills
- Peer support
- Individual and group intervention
- Social skills
- Community re-integration
- Medication support
- Co-occurring services,
- Pre-vocational/educational support
- Discharge planning

SOURCE OF CONSUMER REFERRALS FOR CRTP ADMISSIONS (n = 1,374)
FY 19-20



This space was intentionally left blank

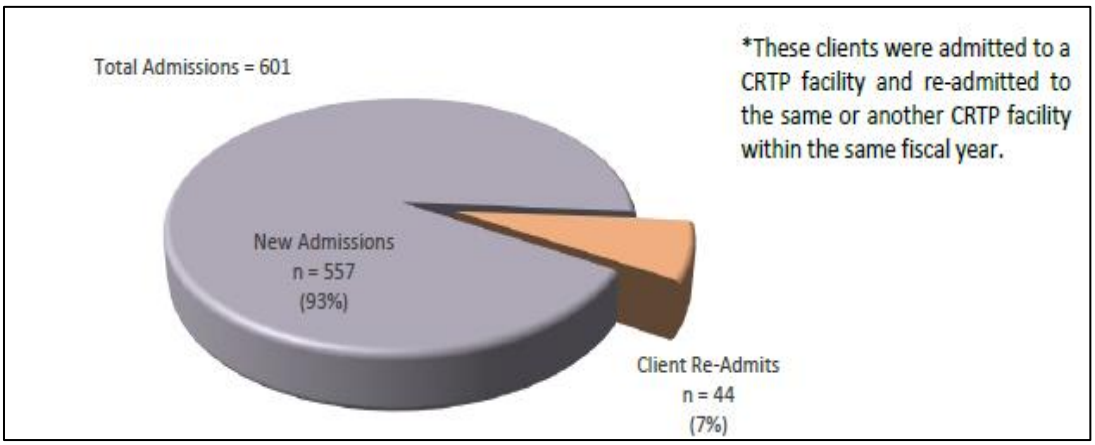
CONSUMER REFERRALS, ADMISSIONS AND DISCHARGE RATES TO CRTP FY 19-20



	Hillview	CLARE Foundation	Gateways SRP	Exodus	Freehab (Teen Project)
Total Referrals*	44	199	165	249	19
Total Admissions	34	173	159	219	16
Total Discharges	30	170	150	213	16
Discharged	88%	98%	94%	97%	100%
Average Length of Stay	76	28	26	23	26

Not all CRTP referrals result in an admission. For FY 2019-20, there were 1,392 CRTP referrals, of those 790 clients 'were no longer referred'. Clients are no longer referred for the following reasons: (1) client discharged from the hospital prior to admission; (2) client declined the CRTP; (3) client discharged to CRTP but decided to no-show; (4) client admitted to another CRTP. Freehab (Teen Project) opened in November 2019.

CONSUMER ADMISSION TYPES TO CRTP FACILITIES (n = 601) FY 19-20



Source: Mental Health Services Act-Three Year (MHSA) Program & Expenditure Plan, FY 21-22 through 23-24.

Law Enforcement Teams (LET)

The countywide police and mental health co-responder teams consist of LACDMH staff working collaboratively with local police departments in Los Angeles County. The primary mission of LET is to assist patrol officers when responding to 911 calls involving persons with a mental illness. These crisis intervention services are aimed to reduce incarcerations, mitigate police use of force, and allow patrol officers to return quickly to patrol duties.

The County's diverse population requires compassionate and equitable intervention methods across the spectrum of care. LACDMH serves those most vulnerable and at-risk in the community through expanded and personalized programs and collaboration with other County departments.

LET co-response teams consist of a law enforcement officer and a LACDMH mental health clinician who respond to 911 calls involving mental health crises. These teams ensure that the individuals in crisis receive appropriate, specialized care and safe transportation to the treatment facilities. LET and LACDMH's Psychiatric Mobile Response Teams (PMRT) support one another as resources permit. Mental health clinicians have already been assigned to work with 40 of the 46 police departments throughout the County.

During FY 19-20, there were 14,472 calls, of which 31% involved homeless individuals; 3% resulted in arrests; and 61% required hospitalizations.

The Training Unit, formerly the Workforce, Education and Training Division

The Training Unit coordinates the majority of Department-wide training offerings for Directly Operated and Contracted programs. The Unit is responsible 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 premises:

- 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
- The Los Angeles County MHSA-WET Plan seeks to address the fundamental concepts of creating and supporting a workforce (both present and future) that is culturally competent, consumer/family driven, and promotes the transformation of

mental health services to a strength-based approach that is inclusive of recovery, resilience and wellness. Such tenets are cornerstones of MHSA. The Plan provides opportunities to recruit, train and re-train public mental health staff to meet those mandates.

For detailed information regarding workforce capacity building efforts, see the Criterion 6.

<table>
<tr><th colspan="3">MHSA WET</th></tr>
<tr><th>Projects/Activities/Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>1. Public Mental Health Partnership (PMHP)
The mission of the UCLA-DMH Public Mental Health Partnership (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 Los Angeles County (LAC); and to do so in the context of a transparent, trusting partnership with the Los Angeles County Department of Mental Health (LACDMH) that generates benefits for both the University and public health communities. The PMHP is comprised of two (2) sections focused on serious mental illness -- the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) Training and Implementation Program.</td><td>Due to COVID-19, some services transitioned to online, while others were cancelled.</td><td>During FY 19-20, UCLA provided the following trainings services.

Public Mental Health Partnership:
<table>
<tr><td>Initiative for Community Psychiatry
A. Core curricular training workshops (HOME)
B. Consultation with Homeless outreach leaders, clinicians, and agencies.
C. Quality Assurance</td><td>Services Provided:
A. Ten (10) day long workshops within each Service Area.
Creation of a HOME Manual
B. As needed training and consultation
C. Created Brief and Final Case Dossier Templates
Development of a HOME client screener</td></tr>
<tr><td>FSP Training and Implementation
A. In person/Zoom training and coaching
B. Quality Assurance
C. Innovating for Performance Improvement</td><td>A. Planning and development
100 FSP Training & Consultation sessions
FSP Team Shadows
FSP Site visits
FSP Supervisors Training
FSP Conference
FSP Training Collaborative
B. Developed FSP Training Champions Proposal
Finalized Conservatorship FAQs
Outcome Measures Dev.
Fidelity Measure Dev.
Three (3) FSP Adult Focus Groups
C. Prepare and disseminate team newsletters
Occupational Therapy Report
FSP Team Guide on “Maintaining engagement with substance using clients.”
Develop an online library for FSP
Create a Psychiatry listserv</td></tr>
<tr><td>UCLA Extension Course</td><td>Develop curriculum for Role and Functions of Substance Use Disorder Counselors in s multi-disciplinary team.
14 (three hour) courses delivered</td></tr>
</table></td></tr>
</table>

<table>
<tr><th colspan="3">MHSA WET</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>Training & Consultation for Older Adults
A. OACT MD Journal Club
B. Didactic Training
C. Curriculum Training Development</td><td>A. Six sessions
B. 10 sessions
C. 30 hours</td></tr>
<tr><td>AOT Evaluation</td><td>Quarterly Report (2)
HSRC Review
Final Report</td></tr>
</table>
BASIC T:
<table>
<tr><td>BASIC T Pipeline</td><td>Recruit and onboard:
Postdoctoral Fellows (1)
Early Entry Neuropsychologists (2)
Social Workers (2)
Training Plans for Post Doc Fellows

Staff above provide training to in-house staff across disciplines.
Respond to DMH referrals for a Comprehensive

Neuropsychological Assessment (CNAs) for clients.
Performed CNAs for ten (10) children in Palmdale
Four (4) trainings to 100 DMH Psychologists</td></tr>
<tr><td>Continuing Education</td><td>• Curriculum Development
• Peer Consultation and on call consultation
• Developed assessment skills (one-on-one peer consultation)
• Developed COVID specific curriculum for Promotores De Salud Mental
• Trained Promotores and Community Based and Faith Based organizations on COVID-19.</td></tr>
</table>
</td></tr>
<tr><td>2. Navigator Skill Development Program
• Health Navigation Certification Training

This program trains individuals employed as community workers, medical case works,</td><td>Due to COVID-19, recruitment and delivery of this training has been delayed and was not</td><td>n/a</td></tr>
</table>

<table>
<tr><th colspan="3">MHSA WET</th></tr>
<tr><th>Projects/Activities/Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>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.</td><td>delivered during FY 19-20.</td><td></td></tr>
<tr><td>3. Interpreter Training Program
The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual 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.</td><td>Due to COVID-19, not all trainings were delivered during FY 19-20.</td><td>. FY 2019/2020 Outcomes:
<table><tr><th>TRAINING</th><th># OF ATTENDEES</th></tr><tr><td>Increasing Spanish Mental Health Clinical Terminology</td><td>29</td></tr><tr><td>Introduction To Interpreting in Mental Health Settings</td><td>24</td></tr><tr><td>Increasing Spanish Mental Health Clinical Terminology</td><td>28</td></tr><tr><td>Increasing Mandarin Mental Health Clinical Terminology</td><td>18</td></tr><tr><td>Increasing Spanish Mental Health Clinical Terminology</td><td>26</td></tr><tr><td>TOTAL</td><td>125</td></tr></table></td></tr>
<tr><td>4. Learning Net System
The Department is developing an online registration system that manages both registration and payment for trainings and conferences coordinated by the Department. This system is being developed in multiple phases.</td><td>Development and partial rollout continue</td><td>Not applicable during this continued development stage.</td></tr>
</table>

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Charles R. Drew Affiliation Agreement **5. Pathways to Health Academy Program** This academic and internship program is for high school students in SA 6 interested in behavioral health careers including mental health. **6. Psychiatric Residency Program** The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County. The first class started in Academic Year 18-19 with 24 trainees ranging from Post Graduate Year I to IV. The first class will graduate in June 2022.		During FY 19-20, 36 students participated, with 94% representing un- or under- served communities. Of these students, 66% spoke a second language. **During FY 19-20, residents included:** PGY1: six psychiatric residents PGY2: six psychiatric residents Total: 12 psychiatric residents **Rotations:** <u>PGY1</u> One month of university onboarding is done at CDU VA Long Beach (Inpatient Psychiatry): four months Rancho Los Amigos (Inpatient Medicine): two months Rancho Los Amigos (Neurology): two months Kedren (Outpatient Medicine): tow months Harbor-UCLA (Emergency Psychiatry): one month <u>PGY2</u> VA Long Beach (Inpatient Psychiatry): three months VA Long Beach (Consultation and Liaison): two months VA Long Beach (Emergency Psychiatry): one month VA Long Beach (Substance Abuse): two months VA Long Beach (Geriatric Psychiatry): one month Kedren (Inpatient Psychiatry): one month Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): two months The above PGY two (2) rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
7. Intensive Mental Health Recovery Specialist Training Program Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members, with a minimum of two (2) years of college 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 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. Due to COVID-19, only one (1) cohort was able to complete this training.	Due to COVID-19, only one (1) training cohort completed this training.	During FY 19-20, 27 individuals started the training and 21 completed the training. Of those participants, 81% represented individuals from un- or under- served populations, and 57% spoke a second language, other than English.
Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System		
8. Honest, Open, Proud Program Through the Illinois Institute of Technology, the Department offered technical assistance to participants who had completed the training during FY 18-19.	Due to Covid-19, only one (1) participant was able to take advantage of this technical assistance offer during FY 19-20.	Additional components of this training are planned for subsequent Fiscal Years.
9. Community Inclusion and Peer Support Program Through this training effort, the County has secured a trainer to develop and offer training and	Due to COVID-19, not all cohorts completed	During FY 19-20, 74 individuals completed this training. Additional components of this training are planned for subsequent Fiscal Years.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
technical assistance to assist the health system in the implementation of practices and tools to promote and advance community participation for people in recovery through the intentional skills of Peer Supporters	the training within the FY.	
10. Wellness Recovery Action Plan (WRAP) The WRAP program trained participants through the process of identifying their personal wellness resources and how to use those resources as a guide for daily living, dealing with triggers, early warning signs of symptoms, indicators that things are breaking down, and developing advance directive and post- crisis plans.	Due to COVID-19, no training components were delivered during FY 19-20.	It is projected that delivery of this training will begin in subsequent Fiscal Years.
11. 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 the participants' understanding of resilience and wellness, and increases the availability of a workforce oriented to self-help and empowerment of parent advocates/parent partner in the mental health system. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.	Due to COVID-19, this program did experience a reduction in delivered training.	During FY 19-20, 96 Parent Partners were trained.
12. Parent Partner Training Symposium These training opportunities covered a wide range of topics, including: integrating care/co-occurring disorders; criminal justice issues; crisis intervention	Due to COVID-19, this program did experience a	The Three (3)-day symposium was held once during FY 19-20 and was attended by approximately 164 parent partners.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
and support strategies; education; employment; homelessness; housing; inpatient/hospitalizations; LGBTQI issues; Older Adults; residential and group homes; and suicide prevention. **13. Continuum of Care Reform (CCR)** Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular, this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, LACDMH offered the following trainings: **1) Continuum of Care Reform: Child and Family Team Process Overview (CFT)** This training provides an overview of how the Child and Family Team process is utilized in the Continuum of Care Reform (CCR). In CCR, the Child and Family Teaming process is the decision-making vehicle for case planning and service delivery. This training reviews the elements involved in the Child and Family process, team members, and their roles. This training identifies the Integrated Core Practice Model elements embedded in the Child and Family Teaming process, and its role in providing collaborative services. Participants learn engagement strategies and the importance of keeping the child and family's voice and	reduction in delivered training.	FY 19-20, this was delivered to 20 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
choice at the center. Participants learn strategies for effective teaming with children and families, and formal and informal supports. This training reviews how teaming can promote positive permanency outcomes and assist with meeting the underlying needs of children. This training utilizes both didactic and experiential learning strategies to support the transfer of learning. **2) Continuum of Care Reform: Integrated Core Practice Model Overview (ICPM)** This training provides an overview of the Continuum of Care Reform, Integrated Core Practice Model practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice behaviors. Participants learn to utilize interagency teaming strategies while providing services to children and families involved in the Child Welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and Wellbeing promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge. **3) Crafting Underlying Needs Statements and Services (UNDERLYING NEEDS)** This training provides information on Underlying Needs and its application in the Continuum of Care Reform		During 19-20, this training was delivered to 292 individuals. During FY 19-20, this training was delivered to 25 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
(CCR) process. It prepares providers to identify the relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs based statement and support development of individualized services for youth and families in the Child Welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills and implementation of training strategies. **4) Engaging Probation Youth (PROBATION)** This training provides the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. The impact of trauma and its effects on the brain, attachment, physiology, and social relationships are examined. The overview includes discussion of the trauma informed approach, cultural sensitivity, and underlying needs. Strategies for engagement as well as staff's awareness of their countertransference are explored. Group activities are incorporated to enhance application of learning and address challenging behaviors. Lastly, the training covers self-care, and participants develop self-care strategies for themselves.		During FY 19-20, this training was delivered to 397 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
5) Everything You Have Wanted to Know About Psycho-Pharmacology: Medication Side Effects (MEDICATION) This workshop provides an introduction to common side effects that may be experienced by youth being prescribed psychotropic medications. Basic neurobiology and the role of neurotransmitters in psychiatric illness and medication response is reviewed along with an update on the desired effects, duration of action, and side effect profiles of antidepressants, stimulants, anti-anxiety agents and anti-psychotic medications. The differences between an allergic response and a side effect is reviewed and illustrated. The role of the FDA is reviewed in order to understand how medications come to market and side effects monitored. Cultural differences (based on population genetics) is illustrated to demonstrate why certain illnesses/syndromes are more common in some groups, while medication side effects may occur more frequently in some populations and not others.		During FY 19-20, this training was delivered to 51 individuals.
6) LGBTQ+ Youth in Placement: Strategies and Interventions (LGBTQ) This training provides the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens is utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma and trauma, particularly as it relates to LGBTQ+ youth of		During FY 19-20, this training was delivered to 241 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
color. This training discusses how community impacts LGBTQ+ youth and suggests strategies to support positive connections. Participants learn about the Helm's Identity Development Model as a way to conceptualize the coming out process and how to employ healthy approaches in their daily interactions with the youth. Trainers provide practical applications to address bullying, LGBTQ+ challenges, the coming out process, and the CFT model. Group activities enhance learning and increase one's self-awareness as it relates to this population. **7) Permanency Values and Skills for Child Welfare, Probation, and Mental Health Professionals (PERMANENCY)** 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 Wellbeing. One of the core values of the Continuum of Care Reform (CCR) is permanency. This training supports the goal of permanency for children and youth involved in the Child Welfare system. Training discussions include understanding the value of taking a "both/and" approach when working with children and youth as well as learning skills and strategies that support achieving a "no matter what" family for every child. Case-based practice interventions are embedded to enhance the application of trauma-responsive, team-based 5-step approach. The training provides tools for addressing and		During FY 19-20, this training was delivered to 110 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
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.		
8) Prevent the Eruption: Trauma Informed De-Escalation Strategies (DE-ESCALATION) This training provides LACDMH, DCFS, Probation and Contract Provider staff with: knowledge to: recognize and better understand trauma when observed in children and youth; address the impact of trauma on the brain; and provide trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training reviews the ascent of escalation phases, de-escalation phase clues and offer trauma informed interventions for each phase including specifics regarding the debriefing process and strategies for prevention of self-injurious behavior. Finally, the importance of self-care is discussed, and the participants develop self-care strategies for their use.		During FY 19-20, this training was delivered to 634 individuals.
9) Engaging Runaway Youth in Placement: Overview and Strategies for Response (RUNAWAY) Most runaway youths struggle with substance abuse and mental health issues, are at high risk for being a victim of sex trafficking and have higher rates of involvement with the juvenile justice system. This training increases participants' understanding of the characteristics of youth who run and the impact of traumatic experiences and development on running behavior. It provides strategies to reduce the risk of		During FY 19-20, this training was delivered to 30 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
running, including recommended policy, practice, training, and direct engagement with youth. The curriculum takes a case-based approach to designing implementable strategies to reduce risk to run. Following the introduction of core content, attendees review case information using a multidisciplinary and collaborative lens to assist them in identifying effective strategies for engaging youth and reducing run risk. Teams learn to develop safety plans that encompass run behavior prevention and intervention.		
10) Self-Care for Providers (SELF-CARE) This training prepares Continuum of Care Reform (CCR) providers to identify the relationship between compassion fatigue and self-care strategies. Self-care and general wellbeing are essential components to prevent compassion fatigue and support quality services. Discussion includes risks factors, signs, and impact associated with compassion fatigue. Participants learn the relationship between culture and self-care. Also reviewed are prevention approaches important for mitigating compassion fatigue risk and increasing self-care and resilience. Identification and integration of self- care strategies into daily practice are addressed. Lastly, this training incorporates both didactic and experiential learning to support transfer of understanding, knowledge, and integration of training objectives.		During FY 19-20, this training was delivered to 21 individuals.
11) Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (STIC)		During FY 19-20, this training was delivered to 78 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
This six (6)-hour training reviews the use of competency-based supervision and essential components of trauma-informed care for implementation and monitoring purposes. Trauma-informed supervision is known for its protective factor attributes and in conjunction with trauma-informed self-care support are critical to supporting personnel. (Please Note: Trauma-informed supervision refers to security, respect, and trust within the supervisory relationship.) Knowledge, skills, and understandings regarding trauma-informed care, secondary trauma, the role of supervision within those, and positive self-care practices are explored. This training is highly experiential, focused on skills and enhancing understanding using vignettes and role-play by the trainer and the participants.		
12) Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (SVT) 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 vicarious traumatization on clinicians as well as supervisors of clinicians who work with the complexity traumatized. Included in the discussion is the role of effective competency-based supervision as a protective factor for clinicians and its facilitative factor impact on client efficacy treatment. This training has both didactic and experiential components and incorporate current competency-based supervision strategies applicable to working in trauma-informed care.		During FY 19-20, this training was delivered to 98 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Vignettes serve to enhance the understanding and implementation of content to the supervisory role. The experiential component of the training addresses both supervisor and supervisee psychological resilience promoting their health and wellbeing within the context of trauma work.		
13) Trauma-Informed Practice for Child Welfare Involved Children and Families (TIC) This foundational trauma-informed care training supports the Continuum of Care Reform requirement that services provided to Child Welfare children and families are trauma-informed. This training introduces key and essential trauma recovery skills that staff and programs can use to provide a safety-oriented, trauma-informed framework for youth and families. Participants are provided with an overview of developmental trauma implications on the brain and behavior. Participants learn tools to recognize trauma related behaviors and respond in ways that foster resilience. This training reviews practice strategies to effectively engage foster youth who have experienced trauma. As a result of this training, participants gain knowledge and skills to deliver services through a trauma-informed lens.		During FY 19-20, this training was delivered to 370 individuals.
14) Youth Mental Health First Aid Course (YMHFA) Mental Health First Aid teaches a 5-step action plan to offer initial help to people with the signs and symptoms of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care. Anyone can take the 8-hour		During FY 19-20, this training was delivered to 35 individuals.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Mental Health First Aid course - first responders, students, teachers, leaders of faith communities, human resources professionals, and caring community members. **15) Youth with Developmental Disabilities and Mental Illness: Overview and Interventions (MHDD)** The Co-occurring Development Disabilities (CDD) Program trains mental health clinicians to assess and treat mental health issues that consumers with CDD are at high risk of developing. The curriculum provides participants with tools to differentiate the mental health issue from the intellectual/developmental disability and to treat the mental health issue in context of the CDD as well. During the training, the participants learn to apply the Diagnostic Manual-Intellectual Disability (DM-ID-2): A Textbook of Diagnosis of Mental Disorders in Person with Intellectual mental health problem(s). Knowledge and expertise related to these diagnostic tools are increasingly valued as a complement to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM V).		During FY 19-20, this training was delivered to 22 individuals.
FINANCIAL INCENTIVE PROGRAMS **14. Mental Health Psychiatrist Student Loan Repayment Incentive** DMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at LACDMH and have active, unpaid,	Due to COVID-19, these programs experience curtailment. Their potential for re-implementation will be accessed as the economy returns to	During FY 19-20, 17 mental health psychiatrists where awarded. Of these awardees, 13 (76%) identified as representing ethnic minorities and seven (41%) spoke a second language.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MH 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.	normal and funding is secured.	
15. MH 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 is 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.		During FY 19-20, two (2) individuals were recruited and awarded.
16. MH 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		During FY 19-20, one (1) individual was awarded.

MHSA WET		
Projects/Activities/Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
within one-year from employment start date, the full reimbursement amount must be repaid. **17. Stipend Program for MSWs, MFTs, and Psychiatric Nurse** 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 service the traditionally unserved and underserved populations of the County.		During FY 19-20, this program awarded stipends to four (4) Nurse Practitioner, 70 MFT and 70 MSW students. Of all awardees, 81% of recipients identified from populations recognized as un- or under- served. Likewise, 78% spoke a threshold language. In addition to the stipends, nine (9) post-doctoral fellows were also funded as part of the Department's Psychology Post-Doctoral Fellowship Program. Of these fellows, five (5) represented un- or under- served communities and four (4) individuals spoke a second language, other than English.

This space was intentionally left blank

Criterion 3 APPENDIX

Attachment 1: 2021 Cultural Competence Plan CR 3 Acronyms

Attachment 1_Acronyms CR 3_Upc

Attachment 2: Mental Health Services Act (MHSA) Three Year Program & Expenditure Plan FY 21-22 through FY 23-24

MHSA 3 Year Plan FY 21-22 through FY

Attachment 3: Clergy Self-Care Event Evaluation Summary Report

Clergy Self-Care Event Evaluation Su

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 4

Cultural Competency Committee

August 2021

Criterion 4: Cultural Competency Committee: Client/Family, Member/Community Committee and its Integration of the Committee within the County Mental Health System

I. LACDMH Cultural Competency Committee

A. Description, Organizational Chart and Committee Membership

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. Organizationally, the CCC is housed within the Office of Administrative Operations (OAO)-Cultural Competency Unit (CCU). The CCC membership includes the cultural and linguistic 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 and goals 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 program manager 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 regularly reported to the membership at the monthly Departmental QIC meeting.

For Calendar Year (CY) 2020, the CCC leadership was composed of:

- Two Co-Chairs who are community representatives
- LACDMH Ethnic Services Manager (ESM)

In accordance with its bylaws, the committee operates under the following principles:

- The CCC actively engages with and amplifies the collective voice of consumers; family members; community members; cultural groups and brokers; peers; staff from LACDMH Directly Operated, Legal entities/Contracted and administrative programs; and Community-Based Organizations
- CCC meetings are held on a monthly basis and are open to everyone
- The CCC embraces all elements of culture and advocates for equity and inclusion of all cultural groups inclusive of, but not limited to:
    - Age
    - Country of origin, degree of acculturation, generation
    - Educational level obtained
    - Family and household composition
    - Gender Identity and sexual orientation
    - Health practices including use of traditional healers
    - Language
    - Perceptions of health and well being
    - Physical abilities or disabilities; cognitive ability or disabilities
    - Political beliefs
    - Racial and ethnic groups
    - Religious and spiritual characteristics
    - Socio-economic status

      Source: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A blueprint for Advancing and Sustaining CLAS policy and Practice, April 2013

(See Attachment 3: CCC Bylaws for additional details)

B. Policies, procedures and practices that assure members of the CCC reflect the community

CCC Membership

During CY 2020, the CCC had a total of ninety-two (92) active members. The CCC membership consisted of representatives from different cultural and linguistic groups, different roles and walks of life including consumers, family members, caregivers, community members, advocates, peers, LACDMH stakeholder groups. Among them, the Underserved Cultural Communities Subcommittees (UsCC), Service Area Leadership Team (SALT), consumer run organizations, community-based organizations, State and local advocacy agencies, mental health providers, and Los Angeles County sister Health Departments. The functions of the LACDMH-affiliated members include volunteers, peers, management, and staff from administrative and clinical programs.

The richness of the CCC's diversity can be easily appreciated across multiple elements of culture including race and ethnicity, linguistic capability, gender identity, preferred gender pronouns, sexual orientation, physical and cognitive abilities and disabilities, and a wide variety of agency affiliations.

Race and Ethnicity

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

- African American
- American
- Armenian
- Asian
- Black, Black American
- Caucasian
- Filipino
- Guatemalan
- Latino,
- Indígena (indigenous) Latina
- Latino(a)
- Mexican
- Mexican American
- Spaniard/Latino/American Indian
- Irish and German
- Italian
- Japanese
- Korean
- Native Indian
- Spanish
- White

Language

The linguistic diversity of the CCC for CY 2020 consisted of the following eleven (11) languages:

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

Gender and Gender Pronouns

Out of 92 members, twenty-one (21) self-identified as male and seventy-one (71) as female. The preferred gender pronouns endorsed by our members include:

- He/him
- She/her
- They/them
- We/us
- Ze/hir

Sexual Orientation

During CY 2020, all CCC members reported being cisgender. Furthermore, the committee's diversity in terms of self-reported sexual orientations included heterosexual, lesbian and gay.

LACDMH Stakeholder Group Affiliations

- Access for All Underserved Cultural Communities Subcommittee (UsCC)
- Asian Pacific Islander (API UsCC)
- American Indian/Alaska Native (AI/AN UsCC)
- Black & African Heritage (BAH UsCC)
- Eastern European/Middle Eastern (EE/ME UsCC)
- Latino UsCC
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two-Spirit (LGBTQIA2-S UsCC)
- Service Area Leadership Team (SALT 1)

LACDMH Program Representation

1. Directly Operated Programs

- Department of Mental Health (DMH) Downtown Mental Health Services
- DMH Edelman Mental Health Clinic
- DMH East San Gabriel Valley Mental Health Center

- DMH Martin Luther King-Augustus Psychiatric Hospital
- DMH Rio Hondo Community Mental Health Center
- DMH West Central Mental Health Service

2. Contracted/Legal Entity Providers

- Alafia Mental Health
- Alma Family Services
- Asian Pacific Counseling and Treatment Centers (APCTC)
- Amanecer Community Counseling Services
- Children's Institute Inc.
- El Centro Del Pueblo
- Five Acres
- Koreatown Youth and Community Center
- Gateways Hospital
- Hillsides
- Mount St. Mary's University
- North East Mental Health Clinic
- San Fernando Valley Community Mental Health Clinic (SFVCMHC)
- Shields for Families
- Southern California Health and Rehabilitation Program (SCHARP) & Barbour Medical Associates
- Stars Inc.
- Star View Behavioral Health
- Star View Community Services
- Tarzana Treatment Center
- The Children's Center of the Antelope Valley
- The Village Family Services
- Trinity Youth Services
- Victor Treatment Center

3. LACDMH Administrative Programs

- Cultural Competency Unit (CCU)
- DMH Helpline/ACCESS Center
- LGBTQ+ Services
- DMH Quality & Outcomes Training Division
- Office of Discipline Chiefs
- Service Area Leadership Team - SALT 1
- SALT 4
- SA 2 Administration
- SA 3 Administration
- SA 4 Administration
- SA 5 Administration
- SA 6 Administration

CCC Members' Agency Affiliation in the Community at Large

CCC members contribute a rich combination of organizations representing different aspects of community life. The list below specifies the community organizations represented by members

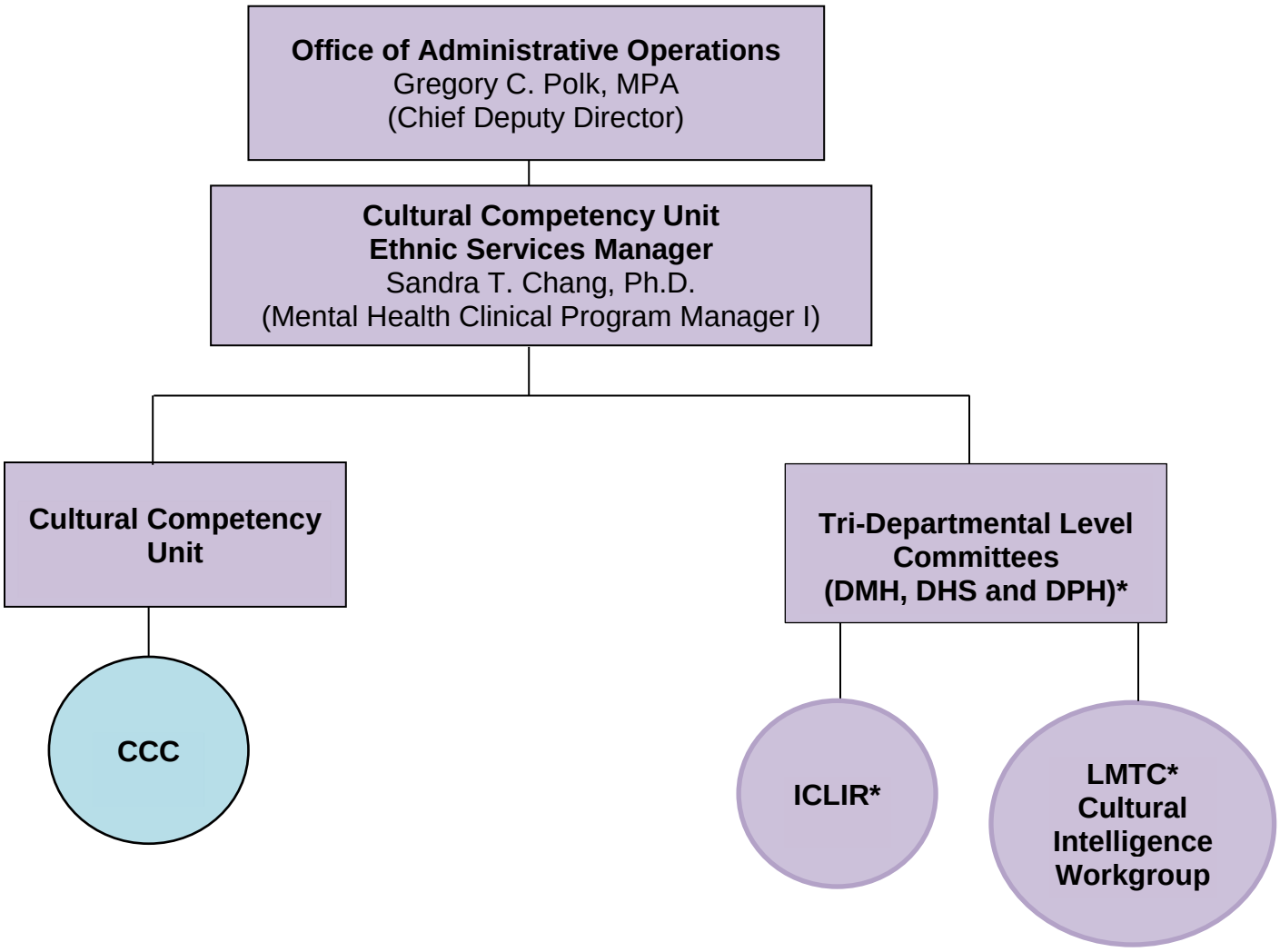
1. Consumer-Based Organizations
   - Asian Coalition
   - Aurrera Health
   - Latino Coalition
   - Los Angeles County Client Coalition
   - Peer Resource Center

2. Community-Based Organizations
   - Academy of East Los Angeles (AELA)
   - ACCESS Los Angeles County
   - Alzheimer's Association
   - Amanecer Semillas Charter Schools
   - Cal Voices
   - Child & Family Center
   - City of Pasadena
   - Disability Rights California (DRC)
   - Greater Los Angeles Agency on Deafness (GLAD)
   - Olive Support Services
   - Rancho San Antonio
   - State ACCESS
   - Wellness Los Angeles

3. Los Angeles County Departments
   - Department of Children and Family Services (DCFS)
   - Department of Public Health (DPH)
   - Department of Workforce Development, Aging and Community Services
   - Department of Health Care Services (DHCS)
   - Los Angeles County Commission on Human Relations

4. Additional Government Entities not listed above
   - Pasadena Public Health
   - National Disability Rights (NDR)
   - California Health & Human Services Agency (CHHS)
   - Office of Statewide Health Planning & Development (OSHPD)

C. Organizational Chart of the CCC, CY 2020



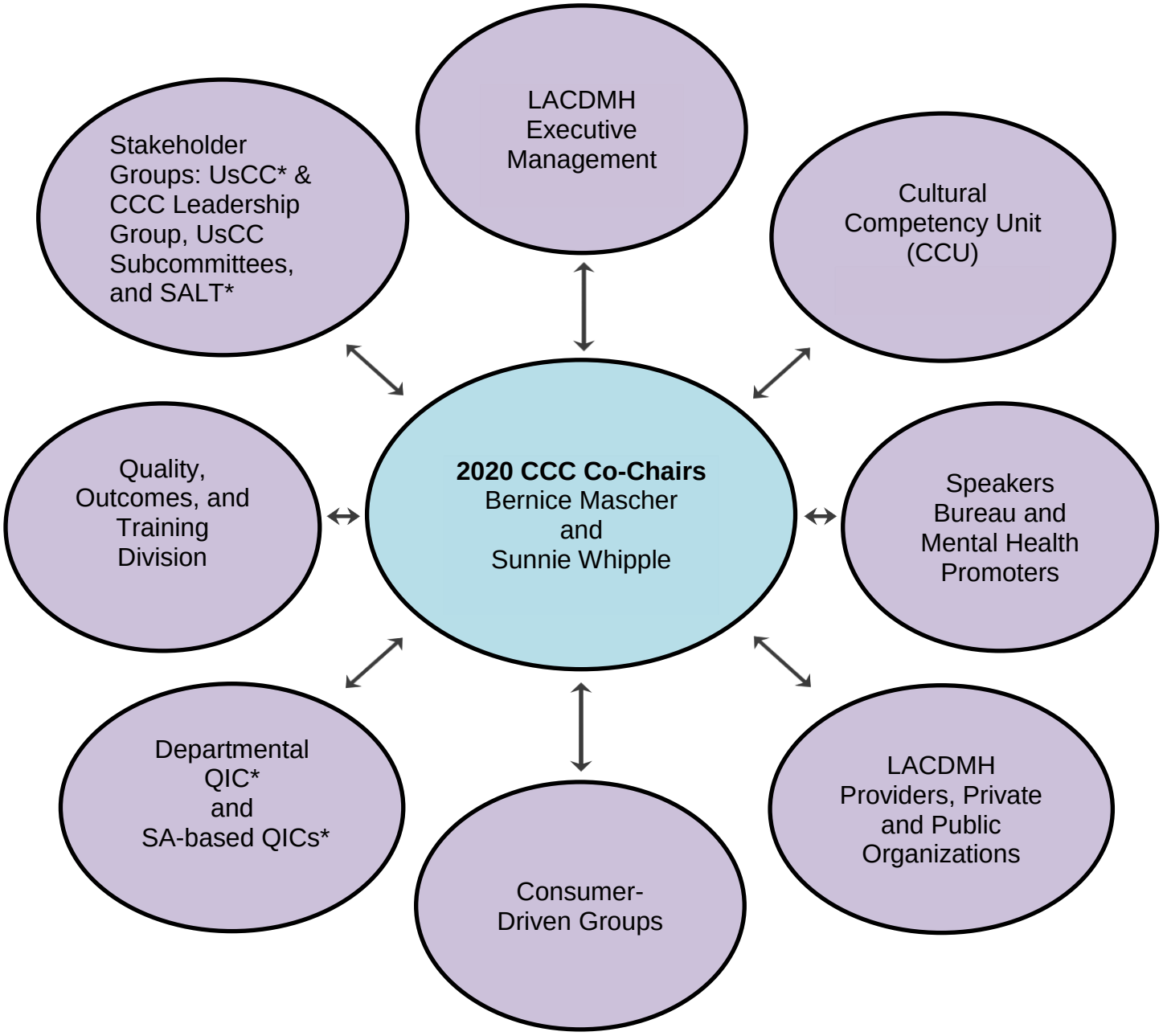
* DMH = LACDMH, DHS = Department of Health Services and DPH = Department of Public Health

ICLIR = Institute for Cultural and Linguistic Inclusion and Responsiveness

LMTC = Labor Management Transformational Council

II. CCC integration within the Mental Health System

CCC Departmental Partnerships and Collaborations, CY 2020



***** UsCC = Underserved Cultural Communities
SALT= Service Area Leadership Teams
QIC = Quality Improvement Council
QICs = Quality Improvement Committees

A. Evidence of policies, procedures, and practices that demonstrate the CCC's activities

The CCC embodies and carries out the Cultural Competence Plan Requirements pertinent to Criterion 4 as mandated by the Department of Health Care Services. LACDMH P&P 200.09 "Culturally and Linguistically Inclusive Services" defines the CCC as follows: "The ***Cultural Competency Committee*** serves as an advisory group for the infusion of cultural competency in all DMH operations. Administratively, the CCC is housed within the Office of Administrative Operations - Cultural Competency Unit (CCU). Per DHCS Cultural Competence Plan Requirements, all Counties are mandated to have an established committee to address cultural issues and concerns with representation from different cultural groups. The CCC membership includes the cultural perspectives of consumers, family members, advocates, peers, staff from Directly Operated (DO) providers and legal entities/contracted providers, and community-based organizations. The CCC advocates for the needs of all cultural and linguistic groups. Additionally, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining the mission of the Committee.

(P&P 200.09, Policy section, II. Definitions. See attachment 1: LACDMH P&P 200.09 for additional details)

P&P 200.09 also specifies LACDMH's recognition of the role of the CCC as an advisory body for cultural competence and states that "DMH clinical and administrative programs support the activities of the CCC by participating in monthly meetings and contributing toward the fulfillment of committee goals and activities, (i.e., delivering presentations, providing information regarding program outcomes, and implementing the committee recommendations in projects and initiatives)."

(***See Attachment 1: LACDMH P&P 200.09, Section, II. Definitions. for additional details)***

CCC Activities and Work Flow

At the end of each CY, the CCC holds an annual retreat to review its goals, activities and accomplishments; vote on cultural competency $object$ives 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 2020, the CCC membership decided on a model based on monthly presentations scheduled by strategically selected LACDMH programs and initiatives related to cultural competence. This model ensures the engagement of the CCC as an advisory body to provide recommendations for the planning, implementation, and evaluation of cultural diversity and cultural competence-related efforts.

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. Presenter programs and units are invited back to provide updates and follow-ups on CCC recommendations. The table below summarizes the presentations and discussions of the CCC during CY 2020.

TABLE 1: SUMMARY OF PRESENTATIONS PROVIDED TO AND TOPICS OF DISCUSSIONS HELD BY THE CCC, CY 2020

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
January	1. LACDMH Bilingual Certified Capabilities 2. 2019 CCC Annual Report
February	3. Peer Resource Center (PRC) 4. Discussion - Continuation of Parameter 4.8, "Delivery of Culturally Competent Clinical Services" and Policy 302.02, "Coordination of Care"
March	5. Story Telling and Arts Based Community Engagement Strategies 6. Discussion – "Share Your Culture" Webinar Development Project
April	DARK*
May	7. Discussion - Coping with the COVID-19 pandemic 8. LGBTQIA-2S DMH Staff Survey Proposal
June	9. Headspace Presentation and Demonstration 10. Discussion - Coping with COVID-19 and Social Unrest
July	11. Client/Family Satisfaction Data: A Stakeholder Engagement Project 12. Discussion - Coping with COVID-19: Balancing One's Mental health and Creative Outlets as a Form of Coping
August	13. Racism: An Uncontrolled Global Pandemic 14. State MHSA WET Regional Partnership: Mental Health Loan Repayment Program"
September	15. Suicide Prevention Activation Kit
October	16. Promotores de Salud Program's: Bridging the Digital Divide in the Community
November	17. Faith and Spirituality as It Relates to COVID-19 and Mental Health 18. Expansion of Health Promoters Program
December	19. Summary of 2020 CCC Activities 20. Discussion - Existing CCC Code of Conduct and Addition of New Language to Address Virtual Meetings 21. Discussion - CCC Bylaws: Role of CCC and CCU 22. Discussion - Coping with COVID-19: Wellbeing Practices and Adventures

* As a result of the COVID-19 global pandemic, the CCC meetings were shifted to a virtual platform. A significant area of focus during monthly meetings was the inclusion of discussions pertinent to COVID-19 in order to create safe spaces for members to share and process the impact of COVID-19 on their personal, familial and community

lives. Further, special presentations and a series of discussions were offered to the CCC and stakeholder partners with the goal of providing support and opportunities to learn, process, and discuss the impacts of COVID-19 and social unrest. These specialized presentations and discussions included the following:

- Faith and Spirituality as It Relates to COVID-19 and Mental Health
- Suicide Prevention Activation Kit
- Headspace App Presentation and Demonstration
- Racism: An Uncontrolled Global Pandemic
- Discussion - Coping with the COVID-19 pandemic
- Discussion - Coping with COVID-19 and Social Unrest
- Discussion - Coping with COVID-19: Balancing One's Mental health and Creative Outlets as a Form of Coping
- Discussion - Coping with COVID-19: Wellbeing Practices and Adventures

(See Attachment 2 to access the CCC's special presentation flyers)

II. A. 1. Review of 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 departmental programs and initiatives related to cultural and linguistic competence. The collective voice of the CCC is also represented at the "YourDMH" and 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.

1. <u>Presentation on LACDMH Bilingual Certification and Language Capabilities by the Department of Mental Health Human Resources</u>

   The CCC welcomed a presentation on the bilingual capability of DMH and its bilingual certification process for employees. The presentation covered the following:

   - DMH has approximately 5,300 employees out of which, approximately 1,860 receive a bonus for speaking, reading and/or writing in another language
   - DMH pays bilingual bonus for 40 different languages. If there is specific language not listed and there is a need for it, DMH will approve the language and certify the employee once the employee has successfully passed the bilingual certification test
   - Bilingual bonus compensation is paid to employees who are required to use a language in addition to English on a frequent and continuing basis

    - $50 per pay period
    - $25 additional for the following classes: Mental Health Services Coordinator, Mental Health Services Clinician I and II, Psychiatric Social Work I and II, and Mental Health Clinical Supervisor
- Relevant Los Angeles County Policies: County Code 6.10.140
- Monthly or temporary employees may qualify for bilingual bonus if their assignment requires fluency in a foreign language (including American Sign Language)
- Bilingual certified employee must possess knowledge of and sensitivity to the culture and needs of consumers

LACDMH's Bilingual Certification Process
Upon determining that a bilingual need exists:

- Programs may call HR to request a canvassing of a certification list to meet the language needs of the unit
- Human Resources (HR) sends out canvass letters for bilingual language proficiency based on the needs of each area
- DMH 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
- The Department must certify that the employee possesses the required fluency. 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 requested target language
- Upon successful testing, the employee is certified
- Requests 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 when 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

CCC Feedback and Questions

- The CCC membership appreciated this information and learning about the process of determining employees' bilingual capabilities.
- A CCC member asked what is the score an employee must have to pass the exam
- Another member asked if the certificate for bilingual fluency is available to consumers

2. Summary of the CCC Annual Report, CY 2019

In January 2020, the ESM provided a summary of 2019 CCC activities and appreciated their participations and efforts. Main highlights of the CCC's 2019 activities:

- Review and recommendations for Policy & Procedure (P&P) 200.02, "Hearing Impaired Mental Health Access"
- Review P&P 200.09 draft, "Culturally and Linguistically Inclusive Services" developed by the ESM
- Participation in the CCU's "2019 Multicultural Mental Health Conference"
- Engagement in "Share and Show Your Culture" presentations during monthly meetings. Presentations were made by CCC consumers and staff.

CCC Feedback

The CCC membership applauded and praised all the work done and accomplishments.

3. Presentation on the Peer Resource Center (PRC)

In February 2020, the CCC membership welcomed a presentation on the LACDMH Peer Resource Center. The presentation highlights included:

- Role of the PRC in fostering a positive connection with all visitors through peer support
- All staff has lived-experience and knowledge in various resources
- Wellness Outreach Worker (WOW) Volunteers have lived experience and must be affiliated to a Directly Operated clinic
- PRC also provides linkage and referral to appropriate community resources and makes sure that "everyone leaves with something"
- Linkage Services to Peers include mental health services, physical health services, food, clothing, hygiene facilities, housing services, temporary shelter, benefit establishment, legal services, education and job training, volunteer and employment opportunities
- Activities at the PRC include National Alliance on Mental Illness (NAMI), poetry and creative writing, social or cultural events.
- Average of 47 visitors a day over 1,000 visitors a month during CY 2019
- 46% identified to be homeless based on visitor reports

CCC feedback

The CCC members expressed their interest and appreciation for the PRC services in particular the PRC's philosophy and wellbeing activities

4. Review and Discussion on Continuation of Parameter 4.8, "Delivery of Culturally Competent Clinical Services" and Policy 302.02, "Coordination of Care"

In February 2020, the ESM engaged the Committee in the process of reviewing Parameter 4.8, "Delivery of Culturally Competent Clinical Services" and P&P

302.02, “Coordination of Care.” The CCC membership provided feedback as follows:

A. Continuation of Review: Parameter 4.8, “Delivery of Culturally Competent Clinical Services”

- *Section V. Clinical Environment*
  - A member recommended that it is important for clinics to show hospitality to build a connection with clients such as having coffee readily available or traditional foods representative of the clients they serve
  - Some members also shared situations where a certain cultural group was segregating other groups at clinics.
  - The membership concluded that embracing all cultures is of at-most importance and a shared responsibility.
  - The CCC membership agreed to this shared responsibility to make sure that everyone feels welcome.
- *Section V. Security Personnel*
  - A CCC member stated that security personnel need to be respectful and not act rudely in clinics or other public settings.
  - Another member shared personal experiences related to safety issues at clinics which are complicated as facilities should not utilize excessive force particularly for consumers who may feel threatened due to their immigration status
  - Some members recommended more cultural competency and cultural humility trainings as well as de-escalation training for police officers, private security personnel, and MTA bus drivers
  - A brief discussion followed about the importance for clients and the public in general not engage in behaviors that could be perceived as challenging of authorities, especially when different cultures are involved
- *Section VI. Cultural Perceptions Relevant to Mental Health Services*
  - A member commented that it has been difficult for Native American consumers to receive reimbursement when they have tried to utilize traditional “healers” for their treatment
  - Another member recommended more support or information for men/single fathers at the clinics mentioning that at the Peer Resource Center, there has been a rise in young fathers taking care of young children due to mother’s mental illness
  - A member asked for clarification in terms of how clinicians would be trained to become “familiar” with the various cultural traditions. Will there be training for clinicians, or a set of recommended practices? Will there be some form of testing to gauge the current knowledge of clinicians? Will there be additional training offered to assist clinicians in these areas

- A member suggested it is important for clients to dress appropriately as well and to be respectful of everyone
- One of the CCC Co-Chairs emphasized the importance of culture and recommended adding an appendix at the end of the policy with suggestions, recommendations on how clinicians can become more culturally relevant.

B. Policy 302.02, "Coordination of Care"

The committee members reviewed this policy and provided recommendations to ensure that the content takes into consideration the experiences of consumers in the process of receiving mental health services.

CCC Feedback

- A member mentioned that in many adult residential centers there are a lot of abuses and a lack of cultural sensitivity with the patients
- Another member suggested that it is important for clients to keep up with their appointments with their psychiatrist or therapist. This is very important especially when prescribed medications are not working. For example, someone is feeling depressed can let their provider know so that the provider can prescribe a new or different medication to help with the depression
- A member asked for an elaboration on what "treatment teams" means.
- A member shared a work experience at a contracted provider and stated that the treatment team had meetings inclusive of the psychiatrist, the psychotherapist, and the peer specialist. It was very useful for the entire team to be aware of the client's status and needs
- A member asked about who prescribes medications and how to follow up when the medication dosage was reduced and was not helping. Another member provided a general information for the question and added that a client can always contact the Ombudsman if the client feels what is being prescribed is not adequate and would like to try to advocate on a higher level
- A member commented that there are times when a person asks the psychiatrist to have their medication reduced because they are feeling better, but in fact, this may not be the case. Psychiatrists go by the information provided by the client.

5. <u>Presentation on the "Story Telling and Arts Based Community Engagement Strategies"</u>

In March 2020, the CCC listened to a presentation regarding the Story Telling and Arts-Based Community Engagement Strategies was delivered to the CCC. The CCC members also participated in an active listening activity and learned more insights on cultural sensitivity. The presentation highlights included:

- The presenter proposed that everyone is an artist in some form and has the ability to use that process to build up and advocate for one's community.

- Community organizing is about sharing your story, while advocating for change. Presently, she is working on a final report which will include her observations
- Listening Activity: The presenter asked the members of the CCC to break into groups of two. One person will be the speaker and the other will be the listener. The listener could not ask questions, cannot interrupt the speaker. In turn, the speaker will share with the listener what is on their mind or choose to share why they chose the particular word of value. The purpose of this exercise was to experience what it means to hold space. The importance of keeping in mind the cultural sensitivities of other person's resiliency, peace, empathy, transparency, empowerment, hope, honesty, and advocacy.

CCC feedback
The CCC members appreciated the opportunity to learn about story-telling and arts projects. They also expressed thankfulness to the presenter for the active listening exercise.

6. <u>"Share Your Culture" Webinar Development Project</u>
In March 2020, the ESM solicited input from the Committee on the "Share Your Culture" Webinar Development Project. The CCC membership unanimously endorsed this project stating that the "Share and Show Your Culture" segment during of the monthly CCC meetings was a valuable learning experience about the diverse cultures and points of view.
The CCC members agreed that members who had already presented could have their presentations recorded as well. Additionally, the group identified potential presentation topics such as age, gender, sexual orientation, culture-specific health beliefs and practices, and the impact of incarceration on a family, among others.

CCC feedback

The committee provided the following input and recommendations:

- CCC members expressed interest in participating in the webinar development project as presenters or part of the audience. The "Share and Show Your Culture." presentation format will be approximately 20-30 minutes.
- A member asked if the fellow members who had already presented could also have their presentations recorded separately
- Another member commented that this would be a good opportunity for members who have not presented
- A member stated that she would like to motivate the members of the Latino Coalition to participate in the "Share and Show Your Culture" webinars. This is important in that it will show that the Client Coalitions are involved not only in their own recovery but also in the CCC
- Another member suggested groups of three to four members who could delivered presentations as a group
- A member commented that culture does not just mean ethnicity, it can also be a subculture, for example the marathon culture. A member suggested

including objects as part of the webinar presentation. For example, someone from the surfer culture can bring in two different types of surfboards: imagery, objects, songs, and different types of music.

7. Discussion regarding Coping with the COVID-19 Pandemic

   In May 2020, the ESM facilitated discussions regarding how the CCC members have coped with the COVID-19 pandemic and what their concerns were, and how LACDMH and CCC could support them during the pandemic. The CCC membership shared their experiences of COVID-19 and provided the following input and feedback:

   - Members shared personal experiences. One member expressed concerns for persons experiencing homelessness. Information was provided to the committee about Project Room Key and LACDMH's commitment to support Los Angeles County by allowing staff to serve as Disaster Services Workers
   - CCC co-chairs engaged the group in learning about current resources for food and clothing. Resources highlighted included: 211 LA, the LACDMH Help Line and LACDMH's COVID-19 webpage were highlighted as a guides to access various services, resources and information available to navigate through COVID-19
   - Another member mentioned that the Latino UsCC has organized seven COVID-19 ad-hoc workgroups (children, young adults, older adults, basic needs, computer technical support and immigration).
   - A member commented that there are often barriers to receiving assistance. Consumers may be hesitant to provide personal information. This member asked if there are easier avenues to connecting community members.
   - A CCC co-chair shared with the group that the Native American UsCC put out PSAs, which included a toll-free number for clients to access. His concern was in terms of Native Americans calling in to the Access Line and whether they will be directed to someone who is Native American that can assist particularly if the person is experiencing trauma, depression, or anxiety due to the COVID-19 pandemic. He also shared with the members that with the COVID-19 pandemic, some medical terms cannot be translated into the native language and often the translation is lost.

8. Presentation on the "LGBTQIA-2S DMH Staff Survey" Proposal

   In May 2020, a presentation on the "LGBTQIA-2S DHM Staff Survey" was delivered to the CCC membership by the LGBTQIA-2S Services Specialist from LACDMH. The LGBTQIA-2S DMH Staff Survey was developed in order to establish a baseline to gauge where the Department is in terms of providing quality services to the LGBTQIA-2S community. The presentation covered the following information:

   - The survey is voluntary and anonymous and will be sent to all LACDMH staff
   - The purpose of the survey is to assess the strengths and needs in providing responsive mental health services for LGBTQIA-2S community members
   - Survey content includes:
     - Professional information (job item, population(s) served, etc.)

- Knowledge baseline (5 questions)
- What does it mean when someone asks, “What are your pronouns or “Which pronouns do you use?”
- Which gender(s) I am attracted to
- The pronouns I use to refer to myself
- The pronouns I recognize as grammatically correct within the English language
- I have never heard anyone ask this question before/I don’t know

CCC feedback
The CCC members appreciated the information and the Department’s effort to be more inclusive and respectful of diverse cultural groups including LGBTQIA-2S community.

9. Headspace Presentation
In June 2020, the CCC received a special presentation and demonstration on the Headspace App as an additional source of mental health support during COVID-19 times. Presentation highlights:
   - Headspace offers inspiration and guidance and support to living a mindful life in the pursuit of improving and health and happiness of the world.
   - DMH’s partnership with Headspace allows all Los Angeles County residents free access to Headspace in English or Spanish with a collection of mindfulness and meditation resources.
     - Over forty courses of themed meditations on specific topics like stress and sleep
     - Dozens of exercises to add more mindfulness to your day
     - Mini meditations you can do anytime
     - Sleep by Headspace that helps ease the mind into a truly restful night’s sleep
     - Headspace is accessible through the following platforms: Apple iPhone, iPad, iPod Touch with iOS 11+ Android phones or tablets 5+

   The presentation included a brief demo of relaxation exercises and discussion on the benefits of setting time aside to relax the mind and engage in wellbeing practices.

   CCC Feedback
   - The CCC members expressed appreciation for this information and LACDMH’s coordination for L.A. County residents to access to this App for free
   - A member asked if you can access Headspace outside of Los Angeles County
   - Another member replied and stated that as long as you register on Headspace and state that you are a resident of Los Angeles County, you will have access to Headspace going forward, even if you are not in Los Angeles at the time.
   - Members who has already tried this App reported having a very positive experience using Headspace.

10. CCC Discussion - Coping with COVID-19 and Social Unrest

In June 2020, the ESM engaged the CCC membership in the discussion by looking at not only navigating the pandemic but also coping with social unrest. The CCC members shared their experiences related to the pandemic and social unrest generated by the death of Mr. George Floyd.

CCC feedback

- A member commented that in the beginning of the pandemic, he was skeptical of whether it was "real." There was a point where the situation was taking a toll on his mental health. There was confusion of the severity of the pandemic and its effects
- Another member mentioned that what has helped is to be part of meetings where people come together to exchange resources such as masks and food.
- A member reported that as a County employee, she was deployed as a Disaster Service Worker (DSW) to assist with Project Room Key, housing homeless with underlying health conditions, high blood pressure, diabetes. The concern is what will happen to the clients who are at these sites, once the ninety-day period ends
- Another member commented as one of the co-chairs of the Latino UsCC, they created ad-hoc groups to focus on COVID-19 but also to have discussions about the current civil unrest. These ad-hoc groups are still being formed but would like to invite anyone who is interested in participating in one of the groups. Currently there are seven ad-hoc groups. The structure of these groups is more of a support group where participants can discuss what it is like to access services, what are some of the barriers encountered, how have they overcome these barriers. The key is to hold a space for participants to feel comfortable. She extended the invitation to the CCC membership
- A member welcomed having the spiritual connection as a future presentation or an ad-hoc group
- Another member stated regarding the homeless population. She recommended LACDMH provides its own outreach to third party contractors and subcontractors to provide resources and tips on how to assist the homeless population
- A member shared that as a consumer, she has written letters to LACDMH to address concerns and issues occurring in the community and what the Department can do to implement some strategies for the community. She further commented that she would follows up the letter with emails and phone calls
- A member shared that during the initial stages of the pandemic, there were days she could not hold back the tears. She shared that she has been on her personal journey of recovery

11. Presentation on the Client/Family Satisfaction Data: A Stakeholder Engagement Project

In July 2020, the Quality Improvement Unit (QIU) delivered a presentation on the Client/Family Satisfaction Data: A Stakeholder Engagement Project to the CCC membership. The QIU is in charge of collecting Consumer Perception Surveys (CPS). The presentation provided an opportunity for the CCC membership to learn more about the Consumer Satisfaction Surveys (AKA CPS), review data from the previous survey administrations and provide feedback on the new CPS data collection and reporting process. The key information of the presentation included the following:

- LACDMH administers four (4) CPS twice annually, in Spring and Fall:
  - Mental Health Statistics Improvement Project (MHSIP) survey for adults and older adults
  - Youth Satisfaction Survey (YSS) and YSS-family version for youth and their families
- Adult Survey – Instructions and CPS Statements
  A sample of the survey questions was shared during the presentation. The survey questions are answered on Likert scale that ranges from "Strongly Agree, Agree, Neutral, Disagree, Strongly Disagree, or Not Applicable." The sample of survey questions are as follows:
  1. "I like the services I received here"
  2. "If I had other choices, I would still get services from this agency"
  3. "I would recommend this agency to a friend or a family member"
  4. "The location of services was convenient (e.g. parking, public transportation, distance, etc."
  5. "Staff were willing to see me as often as I felt"

  The survey also asks adult participants the following:
  - How long the participants received services from the provider?
  - Consumer demographic information, i.e., gender, race, ethnicity and age group
  - Accessibility of services
  - Availability of written materials in their preferred language
  - Survey completion assistance provided
  - Comments from participants
  - Optional County Questions
- Completed and Returned Survey Statistics, May 2018:
  - Families 83.2%, Youth 82.6%, Older Adults 77%, Adults 67%
- Domain Statistics and Benchmarks
  - Participation in Treatment Planning: 92%
  - General Satisfaction: 91.1%
  - Quality and Appropriateness: 91%
  - Access 89: 6%
  - Social Connectedness: 74.2%
  - Outcomes: 72.9%
  - Functioning: 69.2%

- Communication Plan
  - Outreach to CCC, SALT, and Departmental QIC Quality Improvement Council
  - Solicit Stakeholder input (in-person & via surveys)
  - Summarize feedback and survey results
  - Revise data reporting plan
  - Publish CPS data in revised format

CCC feedback
After the presentation, the CCC members provided several recommendations:

- A member recommended that the QIU consider translating the survey questions into the thirteen threshold languages, some languages are missing
- A member suggested that it would be helpful to have open-ended questions and add a space for comments
- Another member recommended having someone available at the clinics to assist in filling out the surveys
- A member asked if the data collected included Native Americans, consumers who have experienced trauma, and if the survey the immigrant population
- A member commented that survey questions may be interpreted differently given that Los Angeles has such a diverse population, with various cultures, languages, beliefs, customs, etc.
- The committee agreed that it is important to include feedback from a wide range of stakeholder groups that will help shape the survey questions be more suitable for various groups

12. Discussion - Coping with COVID-19: Balancing One's Mental health and Creative Outlets as a Form of Coping
    In July 2020, the CCC members continued their discussions on the COVID-19 pandemic especially focusing on balancing one's mental health and creative outlets as a form of coping. The CCC Co-Chairs facilitated and opened the discussion by asking the members how they were balancing their mental health during the pandemic. The CCC members shared the following feedback, recommendations, and coping strategies:

    - A member commented that connecting with family via video chats was helpful. Although it is not the same as being there in person, it helps to see and connect with her family
    - Another member shared that a community has organized food drop-offs to elderly neighbors, and take them to appointments
    - Another member reported that running is helpful to release stress and cope with the pandemic
    - A CCC Co-chair stated that it is important for the members to continue to find ways of connecting with others, friends and family by various ways of social media outlets.

- Other coping suggestions and strategies were also identified such as journaling and baking.

13. Special Presentation on the "Racism: An Uncontrolled Global Pandemic"

In August 2020, the CCC membership sponsored a presentation on the "Racism: An Uncontrolled Global Pandemic" provided by Mr. Robert Sowell, Assistant Executive Director, Los Angeles County Commission on Human Relations. A total of 153 participants joined the meeting via phone or Microsoft Teams. The CCC extended an invitation to all Underserved Cultural Communities (UsCC) subcommittees, SA1-8 Quality Improvement Committees, O&E Teams, Speakers Bureau and Faith-Based Advocacy Committee (FBAC), and Service Area Leadership Teams (SALT). The presentation highlights:

- Racism – A virulent complex of hostile attitudes expressed in destructive actions that target specific persons and cultural groups based on how they look
- Racism has been developing over hundreds of years. If COVID-19 had been treated the way racism has been, it would be as if COVID-19 had become so common that no one remembered that it is neither normal or unavoidable. This is how racism has become "normalized" around the world
- The habit that humans have developed to hold one's group as superior is the root of what has come to be racism. Some groups would say they are superior over others because of what they have identified as race
- Systemic Racism – When periodic cases of racial discrimination against individuals have become routine racial discrimination against populations
- When racism is the norm across social systems of a society in health systems, education, and economic class, jobs, wages, and wealth, the legal system and political power systems
- Systemic Racism Symptoms – A society's resources and restrictions are skewed by race; the ways those systems are controlled or limited, how restrictions are used

The CCC members and guests had the opportunity to review various slides with data highlighting disproportionate inequalities in different parts of the world and across systems such as

- Mortality rate of children under the age of 5
- Life expectancy at birth
- Educational system (opportunities)
- School disciplinary actions toward students
- Involvement with the criminal justice system
- Average income
- Home ownership
- Wealth accumulation
- Religious beliefs and institutions
- Health insurance
- Rates of suicide

- COVID-19 data from the National Center for Disease Control, dated August 6, 2020:
    - For American Indian/Alaska Natives, the rate of cases is 2.8 times higher, hospitalizations 5.3 times higher, and deaths 1.4 times higher than Whites
    - Black/African American – cases 2.6 times higher, hospitalizations 4.7 times higher, and deaths 2.1 times higher
    - Latinos – cases 2.8 times higher, hospitalizations 4.6 times higher, and deaths 1.1 times higher

The presenter publicly acknowledged the CCC as a committee that comes together to increase cultural awareness, sensitivity and responsiveness within DMH for many years. He also stated that the CCC has provided a powerful example of how to fight against racism in our community by creating spaces to engage different groups in these difficult though necessary conversations.

CCC feedback and questions
The CCC members appreciated the presentation as well as the presenter's insights and his inspiring words.

- A member stated she found the presentation to be insightful and educational. She requested that future presentations on this topic. She also asked to include speakers who have experienced systemic racism and have lived experience with mental health
- Another member asked whether racism could "burn out" on its own and who will be protected
- Another member posed the question to the group regarding the likelihood that a group of people will put their needs aside for someone else
- A member stated that as the world waits for the COVID-19 vaccine, there is a need to develop a vaccine against racism. The presenter responded that he is not sure if a vaccine will be developed for the racism. He stated that we have to start with the very young because racism is being passed on to children before they can talk.

14. <u>Presentation on the "State MHSA WET Regional Partnership: Mental Health Loan Repayment Program"</u>

In August 2020, the CCC membership participated in a presentation regarding the Mental Health Services Act (MHSA) Workforce Education and Training (WET) Partnership Grant, by the LACDMH Training Unit. The key details of the presentation included:

- Los Angeles received 10 million from the State of California and these funds were made available to LACDMH. The grant information is available on the LACDMH site and open for comment at dmh.lacounty.gov.
- The Department offers its Mental Health Loan Repayment Program to LACDMH workforce from Directly Operated or Contracted Agencies
- The program targets different positions such as peer specialist, psychologists, substance abuse counselors, case managers, and social workers. Individuals who have these positions can apply for the loan repayment program.

- LACDMH is looking for individuals who will provide direct services, specifically in areas that are hard to recruit, and retain. For example, staff doing outreach to the homeless community or working in FSP programs, juvenile justice, SA 1, SA 6, and/or working with specialized foster care
- The individuals who are applying for this program will have to work delivering these types of services. The program is also looking for individuals who are servicing underserved/unserved communities, individuals that represent these communities and who speak one of the 13 threshold languages
- All of these variables are MHSA guidelines. The grant is for four years, beginning CY 2021 through CY 2025. This loan repayment program that WET submitted will award approximately 1,000 individuals. The highest amount that an employee can obtain is $10,000.

CCC feedback

The CCC members showed interest in the presentation topic by providing input and asking questions:

- A member asked what if an employee already works for DMH, is the stipend provided in addition to the salary received for paid employment? The Training Unit confirmed that this is correct, a person will continue to work for DMH. A member requested for clarification in terms of the award. Is the money only for one year or for four fiscal years? The presenters responded that LACDMH will award 357 awards per fiscal year. Every year it would be a certain number of people that could apply and be awarded.
- Another question was whether SALT co-chairs could apply for the grant. The presenter responded that any person can apply if the person is currently working for LACDMH or a contract provider and work full-time, or if you provide direct services.
- Another member asked if someone is in a certificated program, qualify as long as the individual is working for DMH or for a contracted provider.

15. <u>Presentation on the "Suicide Prevention Activation Kit</u>"

In September 2020, Ms. Jana Sczersputowski, MPH, Each Mind Matters delivered a presentation on the Suicide Prevention Activation Kit to the CCC membership. National Suicide Prevention Awareness Week, as well as National Recovery month take place during the month of September. They highlight a time for individuals, organizations and communities to join their voices to broadcast the message that suicide can be prevented, and recovery is possible. The presentation included the following:

- The "Know the Signs" campaign is a statewide suicide prevention social marketing effort. The overarching goal of this campaign to increase Californians' capacity to prevent suicide by encouraging ledge of the signs, how to talk to someone at risk of suicide, and resources available
- Suicide Prevention Resources – a wide range of mental health and suicide prevention educational resources are available for FY 19-20 and FY 21-22.
- For FY 22-23, there will be 356 awardees from diverse communities across the lifespan and in different languages such as Cambodian, Filipino, Hmong,

Korean, Lao, Spanish-speaking, Vietnamese, Russian, Punjabi, African American, API Youth, Individuals in crisis, LGBTQ youth and young adults, Middle-aged men

- Steps for creating linguistically and culturally competent suicide prevention materials:
  - Choose a target population
  - Establish a workgroup
  - Understand the target population
  - Select appropriate messages, audience, and formats
  - Adapt materials into other languages
  - Design materials
  - Plan outreach and dissemination strategies
  - Evaluate your materials and outreach

- The Suicide Prevention Activation Kit 2020 for the General Public includes
  - Virtual Activity Guides
  - Proclamation Template
  - Social Media Posts (English and Spanish)
  - Suicide Prevention Week Poster (English and Spanish)
  - Digital Banners (English and Spanish)
  - Drop-In Articles (English and Spanish)
  - Daily E-mail Blasts (English and Spanish)
  - Zoom Background
  - Links to Helpful Resources and Messaging
  - Links to Know the Signs Resources
  - Is someone you love not acting like themselves? Trust your instincts and speak up. Express your concern and mention the behaviors you have been noticing and ask directly: “Are you thinking about suicide”?
  - Few phrases are as difficult to say to a loved one. However, when it comes to suicide prevention, none are more important.
  - Start the conversation: listen, express concern, reassure, create a safety plan, get help
  - Encourage activities like Hope Journaling
    - If unable to purchase one, it can be made one using only one piece of paper and adding to it
    - The journal can be decorated with coloring utensils, stickers, magazines, and glitter
  - Sample writing topics:
    - Your wildest dream?
    - A moment you felt loved. What made you feel loved?
    - Three things that make you feel better when you are feeling down
    - A unique quality you have that makes you “special”

The presenter ended by sharing about the “Share Hope on World Suicide Prevention Day” on September 10, at 8 pm. She asked members to join Each Mind Matters and light a candle near a window or participate in a social media as

a symbol of hope and support for suicide prevention and in memory of persons we have lost to suicide.

CCC feedback
The CCC membership welcomed the information with great interest and concern for community Wellbeing and provided the following recommendation and feedback:

- A member commented that there are not enough guide resources specifically for the Native American population
- Another member asked what the youngest age was reported for suicide. The presenter stated that in Los Angeles County there is a Child Death Review Team, which puts together an annual report on all child death. Although the numbers are low, some children are as young as eight years old. The data also indicates that these numbers have been increasing. Building resilience and problem solving are important factors. For more information, refer to ican4kids.org

16. Presentation on "At a Crossroad: Bridging the Digital Divide in the Community"
In October 2020, the Mental Health Promotors team presented their virtual technology kit available in English and Spanish. They provided information on helping Spanish community using virtual technology and a health promotors shared her testimonial experience regarding using this technology. The presentation covered the following:
    - The Health Promotors program is designed to hire community members and its model is based on community helping community with the goal of teaching about mental health
    - The primary goal of the program is to reduce mental health stigma in the community, particularly in the Spanish speaking community. The program also works on removing barriers to access to care by connecting community members to mental health clinics, and improving the timeliness to culturally and linguistically relevant resources
    - The health promoter program is strength-based, using culture and traditions to heal
    - Currently, the program has thirteen (13) mental health workshops. The focus of these workshops is the impact of COVID-19 including stress, grief, and loss in underserved communities due to the pandemic
    - Health Promotors are knowledgeable about local resources such as food banks and other practical resources for community
    - The primary focus of the program is a peer-to-peer learning approach
    - The Mental Health Promotor program is primarily a face-to-face program; going to churches, private homes, schools and parks to provide workshops but due to COVID-19, the program had to shift to a virtual presentation format
    - In this new virtual platform, presenters have built community capacity, the literacy and use of technology
    - Another area of focus is on providing support to mental health promoters. To accomplish this, the program leads identified the skills the promoters already

had and teach them utilizing the peer-to-peer model. The first step was to conduct a survey in the Service Areas to understand what technology is being used in the community. The survey and working with the promotors and staff helped bridge the gap in terms of:

- Learning a new skill (new virtual platforms, Internet speed, downloading and launching Apps, etc.)
- Building confidence level, audience engagement and virtual etiquette
- Addressing fears (e.g. change, unknown, failure)
- Promoting a higher self-image (social media engagements)
- Addressing generational gaps, acculturation, language and education level

17. Learning About Technology: A guide to use Microsoft Teams software

- The presenters introduced the guide and explained its main consent areas. For example:
  - Instructions on how to download the MS Teams app to your computer. Videos from YouTube have been embedded to assist staff. An example of these videos includes: a guide to download MS Teams in Windows, a guide to download MS Teams on your Android
  - Step-by-step or how to join an MS Teams meeting by way of the app or through the web browser
- Promotor testimony by Maria Zuniga. SA Promotoras Coordinator: stated that their activities have increased, particularly due to COVID-19. Taking into consideration the pandemic, the Promoters program had to revamp how it was reaching out to its constituents. She found herself new to this new way of communication by way of a video chat. She began by working with the promoters in SA 8 focusing on the goals and values of the program. The dialogue with the promoters was to look at program goals and values, working on what the program can do to continue the mission of reaching out to the Latino community. There was dialogue about the barriers of not only the technology but within the health promoters
- Capacity-building was established in SA 8 by practicing as a group, individually, and with each other. Most importantly, providing support to each other
- Monthly meetings are held where promoters share their experiences; how it has been to conduct these virtual presentations and lessons learned. As a result, they have been able to build their capacity in SA 8
- In May, the program began with eight presentations. In the month of September, they completed 90 virtual presentations. 90% of their Promotors are actively doing presentations. They have witnessed the impact these presentations have had in the community
- The CCC members thanked the presenters and appreciated sharing their experiences with the CCC. The feedback and recommendations from CCC membership included:
- A member recommended for Health Promotors to have participants review the videos before the meeting takes place

- Ms. Zuniga commented that their Promotors spend a lot of time with the community prior to attending the first presentation. The promoters connect with the community at least a few weeks before the presentation, practicing how to connect onto the technology platform. The brochure created with all of the interactive links was disseminated to the community and have received positive feedback

CCC feedback

- A member the promotor whether she had received support and resources from LACDMH. The promotor replied that she has felt support and received all the tools necessary for her to confidently work with her community with this new technology
- Another member praised the health promoter program for providing support to its Promotors as well as the community
- A recommendation was made to provide trainings to consumers who have mental health issues and have more difficulty in learning how to learn and navigate technology

18. <u>Presentation on "Faith and Spirituality As It Relates to COVID-19 & Mental Health"</u>
In November 2020, a panel presentation regarding "Faith and Spirituality As It Relates to COVID-19 and Mental Health" was provided to the CCC membership by members of the Faith-Based Advocacy Council and other faith leaders. The panel presenters included: Rev. Dr. Mary Crist, Chaplain Ruth Belonsky, Pastor Christian Ponciano, Judy Gilliland, Harvey Keenan, and Dr. Damali Najuma Smith-Pollard, DMH Advocacy Council. The highlights of the presentation:
    - The opening presenter posed the following reflective questions: How do we function in these times as a faith-based community? How do we put together faith? How will our world look like when COVID-19 has been controlled? How do we cope when we have lost our jobs? How do we take care of ourselves during this pandemic?
    - The presenter referenced Dr. Maria Yellowhorse Braveheart's writing which focusing on the values we live with, specifically "native values" that can work for everyone. These values are as follows:
        - Generosity
        - Compassion
        - Respect
        - Having a good mind and not being afraid to use it
        - Humility and silence
        - Courage, bravery and wisdom
    - The presenters stated that it is best done step-by-step, make a list of the values that are important to each of you, your family. These values form the basis of one's spirituality
    - In terms of religious beliefs, identifying what values are important and run lives is essential as they are the values that we lean on in difficult times
    - The value of generous love for one another as living people is important, no matter what your religious path is. "Life is sacred; all people are sacred." This

is a spiritual value that everyone needs to hold onto, particularly in these trying times

- It is important for everyone to understand the trauma we are facing and we cannot deny it. Feeling the pain of the trauma, releasing it and transcend it are important. The presenter stated that it is possible to transcend that pain through prayer, use of sage, song, dance, and talking together
- The presenter added that it is important to confront one's history, but at the same time get beyond it. It is important not to pretend that COVID-19 has not happened. However, there are no victims of COVID-19. Communities can experience it, be afraid of it, and transcended it.
- Faith-Based Advocacy Council (FBAC): This council engages clergy, lay leaders, faith leaders and all faith communities to experience wellness and champion mental health. LACDMH supports the work of faith-based organizations as well as non-faith-based groups, which have their own way of finding and expressing their spirituality
- It is important to recognize the vital role of spirituality in reducing stigma, achieving hope, wellness and recovery. Some of their outcomes have been increased integration of spirituality and mental health messages and resources, increased awareness of mental health and access to care and decreased stigma in seeking mental health help
- The panel presenters shared their backgrounds and experiences of family and community in regards to the COVID-19 pandemic. They openly shared coping skills, sources of resilience, resources, the importance of staying connected, and what they have been doing to create safe spaces of hope and support

CCC feedback

The CCC membership praised their presentation and greatly appreciated what each panel presenter shared with. The feedback and input gathered from the Committee included the following:

- A member commented that during this pandemic they have learned to appreciate the things that really matter. For example, having dinner together as a family is cherished. There are so many blessings that everyone can appreciate and focus on
- Another member talked about rise in homelessness since the pandemic. She recommended that educating law enforcement and community members about mental health is vital. She thanked everyone for their hard work and for providing much needed services
- Another member with First African Methodist Church has been working to provide mental health services to her community. They have been providing workshops and hope to continue to do this once the pandemic has been controlled. She recommended having a podcast for the community on mental health and first aid, which will help many communities and not just a small group of people

19. Presentation on "DMH Update: Expansion of Health Promoters Program"

In November 2020, Dr. Jorge Partida Del Toro, Chief of Psychology and newly-appointed lead for the Promotor Program provided an overview and update on the expansion of this program. The key updates included the following:

- Initially the health promoters program focused on the Latino community and rural communities. Last year was the first year that the program was adopted countywide, in all eight Service Areas (SA). With limited resources and funding, the program excelled at providing outreach to the targeted areas
- The Board of Supervisors (BOS) has directed LACDMH to expand the program focusing on the African American community, the Asian Pacific Islander (API) community, which historically has been underserved in both Prevention and Early Intervention (PEI) and critical care services
- The third BOS target community is the Alaska Native/Native American community. This initiative would create positions to focus on all three of these communities
- The expansion of the health promoters program will also provide equity for all the other underserved groups, specifically trauma-informed services for the Middle Eastern/Eastern European, the LGBTQIA2-S communities, as well as for persons who are deaf and hard of hearing, or have other physical disabilities
- There are 150 temporary items, up to 30 hours of employment per week. The positions include some benefits, including retirement. Funds are coming from the CARES Act initiative, which are due to expire on December 30, 2020. The Department hopes to have everyone hired and deployed by that target date. The Department is committed to continue funding these positions through other funding sources, particularly from MHSA. Although these are temporary positions, LACDMH will explore feasible mechanisms to make these positions permanent
- There are two (2) processes that are happening simultaneously; the formation of a culture specific model. The intent is not to take the Latino model and replicate it for different cultures and language. LACDMH looks to create a culture specific, language specific approach that is intended for the community
- The Department will be collaborating with the UCLA Psychiatric Center of Excellence to provide assistance in helping develop these culture and language specific models. This will be done by facilitating focus groups, where supervisors of Promoters will review the critical concepts of the model to highlight how it will apply to the communities' being targeted
- LACDMH is looking to fast-track this process by creating flyers that are language and culture specific, requesting the communities' help in distributing to individuals who can be identified as potential leaders to represent their respective communities

CCC feedback

The CCC membership expressed a great interest in the expansion of the Health Promotors program and appreciated the updated information delivered to the members. The CCC members' feedback and questions included the following:

- A member asked how the new health promoters would be introduced to the various Underserved Cultural Communities (UsCC), specifically the Native American community. The presenter commented that LACDMH hopes to focus on and reach out to these individuals by understanding the role of culture, spirituality, and customs. The Department looks to creating a culture-affirming model that allows for communities to investigate past wounds and trauma and what the trauma has done collectively to the community
- Another member inquired about which geographical areas this expansion will cover and the presenter stated that the Promoters program would expand only in Los Angeles County
- Another member asked when the flyer would be ready to be distributed
- A member raised a question regarding the type of background and qualifications the Department is looking for the new promoters. The presenter clarified the requirement and said that an applicant for the position has to have at least six months of community service outreach in the area the person is representing. Additionally, there will be a bilingual language bonus paid to new Promoters who are hired

20. Summary of 2020 CCC Activities

In December 2020, the ESM presented the draft CCC Annual report to the members as a special activity during the virtual the end-of-year retreat. The ESM highlighted the collaborative efforts with the CCC Co-Chairs and CCU to support the membership and find meaningful connections during the unprecedented COVID-19 pandemic. Highlights:

- The CCUs personalized calls to CCC members who were not attending the virtual meetings
- Creating safe spaces for members to process the impact of COVID-19 and social unrest
- Hosting special presentations relevant to the COVID-19 pandemic and civil unrest
- Promoting opportunities for all stakeholder groups inclusive of the seven UsCCs, eight SALTs, eight Service Area QICs, FBAC, eight Outreach and Engagement Teams and Speakers Bureau to build a sense of community

21. Discussion – Existing CCC Code of Conduct and Addition of New Language to Address Virtual Meetings

In December 2020, the CCC Co-Chairs facilitated a discussion on the committee's code of conduct with the goal of revising it to content for virtual meetings etiquette. The Co-Chairs addressed concerns regarding the of the chat box during various stakeholder virtual meetings by participants who publicly attack the Department, humiliate programs and staff and disrespect other fellow members. To keep these behaviors from happening during CCC meetings, the Co-Chair clarified the function of the chat box in the virtual meeting stating that it is a great tool to use for providing useful information, links, and resources related to the discussions held during meetings. The use of the chat box during CCC meeting is to keep comments positive and supportive. They asked members to voice their opinions and needs during the meetings and not resorting to the chat box to dehumanize

the purpose of monthly meetings. The CCC membership engaged in this discussion and made recommendations.

CCC feedback

- A member asked who would address the comments written in the chat box in the event these are misinterpreted or considered offensive. The CCC Co-Chair replied that the co-chairs or the liaisons should immediately address any misunderstandings including offensive language in the chat box
- Another member commented it would be important to address how to deal with this issue as there could be a situation where Co-Chairs from other stakeholder groups use language and communication style that may be interpreted as inappropriate
- A member suggested when someone is using the chat box to respond to someone's comment, it would be best to address that person by name to reduce any chance of misunderstanding
- A member thanked both CCC Co-Chairs and CCU for ensuring that the essence and dignity of each person is respected in the meeting regardless of their background. She stated it is important that the CCC meetings continue to be a positive and safe environment, where all members can participate in discussions without fear of any negative or disparaging comments
- Another CCC Co-Chair commented that much of the language in the code of conduct is specifically for in-person meetings. Language that could be added specifically for a virtual platform could be like "mute yourself until you are ready to speak and place cell phones on vibrate." Regarding arriving on time, it is best to log in to the virtual meeting a few minutes before the start of the meeting to allow for any technical challenges that may arise
- The CCC Co-Chair asked the members whether it would be best to have a virtual code of conduct separate from the current in-person code of conduct at least for the time being or until further notice
- Some members recommended forming an ad-hoc virtual code of conduct meeting. The CCC Co-Chairs will work directly with this ad-hoc group and draft the CCC virtual code of conduct.
  (See attachment 3, For CCC Virtual Meeting Code of Conduct)

22. <u>Presentation – CCC Bylaws: The role of the CCC and CCU</u>
In December 2020, the CCC membership heard a presentation from the ESM on the differences among the CCC, CCU and UsCC subcommittees. The membership also reviewed the goals, functions, and outcomes of both committee and CCU. The information reviewed by the CCC membership included:
a. The Cultural Competency Unit (CCU)
    - The mission of the CCU is to enhance, uphold and advance cultural and linguistic competence within the LACDMH system of care. The CCU also addresses mental health disparities and inequalities
    - The goal of the CCU is to ensure that cultural and linguistic competence are integrated in our system of care, based on Federal, State, and County mandates. The Unit promotes cultural competence, cultural humility, cultural appropriateness, relevance and safety.

- Examples of CCU on-going activities:
- The CCU coordinates language interpreter services inclusive of the threshold languages and American Sign Language as well as closed captioning services for stakeholder and other meetings across all eight Service Areas
    - The CCU writes LACDMH's annual Cultural Competence Plan (CCP) report based on State mandates issued by the Department Health Care Services
    - The CCU collaborates with other departmental units and programs in the Department and provides technical assistance regarding cultural competence, inclusion, and responsiveness
    - The CCU provides trainings on cultural competence and cultural humility in the Department as well as communities
    - The CCU provides administrative support to the CCC including the preparation. This consists of the completion of the meeting minutes, collaborating with the Co-Chairs to set the meeting agenda and attain the goals set the committee. The CCU also attends all of the CCC meetings and provides technical support for any issues that may arise
    - The CCU upholds the CCC as its advisory board project and vets all its projects with the committee. The CCU has partnered with the CCC to:
        - Review existing Policies and Procedures (P&P) related to cultural competence.
        - Review of Policy 200.09, "Culturally and Linguistically Inclusive Services" developed by the ESM's
        - Implementation of the LGBTQ and needs of persons with physical disabilities workgroups. These workgroups are now the LGBTQIA2-S and Access for All UsCC subcommittees
        - Translation of various Consent forms for LACDMH clinical services

b. About the CCC

The Department of Health Care Services requires that all Departments of Mental Health implement a committee to address cultural diversity. The CCC is the fulfillment of this mandate from the State within LACDMH. The CCC advocates for <u>all cultural and language groups</u> with representation from the community inclusive of consumers, family members, peers, advocates, community-based organizations, and staff from directly operated, legal entities/contracted agencies and administrative programs. The CCC does not do capacity-building projects because it does not receive any funding to implement such projects. The mission of the CCC is to determine ways to further advance cultural and linguistic inclusion and responsiveness in departmental functions.

c. UsCC subcommittees

The ESM explained that the UsCCs and the CCC are stakeholder groups. The UsCCs however, are LACDMH's response to Proposition 63, which became the Mental Health Services Act in 2004. Originally, five (5) committees were created with the former name of Under Represented Ethnic Populations (UREP) subcommittees. The five (5) original committees were:

- American Indian/Alaska Native (AI/AN) UREP
- Asian Pacific Islander (API) UREP
- Black & African Heritage UREP
- Latino UREP
- Eastern European/Middle Eastern (EE/ME) UREP

During CY 2017 and 2018, the CCU in partnership with the CCC implemented two workgroups, one for the LGBTQ communities and one for persons with physical disabilities. Both of these workgroups were transferred to the UsCC Unit and have become UsCC subcommittees:

- LGBTQIA2-S
- Access for All (formerly known as Deaf, Hard of Hearing, Blind, and Physical Disabilities)

The addition of these two subcommittees generated the need to change the name from UREP subcommittees to UsCC.

The UsCC subcommittees advocate for the specific cultural group they each represent. Each subcommittee receives $200,000 every year to implement capacity-building projects. UsCCs gather ideas for these projects through their respective memberships who in turn votes on these project ideas. Once a project is approved for implementation, the UsCC Unit liaisons develop a project proposal and work within LACDMH to hire vendors to implement these projects. Each UsCC subcommittee liaison provides updates on the status of these capacity-building projects during monthly meetings.

23. <u>Discussion - Coping with COVID-19: Wellbeing Practices and Adventures</u>

In December 2020, as a special annual retreat agenda, an in-depth discussion and reflection were held by the CCC membership looking back at CY 2020. The CCC members shared their coping strategies and daily living practices during the COVID-19 pandemic.

CCC feedback

- A member shared that she is trying to learn the Lakota language during the pandemic
- Another member shared that once she knew she did not have COVID-19, it helped her to reflect and put things into perspective. Although she hasn't been able to see family, she has been trying to enjoy seeing nature, flowers, and birds
- A member commented that this year has been a trying year for everyone but especially for her with the war in Armenia. The war was lost and Armenia lost

land because of the war. It has been very heartbreaking for her. She stated that she was trying to stay positive in spite of what was happening

- A member stated she has been working with peers who have lost family members due to COVID-19. As a Health Promoter, she continues to offer classes and provides support to her community
- Another member encouraged everyone to stay positive, go outside of the house, and smell the flowers. She stated that she wants everyone to stay hopeful

II. A. CCC's Reports to the Quality Improvement Council

The Ethnic Services Manager represents the CCC at the monthly Quality Improvement Council (QIC) meetings. Additionally, the ESM oversees the administrative support and technical assistance provided to the CCC Co-Chairs and membership. As a standing member of the Departmental QIC, the ESM provides updates and presentations on the CCC activities as well as the CCU's projects. This structure accomplishes several goals: 1) fosters communication, 2) facilitates the advancement of cultural and linguistic competence in the system of care, 3) promotes a sense of responsibility toward the attainment of Cultural Competence Plan goals to reduce disparities and improve the quality and availability of services.

Another level of connection and collaboration with the Departmental QIC involves working directly with the Service Area-based Quality Improvement Committees (SA-QIC). The ESM and CCU provide presentations on cultural and linguistic competence-related projects and new initiatives to the SA-QIC. Furthermore, the CCC invites the SA-QIC memberships to the CCC's monthly meetings and special presentations. This practice increases cross-committee knowledge and understanding, promotes collaborative efforts that focus on cultural and linguistic competence, and facilitates access to the collective wisdom and expertise of these committees**. (*See attachment 2 for CCC special presentation flyers)*.**

II. B. Evidence of CCC participation in reviewing

During FY 2020, the CCC provided feedback and recommendations to the following LACDMH programs:

- Peer Resource Center (PRC)
- LGBTQIA-2S DMH Staff Survey Proposal
- Client/Family Satisfaction Data: A Stakeholder Engagement Project
- State MHSA WET Regional Partnership: Mental Health Loan Repayment Program
- Promotores de Salud Program's: Bridging the Digital Divide in the Community
- Expansion of Health Promoters Program
- DMH Clinical Parameter 4.8, "Delivery of Culturally Competent Clinical Services"
- Policy 302.02, "Coordination of Care"

II. C. Annual Report of the CCC

A complete CCC annual report for CY 2020 can be found on Section II. A. 1. above.

Criterion 4 APPENDIX

1. LACDMH P&P 200.09: "Culturally and Linguistically Inclusive Services"


P&P 200.09 - policy.html


P&P 200.09- Procedures.html

2. CCC Meeting Flyers, CY 2020


CCC flyer for 9-9-2020 meeting


CCC flyer for FIN.10-14-2020 meeting


CCC flyer for F11-05-2020 meeting


CCC flyer for F12-09-2020 annual ret

3. CCC Bylaws and CCC Virtual Meeting Code of Conduct


CCC Bylaws (002) (1).pdf


CCC Virtual Code Of Conduct DRAFT.pdf

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 5

Culturally Competent Training Activities

August 2021

Criterion 5: Culturally Competent Training Activities

I. LACDMH Cultural Competence Training Plan

The LACDMH Cultural Competence Training Plan aims to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge and cross-cultural competencies, all of which are essential to effectively serve our culturally and linguistically diverse communities. It is based on the Cultural Competence Plan 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 OAO-Training Unit 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 Cultural Competency Unit webpage	• 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 Competence 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 OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Cultural Competence related – SMHS offered by the OAO-Training Unit. Training bulletins available via the Intranet	• Same as above	• Same as above
Training alternative 3 • Annual cultural competence related conferences	• Same as above	• Same as above

Training alternative 4
• Language Interpreters Series
  ○ Introduction to interpreting in mental health settings
  ○ Advanced mental health interpreter's training
  ○ Use of interpreter services in mental health settings
	• Same as above	• Language interpreter trainings are available to bilingual certified staff
		• Use of interpreter services training is available to all English monolingual staff

FY 18-19		

Innovative training feature 1
• IB/CC (Los Angeles County Board of Supervisors mandated training)
	• LACDMH – Human Resources Bureau (HRB) and Learning Net	• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 2 • Gender Bias Training Series (See Section F. below)	• LACDMH Learning Net	• Same as above
Innovative training feature 3 • LACDMH Multicultural Mental Health Conference: Health Integration through a "WHO-LISTIC" Approach	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
Innovative training feature 4 • Los Angeles County Equity Summit	• LACDMH app for Network Adequacy (Practitioners)	• Available to Administrative/Management
Training alternative 1 • Cultural competence related SMHS offered by the OAO-Training Unit. Training bulletins available via the intranet	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Foundational Cultural Competence Training (as specified above for FY 17-18)	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Available to all staff including: IB/CC on-line trainings and other training alternatives: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training alternative 3 • Cultural competence related SMHS offered by the OAO-Training Unit. Training bulletins available via the intranet	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
Training alternative 4 • Language interpreter series o Introduction to interpreting in mental health settings o Advanced mental health interpreter's training o Use of interpreter services in mental health settings	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Language interpreter trainings available to bilingual certified staff • Use of interpreter services training is available to all English monolingual staff

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 19-20		
<u>Innovative training feature 1</u> • Positive Psychology and Wellbeing for Clinicians and Consumers Addressing Burnout, Compassion Fatigue and Secondary Trauma in the COVID-19 Era	• LACDMH Learning Net • LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS
<u>Innovative training feature 2</u> • Suicide Prevention and COVID-19: A Training for Disaster Services Workers(DSW) - Warm Line Workers (AM)	• Same as above	• Same as above
<u>Innovative training feature 3</u> • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Community-Based Organizations	• Same as above	• Same as above
<u>Innovative training feature 4</u> • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Faith-Based Organizations	• Same as above	• Same as above

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 5 • Suicide Prevention and COVID-19: A Training for DSW-Shelter Workers	• Same as above	• Same as above
Innovative training feature 6 • Pediatric Psychology COVID-19 Response: Considerations for using Telehealth with Latino/Bilingual Children and other Diverse Youth	• Same as above	• Same as above
Innovative training feature 7 • Building and Maintaining Recovery and Resiliency through the Pandemic: A Culturally-Competent Approach	• Same as above	• Same as above
Training alternative 1 • Cultural competence related SMHS offered by the OAO – Training Unit. Training bulletins available via the intranet Examples of brand new trainings: ○ DMH Clinicians: Culturally Competent COVID-19 Mental Health Intervention with Faith-Based Organizations and Churches ○ 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)	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support • Staff providing SMHS

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Foundational Cultural Competence Training (as specified for FY 17-18)	• LACDMH app for Network Adequacy (Practitioners) • OAO-CCU Annual Cultural Competence Training Attestation (Administrative Programs)	• Same as above
Training alternative 3 • Language interpreter's series ○ Introduction to Interpreting in Mental Health Settings ○ Use of interpreter services in mental health settings ○ Therapeutic Cross-Cultural Communication	• 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

This space was intentionally left blank

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 Office of Administrative Operations – Training Unit.

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 and Cultural Humility"
  This virtual training is offered by the OAO-CCU. The objectives of this training include: engaging participants in a personal understanding of implicit bias, identifying ways to address personal and professional biases and answering a personal call to practice cultural humility with the persons we serve and our co-workers.
- "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 Competence 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–Training Unit 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 interpreter 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 interpreter 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 interpreter 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 interpreter 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 provides 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 interpreter 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 interpreter services upon solicitation by various LACDMH Programs/Units."

  (See Attachment 1: Interpreter Trainings, FY 19-20)

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 OAO–Training Unit. Examples of FY 19-20 offerings include:

- Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
- Multicultural Clinical Supervision
- Los Angeles County Health Agency Just Culture Program for Managers and Supervisors
- Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families

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.

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)

COVID-19 significantly impacted the Department's training operations. The OAO-Training Unit faced these unprecedented challenges and continued to evolve in order to maintain high standards in training coordination and delivery. As of March 2019, all training offerings shifted from in-person/live to a virtual platform. Training coordinators became subject matter experts in delivering trainings virtually utilizing MS Teams, which exponentially increased the technological knowledge and competence of the Unit. Furthermore, the OAO-Training Unit offered services to record and edit trainings for virtual distribution throughout the system of care.

Additionally, the OAO-Training Unit continued to develop its online training registration system called EventsHub, and funded by MHSA Workforce Education and Training Plan. Most clinical trainings are now managed through EventsHub. These trainings

are available to LACDMH staff, Contractors and community partners who are eligible to participate in departmental-sponsored training offerings. Once training participants establish their EventsHub account, they can easily register, receive confirmation of registration, complete training evaluations, and access attendance or continuing education certificates.

II. Annual Cultural Competence Trainings

LACDMH provides a plethora of 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-Training Unit 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-Training Unit 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. A checkbox was added to the bulletins to inform the participants when a training 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-Training Unit tracks training attendance by staff function via the training evaluation form at the request of the OAO-CCU. 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-Training Unit are in accordance with areas of cultural competence specified in the Cultural Competence Plan Requirements. Each year, the OAO-CCU collaborates with the OAO-Training Unit in conducting a brief analysis of all trainings to determine the cultural competence-related themes covered in 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)

Table 2: Examples of Cultural Competence-Related Specialty Mental Health Trainings Offered by the OAO-Training Unit, FY 19-20

Title of Trainings
African American
Black Family Mental Wellness and Inter-Generational Trauma: A Systemic Approach
Disparities Among AA Infant Mortality
The Things That Make Men Cry
Children
Overview: Preparing for Child and Family Teaming
Conferences
15th Annual California Conference Childhood Grief and Traumatic Loss: Restoring Joy to Children & Families
2019 American Indian/Alaska Native MH Conference "Native Health & Resilience"
Asian American MH Training Conference
Nexus Training Conference XXIV: Violence within the Home and Its Effects on Children
COVID - 19
Building and Maintaining Recovery and Resiliency through the Pandemic: A Culturally-Competent Approach

Title of Trainings
Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Community-Based Organizations
Pediatric Psychology COVID-19 Response: Considerations for using Telehealth with Latino/Bilingual Children and other Diverse Youth
Positive Psychology and Wellbeing for Clinicians and Consumers Addressing Burnout, Compassion, Fatigue, and Secondary Trauma in the COVID-19 Era
Suicide Prevention and COVID-19: A Training for Disaster Services Workers(DSW)
Foster Care
Best Practice Interventions with Complex Trauma Victims in Foster Care
General Cultural Competency
Building and Maintaining Recovery and Resiliency Through the Pandemic: A Culturally-Competent Approach
Cultural Humility
Engaging the Muslim American Community
Introduction to Community Inclusion and Preparing the Environment
Los Angeles County Health Agency Just Culture Program for Managers and Supervisors
Where Privilege Meets Oppression: Utilizing A Cultural Lens with The Child Welfare Population
Therapeutic Cross-Cultural Communication
Implicit Bias
Acknowledging and Managing the Hidden Bias of Good People: Implications for Los Angeles County Employees and the Communities they Serve
Justice System
Adapted DBT Core Training for Juvenile Justice Staff
Dialectical Behavior Therapy (DBT) for Justice Involved Consumers
Engaging Probation Youth
Fundamentals in Effective Work with LGBTQI2-S Youth In The Juvenile Justice System
Law and Ethics-Forensic Focused
Permanency Values and Skills for Child Welfare, Probation and Mental Health Professionals
Professional Roles and Boundaries in Juvenile Justice Settings
Risk Assessment for Violence- Forensic Focus
Safety and Crisis Prevention/Interventions when Working with Forensic/Justice Involved Consumers
The Commercial Sexual Exploitation Identification Tool (CSE-IT): User Training for Juvenile Justice Mental Health Program Staff
The Edge of Compassion: Staying Well While Working in High Risk, Trauma-Exposed Juvenile Justice Settings
The Practice of Mindfulness in Clinical Work With Juvenile Justice Involved Youth
Working with The Forensically-Involved, Mandated Consumer
Latino
The Mental Health Needs Among LatinX Immigrant Children and Families
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit

Title of Trainings
(LGBTQIA2-S)
Core Practice Concepts in Working with LGBTQ Youth
LGBTQ+ Youth In Placement
Fundamentals in Effective Work with LGBTQI2-S Youth in the Juvenile Justice System
Mental Health Interpreter
Increasing Mandarin Mental Health Clinical Terminology
Increasing Spanish Mental Health Clinical Terminology
Introduction to Interpreting in Mental Health Settings
Substance Use & Co-Morbidity
Mindfulness-Based Practices for Mental Health Professionals Working with Addiction Populations
Parent Partners
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
Older Adults
Older Adult Sexual Assault
18th Annual Collaboration in Geriatric Mental Health Care
Peers
Intentional Peer Support (IPS) 5-Day Core Training
Intentional Peer Support Advanced Training
Physical and Developmental Disabilities
Mental Health Strategies for Individuals with Co-occurring Developmental Disabilities (CDD)
Working with Mental Health Consumers with Disabilities
Mental Health Needs of Blind and Physical Disabilities
Supervisors/Management
Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
Los Angeles County Health Agency Just Culture Program for Managers and Supervisors
Multicultural Clinical Supervision
Preparing the Next Generation: Cultural Humility in Clinical Supervision
Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, And Families
Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families
Veterans
4 Points Builds A Star: Engaging the Veteran and the Family for Wellness
Violence
Gangs: Evolution, Trends & Updates

Total number of unique trainings = 59

In addition to OAO-Training Unit 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 19-20*

Program Name	Title of Trainings
Countywide Health Neighborhood	• Implicit Bias and Cultural Competency: This training introduces the fundamental concepts of implicit bias and cultural competence • Maternal Mental Health and the Black Birthing Experience: This training was designed to increase awareness about the disparities among black births and the black birthing experience • Intersectionality and Perinatal Maternal Health: This training increases awareness toward intersectionality through consideration of systems of oppression and privilege, assesses differences between identity and socially constructed ideas. • 15-hour Clinical Supervision: This training enhances skills for clinical supervision including implicit bias, legal and ethical issues. • Empowering Professional Training: This training was presented to increase the development of special programs and activities for community awareness and participation. • Clergy Faith-based Communities-Spirituality and Self-care: This training increases the discussion of the role of mental health and faith-based organizations. • Targeted Case Management Training: This training enhances skills for case management and community outreach services. • Implicit Bias: This workshop focuses on the implicit attitudes or stereotypes that shape how we engage others and formulate decisions. • Naloxone and Opioid Overdose Prevention: Peer-to-peer support for families of loved ones using alcohol or drugs. Training on how to administer medication (naloxone) to reverse an opioid overdose. • Antelope Valley First Annual Women's Forum: The health equity theme focused on promoting women's physical and emotional wellness through education, awareness, empowerment, civic engagement, and local community resources

Program Name	Title of Trainings
Older Adult (OA) Service Extenders (SE) Program	• Orientation for Promotores: Outpatient Services Division hosted an orientation for the Service Extenders Volunteer Program. The orientation was for bilingual English/Spanish Promotores who were interested in assisting consumers register for appointment reminders to receive access to their medical record in the Just4me consumer portal. • 18th Annual Collaboration in Geriatric Mental Health Care: With the advent of national, state, and local directives to integrate health and mental healthcare, and especially with the establishment of the Medi-Cal Managed Health and mental health plans, this training highlighted how technology can improve social isolation and morbidity of individuals and how technology can be effectively used by providers. • Webinar for Community Health Workers, A Day in the Life of Community Health Workers: Information about the different roles a Community Health Worker has across the Los Angeles County Health Agency. Representatives from the Departments of Health Services, Mental Health, and Public Health shared their experiences. • Recovery and Older Adults: Supporting the Peer Workforce in advancing treatment and recovery support for older adults. Presenters described the changing landscape of treatment and recovery services for older adults, highlighted best practices emerging across the field, and shared how recovery support services, such as peer services, can improve client outreach and engagement. • Digital Health Literacy Training by Painted Brain: Online Digital Health Literacy Training Program to empower Peers and support overall wellbeing. 6-Module course covering the core digital health competencies for education, workforce development, training, and wellbeing. (E-mail set up, free digital resources, download apps, online storage, online security, Just4me client portal)
HOME (Homeless Outreach and Mobile Engagement) Team	• Cultural Competency 101: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data • Cultural Humility: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources. • Health and Wellbeing of Transgender Individuals: Offered from DMH+UCLA Public Mental Health Partnership. • LGBTQ – Becoming an Ally to the community: Offered from DMH+UCLA Public Mental Health Partnership.

Program Name	Title of Trainings
Pathways to Wellbeing: Katie A. Implementation/Service Delivery	• Where Privilege Meets Oppression: Utilizing a Cultural Lens with the Child Welfare Population: This training increases participants' knowledge of how culture, privilege and oppression influence practice when working with the child welfare population. Participants increase their ability to improve outcomes for children and families by 1) utilizing the concepts of the Shared Core Practice Model; 2) enhancing engagement, assessment and teaming process; and 3) developing individualized interventions. The discussion includes defining privilege and oppression and how they impact collaboration among the professional and the child and family. In addition, participants have the opportunity to explore their thoughts and beliefs about privilege and oppression relevant to working with children and families. • Core Practice Concepts in Working with LGBTQ Youth: This training combines didactic and experiential learning components to inform participants of the high degree of risk of abuse and neglect faced by the LGBTQ youth population. In reference to the Integrated Core Practice Model, participants enhance their skills of engagement, assessment and understanding cultural humility, teaming, and trauma responsive strategies. The discussion includes an overview of the stages of sexual identity development and identification of the physical and emotional stressors experienced by this population. In addition, cultural and institutional dynamics that reinforce this abuse are reviewed. A strength based approach is embedded throughout the discussion and also avails an opportunity for participants to explore their thoughts, beliefs, and values as it relates to working with this population. • Integrated Core Practice Model: In support of the statewide implementation of Continuum of Care Reform, Los Angeles County Department of Mental Health has adopted the Integrated Core Practice Model (ICPM). The ICPM provides practical guidance and direction to support county child welfare, juvenile probation and behavioral health agencies in delivery of timely, effective, and collaborative services to children, youth, families and communities. This foundational training provides an overview of the values, principles, core components, and standards of practice expected from those serving children, youth and families. • Role of the Clinician: Participating in the Child and Family Teaming Process: This training increases participants' knowledge of the clinician's role in the Child and Family Team (CFT) process. More specifically, this training focuses on strengthening the clinician's understanding of trauma and its effects, including its impact on child/youth and family's participation in the CFT process. Participants increase their ability to incorporate their assessments

Program Name	Title of Trainings
	of the child's trauma into the CFT process in a trauma-responsive manner, as well as recognize the importance of translating the child/youth's behaviors into underlying needs. The discussion focuses on outlining complex trauma; considering the impact trauma has on the developing brain; examining how trauma effects behaviors; exploring the influence culture has on understanding trauma; addressing confidentiality; delineating ways the clinician may incorporate trauma-related underlying needs language into the treatment plan; describing how clinicians can assist with avoiding placement disruptions, and ultimately, defining the clinician's role within the CFT process. • Infant and Toddler Development Within a Relational Context: This course provides foundational understanding of the importance of relational factors during the prenatal and perinatal periods in healthy neurological development. Research on the impact of nurturing and attuned early relationships on healthy life-long mental health, physiological, and interpersonal functioning is discussed. Attendees learn about transgenerational transmission of toxic stress and its impact on gene expression (epigenetics) and obtain insight into determining medical necessity for mental health treatment by viewing Birth-5 clients through a dynamic relational perspective. • Shared Core Practice Model with an Emphasis on Underlying Needs**:** In support of the Katie A. Settlement Agreement, Los Angeles County Department of Mental Health and The Department of Children and Family Services have developed a Shared Core Practice Model (SCPM). This course provides foundational training on the practice model elements and how the practice behaviors support the work with families, improves coordination among mental health providers, and enhances outcomes in the child welfare system. Participants also understand the application of the shared values and elements embedded in the SCPM and the relevance to their work with children and families. This interactive training engages participants in exercises that reinforce the value of listening, identifying and working with a child and family team, identifying strengths and underlying needs. Participants learn how to integrate best practices with the family's cultural experience, trauma history, and long term view. • Principles of Teaming and Wraparound Role Definitions and Skills**:** This training focuses on the exploration of the Wraparound team member roles, and the specific tasks and responsibilities performed both during and outside of Child and Family Team Meetings. The training is interactive and includes activities that demonstrate the use of a trauma-informed lens by each Wraparound team member in order to understand the underlying needs of children, youth, and

Program Name	Title of Trainings
	families. This training assists participants in understanding how Wraparound team members engage in teaming and collaboration in order to help children, youth, and families achieve their goals. • Creating Effective Teams: Understanding My Role as a Member of a Team**:** This training focuses on Wraparound teams and how they can effectively work together through shared goals, strategies, and work plans to increase overall success. Interactive activities are aimed at acquiring basic skills to address conflict resolution, communication, creating a shared vision, and working as a member of a team, all while maintaining a sense of individuality. Also covered are stages of teaming, addressing inevitable challenges with a team, understanding how cultural differences affect communication styles, and collaborative communication with outside entities. • Underlying Needs: A Strength Needs-Based Service Crafting Approach: This training increases participants' knowledge about underlying needs and needs that drive behavior. Participants recognize that focusing on a child's behaviors obscures needs and without addressing the needs limits behavioral change. The training includes reviewing criteria elements to support a needs statement, importance of promoting team agreement about the child's needs and practicing writing strong needs statements. In addition, participants get the opportunity to explore strategies for incorporating a family's culture and strengths coupled with tailoring services unique to each child and family. • Trauma Informed Practice for Mental Health Professionals: Trauma-Informed Practice for Mental Health Professionals training has been designed to enhance practitioners' knowledge, skills, and values for working with children and youth in the Child Welfare System who have experienced traumatic events. This training includes defining and recognizing behavioral signs of trauma, understanding the effects on children and youth as well as parents and caregivers and its implications for a trauma informed child welfare practice. Participants understand the neuroscience of trauma and its effect on the brain. Guidelines for recognizing dysregulation and intervening directly in a trauma-sensitive manner are presented. Participants practice engaging effectively with trauma victims. The training supports participants in the integration of the Shared Core Practice Model values and Evidence-Based Practices. It presents participants with self-care strategies and interventions as well. • Overview: Preparing for Child and Family Teaming**:** This training increases participants' knowledge about the Child and Family Teaming Model that is utilized when working with children in

Program Name	Title of Trainings
	intensive mental health programs. Participants increase their ability to incorporate the Shared Core Practice Model to enhance their approach when teaming with the child and family. The discussion includes strategies for more effective teaming and collaboration with families and their formal and informal supports, which can assist in developing individualized plans to meet the underlying needs of the child. In addition, participants have the opportunity to explore how they can incorporate the family's strengths and needs to develop tailored and individualized plans. • Child and Family Team Facilitator Training (2 days)**:** This training provides participants with an in-depth understanding on the tenets of the Child and Family Team (CFT) process and equips participants with the specific facilitation skills that are required to implement an effective teaming process with children and families in intensive mental health programs. The training consists of power point presentations, group activities, Role-plays, group discussions, and an experiential application of skills. The purpose of the training is to provide a clear demonstration of the CFT process, and an opportunity for an active application of skills by the participants. Participants gain an understanding of how to incorporate the Shared Core Practice Model elements and principles when facilitating a teaming approach with children and families. At the conclusion of the training, participants have a working knowledge of the specific components associated with the CFT process, and the strategies for how to better collaborate with the Department of Children and Family Services. • Best Practice Interventions with Complex Trauma Victims in Foster Care: This training is designed to provide didactic and experiential learning to staff who deliver intensive, field-based mental health services to high acuity children and adolescents in the Los Angeles County foster care system. Training topics include neurobiology of trauma and how trauma impacts child and adolescent development; best practice interventions that are grounded in trauma-based play therapy; and art therapy theory and principals that promote healing, resolve trauma and repair attachment disruptions. Participants understand how best to engage and treat children with complex trauma histories by reviewing didactic material, learning to facilitate structured, small-group discussions, and applying other experiential training activities. • Continuum of Care Reform: Integrated Core Practice Model: This training provides an overview of the Continuum of Care Reform, Integrated Core Practice Model practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice

Program Name	Title of Trainings
	behaviors. Participants learn to utilize interagency teaming strategies while providing services to children and families involved in the Child Welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and Wellbeing promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge. • Trauma-Informed Practice for Child Welfare Involved Children and Families: This foundational trauma-informed care training supports the Continuum of Care Reform requirement for trauma-informed services to Child Welfare children and families. This training introduces key and essential trauma recovery understandings within a safety-oriented, trauma-informed framework. Additional topics address: an overview of developmental trauma implications on the brain and behavior; strategies for recognizing trauma related behaviors; foster youth treatment engagement and interventions for enhancing resilience. In summary, participants gain knowledge and skills to deliver services through a trauma-informed lens. • Engaging Probation Youth**:** This training provides the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. The impact of trauma and its effects on the brain, attachment, physiology, and social relationships are examined. The overview includes discussion of the trauma informed approach, cultural sensitivity, and underlying needs. Strategies for engagement as well as staff's awareness of their countertransference are explored. Group activities are incorporated to enhance application of learning and address challenging behaviors. Lastly, the training covers self-care, and participants develop self-care strategies for themselves. • LGBTQ+ Youth in Placement**:** This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens is utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma, particularly as it relates to LGBTQ+ youth of color. Lastly, participants learn about Eli Coleman's Identity Model as a way to conceptualize the coming out process and the value of acceptance. Group activities are facilitated to enhance application of learning and increase one's self-awareness as it relates to this population.

Program Name	Title of Trainings
	• Crafting Underlying Needs Statements and Services**:** This training provides information on Underlying Needs and its application in the Continuum of Care Reform (CCR) process. It prepares providers to identify the relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs based statement and support development of individualized services for youth and families in the Child Welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills and implementation of training strategies. • 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 Wellbeing. One of the core values of the Continuum of Care Reform (CCR) is permanency. This training supports the goal of permanency for children and youth involved in the Child Welfare system. Training discussions include understanding the value of taking a "both/and" approach when working with children and youth as well as learning skills and strategies that support achieving a "no matter what" family for every child. Case-based practice interventions are embedded to enhance the application of trauma-responsive, team-based 5-step approach. The training also provides tools for addressing and working with youth who say "no" to permanency. • Prevent the Eruption: Trauma Informed De-Escalation Strategies: This training seeks to provide DMH, DCFS, Probation and Contract Provider staff with the knowledge in recognizing and better understanding trauma when observed in children and youth, the impact of trauma on the brain and provide learning on trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training reviews and describes the ascent of escalation phases, de-escalation phase clues and offer trauma informed interventions for each phase including specifics regarding the debriefing process and strategies for prevention of self-injurious behavior. Additionally, this training assists the participants with the understanding and application of trauma informed consequences. Finally, the importance of self-care

Program Name	Title of Trainings
	is discussed, and the participants learn how to develop self-care strategies for themselves.
Service Area 1 Maternal Mental Health (MMH)	• Maternal Mental Health and the Black Birthing Experience: This training was designed to increase awareness about the disparities among black births and the black birthing experience • Intersectionality and Perinatal Maternal Health: This training increases awareness toward intersectionality through consideration of systems of oppression and privilege. It also assesses differences between identity and socially constructed ideas. • 15 hour Clinical Supervision: Enhance skills for clinical supervision including implicit bias, legal and ethical issues.
TAY Navigation Team	• LGBTQIA2-S TAY Youth Toolkit Training: This training was offered by Tarzana Treatment Center's 'We Exist' program to our Navigation team staff. • Problem Solving Therapy (PST): This training is an evidence-based, brief intervention, "talking therapy" model for consumers experiencing moderate depression, and its aim is to increase consumer self-efficacy by teaching how to solve "here-and-now" problems contributing to depression.
Wellness Outreach Workers (WOW)	• WOW training (Two days): Culturally diverse presenters train new consumers in the following: overview of the WOW program, advocacy and problem solving, confidentiality, eight dimensions of wellness, how to start support groups, community reintegration, housing, health, employment, co-occurring disorders and benefits

Program Name	Title of Trainings
Promotores de Salud Mental	• Asian American Conference • Understanding Psychosis in different cultural communities: Addressed Psychosis in different cultural communities. • Promotora Conference Workshops: Mental Health and Stigma and Grief and Loss in the Latino Community. • LGBTQI2-S Toolkit: A toolkit for creating a supportive program for LGBTQI2-S Transitional Age Youth. • Employee Essentials Diversity and Inclusion: This training covers the dimensions of diversity and addresses biases that exist toward Culture, Disabilities, Gender, Generations, LGBTQ, Micro-Messages, Religion, and Veterans. • Collaboration in Geriatric Mental Health Care Conference: Addressed Geriatric Mental Health Care issues. • Raising Zoey Film Screening. Advancing Diversity, Inclusion & Acceptance: The goal was to bring more awareness to the LGBTQ+ youth who are disproportionately at risk of entering systems of care. • Increasing Spanish MH Clinical Terminology: Discussion around the various clinical terms/language to appropriately engage clients when providing treatment. Discussion also included various Spanish language dialects. • County Policy of Equity for Employees: This online course is designed to help employees understand their rights to be free from discrimination, unlawful harassment, retaliation, and other inappropriate conduct. • The response of Promoters to the COVID 19 pandemic: Promoters' response to the COVID 19 pandemic. • COVID-19 and Wellbeing (El Efecto de la Pandemia en el Bienestar Emocional de la Comunidad): Teaching/Learning Power Point presentation for Promoters to teach the community. Focus on how the pandemic impacts the wellbeing of the Latino community (UCLA). • The Basics of Just Culture: This module provides the workforce member with the basic knowledge on Just Culture and its concepts and principles. • Serie educativa de Corona Virus (COVID-19) Parte 4: Efectos socio económicos: Culturalmente como la pandemia afecta a nuestras comunidades. This training framed how the pandemic affected underserved communities. • Trauma Informed Care During COVID-19: Increased understanding of trauma informed care during COVID-19.

Program Name	Title of Trainings
	• Therapeutic Support When Working with Young Children (0-5) and Caregivers in a Virtual Setting: Cultural aspects of caregiver/child interactions based on virtual settings and using computers; framed how culturally the pandemic affected communities. • Webinar - Focused on Family Support During COVID-19: Providing Family Support During COVID-19 (NASMHPD). • Clinical Practice: A Framework for Engagement and Retention of Clients during Sessions: Cultural aspects of engagement via virtual platforms; framed how culturally the pandemic affected communities. • The Centers for Disease Control and Prevention COVID-19 Response: Promising Practices in Health Equity: Presenters discussed actions taken to mitigate the disproportionate impact of COVID-19 on racial and ethnic minorities. • Staying Connected While Keeping Apart: An LA County Conversation: Discuss and share how we have been supporting people in maintaining social connections and engaging in meaningful activities with the community. • Managing the Impact of Job-Related Stress for Staff in Human Services: Discussed strategies to manage the impact of job- related stress for staff in human services. • Desarrollando Resistencia y Creando Resiliencia: Depresión, Ansiedad y Violencia Doméstica (Building resilience and Creating resilience: Depression, Anxiety and Domestic Violence): Discuss how the pandemic has triggered a wave of mental health issues. Whether it is managing addiction, depression, social isolation or domestic abuse. The community is strong and are creating resilience during this difficult time. • Psychological First Aid: Supporting Yourself and Others During COVID-19 (American Red Cross). • Improving Mental Health Access for Underserved Latino Communities Impacted by COVID-19: Discussion on how to improve mental health treatment, and strategic directions and recommendations for reducing health disparities in Latinos. • Virtual Dialogue Series "Societal Inequities": County leaders discuss the current state of civil unrest, systemic racism, and what the County is doing to dismantle these societal inequities. • Unconscious Bias: Fuel Diversity and a Better You (Udemy). • Professional Life Coach: Increase understanding of Life coaching (Udemy).

III. Monitoring of staff's skills/post skills learned in trainings

The OAO-Training Unit 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-Training Unit 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 OAO-Training Unit)

This space was intentionally left blank

Criterion 5 Appendix

Attachment 1: Interpreter Trainings, FY 19-20

ATTACHMENT 1 - CR
5 -INTERPRETER TRA

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 2021-22, 2022-23, 2023-24

LE Contract 2021-22, 2022-23, 2023-24.pdf (Command Line)

LE Contract
2021-22, 2022-23, 20

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 19-20

ATT 7 - CC Trainings FY 19-20 CC.docx

2018-19 Cultural Competency Bulletins.

Attachment 8: Examples of trainings with one-month follow-up conducted by OAO-Training Unit, FY 19-20

8 28 19-Law & Ethics Children and

9-25-19 COD training-1 Month Fc

11-18-19 Cultural Humiliy in Clinical Su

11-19-19 Occupational Resilie

11-20-19 Occupational Resilie

11-21-19 Working with Forensically Inv

1-13 to 1-15-20 Interpreting in MH S

2-11-20 Diving Deeper Training - 1

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 6

County's Commitment to Growing a Multicultural Workforce

August 2021

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 19-20:

1) Public Mental Health Partnership (PMHP)

The mission of the UCLA-LACDMH Public Mental Health Partnership (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 Los Angeles County. The PMHP is comprised of two sections: the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) Training and Implementation Program.

2) Navigator Skill Development Program

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.

3) **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.

4) **Interpreter Training Program**
The Interpreter Training Program (ITP) offers trainings for bilingual staff who are currently performing or express interest in providing interpreter services for monolingual 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.

5) **Learning Net System**
This is an online registration system that manages both registration and payment for trainings and conferences coordinated by the Department. This system was developed in multiple phases.

6) **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.

7) **Psychiatric Residency Program**
The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and LACDMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County. The first class started Academic Year 18-19 and the program included 24 trainees raging from Post Graduate Years I to IV. The first class will graduate in June 2022.

8) **Intensive Mental Health Recovery Specialist Training Program** prepares individuals, mental health consumers and family members, with a minimum of two (2) years of college 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. Due to COVID-19, only one cohort was able to complete this training**.**

9) **Intensive Mental Health Recovery Specialist Training Program**
This training program prepares individual, mental health consumers, and family members who hold a minimum of two (2) years of college 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. Due to COVID-19, only one cohort was able to complete this training**.**

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

11) Honest, Open, Proud Program
Through the Illinois Institute of Technology, the Department offered technical assistance to participants who had completed the training during FY 18-19.

12) Community Inclusion and Peer Support Program
Through this effort, the County has secured a trainer to develop and offer training and technical assistance to assist the health system in the implementation of practices and tools to promote and advance community participation for people in recovery through the intentional skills of Peer Supporters.

13) Wellness Recovery Action Plan (WRAP)
This WRAP program trains participants in the process of identifying their personal wellness resources and how to use those as a guide for daily living, dealing with triggers, identifying early warning signs of symptoms, and developing advance directive and post-crisis plans.

14) Parent Partners Training Program
This training program promotes knowledge and skills relevant to individuals who are interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances the participants' understanding of resilience and wellness thereby increasing the availability of a workforce oriented to self-help and parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.

15) Parent Partner Training Symposium
These training opportunities cover a wide range of topics inclusive of criminal justice issues, crisis intervention and support strategies, education, employment, homelessness, housing, inpatient/hospitalizations, LGBTQIA2-S issues, older adults, residential and group homes, suicide prevention, and the integration/ care of co-occurring disorders.

16) Continuum of Care Reform (CCR)
Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular, this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end,

LACDMH offered the following trainings and include topics subjects such as introduction to mental health, diagnosis/assessment and self-care:

17) **Continuum of Care Reform: Child and Family Team Process Overview (CFT)**
This training provides an overview of how the Child and Family Team process is utilized in the Continuum of Care Reform (CCR). In CCR, the Child and Family Teaming process is the decision-making vehicle for case planning and service delivery. This training reviews the elements involved in the Child and Family process, team members, and their roles. This training identifies the Integrated Core Practice Model elements embedded in the Child and Family Teaming process, and its role in providing collaborative services. Participants learn engagement strategies and the importance of keeping the child and family's voice and choice at the center. Participants also learn strategies for effective teaming with children and families, and formal and informal supports. This training reviews how teaming can promote positive permanency outcomes and assist with meeting the underlying needs of children. This training utilizes both didactic and experiential learning strategies to support the transfer of learning. During

18) **Continuum of Care Reform: Integrated Core Practice Model Overview (ICPM)**
This training provides an overview of the Continuum of Care Reform, Integrated Core Practice Model practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements, additional discussion incorporates the model's practice wheel components and practice behaviors. Participants learn to utilize interagency teaming strategies while providing services to children and families involved in the Child Welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and Wellbeing promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge.

19) **Crafting Underlying Needs Statements and Services (Underlying Needs)**
This training provides information on Underlying Needs and its application in the Continuum of Care Reform (CCR) process. It prepares providers to identify the relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs based statement and support development of individualized services for youth and families in the Child Welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills and implementation of training strategies.

20) **Engaging Probation Youth (PROBATION)**
This training provides the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. The impact of trauma and its effects on the brain, attachment, physiology, and social

relationships are examined. The overview includes discussion of the trauma informed approach, cultural sensitivity, and underlying needs. Strategies for engagement as well as staff's awareness of their countertransference are explored. Group activities are incorporated to enhance application of learning and address challenging behaviors. Lastly, the training covers self-care, and participants will develop self-care strategies for themselves.

21) Everything You Have Wanted to Know About Psycho-Pharmacology: Medication Side Effects (Medication)

This workshop provides an introduction to common side effects that may be experienced by youth being prescribed psychotropic medications. Basic neurobiology and the role of neurotransmitters in psychiatric illness/medication response will be reviewed along with an update on the desired effects, duration of action, and side effect profiles of antidepressants, stimulants, anti-anxiety agents and anti-psychotic medications. The differences between an allergic response and a side effect will be reviewed and illustrated. The role of the FDA will be reviewed in order to understand how medications come to market and side effects monitored. Cultural differences (based on population genetics) will be illustrated to demonstrate why certain illnesses/syndromes are more common in some groups, while medication side effects may occur more frequently in some populations and not others.

22) LGBTQ+ Youth in Placement: Strategies and Interventions

This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens is utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma and trauma, particularly as it relates to LGBTQ+ youth of color. This training discusses how community impacts LGBTQ+ youth and suggests strategies to support positive connections. Participants learn about the Helm's Identity Development Model as a way to conceptualize the coming out process and how to employ healthy approaches in their daily interactions with these youth. Trainers provide practical applications to address bullying, LGBTQ+ challenges, the coming out process, and the CFT model. Group activities enhance learning and increase one's self-awareness as it relates to this population.

23) Permanency Values and Skills for Child Welfare, Probation, and Mental Health Professionals (Permanency)

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 Wellbeing. One of the core values of the Continuum of Care Reform (CCR) is permanency. This training supports the goal of permanency for children and youth involved in the Child Welfare system. Training discussions include understanding the value of taking a "both/and" approach when working with children and youth as well as learning skills and

strategies that support achieving a “no matter what” family for every child. Case-based practice interventions are embedded to enhance the application of trauma-responsive, team-based 5-step approach. 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.

24) Prevent the Eruption: Trauma Informed De-Escalation Strategies (De-escalation)

This training seeks to provide LACDMH, DCFS, Probation and Contract Provider staff with: knowledge to: recognize and better understand trauma when observed in children and youth, address the impact of trauma on the brain, and provide trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training reviews the ascent of escalation phases, de-escalation phase clues and offer trauma informed interventions for each phase including specifics regarding the debriefing process and strategies for prevention of self-injurious behavior. Finally, the importance of self-care is discussed, and the participants develop self-care strategies for their use.

25) Engaging Runaway Youth in Placement: Overview and Strategies for Response (Runaway)

Most runaway youths struggle with substance abuse and mental health issues, are at high risk for being a victim of sex trafficking and have higher rates of involvement with the juvenile justice system. This training increases the participants’ understanding of the characteristics of youth who run and the impact of traumatic experiences and development on running behavior. It provides strategies to reduce the risk of running, including recommended policy, practice, training, and direct engagement with youth. The curriculum follows a case-based approach to designing implementable strategies to reduce risk to run. Following the introduction of core content, attendees review case information using a multidisciplinary and collaborative lens to assist them in identifying effective strategies for engaging youth and reducing run risk. Teams learn to develop safety plans that encompass run behavior prevention and intervention.

26) Self-Care for Providers (Self-care)

This training prepares Continuum of Care Reform (CCR) providers to identify the relationship between compassion fatigue and self-care strategies. Self-care and general wellbeing are essential components to prevent compassion fatigue and support quality services. Discussion includes risks factors, signs, and impact associated with compassion fatigue. Participants learn the relationship between culture and self-care. Also reviewed are prevention approaches important for mitigating compassion fatigue risk, and increasing self-care and resilience. Identification and integration of self- care strategies into daily practice are addressed. Lastly, this training incorporates both didactic and experiential learning to support transfer of understanding, knowledge and integration of training objectives.

27) **Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (STIC)**
This six-hour training reviews the use of competency-based supervision and essential components of trauma-informed care for implementation and monitoring purposes. Trauma-informed supervision is known for its protective factor attributes and in conjunction with trauma-informed self-care support are critical to supporting personnel. (Please Note: Trauma-informed supervision refers to security, respect, and trust within the supervisory relationship.) Knowledge, skills, and understandings regarding trauma-informed care, secondary trauma, the role of supervision within those, and positive self-care practices will be explored. This training is highly experiential, focused on skills and enhancing understanding using vignettes and role-play by the trainer and the participants.

28) **Supervision of Vicarious Trauma of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families (SVT)**
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 vicarious traumatization on clinicians as well as supervisors of clinicians who work with the complexity traumatized. Included in the discussion is the role of effective competency-based supervision as a protective factor for clinicians and its facilitative factor impact on client efficacy treatment. This training contains didactic and experiential components and incorporate current competency-based supervision strategies applicable to working in trauma-informed care. Vignettes serve to enhance the understanding and implementation of content to the supervisory role. The experiential component of the training addresses both supervisor and supervisee psychological resilience promoting their health and wellbeing within the context of trauma work.

29) **Trauma-Informed Practice for Child Welfare Involved Children and Families (TIC)**
This foundational trauma-informed care training supports the Continuum of Care Reform requirement that services provided to Child Welfare children and families are trauma-informed. This training introduces key and essential trauma recovery skills that staff and programs can use to provide a safety-oriented, trauma-informed framework for youth and families. Participants receive an overview of developmental trauma implications on the brain and behavior. Participants learn tools to recognize trauma related behaviors and respond in ways that foster resilience. This training reviews practice strategies to effectively engage foster youth who have experienced trauma. As a result of this training, participants gain knowledge and skills to deliver services through a trauma-informed lens.

30) **Youth Mental Health First Aid Course (YMHFA)**
Mental Health First Aid teaches a five (5)-step action plan to offer initial help to people with the signs and symptoms of a mental illness or in a crisis, and connect them with the appropriate professional, peer, social, or self-help care. Anyone can take the eight (8)-hour Mental Health First Aid course: first responders, students,

teachers, leaders of faith communities, human resources professionals, and caring community members.

31) Youth with Developmental Disabilities and Mental Illness: Overview and Interventions (MHDD)

The Co-occurring Development Disabilities (CDD) Program trains mental health clinicians to assess and treat mental health issues that consumers with CDD are at high risk of developing. The curriculum provides participants with tools to differentiate the mental health issue from the intellectual/developmental disability and to treat the mental health issue in context of the CDD as well. During the training, the participants earn to apply the Diagnostic Manual-Intellectual Disability (DM-ID-2): A Textbook of Diagnosis of Mental Disorders in Person with Intellectual mental health problem(s). Knowledge and expertise related to these diagnostic tools are increasingly valued as a complement to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM V).

32) Financial Incentive Programs

Mental Health Psychiatrist Student Loan Repayment Incentive

LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at LACDMH and have active, unpaid, graduate, or medical, student loans. 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.

33) Mental Health Psychiatrist Recruitment Incentive Program

This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. It is designed 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. It grants a one-time award of $50,000 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.

34) 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.

35) Stipend Program for MSWs, MFTs, and Psychiatric Nurse

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 traditionally unserved and underserved populations of the County.

Collectively, these 35 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 35 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.

ESSENTIAL JOB DUTIES

- 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 LACDMH 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:

A. 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, 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 three 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** – LuAnn 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 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. ***– LuAnn Sanderson, Chief of Nursing***

- "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***

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 Practice for Psychiatric-Mental Health Nursing and ensure awareness of clinical competency requirements
- Serve as the voice of LACDMH nursing
- Provide professional and effective leadership to LACDMH nursing staff
- Ensure bidirectional communications with frontline nursing staff through regularly scheduled meetings
- Serve as LACDMH nursing liaison with SEIU and professional organizations
- Collaborate with Human Resources to update language used in Class Specifications, promote standardization of duty statements for nursing staff
- Identify Psychiatric-Mental Health Nursing education gaps and identify the quality resources to meet the educational needs of the Registered Nurses and Psychiatric Technicians
- Support the higher education and career 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 and maintain quality relationships and collaborate with affiliated university nursing programs to ensure valued learning opportunities for Psychiatric-Mental Health Nursing students
- Advocate for professional nursing voice on multidisciplinary treatment team structures
- Ensure evidence-based nursing practice serves as the foundation for direct and indirect client care
- Collaborate with Chief of Pharmacy on policy that incorporates nursing practices
- Collaborate with Psychiatry and Training Unit to provide clinical placements for Psychiatric-Mental Health Nurse Practitioner students

Goals for 2020	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.	• Build capacity for ongoing LACDMH Psychiatric-Mental Health Nursing Continuing Education (CE) development and delivery • Reinforce RN and APRN Standards of Practice • Develop virtual platform to deliver stress awareness education and relaxation exercises • Ensure communication modes between executive nursing leadership and frontline nursing staff • Promote efficient use of resources and access to care	• Mentored RN and APRN staff to develop and provide six (6) specialty nursing education events with over 24 CE credits addressing Standards of Practice and cultural competencies • Provided stress awareness and relaxation exercises (pre and post) during Chief Nurse Meetings delivered virtually • Ongoing bi-directional communications among LACDMH nursing staff through email, personal communications, virtual platforms and Quarterly Chief Nurse's meetings • LACDMH nursing accomplished two (2) presentations at the 34th Annual American Psychiatric Nurses Association conference (virtual) • Maintained positive relationship with American Nurses Association that resulted in 90 RNs receiving a 21-hour psychiatric nursing review course and 16 RN's achieving national certification

Goals for 2020	Strategies	Status/Contributions/ Accomplishments
2. Building Nursing Resources Attract and deploy quality nursing staff for L.A. County Public Mental Health System	• Maintain Nurse Practitioner (NP)program relationships to obtain candidates for placement within LACDMH • Add the Psychiatric-Mental Health NP students to LACDMH clinical practice settings to enhance cultural awareness within the clinical teams and client populations (e.g., multiple language capacities to enhance services that are sensitive to clients' cultural and linguistic diversities)	• Maintained relationships with two (2) affiliated university psychiatric NP programs through pandemic that resulted in clinical placements within LACDMH: Spring = eight (8) students; Summer = three (3) students; Fall = 3 students. LACDMH clinical opportunities with multi-disciplinary teams contributed to successful graduation for five (5) NP students in 2020
3. Introduce and implement Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation (OPPE/FPPE)	• Collaborate across disciplines • Maintain open communication with nursing staff	• Maintained regular quarterly meetings with LACDMH APRNs • Ongoing discussion around policy for APRNs (CNSs and NPs) and involvement in OPPE/FPPE processes • Added NPs to psychiatry OPPE processes
4. Class Specifications – Nurses Series	• Collaborate with LACDMH HR, DHS nursing, DPH nursing, and CEO to update class specification document language and bring it into alignment with current professional practice	• Delivered the following proposed nurse class revisions to nurse's union: ○ Assistant Mental Health Counselor RN ○ Mental Health Counselor RN ○ Sr. Mental Health Counselor RN

II. 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 clinical standards, policies, and performance across the Department, particularly as relevant to the discipline of psychology 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 environment.
- 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. Responsible for credentialing and monitoring adherence of psychology discipline with existing parameters and practice guidelines.
- Actively cultivate a “Pipeline” of psychologists’ talent to fill vacancies in this discipline. 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 Training Unit.
- 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 particularly in distinguishing the practice of psychology. Help implement new and effective assessment instruments, technologies, and/or treatments for psychological disorders or symptoms as they become available.
- 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 particularly in distinguishing the practice of psychology. Help implement new and effective assessment instruments, technologies, and/or treatments for psychological disorders or symptoms as they become available.

Goals for 2020	Strategies	Status/Contributions/ Accomplishments
1. Collaborate with LACDMH Human Resources (HR) to review, revise, and update Psychology related Class Specifications. Work with HR and CEO's office to implement suggested changes	• Through directing meetings with HR and 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. • Provide support to in the implementation of scope of practice within Directly Operated programs	• Assist with implementation of drafted revisions for all Class Specifications under discipline of psychology • Collaborate with training programs to incorporate approved revisions for Psychology items including: ○ Replacement of the previous Associate Behavioral Health Consultant item, with Psychology Intern, Psychology Fellow I and Psychology Fellow II ○ Clinical Psychologist I (CPI), Clinical Psychologist II (CPII), and Supervising Psychologist items
2. Increase capacity and competency for Psychological Testing and Assessment to improve services particularly 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 • Support identified Testing and Assessment leads (North and South SA) to implement countywide services including design, assess, and implement all aspects related to psychological testing, training, and service implementation	• Delegate leadership and implementation of the Testing and Assessment monthly workgroup. Two CPIIs have been identified as LACDMH Testing and Assessment Practice and Training workgroup leads. Together they oversee implementation and testing supervision efforts County wide. • Implement and evaluate a four-course training curriculum to assure Testing and Assessment clinical competency for all LACDMH psychologists. The entire sequence of four training modules were completed assuring baseline testing and assessment competency of training-enrolled LACDMH psychologists • Testing and assessment: Training sequence repeated exploring cultural factors in assessment. Sequence offered in Spanish and English • Neuropsychological testing sequence and brief assessment offered repeated

Goals for 2020	Strategies	Status/Contributions/ Accomplishments
3. Promote core competencies of psychologists working in Public Mental Health	• Assure all LACDMH Psychologist have demonstrated familiarity and success with identification, and regular implementation of core competencies for Clinical Psychologists • Evaluate ability of LACDMH Clinical Psychologist to implement Core Competencies in all aspects of work within LACDMH	• 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 ○ Offered professional performance evaluations for psychologists on individual and as requested basis ○ 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: Clinical Specialty Committee meets on a monthly basis with specific clinical subcommittees meeting separately. Specialty Clinical Practices include: ○ Developmental Disorders ○ Personality Disorders ○ Eating Disorders ○ Co-occurring, Substance Use and Mental Health Disorders ○ Justice-Involved, Community Re-entry, and Re-integration ○ Children and Youth
4. 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	• Collaborate with Public Information Office to create media campaigns designed to provide resources and information to underserved cultural communities

Goals for 2020	Strategies	Status/Contributions/ Accomplishments
5. Improve Training and Professional Development opportunities of future psychologists and assure collaboration with academic institutions to inform culturally competent training environment	• Establish the Training and Professional Development 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. Committee continues to expand by increasing number of academic affiliate programs as well as helping direct training needs of new and existing psychologists Committee leading efforts to create a language and culture specific supervision track for psychologist able to deliver bilingual/bicultural services (Spanish) speaking psychologists
6. Help design and implement position of Department appointed LGBTQ2S lead to oversee contracts and programs 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	• Identification of a countywide LGBTQIA2-S SME to help oversee contracts and service provision to population • In this role, she will coordinate directives to create an inclusive and welcoming environment for LGBTQIA2-S clients within LACDMH Directly Operated programs

This space was intentionally left blank

III. 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.

B. LGBTQ+ Services Specialist Position

Dr. Rebecca Gitlin, Ph.D. (she/her) is LACDMH's first LGBTQ+ Services Specialist. Her position was established on March 2, 2020. This part-time position serves to establish a centralized resource for the provision of culturally responsive services for the LGBTQIA2-S community in L.A. County. The LGBTQ+ Services Specialist serves as a SME for Countywide LGBTQIA2-S behavioral health consultation and program development.

The overall goals of the LGBTQ+ Services Specialist position and strategies to achieve these goals include:

1. Evaluate facilitators and barriers to LGBTQIA2-S responsive service provision within LACDMH's directly operated programs
    - Create and administer survey for LACDMH staff to assess current knowledge, skills, self-efficacy, perception of the professional environment, and training needs focused on serving LGBTQIA2-S community members
2. Oversee culturally responsive service provision for LGBTQIA2-S community members
    - Review LACDMH policies and advocate for necessary updates to expand protections for LGBTQIA2-S community members
    - Develop LGBTQ+ Champion Network within LACDMH

- Establish a department-wide training plan to ensure that all LACDMH employees have the knowledge and skills to provide culturally responsive services
- Provide training and consultation for LACDMH Directly Operated and contract programs to increase capacity to provide LGBTQIA2-S responsive services
- Establish and oversee new clinical role within LACDMH's directly operated programs to ensure improved access to gender affirming treatment for transgender community members

3. Provide guidance on changes within LACDMH's EHR systems to use up-to-date and affirming language and identifier displays
    - Collaborate with Clinical Informatics office to generate affirming language and identify avenues for sustainable implementation

From March 2, 2020 through June 30, 2020, the LGBTQ+ Services Specialist accomplished the following:

- Updated written resources for L.A. County shelters and other facilities on culturally responsive disaster response services for LGBTQIA2-S community members
- Trained LACDMH pharmacists on trauma-informed practice and contraceptive counseling with gender diverse patients
- Initiated creation of survey for LACDMH staff to assess current knowledge, self-efficacy, professional environment, and trainings needs in order to provide effective and high-quality services to LGBTQIA2-S community members
- Integrated feedback from LACDMH and community stakeholders
- Founded the LGBTQIA2-S Specialty Care Workgroup within LACDMH's discipline of psychology in order to form a collaborative body of clinicians who are motivated to establish and improve standard practice in working with LGBTQIA2-S consumers
- Established the Gender Affirming Treatment Advocates clinical role, which includes clinicians with specialized training on writing support letters for transgender community members to facilitate access to gender affirming treatment
- Joined LACDMH Speakers Bureau to provide education and consultation to Countywide and community stakeholders on culturally responsive services for LGBTQIA2-S community members in response to the COVID-19 pandemic.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

CRITERION 7

Language Capacity

August 2021

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 BASED THRESHOLD LANGUAGES
FY 19-20

Service Area	Threshold Languages
1	English and Spanish
2	Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog and Vietnamese
3	Cantonese, English, Korean, Mandarin, Other Chinese, Spanish and Vietnamese
4	Armenian, Cantonese, English, Korean, Russian and Spanish
5	English, Farsi and Spanish
6	English and Spanish
7	English, Korean and Spanish
8	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, 2020.

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 funds for staff trainings and conferences each Fiscal Year (FY). A major portion of this expenditures related to cultural competence trainings. Below is a brief list of sample expenditures for FY 19-20:

- $34,149 for specialized foster care trainings
- $25,686 for juvenile justice trainings
- $11,855 for cultural-specific trainings focusing on underserved populations
- $30,015 for interpreter trainings
- $32,836 for conferences related to cultural diversity

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.

Increasing Mental Health Clinical Terminology in 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 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 19-20, LACDMH had 126 Mental Health Promoters actively engaging the Latino community across the county.

Language Translation and Interpreter Services
LACDMH currently allocates funding for language translation and interpretation services for meetings and conferences.

- $103,803 for language interpreter services, which allowed consumers to participate in various departmental meetings and conferences
- $15,931 for language documents translation services
- $9,318 for American Sign Language (ASL) and Close Captioning Services - CART (Communication Access Realtime Translation) coordinated by the Cultural Competency Unit, for consumers, family members and the community at large to participate in various departmental meetings and conferences
- $158,609 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) and

In addition to efforts to build a multi linguistic workforce and interpreter trainings offerings, LACDMH facilitates participation of consumers, family members and community groups in departmental countywide stakeholder meetings/events across all eight Service Areas, consistent with Federal and State cultural and linguistic competence requirements.

Table 2 below summarizes language assistance services coordinated by the Cultural Competency Unit inclusive of the following:

- American Sign Language (ASL)
- Cambodian
- Korean
- Spanish
- Close Captioning Services

During FY 19-20, the OAO-CCU facilitated and processed language assistance services for 23 different stakeholder meetings. Often, these meetings take place on a monthly basis.

This space was intentionally left blank

TABLE 2: LANGUAGE ASSISTANCE FOR STAKEHOLDER AND COMMUNITY MEETINGS/EVENTS, FY 19-20

MEETING/EVENT	SERVICES PROVIDED	FREQUENCY
Countywide Fund Orientation for Consumers	Spanish	Aug. & Sept. 2019
Cultural Competency Committee	Spanish and ASL	Monthly
Faith-Based Advocacy Council Executive Board	Korean	Monthly
Faith-Based Advocacy Council	Spanish	Monthly
Mental Health Commission Executive Committee	Spanish	Monthly
Mental Health Commission	Spanish	Monthly
Service Area Leadership Team (SALT) 1	Spanish	Monthly
SALT 2	Spanish	Monthly
SALT 3	Spanish	Monthly
SALT 4	Spanish and Korean	Monthly
SALT 5	Spanish	Monthly
SALT 6	Spanish	Monthly
SALT 7	Spanish	Monthly
SALT 8	Spanish	Monthly
Access for All UsCC	ASL	Monthly
Asian Pacific Islander UsCC	Cambodian and Korean	Monthly
Latino UsCC	Spanish	Monthly
LGBTQIA2-S UsCC	ASL	Monthly
SALT – Service Area Leadership Team	Spanish	Monthly
SALT CO-Chair/UsCC	Korean	Monthly
External Quality Review Organization (EQRO) - Focus Groups	Spanish	Annual
Mental Health and Community Event, Clergy Meetings	Spanish	Quarterly
DMH Town Hall Special Event – COVID-19 Information for the Community	Spanish, Close Captioning Services-CART and ASL	April 2020

Source: LACDMH Cultural Competency Unit

During FY 19-20, the Cultural Competency Unit coordinated the language assistance services for 23 different meetings-events. Most of these required monthly coordination with language interpreters' vendors and meetings/events coordinators.

TABLE 3: EXPENDITURES RELATED TO LANGUAGE ASSISTANCE SERVICES FY 19-20

LANGUAGE ASSISTANCE SERVICES (Meetings/Events)	
Language Interpreter Services - Spanish, Korean, Cambodian, Other languages as needed	
	TOTAL $103,803
American Sign Language and Close Captioning-CART (Communication Access Realtime Translation)	
	TOTAL $9,318
Translations (Various threshold languages) – Documents: forms, surveys, informational brochures, handouts for Non- English speaking consumers, family members and community groups.	
	TOTAL $15,931
	GRAD TOTAL $129,052

Source: LACDMH Cultural Competency Unit

Table 3 summarizes the expenditures for language assistance services provided in various departmental stakeholder meetings and events. Multi language interpreter services accounted for the majority of expenditures totaling $103,803.

III. Provision of bilingual staff and/or interpreters for the threshold languages at all points of contact

24/7 Help Line (formerly known as the ACCESS Center)

LACDMH's Help Line provides emergency and non-emergency services. The Help Line 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 Help Line provides referrals to culture-specific providers and services that are appropriate and conveniently located. The Help Line tracks the number of calls received in non-English languages. Additionally, the Help Line also provides equitable language assistance services to deaf and hard of hearing consumers and providers requesting ASL interpretation services for their consumers.

The Help Line 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
- 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 4: SUMMARY OF APPOINTMENTS FOR ASL SERVICES
FY 15-16 to FY 19-20

Fiscal Year (FY)	Number of Assigned Appointments
FY 15-16	1,058
FY 16-17	1,242
FY 17-18	1,140
FY 18-19	983
FY 19-20	1,027
TOTAL	5,450

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 15-16 to FY 19-20

Table 4 presents the number of assigned sign language interpreter services appointments for the five prior FYs. The ACCESS Center coordinated 1,027 requests for sign language interpreter services in FY 19-20. This number represents a 4.5% increase in the ASL appointments from 983 in FY 18-19. 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. The increase on number of requests may be due to the impact of COVID-19.

For FY 19-20, 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.

TABLE 5: FIVE-YEAR TREND IN NON-ENGLISH LANGUAGE CALLS RECEIVED BY ACCESS CENTER

Language	2016	2017	2018	2019	2020
Albanian	0	0	0	1	0
Amharic	0	1	0	2	0
Arabic	16	8	18	21	6
Armenian	130	128	65	32	32
Bahasa	1	0	0	0	0
Bengali	1	0	2	5	0
Burmese	0	0	2	2	0
Cambodian	7	10	26	19	6
Cantonese	40	46	73	59	35
Farsi	56	178	59	40	41
French	2	1	1	1	1
German	0	0	0	0	1
Greek	0	0	0	0	0
Hebrew	0	0	0	0	0
Hindi	0	0	1	1	2
Hmong	0	0	0	1	0
Hungarian	0	0	0	0	0
Italian	0	0	0	0	1
Japanese	4	2	6	6	3
Khmer	1	0	0	0	1
Korean	116	140	224	149	113
Luganda	0	0	1	0	0
Mandarin	86	82	166	126	79
Persian	1	5	4	3	0
Polish	1	0	1	0	0
Portuguese	1	1	1	1	1
Punjabi	0	2	1	1	0
Romanian	1	0	0	0	0
Russian	16	37	13	25	17
Serbian	2	0	0	0	0
Sinhala	0	0	0	0	1
Slovak	1	0	0	0	0
Spanish (LISMA)	1,474	2,303	1,370	1,373	896
*Spanish ACCESS Center	6,040	6,150	6,612	6,398	9,009
Spanish Subtotal	7,514	8,453	7,982		9,905
Tagalog	10	9	16	10	7
Thai	0	7	0	5	2
Urdu	0	0	1	1	0
Vietnamese	28	195	34	26	16
TOTAL	8,035	9,305	8,697	8,308	10,270

NOTE: * ACCESS Center Spanish speaking employee assisted with interpreter services. Data Source: Virtual Contact Center (VCC) effective 11/29/2013.

Effective 10/13/2016, per the new Language Interpreter Services Master Agreement (LISMA), telephone interpreter services are provided by the following: Language Line Services Inc., TransPerfect Translations International, Inc., and Worldwide Interpreters, Inc.

Table 5 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2016 through CY 2020. Over the past five years, the majority of the requests for non-English language calls, other than Spanish, were for Korean (N=742), followed Mandarin (N=539), Armenian (N=387), Farsi (N=374), and Vietnamese (N=299).

In CY 2020, ACCESS Center staff provided language interpreter services in the Spanish language for 9,009 calls. An additional 896 Spanish language calls were interpreted through a language interpreter service vendor. Approximately (96% of the non-English calls received by ACCESS Center staff were in Spanish (N=9,905), followed by Korean (N-113) at 1.1% and Mandarin (N-79) at 0.8%. For the remaining languages, a total of 173 calls were received in CY 2020 and accounted for 1.7% 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/pd LACDMH staff can also access this tool using the Provider Locator feature in the Intranet at https://lacounty.sharepoint.com/sites/DMH/SitePages/DMH%20Provider%20Directory.aspx

Language Interpreter Services

Language interpreter 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 interpreter and translation services are needed ***(See Attachment 3: LACDMH Policy on Language Translation and Interpreter Services.)*** Additionally, the procedure for language interpreter services for meetings and conferences is outlined in this policy. The language assistance services addressed in this policy include: Face-to-face, telephonic, and interpreter 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 "Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services" indicate how linguistic

needs of consumers are to be documented. Pages 11 and 12 delineate the following instructions pertinent to documentation of language-related assistance:

"Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):

- **Visual and hearing impairments**
- **Client's whose primary language is not English -** Clients should not be expected to provide interpretive services through friends or family members. (See LACDMH Policy #200.03, "Language Interpreters", for further information.) Oral interpretation and sign language services must be available free of charge (State Contract)

  NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.

  NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.
- **Cultural and/or linguistic considerations -** When special cultural and/or linguistic needs are present, there must be documentation in the assessment, client treatment plan or initial progress note indicating the plan to address the cultural and/or linguistic needs.
  - If an exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled.

    NOTE: Culture is "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture defines:
  - How health care information is received;
  - How rights and protections are exercised;
  - What is considered to be a health problem;
  - How symptoms and concerns about the problem are expressed;
  - Who should provide treatment for the problem; and
  - What type of treatment should be given (*U.S. Department of Health and Human Services, Office of Minority Health (2013); The National Culturally and Linguistically Appropriate Services (CLAS) Standards.*)

Cultural considerations may include but are not limited to: racial/ethnic/national origin, religious/spiritual background or affiliation, gender/sexual orientation, other cultural considerations expressed by the consumer". Additionally, the manual highlights that the clinical assessment is "important in beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a

whole person. The Assessment enables the reader to see the role of culture and ethnicity in the client's life and documents the impact of significant supports, living situation, substance use, etc. on the mental health of the client. The Assessment identifies the client and his/her family's strengths and identifies the stages of change/recovery for the client. The formulation collected in an Assessment allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery." (p. 16)

A section titled "New Client Assessment Requirements" has been added, which specifies preferred language and linguistic needs as key areas of must to be assessed as follows:

- Assessor Information (LACDMH)
  - Name
  - Discipline
- Identifying Information and Special Service Needs (LACDMH)
  - Name of Client
  - Date of Birth
  - Gender
  - Ethnicity
  - Preferred Language (p.17)
  - Other relevant information
- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma". (p. 19)

(See Attachment 5: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services)

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

TABLE 6: REQUESTS FOR CHANGE OF PROVIDER BY REASONS AND PERCENT APPROVED FY 17-18 to FY 19-20

Reason(s)[1]	FY 17-18		FY 18-19		FY 19-20	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
A - Time/Schedule	235	87.2%	235	87.2%	136	91.9%
B - Language	144	88.9%	144	88.9%	129	93.8%
C - Age	85	89.4%	85	89.4%	61	90.2%
D - Gender	246	94.3%	246	94.3%	156	90.4%
E - Treating Family Member	32	93.8%	32	93.8%	27	92.6%
F - Treatment Concerns	430	89.8%	430	89.8%	267	88.0%
G - Medication Concerns	276	87.0%	276	87.0%	62	87.1%
H - Lack of Assistance	427	85.9%	427	85.9%	290	88.6%
I - Want Previous Provider	89	83.1%	89	83.1%	72	86.1%
J - Want 2nd Option	155	89.0%	155	89.0%	101	92.1%
K - Uncomfortable	613	89.6%	613	89.6%	438	90.1%
L - Insensitive/ Unsympathetic	398	89.7%	398	89.7%	292	91.1%
M - Not Professional	309	90.9%	309	90.9%	229	91.7%
N - Does Not Understand Me	509	88.8%	509	88.8%	354	91.0%
O - Not a Good Match	693	90.3%	693	90.3%	585	90.8%
P - Other	509	87.2%	509	87.2%	502	91.8%
Q - No Reason Given	109	91.7%	109	91.7%	95	84.2%
Total	5,259	89.1%	5,259	89.1%	3,797	90.1%

Note: Multiple reasons may be given by a consumer. Data Source: DMH, PRO, October 2020

Table 6 shows the number of requests for COP by reasons and percent approved for FYs 17-18, 18-19, and 19-20. Data on the requests for COP is based on monthly COP logs submitted to PRO.

According to the FY 19-20 data, the most frequent reason for a COP request was “Not a Good Match” (N=585), and the least frequent reason for a COP request was “Treating a Family Member” (N=27).

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:

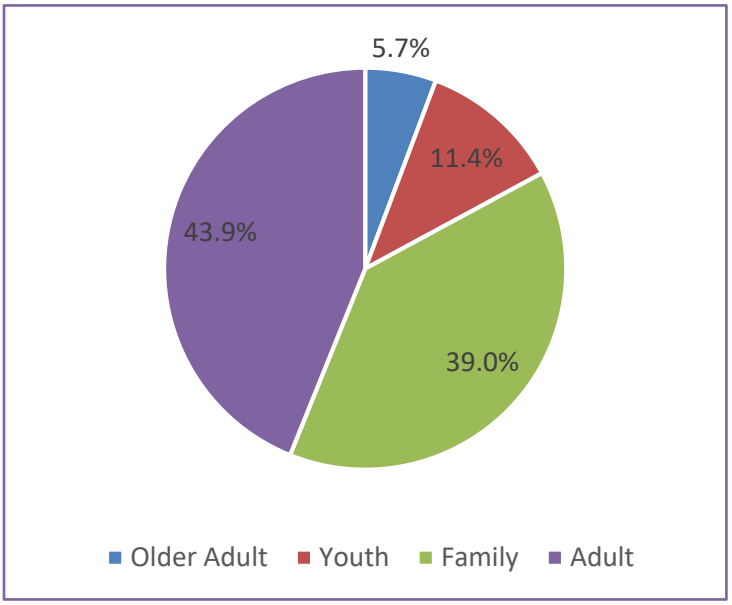
- The Mental Health Statistical Improvement Program (MHSIP) survey for adults and older adults
- The Youth Satisfaction Survey (YSS) and YSS-family version (YSS-F) for youth and their families

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.

Figures 1-13 and Table 7 below summarize CPS completion rates and responses to the item “staff were sensitive to my cultural/ethnic background”

FIGURE 1: NUMBER OF COMPLETED CPS BY AGE GROUP

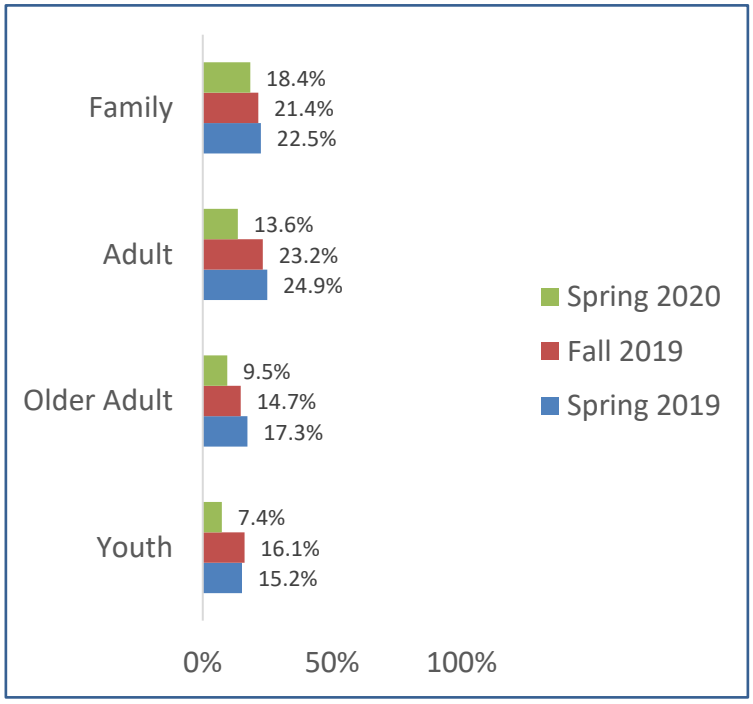


Data Source: Consumer Perception Survey data, June 2020

Of the returned surveys, the majority were completed by Adults and Families. A total of 13,606 surveys were returned for all age groups and 8,615 were completed (63.3%).

Adults had the highest percentage of completed surveys at 43.9%, followed by Families at 39.0%, Youth at 11.4% and Older Adults at 5.7%.

FIGURE 2: RESPONSE RATES FOR SURVEYS COMPLETED BY AGE GROUP

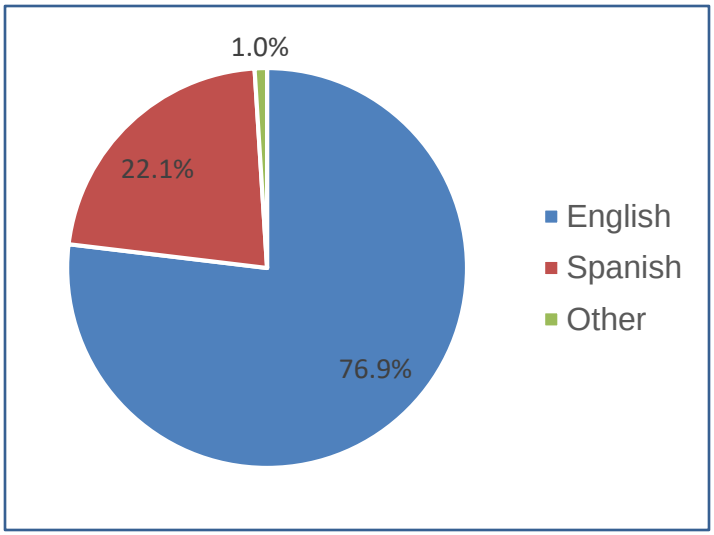


Data Source: Consumer Perception Survey data, May 2019 – June 2020.

Over the past three survey periods, the percent of consumers who participated in the survey out of those receiving services during survey week has ranged from 7.4% to 24.9% and decreased significantly in Spring 2020 due to the COVID-19 pandemic. Youth and Adult response rates decreased the most during this period. Surveys were collected from 16.8% of the consumers seen in outpatient and day treatment programs during the survey period.

FIGURE 3: COMPLETED SURVEYS BY LANGUAGE

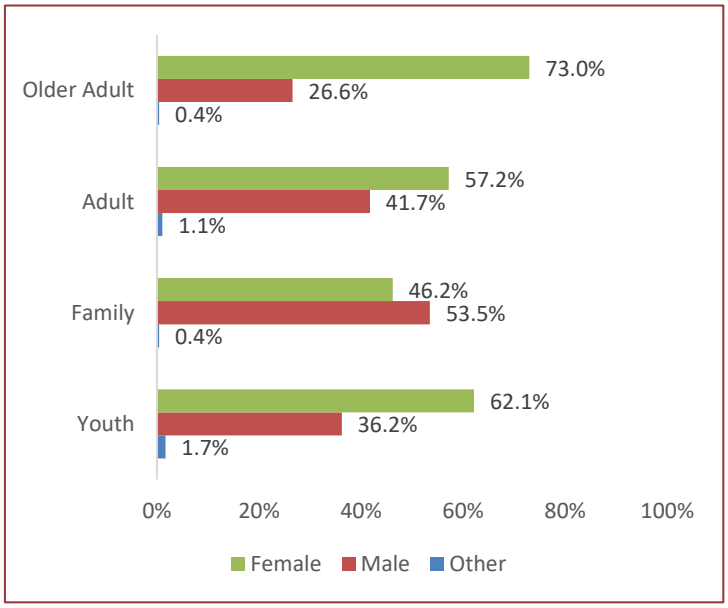
.



Data Source: Consumer Perception Survey data, June 2020.

The majority of consumers (76.9%) completed surveys in the English language and 23.1% of consumers completed the survey in a non-English language. Most of the non-English language surveys were completed in Spanish (95.7%). Surveys completed in other languages such as Korean, (N=54), Chinese (N=25), Vietnamese (N=4), and Russian (N=3) accounted for 1% of the total surveys.

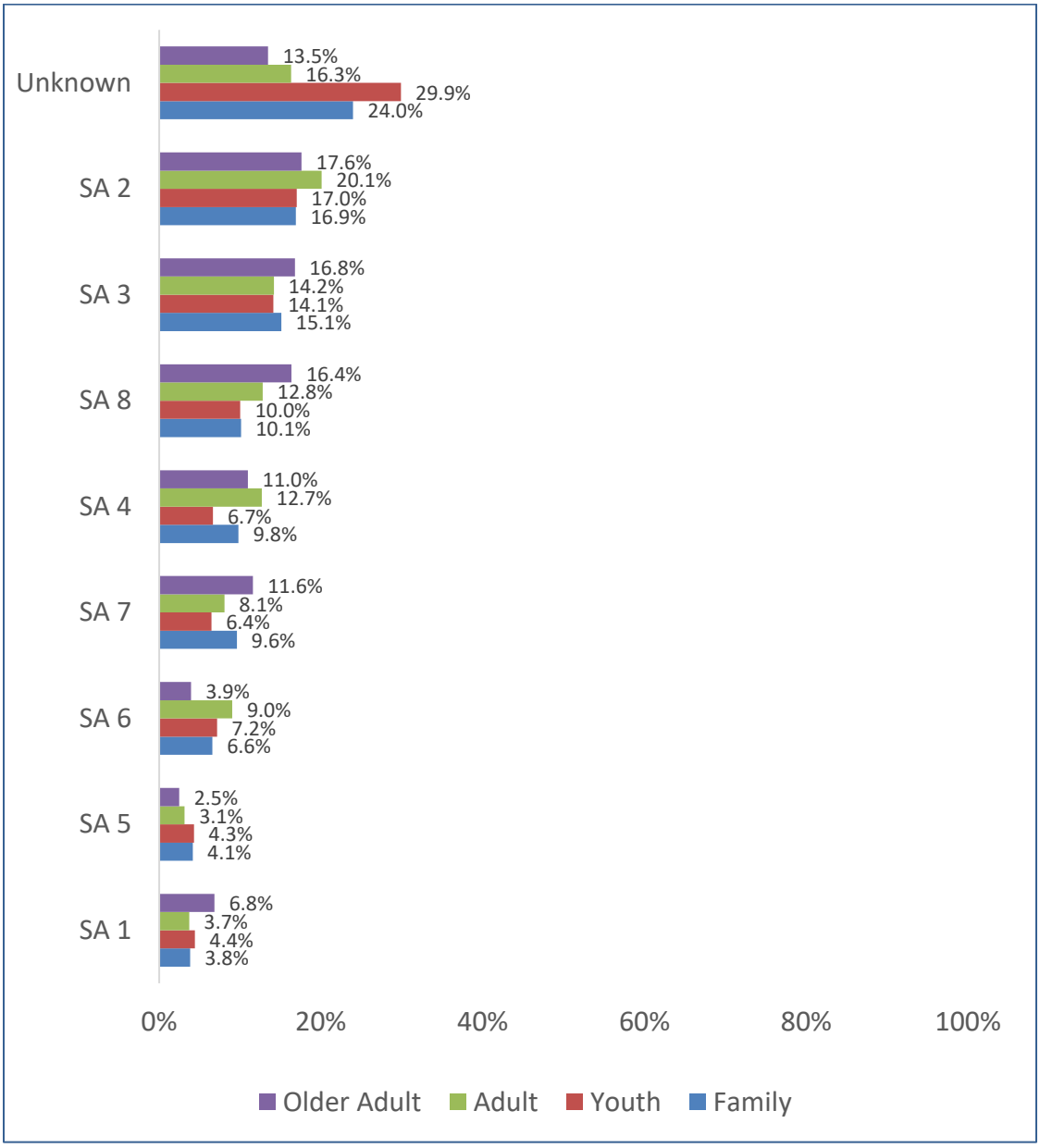
FIGURE 4: COMPLETED SURVEYS BY GENDER AND AGE GROUP



Data Source: Consumer Perception Survey data, June 2020.

For Older Adults, Adults, and Youth, the majority of surveys were completed by Females. For Family surveys, the majority of caregivers reported on Male youth. A total of 3.6% of all participants indicated an Other gender.

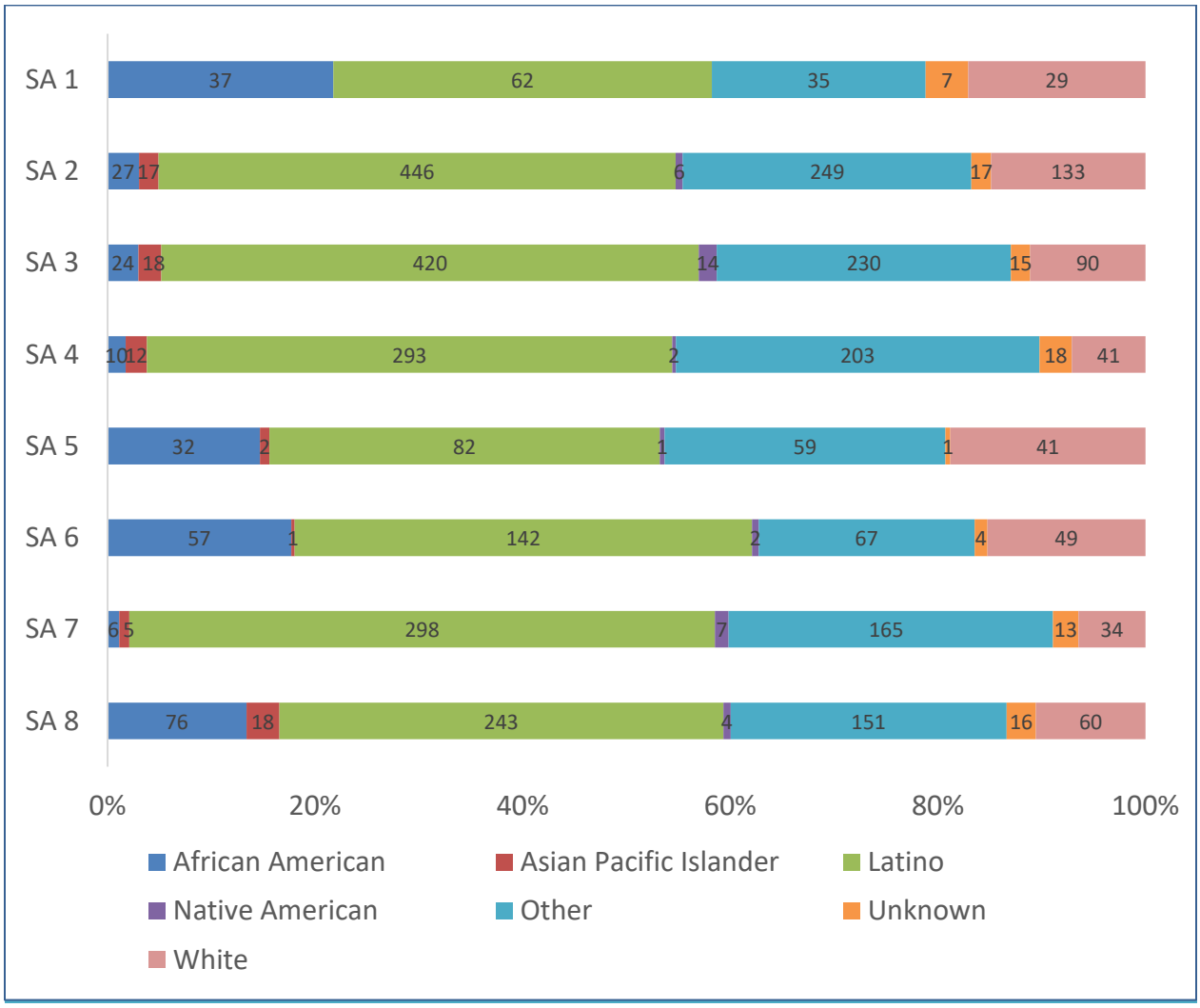
FIGURE 5: PERCENTAGE OF SURVEYS RETURNED BY AGE GROUP AND SERVICE AREA (SA)



Data Source: Consumer Perception Survey data, June 2020.

SA 2 had the highest number of surveys returned from all age groups. The percentage of each age group of surveys collected varied across the SAs. For example, surveys in SAs 2 and 3 were more equally distributed across the age groups than other SAs. A large percentage of surveys did not have a valid provider number this survey period.

FIGURE 6: COMPLETED FAMILY (YSS-F) SURVEYS BY SERVICE AREA AND ETHNICITY

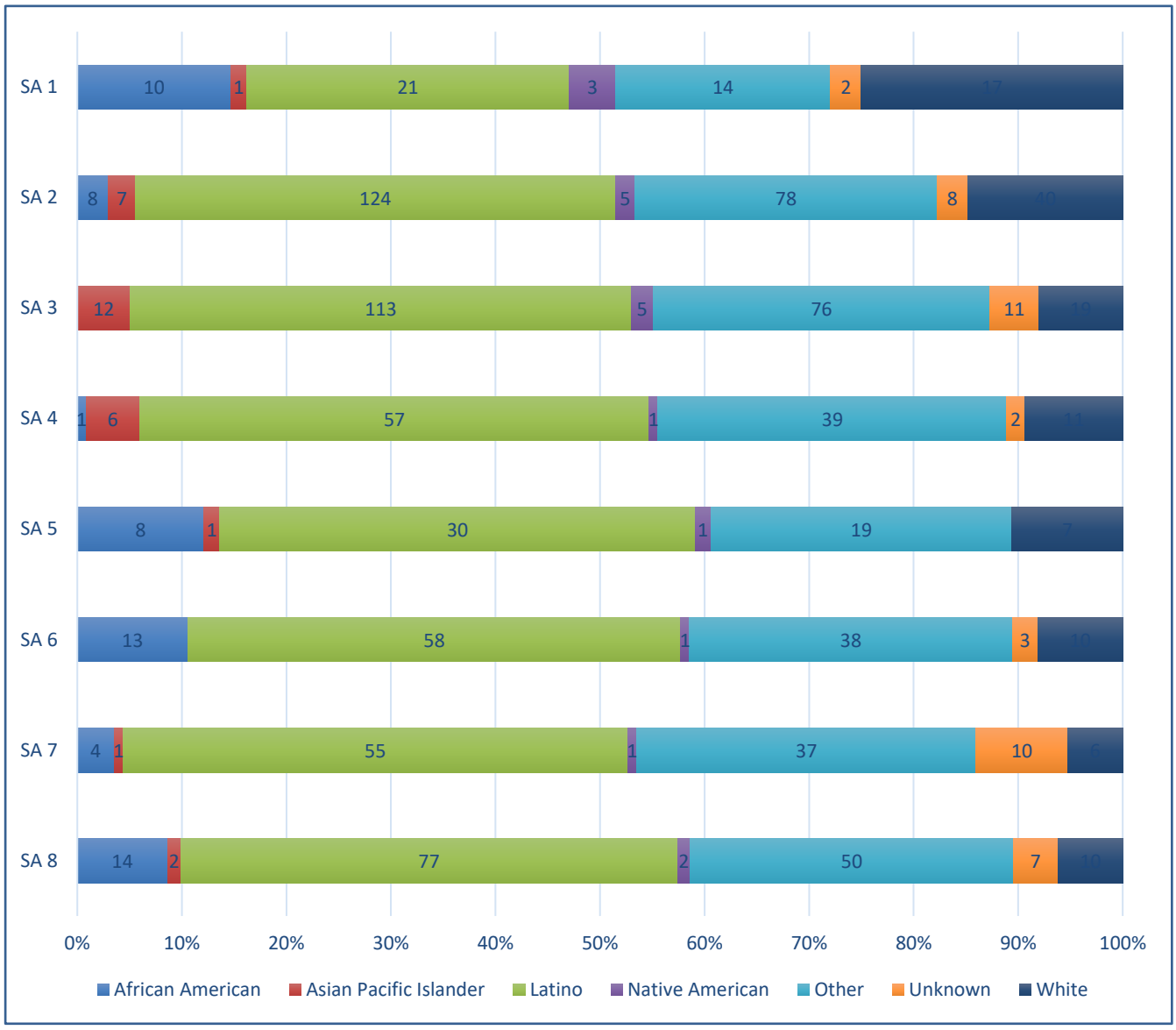


Data Source: Consumer Perception Survey data, June 2020.

Figure 6 shows the number and percent of completed Family (YSS-F) Surveys by SA and ethnicity. Racial and ethnic categories are determined by the American Community Survey conducted by the US Census Bureau in Calendar Year (CY) 2019. The completed surveys by race/ethnicity varied widely for different SAs. The breakdown of percent of surveys completed by race/ethnicity is as follows:

- African Americans (6.6%, Range: 1.1%-21.8%)
- Asian/Pacific Islanders (1.8%, Range: 0%-3.2%)
- Latino (48.5%, Range: 36.5%-56.4%)
- Native Americans (0.9%, Range: 0%-1.7%)
- Consumers that identify as Other (28.3%, Range: 20.6%-35.1%)
- Consumers that identify as Unknown (2.2%, Range: 0.5%-4.1%)
- Whites (11.7%, Range: 6.4%-18.8%)

FIGURE 7: COMPLETED YOUTH (YSS) SURVEYS BY SERVICE AREA AND ETHNICITY

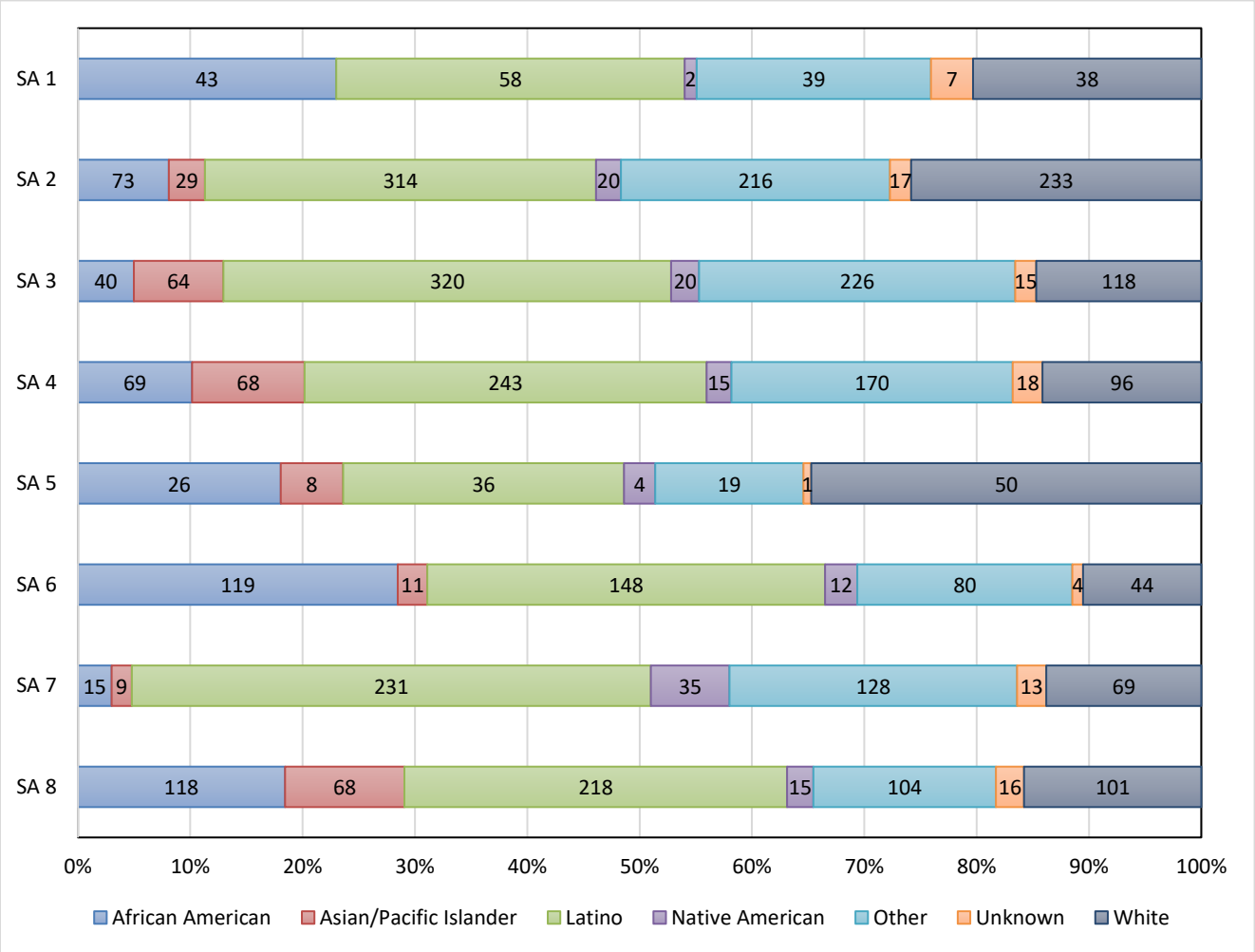


Data Source: Consumer Perception Survey data, June 2020.

Figure 7 shows the number and percent of completed Youth (YSS) Surveys by SA and ethnicity. The completed surveys by ethnicity varied widely for different SAs. For Youth surveys, the breakdown is as follows:

- African Americans (5.0%, Range: 0%-14.7%)
- Asian/Pacific Islanders (2.6%, Range: 0%-5.1%)
- Latinos (46.3%, Range: 30.9%-48.7%)
- Native Americans (1.6%, Range: 0.8%-4.4%)
- Consumers that identify as Other (30.4%, Range: 20.6%-33.3%)
- Consumers that identify as Unknown (3.7%, Range: 0%-8.8%)
- Whites (10.4%, Range: 5.3%-25.0%)

FIGURE 8: COMPLETED ADULT SURVEYS BY SERVICE AREA AND ETHNICITY

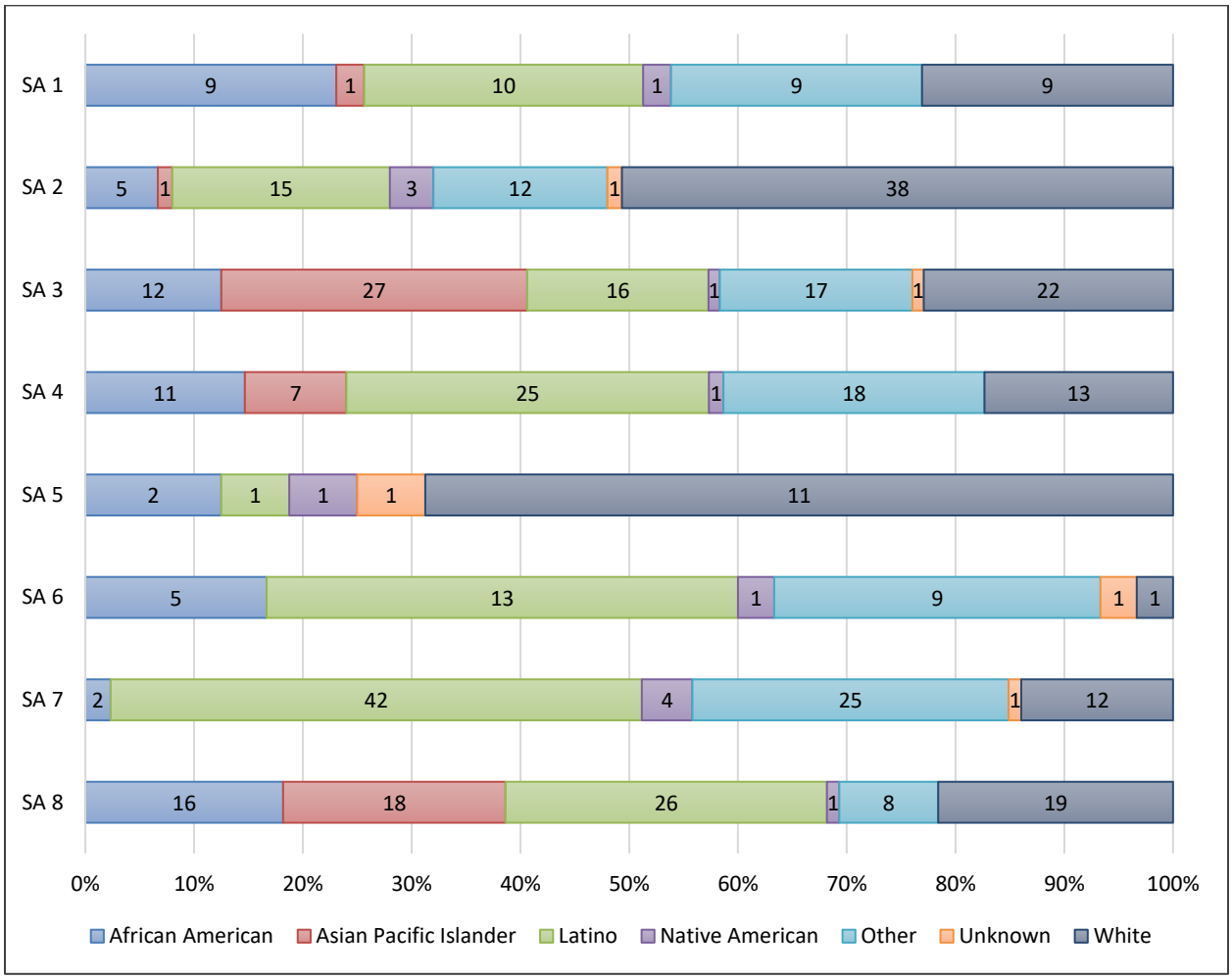


Data Source: Consumer Perception Survey data, June 2020.

Figure 8 shows the number and percent of completed Adult Surveys by SA and ethnicity. Adults surveys demonstrated more variability by ethnicity. The completed surveys by ethnicity varied widely for different SAs. The breakdown is as follows:

- African Americans (11.8%, Range: 3.0%-28.5%)
- Asian/Pacific Islanders (6%, Range: 0%-10.6%)
- Latinos (36.7%, Range: 25.0%-46.2%)
- Native Americans (2.9%, Range: 1.1%-7.0%)
- Consumers that identify as Other (23.0%, Range: 13.2%-28.1%)
- Consumers that identify as Unknown (2.1%, Range: 0.7%-3.7%)
- Whites (17.5%, Range: 10.5%-34.7%)

FIGURE 9: COMPLETED OLDER ADULT SURVEYS BY SERVICE AREA AND ETHNICITY



Data Source: Consumer Perception Survey data, June 2020.

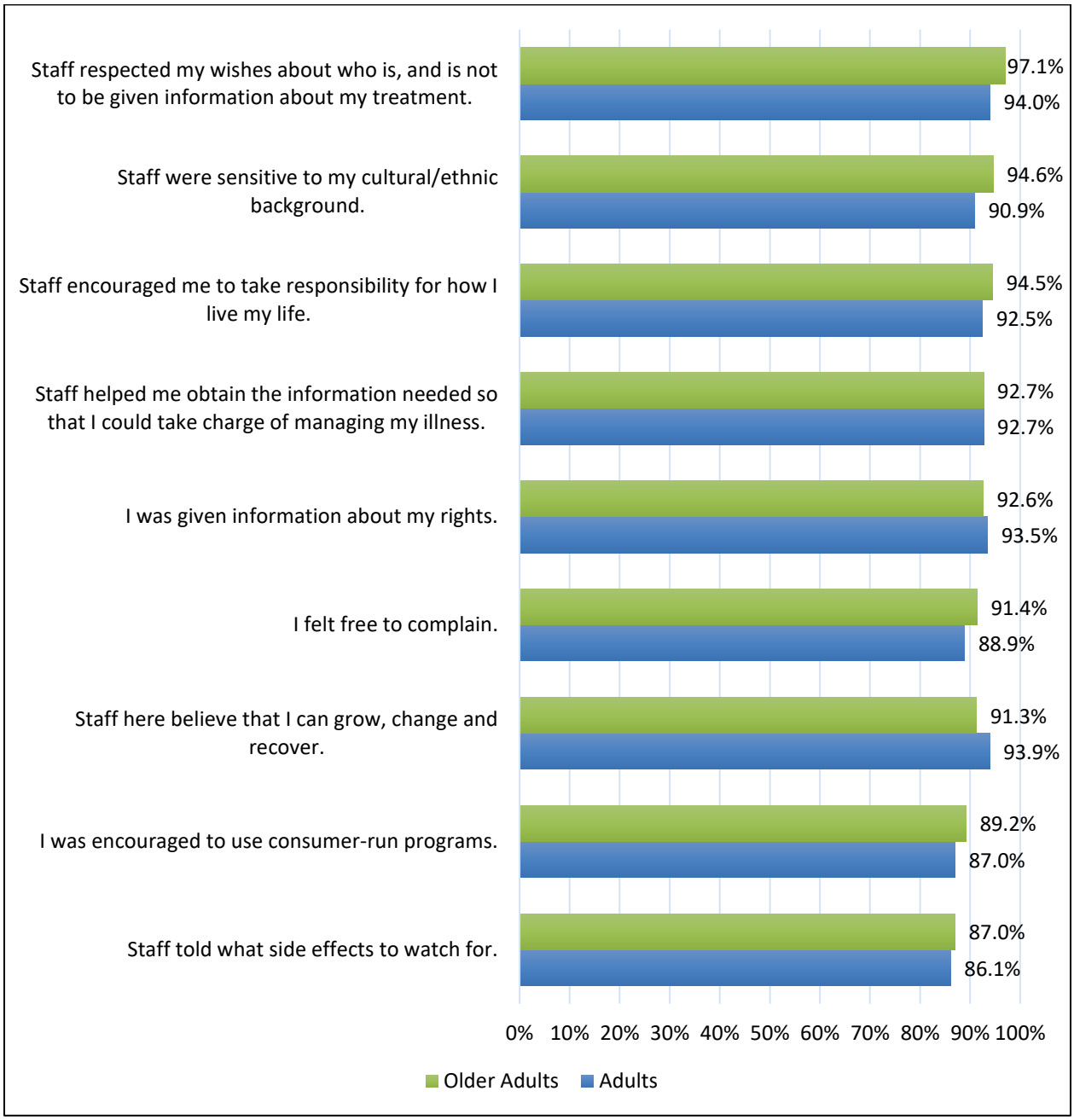
Figure 9 shows the number and percent of completed Older Adult Surveys by SA and ethnicity. The completed surveys by ethnicity varied widely for different SAs. The breakdown by ethnicity is as follows:

- African Americans (12.3%, Range: 2.3%-23.1%)
- Asian/Pacific Islanders (10.7%, Range: 0%-28.1%)
- Latinos (29.3%, Range: 6.3%-48.8%)
- Native Americans (2.6%, Range: 1.0%-6.3%)
- Consumers that identify as Other (19.4%, Range: 0%-30%)
- Consumers that identify as Unknown (1%, Range: 0%-6.3%)
- Whites (24.8%, Range: 3.3%-68.8%)

<u>Quality & Appropriateness/Cultural Sensitivity</u>

On the Quality & Appropriateness domain, 96.2% of Older Adults and 94.1% of Adults agreed or strongly agreed with the items.

FIGURE 10: PERCENT AGREE OR STRONGLY AGREE WITH ADULT AND OLDER ADULT QUALITY AND APPROPRIATENESS ITEMS



Data Source: Consumer Perception Survey data, June 2020.

One item on the MHSIP survey addresses whether Staff was sensitive to the consumers' cultural background. Table 7 below summarizes three-year trending data of this specific item for youth, adults, older adults, and their families.

TABLE 7: PERCENT OF CONSUMERS / FAMILIES WHO STRONGLY AGREE OR AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL/ETHNIC BACKGROUND" BY AGE GROUP
CY 2018 to CY 2020

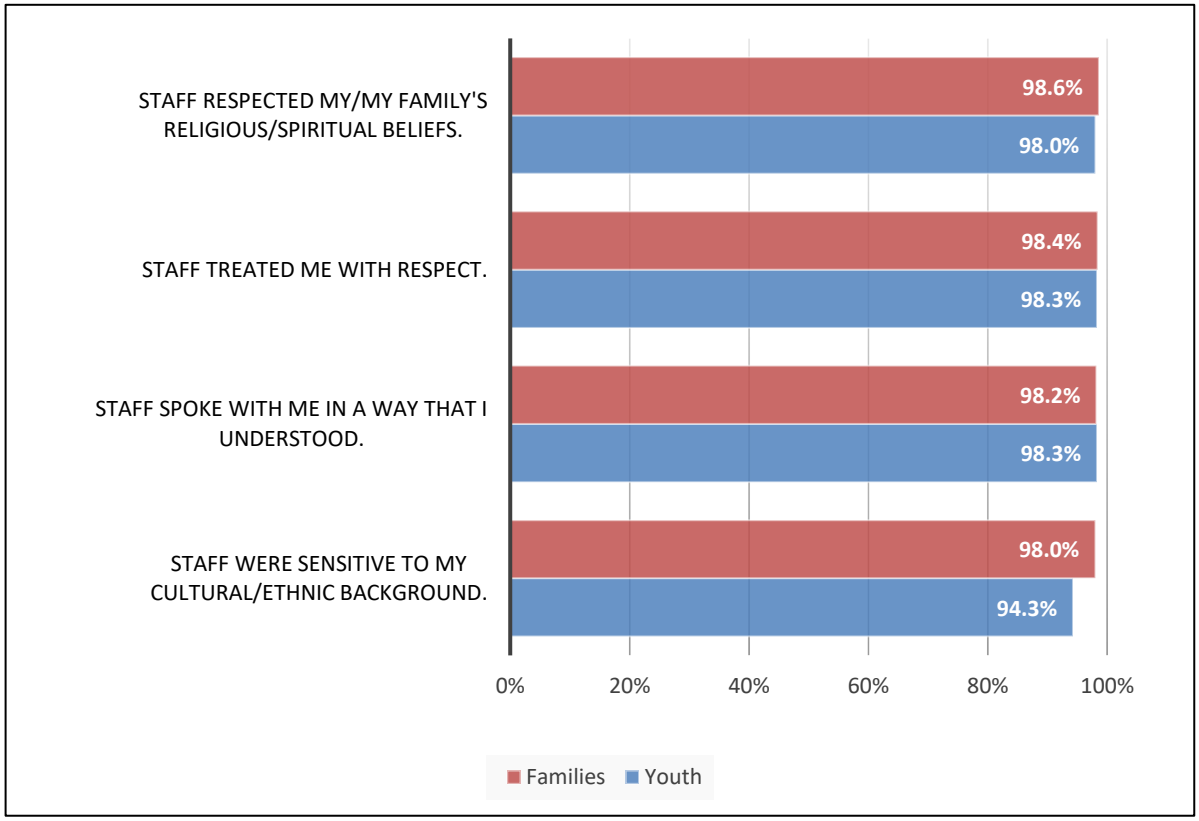
Time Period	Youth	Family	Older Adult	Adult
Spring 2018	2,420	5,124	781	6,791
Fall 2018	1,684	3,464	706	7,158
Spring 2019	2,681	5,443	998	7,973
Fall 2019	2,306	4,262	709	6,286
Spring 2020	981	3,359	493	3,782

Note: Given that Spring 2020 was an outlier survey period during the early stages of the COVID-19 pandemic, DMH will develop goals based on average completed surveys over the past five survey periods. Data Source**:** DMH CPS data, Spring 2018 to Spring 2020

Table 7 reports the percentage of consumers and families in CY 2018, CY 2019 and CY 2020 that agreed to strongly agreed with the statement, “Staff were sensitive to my cultural/ethnic background”. More specifically, a total of 8,615 consumers and families participated in the Spring 2020 survey period. On the corresponding Cultural Sensitivity domain, 98.2% of Families and 97.7% of Youth agreed or strongly agreed with the items.

This space was intentionally left blank

FIGURE 11: PERCENT AGREE OR STRONGLY AGREE WITH YOUTH AND FAMILIES CULTURAL SENSITIVITY ITEMS



Data Source: Consumer Perception Survey data, June 2020.

(See Attachment 6: Consumer Satisfaction Perception Report – Spring Survey Period 2020)

This space was intentionally left blank

FIG. 12: TRENDING DATA: PERCENT AGREE OR STRONGLY AGREE WITH "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND", CY 2018 – 2020

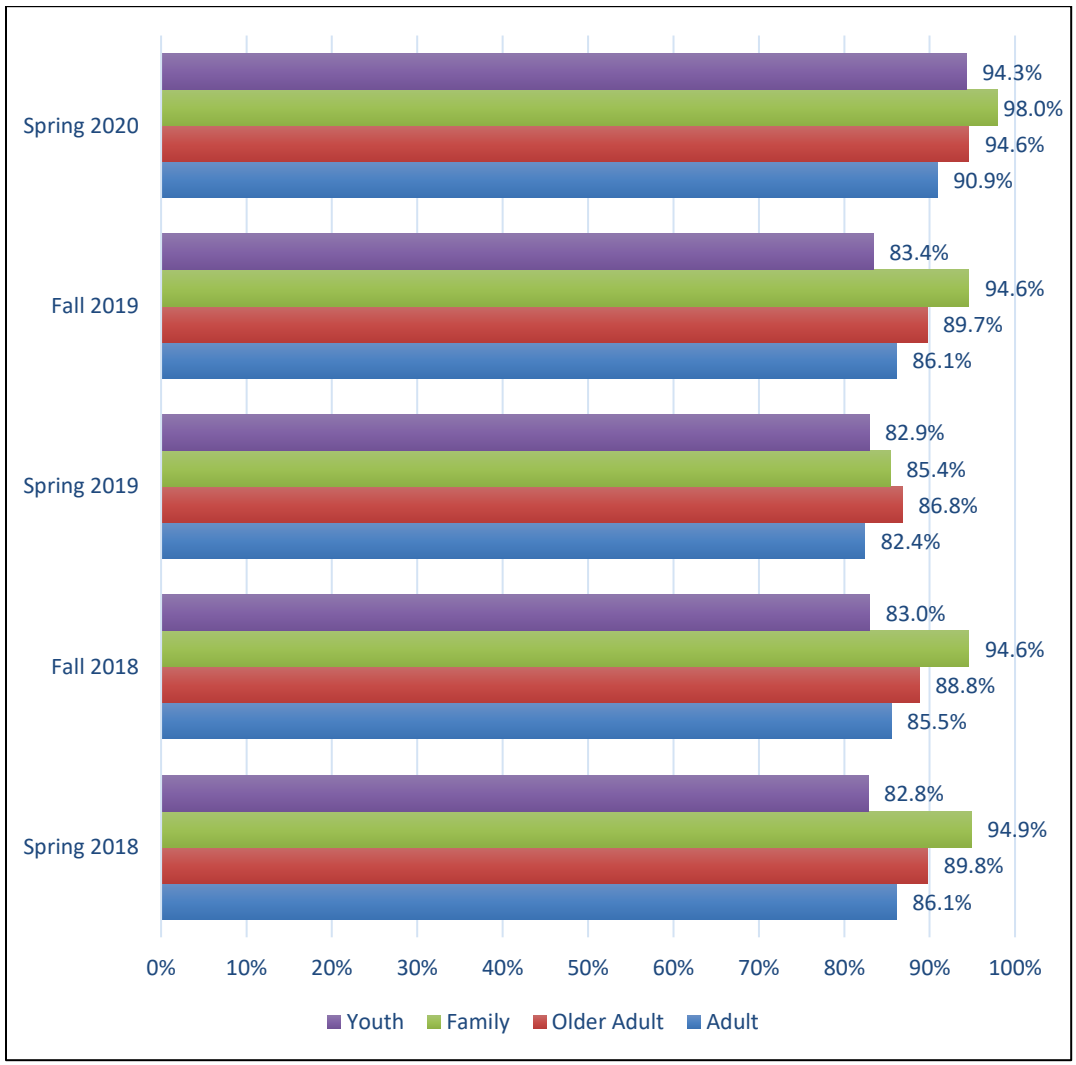


Figure 12 summarizes the percentage of survey participants who endorsed agree or strongly agree to the item “Staff being sensitive to their cultural ethnic/background” across five CPS data collection periods, from Spring 2018 to Spring 2020. The highest percentage of agree responses was received from family/caregivers of consumers for the Spring 2020 at 98%. The lowest percentage was received from adults for the Spring 2019 at 82.4.%.

FIGURE 13: PERCENT AGREE OR STRONGLY AGREE WITH WRITTEN MATERIALS PROVIDED IN PREFERRED LANGUAGE

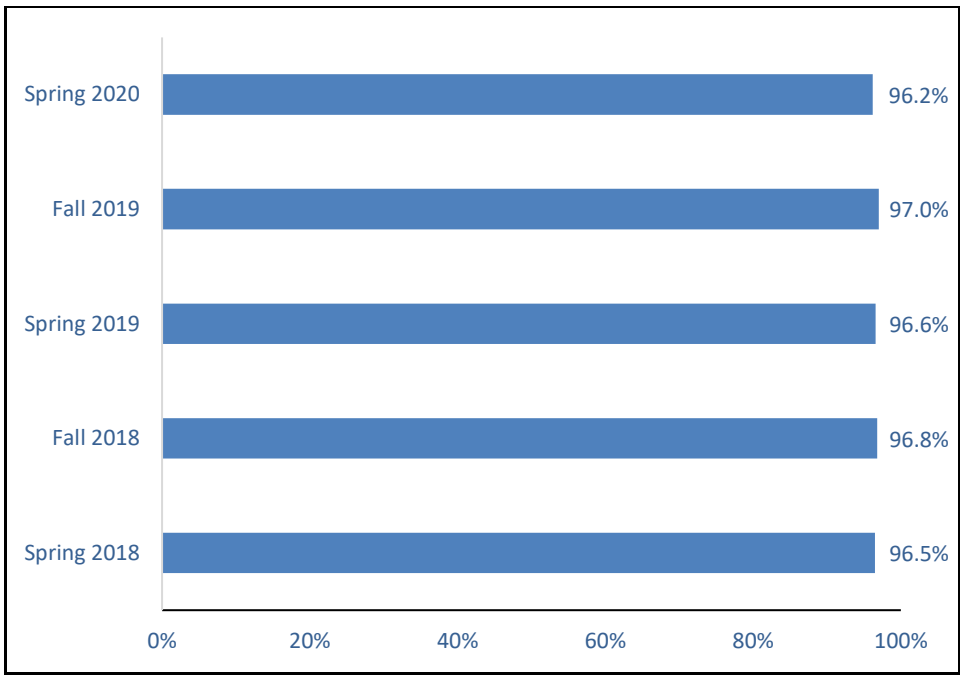


Figure 13 summarizes the percentage of survey participants who endorsed agree or strongly agree to the availability of written materials in their preferred language. Across the five CPS data collection periods, from Spring 2018 to Spring 2020, the highest percentage of agree responses was received for the Fall 2019 survey at 97%. The lowest percentage was for the Spring 2020 at 96.2%.

IV. 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 their 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 7: 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 8: SAMPLE LACDMH FORMS AND BROCHURES TRANSLATED INTO THE THRESHOLD LANGUAGES

Forms and Brochures	THRESHOLD LANGUAGES																
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	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				
Alleviating Fear and Anxiety During Essential Trips in Public		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
Brief Universal Prevention Program Survey v2: Age 6-11		X				X				X			X				
Brief Universal Prevention Program Survey v2: Age 12+		X				X				X			X				
Brief Universal Prevention Program Survey v2: Parents		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

Forms and Brochures	THRESHOLD LANGUAGES																
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
Consent for Services	X	X		X	X	X	X			X		X	X		X		
Consent for Staff/Volunteer/Intern Observation						X											
Consent for Telemental Health Services				X		X				X		X	X		X		
Consent of Minor						X											
Consent for E-mail						X											
Consent For Text Messaging/Video Chat						X											
Consent to Photograph/Audio Record				X		X				X		X	X		X		
Consent for TMS Transcranial Magnetic Stimulation						X											
Coping with Stress During Infectious Disease Outbreaks	X	X				X	X	X	X	X		X	X	X	X	X	X
Coping with the Loss of a Loved One	X	X				X	X	X	X	X		X	X	X	X	X	X
CPS Handout						X							X				
Faith-Based Advocacy Council						X											
FCCS Brochure	X	X			X	X	X			X		X	X		X		X
FSP brochures	X	X		X	X	X	X			X		X	X		X		X
Adult FSP Client Satisfaction Survey	X	X		X	X	X	X			X		X	X		X		X
Grievance and 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
Health Information Exchange						X											
Hope, Wellness and Recovery	X	X		X	X	X	X			X		X	X		X		X
INN 4 TMS Client Satisfaction Survey	X	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				
LACDMH Signage for New HQ Building						X							X				
LACDMH Strategic Plans						X							X				
Maintaining Health and Stability During COVID-19		X				X				X			X			X	
Medication Consent and Treatment Plan						X											
Medication Treatment Authorization Request Form						X											

Forms and Brochures	THRESHOLD LANGUAGES																
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
Mental Health Promoters/Promotores de Salud Mental Brochure						X							X				
Multidisciplinary Assessment Teams Brochure						X							X				
My Wellness Toolbox						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
PIER Early Psychosis Program Brochure	X	X		X		X	X			X		X	X	X	X	X	X
PIER Early Psychosis Program Flyer	X	X		X		X	X			X		X	X	X	X	X	X
Promotores Survey						X							X				
Request for Change of Provider	X	X		X	X	X	X			X		X	X		X		X
Roybal CHC brochure						X							X			X	
SA Provider Directories	X	X	X	X	X	X	X			X	X	X	X		X		X
Staying Connected during Physical Distancing		X				X				X			X			X	
Supportive Counseling Services						X							X				
Transitional Age Youth FSP Brochure	X	X			X	X	X			X			X		X		X
Telemental Health Services Brochure						X							X				
Treatment Foster Care Brochure						X											
Underserved Cultural Communities Flyer						X											
Understanding the Mental Health and Emotional Aspects of COVID-19		X				X				X			X			X	
Veterans and Loved Ones Recovery Program Flyer						X											
Your Wellbeing on Your Terms **B**rochure						X							X				

* Cantonese and Mandarin threshold language are covered under Other Chinese in written form
Data Sources: Quality Assurance Division and Cultural Competency Unit

Table 8 presents a snapshot summary of departmental forms and brochures, which have been translated into the threshold languages. LACDMH's mechanism for ensuring the accuracy of translated materials is field-testing. Internal field-testing takes place via document reviews conducted 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 field-testing process are provided to the hired vendor to finalize the translation of documents.

This space was intentionally left blank

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: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services

1047808_2018-10OrgManual_1_.pdf

Attachment 6: Consumer Satisfaction Perception Report – Spring 2020

Consumer Satisfaction Percepti

Attachment 7: Request for Interpretation and Translation Services Form

CC P&P 602 01 Bilingual Bonus RITS.d

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

OFFICE OF ADMINISTRATIVE OPERATIONS
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 19-20

Criterion 8

Adaptation of Services

August 2021

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

At the PRC, Peers concentrate on forming heart-forward connections with every visitor. The Peer Resource Center is not only a comfortable, safe, and non-judgmental environment for all who enter, but is also a place with intention. The Peer staff and volunteers use their own lived experiences with mental health treatment, homelessness, incarceration, domestic violence, and other life's challenges to make visitors feel welcomed, accepted, and supported. Every visitor will feel assured that they will leave with the appropriate community referrals they need while also developing a positive connection with LACDMH and the Peers at the Center.

Staff and Peer volunteers are available to offer linkage and warm handoffs to community organizations that can help address visitor needs. Collaboration with other public and private social service agencies is a vital component of this program. Social service departments and organizations are also invited to the Center to provide office hours and workshops to encourage the engagement of visitors. The PRC is staffed in part by Wellness Outreach Worker (WOW) Volunteers from all over the County who bring resources from their Service Areas and their lived experience to share with the community. Additionally, utilizers of the PRC provide programmatic input and recommendations through the Unhoused Advisory Committee.

The PRC is strategically staffed with employees who speak, read, and write in English, Spanish, and Korean and match the demographic and linguistic needs of the neighborhood. The PRC prioritizes creating a physical space that provides an open and welcoming environment for all community members. The PRC is located on the street level of the LACDMH headquarters, therefore all visitors have direct access from the street. Also, the PRC places posters, signs, and boards outside (sidewalk) that show community resources, programs, and events of the day. Often, PRC staff stand by the front door engaging, promoting, and inviting people to check out the PRC and its programs. The PRC staff also outreach to local homeless encampments to provide information and support and to encourage individuals to stop by the PRC. There are five (5) laptops, free Wi-Fi, phones, and charging stations that are available for everyone's use. They are surrounded by diverse community resources information in English, Spanish, Korean, and many other key languages in L.A. County.

The PRC is equipped with emergency clothing, snacks, and hygiene kits for all visitors. It offers multiple peer support, educational, and recreational groups that are open to all community members (not just LACDMH clients). All visitors can join anonymously without any registration, evaluation, or screening. The contents of each group are planned and designed to embrace all community members with a common goal of promoting mental health issues and connecting the participants to available community resources. Although it is recommended, visitors are not required to sign in or reveal their identity to access these resources. PRC staff focus on developing a peer-to-peer relationship with the visitors before making any recommendations, providing resources, or doing things for them.

The PRC projects have contributed to LACDMH's provision of culturally and linguistically competent services by focusing on minimizing the barrier for people to access services. The PRC's physical layout, staff composition, procedures for outreach and engagement, and in-person/online groups are designed to encourage people to experience the services and resources before requiring any commitment. Staff are skilled at building relations with visitors at a pace that is not intrusive, overwhelming and without demands.

This approach has encouraged many reluctant individuals to experience available services and resources and resulted in connecting many of them to actual services. The PRC commits first to providing quality information and services before requiring their buy-in. Once individuals are open to receiving mental health services, PRC staff work closely with local providers to ensure a warm handoff. However, once an individual is connected with a mental health program, they are still encouraged to stay connected with the PRC.

Many of the PRC visitors are already connected with a LACDMH provider. They utilize the PRC as an option for Peer Support and to supplement the services they are receiving. Sometimes, individuals may come to the PRC for advocacy regarding the services they are receiving. PRC staff work closely with service providers to ensure individuals are receiving services to best meet their needs. The PRC plans to continue with the above projects and is open to adding more services and resources as it identifies more effective ways to engage the community. The PRC plans to offer all services and resources in-person and online because online groups have been very effective in reducing accessibility issues for the people. The PRC staff are constantly engaging its visitors and participants to provide feedback regarding service needs and recommendations. The PRC encourages regular visitors to transition from utilizers to participants and peer supporters.

TABLE 1: PRC PROJECTS, ACTIVITIES, AND STRATEGIES RELATED TO CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES FY 19-20

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
1) PRC Online Peer Support Groups 1. Healthy Relationships 2. Phenomenal Women's Group 3. Word-Up 4. Art @ Home 5. Poetry 6. Spanish Healthy Relationships 7. Work Readiness 8. Spanish Word-Up	• During the COVID-19 pandemic, PRC transitioned in-person support groups to online support groups so PRC can continue to provide support to people who are further isolated and disconnected from the resources due to the crisis. • PRC has provided individual education in English, Spanish, and Korean on how to loan/receive free devices and use a computer and online meeting apps. This was done to reduce the disparities for the persons who lack access to devices, and education to utilize the computer. • The online groups have been in place since March 2020.	• On average, 10-20 people join each group consistently. PRC started with three online support groups in March 2020 but increased the number of groups to meet the increasing need of the community. • Two groups are held in Spanish. • LACDMH WOW Volunteers assist PRC staff in facilitating these groups.
2) Peer Kinnect	• In addition to the online groups, PRC staff shared contact information with PRC visitors who needed individual peer support. • Staff contacted the individuals regularly to provide check-in, peer support, and resources. • It was provided in English, Spanish, and Korean.	• PRC continues to make regular calls to people who need individual peer support.
3) Homeless Outreach Event	• PRC quarterly invited community homeless outreach agencies and unhoused community members so that they can be connected. Homeless agencies conducted CES surveys and provided information on shelters and housing information.	• Over 60 visitors came and participated in each event. • Homeless Health Care and PATH began to use PRC as one of their connection points for unhoused individuals. • Both agencies regularly stationed their staff for outreach (every other week)

Projects/Activities/Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
4) Winter Shelter Pick-up	• PRC collaborated with LAHSA and became a winter shelter pick-up location.	• Each day, an average of three to five persons got picked up from PRC to access the winter shelter
5) Korean Speaking Clergy Roundtable	• PRC staff has been participating and providing in-person and online space for Korean-speaking Clergy Roundtable. During the COVID-19 pandemic, PRC planned and participated in online mental health resources through an online seminar with the clergy members to Korean speaking community in June 2020.	• Over 80 participants (Korean speaking) participated in this mental health seminar. • A PRC staff presented on communication and stress management skills in Korean.
6) Holiday and Cultural Celebrations	• 2019 Korean Mental Health Resource Fair • 2019 Harvest Festival • 2019 Thanksgiving Celebration Lunch • 2019 End of Year Celebration and Resource Event • 2020 Super Bowl Party and Resource Event	• Approximately 40 participants and reporters from Korean media to disseminate mental health resources. • Approximately 80 participants and HOME team, WOW, and Homeless Healthcare shared resources • Approximately 100 participants from the local community • Approximately 100 participants and Coordinated Entry System (CES) screenings • Approximately 70 participants from the local community.
7) Unhoused Advisory Committee	• Prior to COVID-19, monthly meetings were held where unhoused individuals provided feedback regarding PRC services, resources, and events.	• On average, approximately 20 regular utilizers of the PRC participated.
8) Community Outreach	• PRC staff visit various local community organizations and resources to learn more about the services they offer and to provide information regarding potential PRC collaborations.	• The PRC has developed an extensive resource directory that is constantly being updated. PRC staff have developed connections and expertise in local resources.

2. TAY Drop-in Centers

Drop-In Centers are designed to be entry points to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY, ages 16-25, who may be homeless or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. The complex trauma may manifest in TAY's inability to maintain relationships, keep jobs, or stay in school, often putting them at risk of unemployment, school drop-outs, incarceration, and homelessness. Without early intervention, TAY are at risk of experiencing mental disorders that may impair their daily activities and functioning. Drop-In Centers have a strong emphasis on outreaching TAY who are difficult to engage and would otherwise remain unserved, by linking TAY to a range of resources that promote stability and self-sufficiency. Drop-In Centers operate daily including evenings and some weekends.

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 2: 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

3. 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.

Having Service Extenders who speak clients' languages and are culturally competent and sensitive to their needs facilitates the establishment of rapport, connection, and trust. This enhances access and encourages clients to remain in the services they need and to feel supported. Service Extenders, who are often peers in recovery, inspire other clients through their personal journeys and help them navigate the mental health system. LACDMH Older Adult clients are a culturally diverse group, and to provide culturally sensitive and appropriate services, Service Extenders need to be a culturally diverse group, including: Latinos, African Americans, Armenians, Russians, Iranians, Chinese, and Filipinos.

II. Responsiveness of Mental Health Services

LACDMH actively engages in culturally relevant outreach targeting 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:

- Black and African Heritage
- American Indian/Alaska Native (AI/AN)
- Asian Pacific Islander (API)
- Access for All
- 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.

Summary of UsCC projects for FY 19-20:

Black and African Heritage

1) *Community Agents of Change Network Project*
   The purpose of the project was to disseminate mental health awareness, education, and community resources to African American community members who reside in SA 6 – South Los Angeles and SA 8 - South Bay. This project aimed to educate and empower the African American community about the importance of mental health care to build awareness and community connections by training community members to become Community Agents of Change Educators (CACE). Additionally, this project had a goal of increasing community member involvement in the LACDMH stakeholder process.

2) *African American Youth Community Ambassador Network Project*
   The purpose of the project was to educate and empower Black youth about the importance of mental health care to build awareness and community connections. This project aimed to increase mental health awareness through educational workshops, the arts (dance, music, drama, poetry, etc.), and other outreach and engagement activities that are culturally sensitive to this community. This project targeted SA 1 African American youth ages 12-25.

American Indian/Alaska Native (AI/AN)

1) *AI/AN Community Symposiums Project*
   The purpose of the Community Symposiums project was to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing. Attendees of the Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by community members. Symposium topics included traditional ways of healing and education, art and music as medicine, suicide prevention and harm reduction, and historical trauma to intergenerational resilience.

2) *AI/AN Educational Public Service Announcement (PSA) Project*
   A media consultant was contracted to produce five 60-second PSAs. The production consisted of pre-production (creative development, concepts, ideas, script development/approval, development meetings, breakdowns, casting), production/filming, and post-production (editing, voice-over, and delivery).

3 *AI/AN Video Showcase Project*
   A media consultant was contracted to produce a Video Showcase project that included two (2) videos:

- The first video was developed with the intent to be played in the clinic and to provide viewers with information on how to access services, the process of accessing services, and available services including intake, case management, medication management, substance abuse counseling, housing resources, etc.
- The second video was a five (5)-minute video highlighting AICC, as well as other providers serving the AI/AN community with the intent to be played on social media platforms.

4) AI/AN Mental Health Conference

The theme of the conference was "Native Health and Resilience." Its goals were to inform participants of mental health issues unique to the AI/AN community; improve participants' ability to recognize when to refer an AI/AN community member for mental health services; provide participants with useful information on available mental health resources for AI/AN community members; and improve participants' ability to provide culturally appropriate mental health treatment to AI/AN consumers.

Asian Pacific Islander (API)

1) API Families – Supporting through Recovery

This project aimed to increase awareness about mental health related struggles that API consumers and their family members experience to decrease mental health related stigma and encourage early access of services. The overarching goal of this project was to develop a Mental Health Informational Booklet specifically designed for API family members and friends to understand the scope of mental illness, address their fears and questions, and offer suggestions on how to care for and assist their loved ones. the booklet would be translated into five (5) API languages (specifically Khmer, Simplified Chinese, Korean, Tagalog, and Vietnamese) and distributed to clinics and community-based agencies that serve API consumers and family members.

2) API – Sharing Tea, Sharing Hope

This project aimed to increase awareness about mental health to decrease mental health related stigma and encourage early access of services within the API community: Cambodian, Chinese (Mandarin or Cantonese), Tagalog, Vietnamese, and Korean. The focus of this project was to conduct mental health outreach to the API community using a mobile teacart service, and/or online virtual tea salons via Zoom. Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various outreach events. Through sharing of tea, the goal was to create a space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma and gaps in mental health service delivery in the various API communities.

Access for All

1) *PSA Development Project*
   This project consisted of collaborating with a media consultant to develop the concept and produce a 30-second PSA targeting the Deaf, Hard of Hearing, Blind, Physically Disabled communities throughout the County. The goal of the PSA was to promote mental health services, increase awareness, reduce stigma, and increase the capacity of public mental health system.

2) *Deaf, Hard of Hearing, Blind, and Physical Disabilities Peer-to-Peer Network*
   The Peer-to-Peer Network Project aimed to engage, empower, and enlist the Deaf, Hard of Hearing, Blind, and Physically Disabled community members into advocacy and activism around mental health issues that are affecting their community. Community members with lived experience were trained to become Community Advocates and Activists around issues related to mental health. In addition, they were given the responsibility to conduct community presentations regarding mental health and mental health resources.

3) *Deaf, Hard of Hearing, Blind, and Physical Disabilities Clinical Mental Health Training*
   A mental health training specifically addressing the mental health needs and treatment modalities pertaining to the Deaf, Hard of Hearing, Blind, and Physically disabled community was made available for licensed clinical staff at LACDMH Directly-Operated clinics and contracted providers. This project aimed to provide mental health clinicians with an opportunity to be trained on identifying and treating the unique mental health needs and challenges faced by this community. The consultant was responsible for developing the training curriculum and facilitating the one-day clinical trainings that were conducted using a virtual platform due to social distance guidelines.

Eastern European/Middle Eastern

1) *Parenting Seminars for the Arabic Speaking Community Project*
   The project was designed to increase knowledge about effective parenting practices and accessibility to mental health services for Arabic speaking community members. The goal of the project was to conduct the parenting seminars, and to provide mental health linkage and referral information pertaining to the services offered by LACDMH.

2) *The Armenian Mental Health Show Project*
   The Armenian Mental Health Television Show was developed to help increase knowledge and awareness about mental health issues and treatment modalities and services available for the Armenian community. The local the Armenian-Russian Television Network (ARTN) was contracted to produce, direct, host and broadcast this weekly mental health show in the Armenian language.

3) *The Russian and Farsi Speaking Mental Health Theatrical Performances Project*

This project was developed for the purpose of increasing mental health access and reducing disparities for the Russian and Farsi speaking communities. The goal of this project was to increase mental health awareness and education among the targeted cultural groups and promote mental health services that are offered by the LACDMH.

Latino

1) The Latino Comic Book Project – Cómics Que Curan (Comics that Heal)

This project was developed to engage Latino Transition Age Youth (TAY) in a dialogue about mental health awareness and education. Latino TAY, ages 16-25 were recruited countywide to participate in creating their own 2-page comic about their mental health struggles and experiences. The overarching goal of this project was to display stories written by Latino Youth in a Comic book. The comic book would be used as an outreach tool to educate the community about the mental health issues that Latino youth are experiencing and initiate a community dialogue about their mental health needs and the services that they need.

3) The Latino Mental Health Stigma Reduction Community Theatre Project - "De Sabios y Locos Todos Tenemos un Poco"

This project was developed to increase awareness and education about mental health issues in the Latino community. Through this theatrical play, the community will gain an inside look into the world of those who suffer from a mental health condition. The Latino community was educated on how to access mental health services and understand some of the cultural biases associated with suffering from a mental health condition. The play was conducted in Spanish.

Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two Spirit (LGBTQI2-S)

4) LGBTQIA2-S Indigenous Pride LA Project

The purpose of the Indigenous Pride LA: Voices to Faces project was to spread cultural awareness and education of healing practices that positively affect mental health among the Two-Spirit community. The project aimed to destigmatize mental health issues among Two-Spirit people by highlighting the diversity of the population and the need for culturally sensitive resources.

5) LGBTQIA2-S Black LGBTQ+ Network Project

The purpose of the Black LGBTQ+ Network Project was to identify the needs of Black LGBTQ+ individuals, while educating and empowering this community about the importance of mental health care to build awareness and connection. This project aimed to destigmatize mental health issues among Black LGBTQ+ people by highlighting the diversity of the population and the need for culturally sensitive resources.

2. Promotores de Salud/Health Promoters

On September 1, 2020, the Board of Supervisors instructed LACDMH to continue its Promotores de Salud Mental program and respond to two specific directives.

- *Directive 1*

  LACDMH was directed to retain the Promotores de Salud Mental program as a stand-alone program, convene relevant stakeholders, including Promotores to propose any changes to the program, and report to the Board of Supervisors twice a month and up to December 31, 2020. LACDMH recognizes the increased need for Promotores de Salud Mental to be able to respond in linguistically and culturally competent fashion, to the increased demand for mental health services, education, and access to care. The increased need is most pronounced in Latino, and other under-served communities which have been disproportionately impacted by COVID-19.

  The sustainable capacity for the program to grow and prosper is guided by the formation and convening of a Promotores de Salud Mental Advisory Council, which is comprised of diverse stakeholder groups. It consists of one Promotor for each of the eight Service Areas, two supervisors representing the north and south regions respectively, and the two Speakers Bureau directors. Additional representation in the advisory council consists of three seats for parents and/or consumers as well as two seats for Community-Based Organizations (CBO) and Faith-Based Organizations (FBO) leadership. The Promotores de Salud Mental advisory group convenes once per month to review proposed program changes, growth strategies, and improved ability to respond to community.

  The Promotores de Salud Mental program has increased its outreach platform by being an integral contributor to the Speakers Bureau. The integration of Promotores has effectively increased their ability to serve within a multidisciplinary team, which is comprised of Speakers Bureau clinicians, Faith-Based Liaisons, and Mental Health Clinical Specialty leads. This integration has also extended the network of schools, community and FBO being served.

  The development and recent release of LACDMH Promotor Technology Tool Guide, Version 1.0. was developed and released to the community in September 2020. It is a step- by- step instruction to help community members with non-existing or limited technology knowledge understanding how to download the MS Teams application via either telephone or computer. The toolkit, available in English and Spanish, has been well-received by the community and helps reduce the existing challenges of operating digital devices. The toolkit enables community members to connect and participate in various departmental stakeholder meetings such as the Cultural Competency Committee (CCC), Underserved Cultural Communities (UsCC), the Service Area Leadership Teams (SALTs), Mental Health Commission, and consumer group convenings.

LACDMH recognizes the leadership of Promotores de Salud Mental in connecting underserved communities with the Department's efforts to reach out to the most vulnerable and underserved populations. For example, Promotores have been invited by the CCC to provide a training on their MS Teams technology tool guide. LACDMH supports the role of Promotores de Salud Mental as members of our system of care and welcomes them to actively participate in the established stakeholder process. Promotores de Salud Mental have established active memberships in the Latino UsCC as well as the CCC. Both of these committee meeting agendas include a segment during which the members discuss the needs of the underserved communities they represent as related to the pandemic and social unrest. Promotores shared their direct knowledge and understanding of community cultural and linguistic needs during these meetings.

- *Directive 2*
  LACDMH was directed to collect data enabling reporting for the uptake, utilization, and reach of the Promotores de Salud Mental program, including disaggregation by geography, service planning area, gender, race/ethnicity of program providers and recipient and report back to the Board in 90 days.

3. Community Ambassadors Network Program (CAN)

The Community Ambassador Network (CAN) program is designed to hire, train and certify community members as "lay" mental health workers in the neighborhoods where they reside. In this capacity, the Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community members with resources relevant to their needs. All the Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical and spiritual wellbeing of underserved communities. The CAN Program prioritizes support of communities who self-identify as Black, Asian, Indigenous and People of Color, all of which have been disproportionately impacted by systemic racism and inequality. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in most disenfranchised communities.

As of February of 2021, 213 individuals were part of the Community Ambassador Network (CAN) Program. This included six (6) new community members hired in 2021, 84 new community members hired through the CARES ACT, as well as 123 INN 2 peers, navigators, parent partners and Promotores who became part of the CAN Program. One hundred and forty-six (146) individuals were active Ambassadors, and of those active 21 are Senior level CAN.

INN 2 program managers were asked to complete a hiring and training document which tracked the following information: 1) CANs ethnicity or racial identity; multiracial ambassadors were asked to list all, 2) language(s) spoken aside from English.

Languages Spoken by CAN

- 41.3% of the Ambassadors did not answer the language question. It was not clear whether the information was not available or if these individuals spoke only English
- The most prevalent language spoken (aside from English) was Spanish (49.3%)
- 7.5% (16/213) of CAN speak Khmer
- Other languages spoken by CAN included ASL, Hebrew, Basic Hindi, Laotian, Thai, Tagalog, and Tongan

Racial/Ethnic Identities of CAN

- 6.6% (14/213) of the Ambassadors identify as multiracial
- 47.9% (102/213) of CAN identify as Latino/Latinx, Latino or Mexican
- 15.5% (33/213) of CAN identify as Black and/or African American
- 10.3% (22/213) of CAN identify as Asian, Cambodian, Filipino, East Indian, or Tongan (Asian/Pacific Islander)
- 4.7% (10/213) of CAN identify as White
- 14.6% (31/213) of CAN chose not to answer or the question was left blank
- One person described their ethnicity as Italian

Outreach activities, training/education and linkages with resources and support were collected in the INN2 Health Outcomes Management (iHOMS) System. During the COVID-19 pandemic, the system was modified so INN2 providers were able to designate if their outreach/engagement and activities and/or participant linkages with resources/supports were COVID-related. The following reporting of outcomes summarized COVID-related outreach and referrals associated with the CARES ACT between October 1 - December 31, 2020.

The data included aggregated counts and percentages across all INN2 agencies. These were not de-duplicated numbers, and participants could have received more than one linkage or referral. Similarly, outreach activities had not been de-duplicated by agency.

- 114,813 community members were reached through a total of 895 COVID-related community events and outreach, group activities and social media
- 3,435 COVID-related referrals were made for resources and supports, and 1,057 INN2 participants were successfully linked with supports. As many as 87% of COVID-19 related referrals were marked as successful linkages by INN2 providers
- Almost all (95%) CAN have participated in a training about COVID-19, and 77 CAN have also participated in training on the Community Resilience Model (CRM)
- 2,059 INN2 partners and/or community members have received COVID-related trainings or education

The following reporting of outcomes summarized COVID-related outreach and referrals between January 1 - February 28, 2021. The data included aggregated

counts and percentages across all INN2 agencies. These were not de-duplicated numbers, and participants may have more than one linkage or referral. Similarly, outreach activities had not been de-duplicated by agency. Since the beginning of this year:

- 44,476 community members were reached through a total of 764 COVID-related community events and outreach, group activities and activities on social media
- Providers created a total of 119 email outreach, posts and stories on Facebook and Instagram to spread information about COVID testing and vaccines, INN2 and upcoming events and groups, which amassed approximately 17,065 views
- 2,159 COVID-related referrals were made for resources and supports, and 615 INN2 participants were successfully linked with supports. 90% of COVID-19 related referrals were marked as successful linkages by INN2 providers
- 2,628 INN2 partners and/or community members received COVID-19 related trainings or education
- INN2 staff and CAN led 583 COVID-related education and testing efforts in the community. A total of 1,078 persons were been tested for COVID-19 at 32 testing events where CAN volunteered. COVID-19 education efforts and outreach, often conducted by CAN, included business canvassing and providing PPE and Resources and Relief Flyers
- Almost all CAN participated in a training about COVID-19, and 57 active CAN also participated in training on the Community Resilience Model (CRM)

Preliminary Lessons Learned

- The CAN deep and trusted connections to their communities allowed them to make quick inroads to assess need and provide resources
- Ambassadors appreciated and benefitted from formal training to support their work (for example, CRM, COVID-19 trainings, Mental Health First Aid, etc.)
- Ambassadors were eager to understand pathways to long-term employment in their roles.

4. LACDMH 24/7 Help Line

LACDMH's Help Line continued to provide 24/7 services via its general ACCESS functions, Emotional Support Line for COVID-19, Veterans Warm Line, and the Wellbeing Line for healthcare and first responders. For the months of November and December 2020, the Help Line experienced an increase of calls. Specifically, the Emotional Support Line received approximately 4,500 calls. It was estimated that about 5% of these calls were addressed in a language other than English.

From its inception, the Wellbeing Line has served over 1,500 county employees, first responders, teachers and school staff. Wellbeing Line staff provided emotional support and referrals to a variety of resources. The feedback received from Wellbeing Line callers has been very positive. Some examples include:

- Grateful for the space to be able to express thoughts and feelings
- Appreciated support in thinking about the meaning and purpose of life
- Felt heard and supported while navigating how to return to work safely

- More confident in managing self-care while caring for others
- Thankful for the help requesting mental health services through providers

Wellbeing Line: Quick Facts

- Over 1,500+ county employees and first responders were served
- Callers reach out every day to connect with L.A. County Wellbeing Line listeners for a variety of needs. Some call just needing someone to talk to. Others are looking for help with anxiety, grief, and other powerful emotions. Others just need help figuring out how to ask for mental health services. Whatever the wellbeing need, CAN are ready to help
- The Wellbeing Line serves County Employees and external first responders with emotional support, trained listeners, and wellbeing resource referrals
- The Wellbeing Line has expanded its services to teachers and school staff in L.A. County to help them practice self-care despite massive changes
- Wellbeing Line Staff have expanded the services they provide, helping connect more L.A. County first responders and employees with resources like the Wellbeing4LA Learning Center
- The L.A. County Wellbeing Line with re-launch with Chat and Text options in early 2021

County Employees have been accessing countless services and supports through the line. Below are some of the key challenges they shared that Wellbeing Line staff have been helping them work through:

- Hard to balance work and everything else (pandemic and self-care)
- Feeling burned out, fatigued and at risk
- Communicating with clients and needing to be in contact with them is stressful
- Not knowing how long the pandemic will last creates more stress.
- Feeling lonely/ isolated and missing colleagues at work
- Holding family members accountable for their behaviors regarding safety measures around COVID
- Processing grief around friends and family who have died
- Dealing with racial inequities and injustices in systems of care

County employees and first responders provided feedback about the Wellbeing Line as a support:

- Grateful for the space to be able to express thoughts and feelings
- Appreciated support in thinking about the meaning and purpose of life when work is changing
- Felt heard and supported while navigating how to return to work safely
- More confident in managing self-care while caring for others
- Thankful for the help requesting mental health services through providers

5. LACDMH Speakers Bureau

Speakers Bureau was implemented in April 2020 as a resource to serve the community during and beyond COVID-19 times as a joint effort between the Chief of Psychology Team and the Cultural Competency Unit. Approximately, 75 licensed clinicians were

recruited to serve as Subject Matter Experts (SME). They carry out the functions of the Speakers Bureau in addition to the demands of their usual work. The Speakers Bureau was also enriched by partnerships with LACDMH Health Promoters/Promotores de Salud, Faith-Based Liaisons, and Clinical Specialty Treatment Leads. Speakers Bureau members identify with the underserved communities served by LACDMH because they are active, engaged members of these communities and thus reflect the concerns, culture and language of their respective communities. Collectively, they facilitate culturally competent interventions, problem-solve and assist communities in navigating the complexities often associated with access to competent care and resources, during and beyond the COVID-19 pandemic.

A. Speakers Bureau Mission Statement

To provide highest quality in clinical, culturally and linguistically appropriate solutions. To identify and develop SME for public speaking, media, Town Halls and community meetings, and other public speaking interventions.

- Identify and support relevant and competent solutions to the COVID-19 pandemic and other mental health emergencies that will decrease human suffering, social isolation, and stigma
- Provide reliable information and practical tools necessary for individuals, families, and communities to practice mental/physical safety and experience emotional wellbeing
- Ensure access to available resources by connecting community members to crisis intervention and mental health services to ameliorate the incidence of trauma; cultural and health disparities, domestic, child, and/or elderly abuse; depression; anxiety; addiction; and other mental health concerns

B. Areas of Linguistic Expertise

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Hindi
- Korean
- Additional languages being pursued
- Laotian
- Mandarin
- Russian
- Spanish
- Tagalog
- Vietnamese
- Thai
- Urdu

C. *Areas of Cultural Expertise*

The cultural expertise of the SB reflects communities experiencing health disparities and communities that have been historically and systemically disenfranchised. For example:

African American
American Indian and Alaska Native
Central American
Immigrant communities
Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Asexual and Two-Spirit Communities (LGBTQIA2-S)
Multi-Racial and Multi-Ethnic
Older Adults
Persons Experiencing Homelessness
Persons with Physical and Developmental Disabilities
Spirituality and Faith-based
Veterans

D. *Speakers Bureau Activities*

Examples of Speakers Bureau activities include:
Participation in Town Halls and Board of Supervisors press conferences
Community events sponsored or co-sponsored by LACDMH
Print, radio and television media interviews
Production of Public Service Announcements
Presentations and trainings in the community
Development of COVID-19 and other mental health-related materials
Consultation services
Mental support (COVID-19 and social unrest) for Community-Based and Faith-Based Organizations

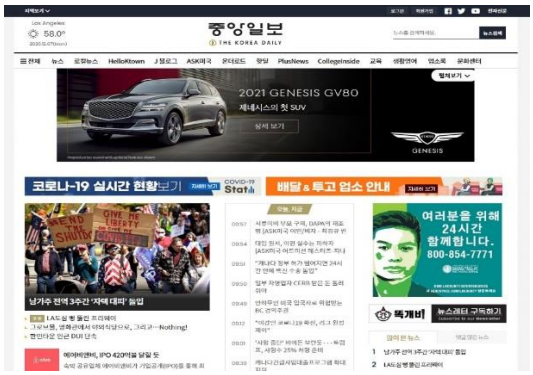
E. *Speakers Bureau Accomplishments during its First Year of Operation*

SB members are highly committed to serve our communities during these challenging times, and do so above and beyond the demands of their usual work responsibilities.

- Provision of services to Los Angeles County Board Offices; educational organizations; community-based, faith-based, and non-profit organizations; professional associations; private business; LACDMH programs; and other governmental agencies
- Speaker Bureau services totaling 711 distinct activities that outreached to 52,723 Los Angeles County residents across all Service Areas. Some of these activities had statewide impact
- On-going mental health outreach and support to 33 Faith-Based Organizations by engaging 2,260 community members via 99 distinct activities
- Mental health support to 27 Community-Based Organizations, thereby serving 1,656 community members through 62 distinct activities

- Collaboration with 13 Government Agencies via 84 activities, which outreached to 3,582 individuals
- Cultural and linguistic expertise for the development of several LACDMH media campaign products inclusive of billboards, Metro and bus line advertisements, and radio and TV spots

F. Examples of Media Products Developed with the Cultural and Linguistic Expertise of the Speaker Bureau Members



6. 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.

The Jail Transition and Linkage Services 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 alongside 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.

7. 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. FSP providers integrate services to meet the needs of children and adults requiring the most intensive care, thereby ensuring 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.

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

New Client Assessment Requirements:
(State Contract unless otherwise noted):

- Assessor Information (LACDMH)
  - *Name*
  - *Discipline*
- Identifying Information and Special Service Needs (LACDMH)
  - *Name of Client*
  - *Date of Birth*
  - *Gender*
  - *Ethnicity*
  - *Preferred Language*
  - *Other relevant information*
- For Children, Biological Parents, Caregivers and Contact Information (LACDMH)
  - *Names*
  - *Contact Information (phone or address)*
  - *Other relevant information*
- Presenting problem(s): The client's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information;
  - *Precipitating Event/Reason for Referral*
  - *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
  - *Impairments in Life Functioning*
- Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals;
  - *Client strengths to assist in achieving treatment goals*
- Mental Health History: Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of

clinical data, such as previous mental health records, and relevant psychological testing or consultation reports;

- *Psychiatric Hospitalizations including dates, locations and reasons*
- *Outpatient Treatment including dates, locations and reasons*
- *Response to Treatment, Recommendations, Satisfaction with Treatment*
- *Past Suicidal/Homicidal Thoughts or Attempts*
- *Other relevant information*

- Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma

NOTE: Examples of risks include (DHCS Information Notice No.: 17-040):

- ✓ History of Danger to Self (DTS) or Danger to Others (DTO);
- ✓ Previous inpatient hospitalizations for DTS or DTO;
- ✓ Prior suicide attempts;
- ✓ Lack of family or other support systems;
- ✓ Arrest history, if any;
- ✓ Probation status;
- ✓ History of alcohol/drug abuse;
- ✓ History of trauma or victimization;
- ✓ History of self-harm behaviors (e.g., cutting);
- ✓ History of assaultive behavior;
- ✓ Physical impairments (e.g., limited vision, deaf, wheelchair bound) which make the client vulnerable to others; and
- ✓ Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

- Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications;
  - *Medication*
  - *Dosage/Frequency*
  - *Period Taken*
  - *Effectiveness, Response, Side Effect, Reactions*
  - *Other relevant information*
- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over-the-counter, and illicit drugs;
- Medical History: Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports;
  - *Doctor's name and contact information*
  - *Allergies*

- *Relevant medical information*
- *Developmental History (for children)*
- *Developmental milestones and environmental stressors (for children)*

- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma;
  - *Education/School history, status, aspirations*
  - *Employment History/Vocational information including means of financial support (for adults)*
  - *Legal/Juvenile court history and current status*
  - *Child abuse/protective service information (for children)*
  - *Dependent Care Issues (for adults)*
  - *Current and past relevant Living Situations including Social Supports*
  - *Family History/Relationships*
  - *Family strengths (for children)*
  - *Other relevant information*
- Mental Status Examination;
  - *Mental Status Examination*
- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data;
  - *Clinical formulation*
- A diagnostic descriptor consistent with the clinical formulation
  - *Diagnostic descriptor*

- A code from the most current ICD code set shall be documented consistent with the diagnostic descriptor;
  - *ICD diagnosis code*
  - *Specialty Mental Health Services Medical Necessity Criteria*
- Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes
  - *Staff signature, discipline/title, identification number (if applicable) and date*

For additional details, see Attachment 2: Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services

IV. Quality Improvement and Quality Assurance

1. The Consumer Perception Survey (CPS)

LACDMH's Office of Administrative Operations - Quality Improvement Unit (OAO-QIU) 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 OAO-QIU 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.

Due to the COVID-19 global pandemic, fewer surveys were completed during the Spring 2020 survey period. The majority of surveys most came from Adults (43.9%), followed by Families (39.0%), Youth (11.4%) and Older Adults (5.7%). Surveys were collected from 16.8% of the consumers who received services from outpatient and day treatment programs during the one-week survey period. Most surveys were completed in English or Spanish and respondents indicated high satisfaction with language availability. Females completed more surveys for the Adults, Older Adults and Youth whereas caregivers reported on more Male youth for the Family surveys. Service Area (SA) 2 had the highest amount of completed surveys and SA 5 had the lowest amount of completed surveys. The race/ethnicities of those completing the surveys varied considerably by SA.

For Spring 2020, domain scores were generally higher across all survey types. Families and Youth had the highest scores for the Cultural Sensitivity domain with 98.2% and 97.7% of respondents agreeing or strongly agreeing with the items in that domain. Adults and Older Adults had the highest scores for General Satisfaction with 94.3% and 96.5% of respondents agreeing or strongly agreeing with the items in those domains, respectively followed by Participation in Treatment Planning for Adults (94.2%), as well as Quality and Appropriateness for Older Adults (96.2%).

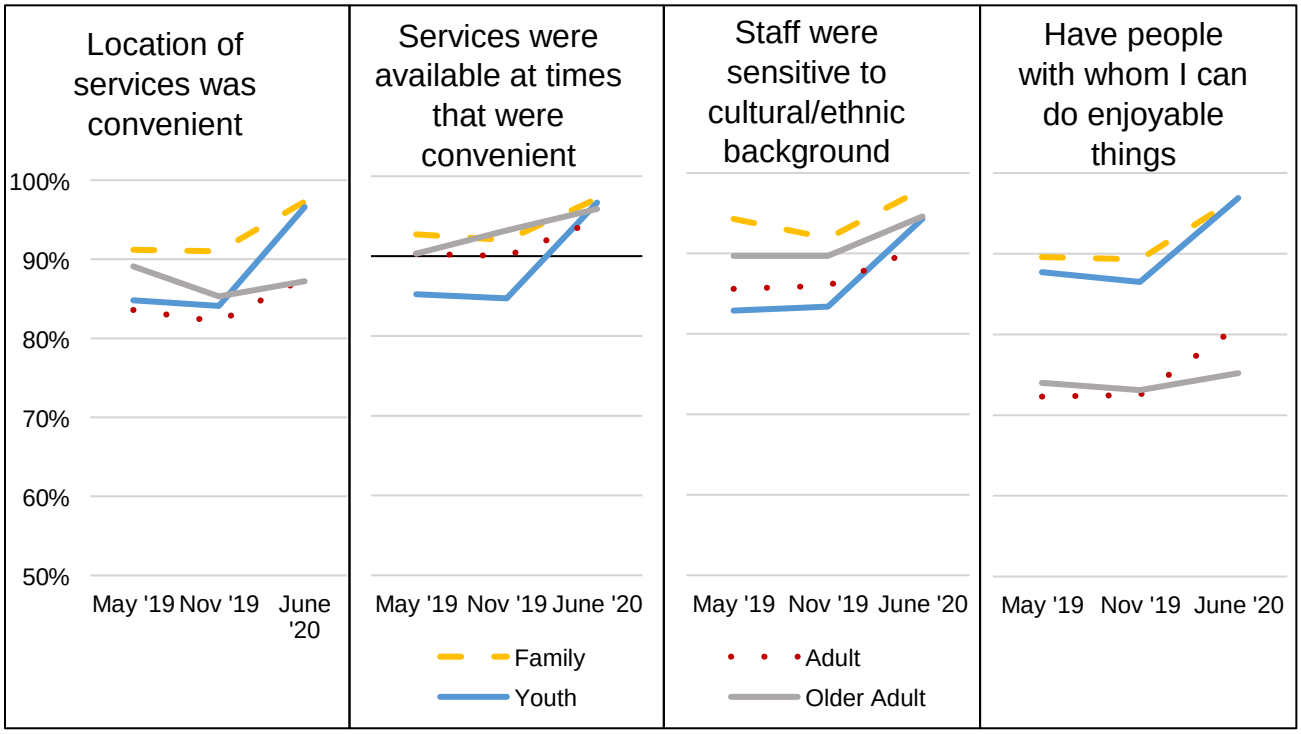
About a fifth of both Families (19.2%) and Youth (17.9%) reported being on medication for emotional or behavioral problems. This varied across SA with SA 2 having the highest rates of medication. Of those prescribed medication, the majority of Youth (92.4%) and Families (97.3%) reported they were told about medication side effects.

Trends for the items that are common across all four versions of the survey were similar for the last three survey periods (May 2019, November 2019, June 2020). Families had the highest percentage respondents that agreed or strongly agreed with the cultural sensitivity item and the highest percentage of Youth with the having people with whom to do enjoyable things item. Adults, and Older Adults agreed or strongly agreed that services were available at convenient times. The lowest percentage that agreed or strongly agreed for all age groups except Older Adults was for the functioning item related to doing better in school and/or work, indicating this is an area for improvement. Similarly, getting along better with family members and being better

able to do desired things tended to have lower ratings than other items and represent targets for improvement.

The following figures summarizes age Group Comparison of Common Survey Items:

FIGURE 1: AGE GROUP COMPARISON OF ACCESS, CULTURAL SENSITIVITY, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME



Data Source: Consumer Perception Survey data, May 2019, November 2019, and June 2020.

Figure 1 shows four of the CPS items that are common to the Families, Youth, Adult, and Older Adult surveys from May 2019 to June 2020. The percentages above reflect the number of respondents selecting either Agree or Strongly Agree for each item.

Families had the highest percentages on all four items as compared to other three age groups for all three time periods except for November 2019 where Older Adults were higher on "Services were available at convenient times." Youth also had high percentages for three of the four items ("Location of services was convenient", "Services were available at convenient times", and "I have people with whom I can do enjoyable things.") Adults tended to have the lower percentages over all three time periods. Youth had the lowest percentage on the "Services were available at times that were convenient" and "Staff were sensitive to my cultural/ethnic background" in May and November 2019. In June 2020, this was lowest for Adults. Adult also had the lowest percentage on the "Location of services was convenient" item at all three time periods except for June 2020, where they were slightly higher than Older Adults.

Both Adult and Older Adults had much lower percentages on the “I have people with whom I can do enjoyable things” item as compared to Youth and Families.

FIGURE 2: AGE GROUP COMPARISON OF OUTCOMES, FUNCTIONING, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME

Data Source: Consumer Perception Survey data, May 2019, November 2019, and June 2020.

Figure 2 shows the other four of the CPS items that are common to the Families, Youth, Adult, and Older Adult surveys from May 2019 to June 2020. The percentages above reflect the number of respondents selecting either Agree or Strongly Agree for each item.

In June 2020, Youth had the highest percentage on all items except for “I get along better with family members.” In previous survey periods, Families tended to have the highest percentages of agreement with these items. Given the lower number of surveys collected across all groups and especially for Youth, it is difficult to assess if this reflects a larger change.

Adults and Older Adults tended to have the lower percentages over all three time periods. Adults and Older Adults had the lowest percentage on the “In a crisis, I have the support I need from family and friends” across all three times periods. Adults were lowest on the “I am doing better in school and/or work” item except for the November 2019 period, in which they were slightly higher than Older Adults. The “Doing better

in school and/or work" measure had much lower percentages overall, ranging from 60.6% to 71.3% prior to the June 2020 survey period. Youth and Families percent agreement increased significantly for this item in June 2020. Again, given the much lower response rate, it is difficult to assess if this reflects true improvement. These items will continue to be monitored at future survey periods to evaluate trends over time.

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 EQRO annually.

The OAO-QIU is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. Each year, the OAO-QIU conducts a Clinical and Non-clinical PIP. The PIPs are conducted to ensure that selected administrative and clinical processes are reviewed to improve performance outcomes.

A. Non-Clinical Performance Improvement Project (Non-clinical PIP)

In FY 19-20, the non-clinical PIP concept, *Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected*, was developed in collaboration with the QA and QI Units to improve the timeliness of outpatient SMHS at a system-wide level. QA discovered that despite meeting State requirements of 70% timeliness, a more in-depth look at the data suggested many providers struggled to provide beneficiaries with timely appointments. The PIP committee aimed to determine if implementing an Audit and Feedback (A&F) process (i.e., access to care monitoring reports, timeliness template, and conference call) would improve the rate at which beneficiaries received timely appointments. The concept focused on comparing timeliness percentages and facilitating provider-level improvement strategies.

An implementation team, also known as the Access to Care Leadership committee, was developed to establish clear processes for monitoring timely access and compliance, identifying and monitoring issues to be addressed, and ensuring all efforts are distributed equally across the network. This team of core managers from various sectors of LACDMH's outpatient system of care met on a bimonthly basis, with system-wide data review occurring at least monthly. The Leadership committee worked collaboratively to address the external (systemic) factors contributing to timely access challenges seen in the data or as identified by providers. The Deputy Director of QOTD is the Chairperson for the Access to Care Leadership committee. The committee collaborated on a plan before each meeting, and QA maintained the meeting minutes.

During the annual External Quality Review in September 2020, the quality reviewers determined the PIP as concept-only – requiring additional refinements before validation. Therefore, as a continuation, the FY 20-21 PIP project is shifting focus on the effectiveness of provider-developed interventions to address timeliness barriers.

The FY 20-21 PIP efforts will continue to target improvements in timely access. CalEQRO recommended an increased focus on beneficiary impact and developing a catalog of best practices addressing various timeliness access issues. The Access to Care Leadership committee will continue to support problem identification and implementation. OAO-QIU unit will play a role in data analysis, tool development, and tracking Plan-Do-Study-Act cycles. The QA unit will facilitate access to care monitoring processes intended to inform, assist in problem-solving, and support DO and LE/Contracted providers with making timely appointments available. By September 2021, LACDMH should be better able to speak to the effectiveness of agency-driven and provider-developed improvement strategies.

B. Clinical PIP

The Clinical Performance Improvement Project entitled "Improving Quality of Services for Consumers with Co-Occurring Disorders (COD)" was in place from Quarter 3 of FY 18-19 to the end of Quarter 2 of FY 20-21. The improvement strategy was focused on delivering integrated treatment models to consumers with CODs to directly address and mitigate the impact of substance use on mental health. The intent was to address mental health symptoms and enhance COD consumers' ability to reduce substance use and improve functioning by coping and practicing safety in relationships, feelings, thoughts and actions. In Phase I (year one) of the project, interventions included implementing treatment strategies with Seeking Safety (SS), a specific evidence-based practice (EBP) for trauma and substance use, broader education of Substance Abuse Counselor (SAC) staff in substance use disorder (SUD) treatment through the University of California, Los Angeles (UCLA) extension classes, and initial implementation of Integr8Recovery groups. In Phase II (year two) of the project, interventions focused on improved teaming and the use of multidisciplinary groups.

Regarding the objectives, the number of consumers documented as receiving Seeking Safety from a Substance Abuse Counselor increased minimally from quarter to quarter as 19 consumers received Seeking Safety in Quarter 2 and 28 received Seeking Safety in Quarter 3. Integr8Recovery groups started in January 2020 in two clinics and the protocol for these groups was adapted over time to fit the workflow and recruitment process for each clinic. There were no significant changes to 7- and 30-day hospitalization rates for any of the interventions in terms of project findings. Some interventions (i.e., Integr8Recovery, documented use of SS) were associated with significant changes in consumer engagement and retention rates and the number of mental health services received.

However, the sample sizes for these groups were generally small (~30 consumers). At the recommendation of the EQRO, this PIP was converted to a general system improvement process for SAC services to individuals with COD. A new Clinical PIP topic will be selected in CY 2021.
Source: Annual Report on Quality Improvement, Reporting Period: July 1, 2019 to December 21, 2020

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).

<u>Project Methodology</u>

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

The CCOAT was developed utilizing the themes that emerged from the focus groups. It was structured around the following five (5) key conceptual components of cultural competence:

(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.

<u>Data Analysis</u>

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*: 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*: 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*: 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*: 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*: Of the 993 respondents who volunteered their age, the average age was 26.7 years
- *Personal and family experience with mental health issues*: 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*: 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*: 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

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. 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. 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. 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. 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. 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.

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)

For additional details, see Attachment 3: 2019 Cultural Competence Organizational Assessment Report.

4. 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 3: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FOR LACDMH MEDI-CAL BENEFICIARIES BY CATEGORY, FY 19-20

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	**18**	**0**		
Treatment Issues or Concerns	**19**	**0**		
Medication Concern	**2**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**2**	**0**		
QUALITY OF CARE – Total by Category	**41**	**0**	**N/A**	**N/A**
Percent	**65.1%**	**0%**		
CHANGE OF PROVIDER – Total by Category	**0**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**		
CONFIDENTIALITY CONCERN – Total by Category	**5**	**0**	**N/A**	**N/A**
Percent	**7.9%**	**0%**	**N/A**	**N/A**
OTHER				
Financial	2	0		
Lost Property	0	0		
Operational	0	0		
Patients' Rights	4	0		
Peer Behaviors	2	0		
Physical Environment	0	0		
Other Grievance not Listed Above	9	0		
Other – Total by Category	**17**	**0**	**N/A**	**N/A**
Percent	**27%**	**0%**	**N/A**	**N/A**
Grand Totals	**63**	**0**	**N/A**	**N/A**

Note: Data above reflects the grievances and appeals for/by Medi-Cal beneficiaries. Data Source: LACDMH, ABGAR Form FY 19-20, prepared by PRO in October 2020.

TABLE 4: INPATIENT AND OUTPATIENT GRIEVANCE DISPOSITIONS FOR LACDMH MEDI-CAL BENEFICIARIES, FY 19-20

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	18	0
Treatment Issues or Concerns	0	19	0
Medication Concern	0	2	0
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	2	0
QUALITY OF CARE – Total by Category	**0**	**41**	**0**
Percent	**0%**	**65.1%**	**0%**
CHANGE OF PROVIDER – Total by Category	**0**	**0**	**0**
Percent	**0%**	**0%**	**0%**
CONFIDENTIALITY CONCERN – Total by Category	**0**	**5**	**0**
Percent	**0%**	**7.9%**	**0%**
OTHER			
Financial	0	2	0
Lost Property	0	0	0
Operational	0	0	0
Patients' Rights	0	4	0
Peer Behaviors	0	2	0
Physical Environment	0	0	0
Other Grievance not Listed Above	0	9	0
OTHER – Total by Category	**0**	**17**	**0**
Percent	**0%**	**27%**	**0%**
Grand Totals	**0**	**63**	**0**

TABLE 5: INPATIENT AND OUTPATIENT APPEAL DISPOSITIONS AND TOTAL NOTICE OF ADVERSE BENEFIT DETERMINATION/NOTICE OF ACTION ISSUED, FY 19-20

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	0
Payment Denial Notice	0	601	309	0	0	0	1,404
Delivery System Notice	0	0	0	0	0	0	1,932
Modification Notice	0	0	0	0	0	0	0
Termination Notice	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice	0	0	0	0	0	0	4,224
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	601	309	0	0	0	7,560

Data Source: LACDMH, ABGAR Form FY 19-20, prepared by PRO in October 2020.

Criterion 8 APPENDIX

Attachment 1: LACDMH Legal Entity Contract

LACDMH Legal Entity Contractual Agreemer

Attachment 2: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services

1047808_2018-10OrgManual_1_.pdf

Attachment 3: 2019 Cultural Competence Organizational Assessment Report

CCOAT Assessment Final Report_ revise