County of Los Angeles - Department of Mental Health

UsCC Capacity Building Project

Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Focus Groups: Arabic Listening Sessions

Project Outcomes and Summary Report

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Project Description:

The Mental Health Needs Assessment for the Arabic Speaking Community Through Virtual Focus Groups: Arabic Listening Sessions developed by the Eastern European Middle Eastern (EE/ME) Underserved Cultural Communities (UsCC) subcommittee with the purpose of increasing mental health access and reducing disparities for the Arabic speaking community was implemented in the County of Los Angeles. The purpose of this project was to conduct a needs assessment of the mental healthcare needs of the Arabic speaking community through virtual listening sessions. The program was set to include 8 virtual listening sessions of 10-12 people each (ages 18-80) assessing the needs, knowledge, and baselines in mental healthcare for this Arabic speaking population to increase access to mental healthcare and decrease stigma toward services and wellness (yielding 80-96 people in total). Due to feedback from the community about privacy concerns, instead of the eight virtual listening sessions 147 individual virtual sessions and interviews were conducted, and one public session to share the results with community members was held. Of the 147 individuals three were removed. Two were removed (1M/1F) for not finishing the interview, and one for not qualifying (1M). These interviews were conducted with informed consent and by a licensed Marriage and Family Therapist. Sessions lasted ranging from 40 minutes to over four hours depending on the age and social location of the individual interviewed. With increasing life experiences the interviews tended to increase in time. This totaled between 6,000 – 32,000 hours of interview time. The interviews consisted of several types of questions including yes/no, open-ended and questions from assessments such as 20 developed questions for the study (Addendum C), and normed assessments such as Patient Health Questionnaire (PHQ-9) (Addendum D), ACES (Addendum E), PCL-5 (Addendum F), Columbia-Suicide Severity Rating Scale (C-SSRS) Risk Assessment Version (Addendum G), and Trauma History Screening (TSQ) (Addendum H).Individuals answered a total of 130 questions and had the opportunity to expand on answers extemporaneously. Each participant was incentivized with a $50 gift card.

Key Findings:

This Project was implemented in 5 phases starting June 2021 to June, 2022. Below is a description of each phase, the methodology, results, discussion, and conclusion of the interviews:

Phase 1: In Phase One of this project, a training curriculum for a four (4) hour presentation that was to be utilized to conduct eight listening sessions was created along with focus group logistics, questions, fliers and promotional materials, a resource guide and identifying an online platform that was HIPPAA-compliant to conduct the virtual listening sessions. The original plan is attached in Addendum A.

A one-page trifold Resource Guide was also created. The Resource Guide included a list of all Los Angeles Department of Mental Health providers that have Arabic language capacity. The Resource Guide was distributed to each participant, and is attached as Addendum B.

Dates of implementation were planned, and participants were beginning to be recruited. However, the Arabic community began to give recruiters feedback that they were not comfortable giving answers to questions in a public, open format. They were willing to answer questions about mental well-being in a private anonymous space, but not in public or in a small group. There were many factors influencing this feedback: 1) stigma and shame around mental illness, 2) distrust of government and past histories of government using information to harm populations, and 3) cultural expectations about sharing family information.

Given this new information and request, the project shifted to accommodate the needs of the community. The project as of September shifted to individual interviews. The individual interviews also included expanding the number of questions to include not only the originally planned questions, but to include some additional questions totaling 20 developed questions for the study (Addendum C), and normed assessments such as Patient Health Questionnaire (PHQ-9) (Addendum D), ACES (Addendum E), PCL-5 (Addendum F), Columbia-Suicide

Severity Rating Scale (C-SSRS) Risk Assessment Version (Addendum G), and Trauma History Screening (TSQ) (Addendum H).

Phases 2-4: In phases 2-4 participants were recruited for the individual interviews, interviews were facilitated. The original plan would have had up to 96 participants in the listening sessions groups, the modified plan expanded this to including from 120-150 individual participants. This may have been an ambitious expansion of participants, as it took longer to recruit just the minimum of the 120 participants, including an addendum to finish recruiting and interviewing participants to reach the 120 minimum goal. The interviews ranged in time from 40 minutes to over four hours in duration. The interviews seemed to last in duration depending on the age of the individual and life experiences. In the end, there were 147 participants recruited, and 144 qualified for analysis. The methodology section will expand on how this phase of the project worked (*please see page --)*

Phase 5: This phase includes the development of the outcome summary report. This can be seen throughout the rest of this report including an introduction, methodology, results section, discussion, and conclusion.

Introduction

The purpose of this project was to move forward with future capacity building projects for the Arab and Arabic speaking people with an understanding directly from the people served what the mental well-being needs of the people are. The Arabic speaking people are far underrepresented in attendance within the UsCC EE/ME cultural subcommittee. This effort was meant to balance this reality by going to the sources within the community that can speak more directly to the mental wellness needs.

A needs assessment was implemented by interviewing and asking 147 participants questions and analyzing 144 participants answers who provided complete interview sessions. There were many ideas revealed and shared that will allow for the EE/ME committee to move forward for several years with projects that directly speak to the needs of this subcommunity within LA County. Additionally, this project has revealed an interest of many people to volunteer and potentially join this subcommittee.

The objectives of this project were accomplished and some objectives that were not expressed in this project, but that can provide insight into this underserved community and the direction of funding for the future. Further clarity is provided as one continues through this report to the methodology, results, discussion, and conclusion.

Methodology

The project was slated for eight virtual listening sessions and reformatted for individual interviews. A recruiter from with knowledge of the Arab community in Los Angeles was subcontracted to assist with the recruitment of participants. The Project Manager and the Recruitment Manager recruited individuals for the study through advertisements on social media, through email, word-of-mouth and newsletters in Arab serving institutions.

Once recruited individuals were provided a qualifying document on Google Forms to ensure the individual met the criteria of the study. A copy of the qualifying form is in Addendum C. The qualifying questions were:

Qualifying Document

1. I am between the ages of 18 and 80 years old	**Yes**	**No**
2. I am an Arabic speaking person or I am a person of Arab descent.	**Yes**	**No**
3. I live in Los Angeles County	**Yes**	**No**

4. **I live in Service Area (please see the map)**

    a. **1**
    b. **2**
    c. **3**
    d. **4**
    e. **5**
    f. **6**
    g. **7**
    h. **8**

5. **I am willing to attend my entire assigned session online on ZOOM. Yes No**

6. **I am willing to share my ideas with others. Yes No**

Out of the 147 individuals recruited, three individuals were disqualified from the qualifying document procedure. Two were removed for not completing the interview and one because they were not of Arab ethnicity.

After passing the qualifying document, individuals were given an informed consent (Addendum D) and a link to candidly to schedule an interview time. Interviews occurred via HIPAA-compliant ZOOM telehealth. Individuals met with the therapist (LMFT) for an interview answering questions (Addendum E) and assessments (Addendums F-J). Individuals were asked what incentive they would prefer between an Amazon gift card ($50) or Visa gift card ($50). Amazon gift cards were delivered via email while Visa gift cards were delivered via USPS. Individuals were interviewed in a manner akin to an initial intake for a therapeutic session. When an individual indicated risk for harm, they would be given resources for immediate assistance. No participants indicated immediate harm. However, a small few indicated a necessity for referrals to therapy. Interviews lasted on average between 40 minutes to 4 hours. Interview responses were collected by the therapist in handwritten summaries. Once finished with the interview, individuals were asked if they had turned in their paperwork with the recruitment manager. The recruitment manager was asked if the paperwork was received. If the recruitment manager answered in the affirmative individuals were either emailed an Amazon gift card or mailed through USPS a Visa gift card. Interviews are stored on paper in a locked cabinet to protect the agreement outlined in the informed consent.

Individuals were given a follow up email including references, suggestions, and an invitation to a community session to hear the results of the interviews. A community session took place on March 25th from 9am-12 pm on HIPAA-compliant ZOOM telehealth.

Limitations to this methodology included the veracity of answers, understanding the meanings of questions, and the individuals' willingness to participate. The Recruitment Manager did not collect all the informed consents of all the participants, despite their indication they did. As such, there were many participants given incentives without returning the documents of the informed consents. All individuals who participated were captured on the Google Form. However, they were ensured that their participation would remain confidential just as one would expect in a therapy session.

Another limitation to the study is fact-of-life sampling. Those individuals who are Arabic speaking in Los Angeles County, but who do not have the technology of a computer or phone and who may be isolated from the larger community would not have had access to this study as recruitment was done via social media, email, word-of-mouth and community involvement and interface with organizations.

Finally, one cannot quantify or capture the importance of trust when interviewing this community of interest. Historical narratives and realities that have caused intergenerational traumas and dislocations at the hands of government systems has created a significant distrust for many. To not recognize the significance of trust and how this is crucial in garnering truth and veracity in this study would be to miss the elephant and only look at its shadow. This is why confidentiality is so important when conducting a project such as this one.

Narrative analysis, demographics, and descriptive statistics were utilized to analyze the answers in the qualitative interviews and are provided in the results section.

Results

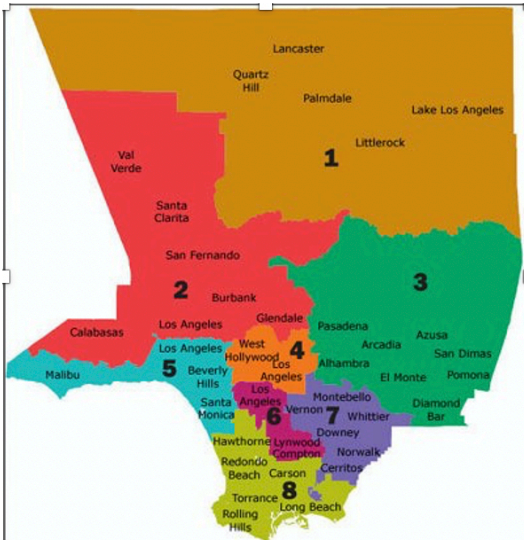
Demographics
(147 Participants/ 144 qualifying participants)

	Age
18-25	81
26-32	30
33-45	16
46-55	8
56-65	9
66-80	0

	Gender
Male	56
Female	88
Other	0

	Religion
Islam	110
Catholic	3
Christian	24
Coptic/Coptic Orthodox	2
Atheist	2
Orthodox Christian	1
Roman Catholic	1
Syrian Orthodox	1

	LA County Service Area
SA1	2
SA2	44
SA3	28
SA4	20
SA5	35
SA6	3
SA7	3
SA8	9



	Ethnic Origins
Algerian	**2**
Egyptian	**24**
Iraqi	**2**
Jordanian	**4**
Lebanese	**20**
Libyan	**1**
Moroccan	**7**
Palestinian	**22**
Saudi Arabian	**3**
Sudanese	**1**
Syrian	**15**
Tunisian	**1**
Emirati (UAE)	**3**
American	**14**
Yemenis	**1**
Mixed (Sudanese, French, Armenian, Two or more Arab countries and/or US)	**15**

The following are the results of the responses of the individuals who completed the interview fully in simple descriptive statistics.

1. As a community member what do you see the most prominent issue(s) of mental health within the Arab community?

There were many answers offered as to the most prominent issues of mental health and well-being within the Arab community including the answer "there are no issues." Many fit within a few categories. These include family, generational issues, diagnoses, emotions, socio-cultural issues and others.

Under the understanding of family issues, the following were suggested: enmeshment and fusion in families, an overdependence on the younger generation, lack of insight into what is a mental health issue, lack of communication and discussions within the family units, only discussed during times of crisis, parental abuse (including corporal punishment, slapping, and other physical punishments are normalized according to participants) and emotional cutoff for speaking out about mental crisis. One last family related issue was the idea of a performative existence whereby there is oppressive levels of pressure to be seen and perform a certain way as to make the family feel looked upon in a positive manner whether it is too much pressure of too high of

expectations for young people to meet. The younger end of the participants stated they felt this often seemed hypocritical and left them confused.

Generationally, issues that were suggested had to do with whether one's worldview and morals or values includes a theory of mental health. Most of the participants above 60 years old were not willing to acknowledge its existence. One participant noted, "I don't see mental health. I don't agree with its existence." In fact, there was a felt sense of trampling on cultural and potentially religious values ("faith is critical" and "you should pray it away") for what seem to be a felt sense that as an American dominant culture is 'imposing' its own worldview on another. Not all elderly shared these sentiments. In fact, one woman who was above 60, stated " The first generation brought their issues from back home and take things too personally. They are judgmental. Their opinion is the right opinion. They gossip. They are insecure and classist, and don't venture outside their specific groups." In the opposite direction, those who were 18-30 seem to suggest that "young people are more aware, and our elders are not." We often find ourselves "living between two worlds, being an Arab in an American world and being afraid to talk to your parents about it." The 18–30-year-old participants also suggested that: "largely, mental health is not thought of (by our elders) as a necessity or contributing to our overall well-being." One person felt that COVID made mental health come to the surface and affected the older generation more when they could not socialize as they would normally. They began to see some of the realities of disconnection.

A number of diagnoses were mentioned as common within the community. It is not clear as to whether people truly know the accuracy of these diagnoses, but they certainly understand a popular or communal understanding of them. They included: depression, anxiety, ADHD, suicide, substance abuse and comorbidities around substances, PTSD due to war, complex PTSD due to sexual violence, marital issues, domestic violence, verbal abuse, financial abuse, and many women (18-30) said they felt "our men don't like us." Emotions were placed in a separate category because they were often referred to independent of an attachment to an understood diagnosis. Emotions identified included fear, shame, and " being able to talk about mental health issues without feeling like an outcast."

Socio-cultural issues were also mentioned starting with stigma. Stigma came up frequently mentioning ideas that included self-stigma, label avoidance, structural stigma ("Access to services and isolated locations (mental health deserts)," and public stigma ("It doesn't exist."). One participant stated there is a "lack of empathy created by our own culture of origin. We don't believe in mental health."

Acknowledging mental health issues can also be seen through the lens of SES for some. One participant commented that "we don't discuss what may make us look less privileged." Other social location issues include bullying, prejudice, stereotyping "leading to depression and poor self-image," name calling such as "Black Sheep," or being told Shame!('Aib)

Lastly, there were socio-political issues mentioned also. These included racial issues, xenophobia, refugees adjusting to a new culture and issues that arise from assimilation/acculturation, and one participant had a child killed by LAPD mistakenly, while there were others who had mentioned false imprisonment for being "brown."

2. What are the mental health services you are aware of in LA County?

Out of the 136 qualifying participants less than five knew of the Los Angeles County Department of Mental Health and even fewer reported knowing specific offerings of LACDMH. Most participants' answers included "I don't know," (40%) or a series of incorrect answers (59%) that were related to either private therapy or some other forms of unregulated online coaching or community support groups like 12-step-programs. One participant volunteers within the LACDMH Interfaith Roundtables, and some have been present in previous MHSA sponsored events. Only roughly 2% or three of the qualifying participants actually can correctly identify anything related to LACDMH.

3. Where do you notice gaps or unserved or underserved mental health issues in service delivery to the Arabic speaking community.

The largest group of participants felt ill-equipped to answer this question as they felt they knew little about the mental health system to identify gaps of service within it, and answered "I don't know" (41%), and another roughly 5% answered, "they didn't understand the question." However, there were some anecdotal remarks addressing concerns of the goals of capacity building. These remarks and suggestions included both systemic and personal responses.

Systemically participants suggested the community did not understand "what depression is," and a general "lack of awareness about mental illness." Participants also mentioned "a lack of resources, lack of access to resources, lack of programming and events, information is absent, not presented or presented in an unstructured manner, is sometimes confusing and not available in Arabic, or no openings/ available appointment times" and that "nothing seems to be centralized." Participants reported "not knowing where to go," and indicated a preference to have services available in relevant locations such as "mosques, churches and/or community centers."

Additionally, generational gaps were identified between the youth and elderly, "especially in 1st generation." Elder participants (age 50 and above) had mixed responses, but some iterated that " we should be able to handle our own emotions and not have to go through a third party," and that the youth need to "toughen up." Some of the older participants suggested the youth were "lazy and weak" for not being able to cope with generational traumas. A few (roughly 4%) identified both a "lack of cultural competency" within the mental healthcare system and that people don't know what is normative when it comes to mental well-being – "how things ought to be." The younger participants (ages 18-30) reported that "parental support doesn't really exist." "Many people have to wait until after the age of 18 to get help," because they are believed. One participant said, " Unless I try to kill myself it wouldn't be taken seriously by my parents."

There were also some general remarks to this question about gaps in "behavioral support," " culturally competent providers," " financial ability," and "access for substance abuse treatment."

Lastly, approximately 6% of participants had sentiments resembling this statement, " *We are never included in things. The census does not say Middle East. We don't count and have no representation.*"

4. What are some challenges or barriers in seeking or accessing mental health services?

Challenges and barriers in seeking or accessing mental health care included the following: acknowledging one has issues and stigma (self, structural, labels and public), not enough access to healthcare and telehealth, insurance and affordability, referrals to appropriate and culturally aware therapists, and appointment wait times. A few report a general disregard for elderly concerns. Close to 5% reported poor previous therapy experiences that deter them from seeking other therapists, and that "non-Muslim therapists are not culturally sensitive." One participant noted "I don't think we are targeted for services. Other than the outreach you (Dr. XXXXX) have done over the years I have not seen anything from the DMH." A few people stated they go to the private sector for services (3%).

Some of the more statistically significant responses fall under cultural understandings and beliefs, or even self-stigma. These included: men not being able to receive services because it is "not manly," " psychologists need help themselves," " "it is shameful to go; internalized shame; shame on you; what will people think; people will not trust you and your children will be seen as crazy; it should be kept to yourself or within; you should laugh it off; the inability to recognize you have an issue or admitting it; it is taboo; a sign of weakness; parents are a barrier, judgement of self and others, and collective guilt."

A few responders continue to deny its existence. They gave anecdotal evidence with statements like: "I don't have troubles," and "It doesn't exist," or " I don't know, because I never looked into it." One person stated, " I don't even know where to start."

5. What are stigmas related to mental health for the Arab community?

There are two types of stigmas that are generally acknowledged in the helping professions. These are public and self. Corrigan et al. (2017) included two other types label avoidance and structural stigma. Laird

(2018) identified in her dissertation that at least two of these stigmas self and public are relevant to this population. In LA County the participants in this project responded with answers that fall into four types of stigmas: self, public, label avoidance and structural, and potentially an unidentified fifth type of cultural stigma. I distinguish this 5th type from public stigma noting that public stigma includes norms of the dominant culture while this group of participants is an underserved population with a subculture that may be different from the dominant culture and therefore, a cultural/spiritual stigma distinct from public stigma. A small few stated they didn't know an answer to this question.

The responses are separated into self, public, labels, structural and cultural.

Self

Parents feel it is a reflection on themselves or something is wrong with them (27%)
Things are out-of-control
Barriers within you
It's something you should keep to yourself

Public

Ostracization
Letting our parents or community down
You are corrupt or unclean if you have a mental health issue
It doesn't exist example Colorado case
You are just like so-and-so
You are not allowed to have feelings
Something is wrong with you and you need to go to the psych ward
Looked down upon
It's just stress from school
You must be having grief
Smoke a cigarette and get over it
Many people want to keep up perceptions
Medication is a crutch

Label Avoidance

(55%) **Arabic words Majnoon and Ihbal , Dalaa, Moktab, 'Aib**
You are broken
You are weak
Just attention seeking
You just don't have confidence
Oppressed
Born that way/ Born Abusive
Untrustworthy

Structural

People don't acknowledge it
No one asks how being Arab affects them

Cultural/Spiritual

Your connection to God and faith are enough.
Pray it away.
An American thing to do – It is not something we do.
You may be a Kafir
It is all in your head, pray about it

Westerners do that
Especially with men "Be a man! Don't cry. Not a masculine trait and not something to be open about.
If you have a mental health issue you have low faith.
You are not close to God if you have a mental health issue
Women cannot be outspoken
Men are not allowed to seek services
Depression doesn't exist
Put on a face, what will "they" say" Shame," keep your status or else be judged and gossiped about

Lastly, there were about 16% of people who responded with phrases like "I don't see any stigmas," "It's in your head," and stigma/ mental illness doesn't play a part in someone's life."

6. What are better ways LA County DMH can offer mental health services to the Arab community?

Participants responded with many similar answers as read previously when answering the question of better ways LACDMH can offer mental health services to the Arab community. These answers included various forms of outreach, implementation, stigma, and assistance. Outreach included responses such as, "outreach, advertising existing services in Arabic, reaching out to religious institutions, college campuses and other schools (12%), promotion, social media (Snapchat, Twitter) (15%), youth groups, and have people of position within the community voice and promote." Some specific recommendations were made as to context of outreach including: "Being involved in community with events and talk not about mental health or depression but talk about what it looks like so that people can recognize it themselves; messaging that it is not only for emergencies; provide education that is culturally appropriate; start by socializing the constructs of wellness and well-being; attach it to something that already exists like church or other religious institutions; and let people know they have diverse services."

In terms of implementation a few suggestions were given. These included: "more Arabic speaking therapists (10%) and/or the use of interpreters in sessions; hiring people from within the community for familiarity; making therapy more affordable and available; increasing cultural competency within the LACDMH around Arab culture, people and Arabic speaking peoples; offering integrative mental health; and sliding scale fees and emphasizing the importance and guarantee of confidentiality. Many hold the belief that government is monitoring everything, and therefore, they cannot even share their thoughts (47%).

Some people made stigma related comments such as "it is a reflection that the family is not perfect," and "what would people think if they knew."

Roughly 20% of the participants indicated "I don't know," or "I cannot say because I don't know what LACDMH does," or "I don't know what they offer." Additionally, about 2% said "It's available and there is nothing wrong with it." While two participants noted "we are fine in our community and do not need outside help," and "there is nothing wrong with us."

7. What is the best way to conduct outreach the Arabic community?

Participants were much more willing to answer this question as it is not as challenging. Responses are not unusual and identified several methods of outreach. This is one where elders and younger participants agreed alike. Suggestions included social media from nearly 20% of participants and specifically identifying "Instagram, TicToc, YouTube, and Snap Chat with Facebook being identified for people 40-years old and older, and videos lasting no longer than five minutes to keep the elders attention." Some specific outreach suggestions included the creation of "blogs, videos, surveys, research, dinners, and events." One participant suggested that "blogs that are culturally relevant are more affecting than language-based materials, as many families stopped teaching their children Arabic post- 9/11 out of fear of retaliation and targeting." While a small few (less than 5%) suggested utilizing promotions on "Arabic TV via DISH like Al-Jazeera." Another 65% of participants identified "community centers, cultural centers and school settings, and religious institutions as places for outreach including large events, tabling, booths, listservs, and newsletters as opportunities to promote outreach." A few suggested "alliances with leadership in religious institutions, people

with status and public recognition, and aunties, friends and family speaking out and promoting mental wellness in sermons and community events would lend more credibility to outreach efforts, and also persuading organizations within the community to post and repost information.” Some interesting individual suggestions included: “ mobile units, honoring holidays, walk-in centers for mental health, educational events and 12-step meetings.” About 10% of the participants stated “I don’t know” to this question with one participant stating “ If I knew I would have done it a longtime ago.”

8. Is there anything else you would like to discuss in the area of mental health and wellness for the Arabic population?

Over 99.5% of the participants responded “no” or “no thanks.” Less than 1% had other responses. These responses were the following:

a. There should be a way for family to talk about mental health
b. It’s important that parents are educated. There should be educational lectures about passing on Trauma
c. We need more culturally competent therapists with a connection to the community
d. It is a major issue that needs to be normalized, and please cater to elders not just the youth
e. I lost my son and myself.
f. Youth need to be reached out to personally – I need someone to reach out to me.

9. What would it take for you or people you know to access mental health services?

There was some incongruence in this question with the rest of the responses. When asked the question of what it would take for you or people you know to access mental health services over 70% of participants either responded with “they would not need it,” or “they would speak about how others might need it.” These responses may signal or reinforce the very stigma that people can recognize but may not be able to transcend even though there is clear indication that people see the need for mental well-being and that there are those in their community who need treatment. Others, roughly 20% indicated they do seek treatment currently with either a therapist or psychiatrist and know how to seek services. Lastly, about 5% offered some other solutions. These suggestions included promotion via aunties, specific messages, e.g., everyone can benefit from therapy, reassuring privacy and confidentiality, hearing others’ stories about going through it, social media and promoting and FOMO. They suggested financial assistance, reducing financial barriers, affordability, accessibility, accountability, and increased language capacity, and access to internet connection. Another suggestion was a “safe place.” Another approximately 3% spoke of suggestions about format including support groups, group formats, ensuring high school students have access, and particular resources for domestic violence and substance abuse; “They are just non-existent.”. About 2% answered, “they didn’t know.”

10. What do you see as the main mental health issues/topics within the Arab community at present? How is this different from 10 years ago? 20 years ago?

This question was not the best answered question given the population we ended up being able to include. Over 77% of our participants could definitely not answer the 20 years question and only and not many more really could answer the 10-year question. Those who did answer these questions had a large array of answers. There were no consistent themes, and some people gave the same answers for 20 years that others gave for 10 years. Those who answered the 10 years question ranged in answers from personal to systemic in nature and included answers like: fear, things are much worse than 10 years ago, there has been more assimilation to American ideals, identity conflicts, familial conflicts around education, dress, and who one socializes with, depression, anxiety, addiction, trust, “ no one was getting treated.” marital stress, and it was “easier to live back home.”

The answer to 20 years ago was very similar and had some differences. The spectrum of answers included answers like we were all terrorists to it was the golden age of our community. Specifics like fear, shame, depression, anxiety and addiction, and identity conflict are identified as well as living between two worlds.

When asked about the present, there were more hopeful answers like “ younger people are standing up,” “we are more aware,” and things are more accepted. On the other end of the spectrum there was a sentiment that “people need a leader now.” One person stated : “People need a leader now. They are looking for someone to fill an opening. There is a lack of connection. Still connected to back home, and the older generation are narcissistic. Younger generation whether to adapt or flee the ways of their families and lack identity.” “There is a disconnect between parents and children, “living between two worlds.”

Some identified issues at present including domestic violence, war, trauma, e.g., Gaza bombing and Syria, cognitive dissonance, issues with identity(everyone has to keep up with the Jones’), not wanting to get married, LGBTQIA+, stress, depression, anxiety and addiction. Some also mentioned promotion of therapy to “be normalized and have stigma reduced.” A couple people asserted that there is more acceptance of mental well-being now, and less stigma exists and more people are willing to go the therapy

11. What programs would you like to see more of in your community or service area?

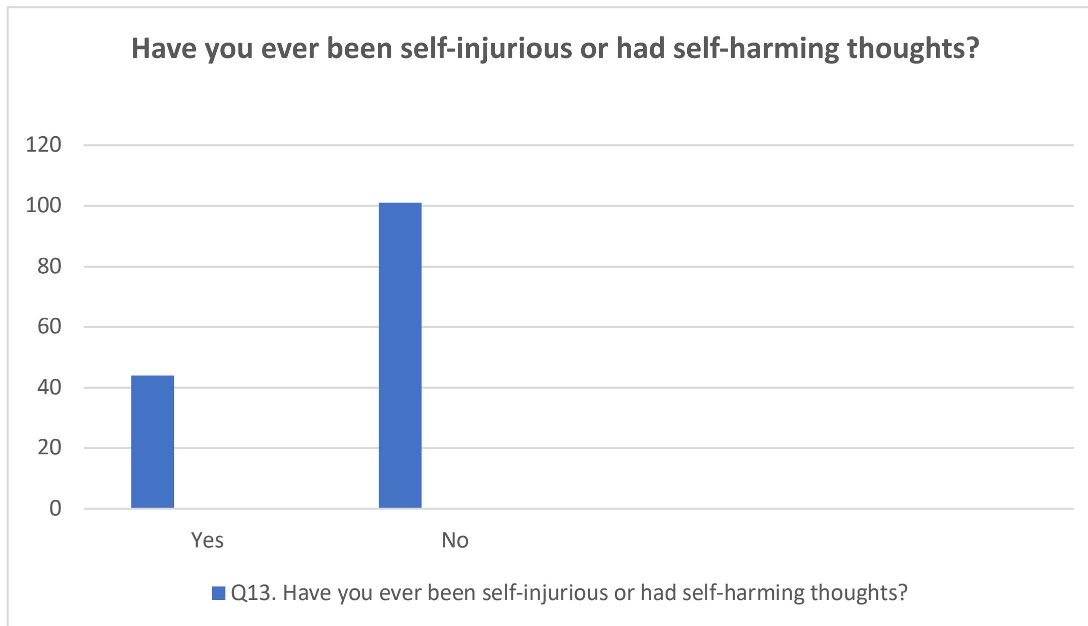
There were many individual answers to this question and very few statistically significant answers. One common answer of 10% of participants was “parenting workshops.” Another roughly 48% of people stated, “I don’t know”, or some variation of this statement along the lines of “ I don’t know what is available,” or “what are my choices,” and “ any programs that could be provided.” One participant noted they were “anti-community.” Some answers did not make sense. Other answers were individual responses including the following topics: “PTSD workshops, life coaching, sex education (6%), understanding sexual harassment, communication, family therapy, body positivity, specialized programs for various age groups (3%), programs for men, groups and group check-ins on mental health, trauma education, art and culture therapy (4%), substance abuse, domestic and intimate partner violence, programs for refugees, social welfare programs and immigrants (12%), corporal punishment, how to recognize when someone has a mental health issue and where to get help, and how to cope with mental anguish.” Still a few more suggestions that included programs about “financial affordability, low fee or no fee, better cost initiatives, normalizing mental health through language and native tongue, health insurance, counseling accessible within religious institutions and community centers and more general conversations so people don’t feel alone.”

12. Would you like to be more involved in volunteering for LACDMH?

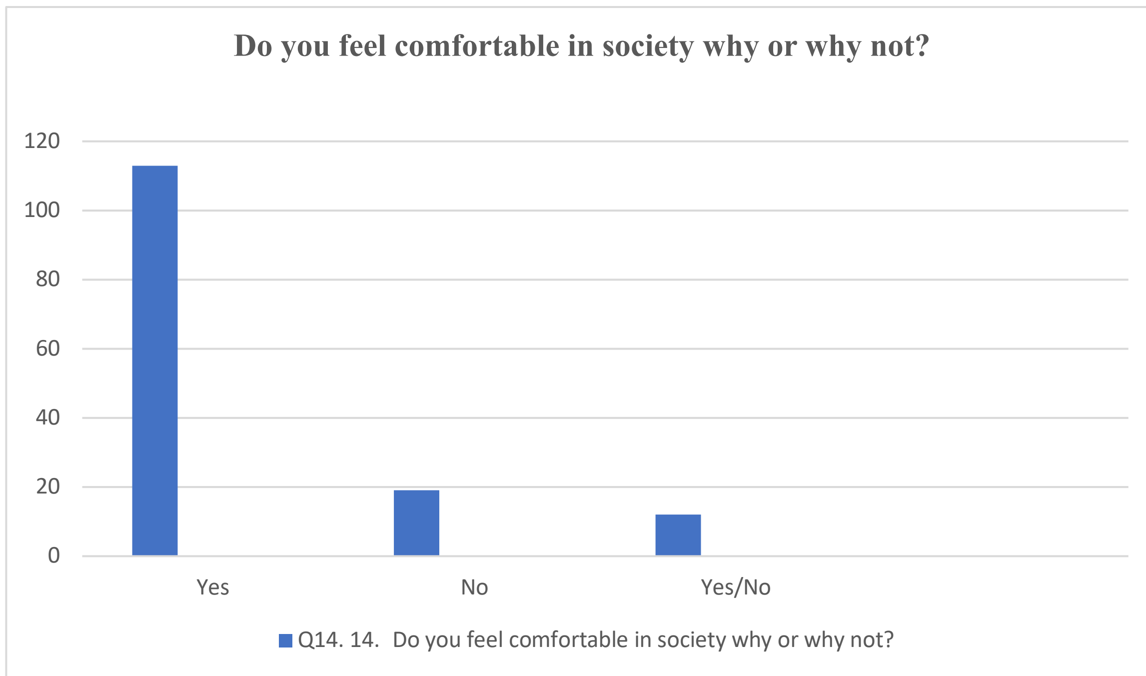
Of the 144 qualifying participants 122 said that they would either be willing to volunteer with LACDMH or they would at least consider volunteering, 12 additional participants indicated they may be willing, and eight said “No,” while two additional participants said they would support efforts but not volunteer.

Additional Questions
These questions were added in the Phase 2 iteration of this project.

13. Have you ever been self-injurious or had self-harming thoughts?
Out of the 144 qualifying participants, 43 participants had either been self-injurious, had self-harming thoughts or both, while 101 participants did not. This represents **nearly 30%** of the participants. This is **well above** the 17% worldwide based on a meta-analysis by Gillies, D., Christou, M. A., Dixon, A. C., Featherston, O. J., Rapti, I., Garcia-Anguita, A., Villasis-Keever, M., Reebye, P., Christou, E., Al Kabir, N., & Christou, P. A. (2018). Prevalence and Characteristics of Self-Harm in Adolescents: Meta-Analyses of Community-Based Studies 1990-2015. *Journal of the American Academy of Child and Adolescent Psychiatry*, *57*(10), 733–741. https://doi.org/10.1016/j.jaac.2018.06.018

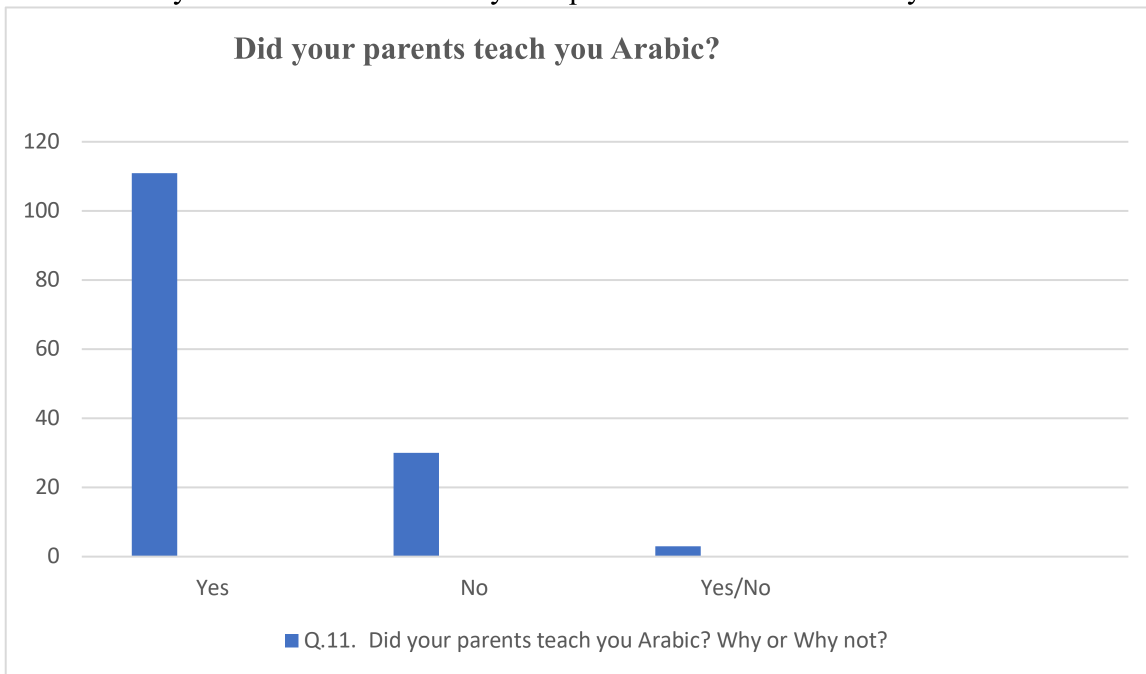


14. Do you feel comfortable in society why or why not?
Out of the 144 qualifying participants, 113 said they felt comfortable in society, while 19 participants did not, and 12 stated they felt comfortable at times and at times not. This result is quite positive indicating either people find themselves well acculturated or assimilated. Either way self-esteem seems to be present.



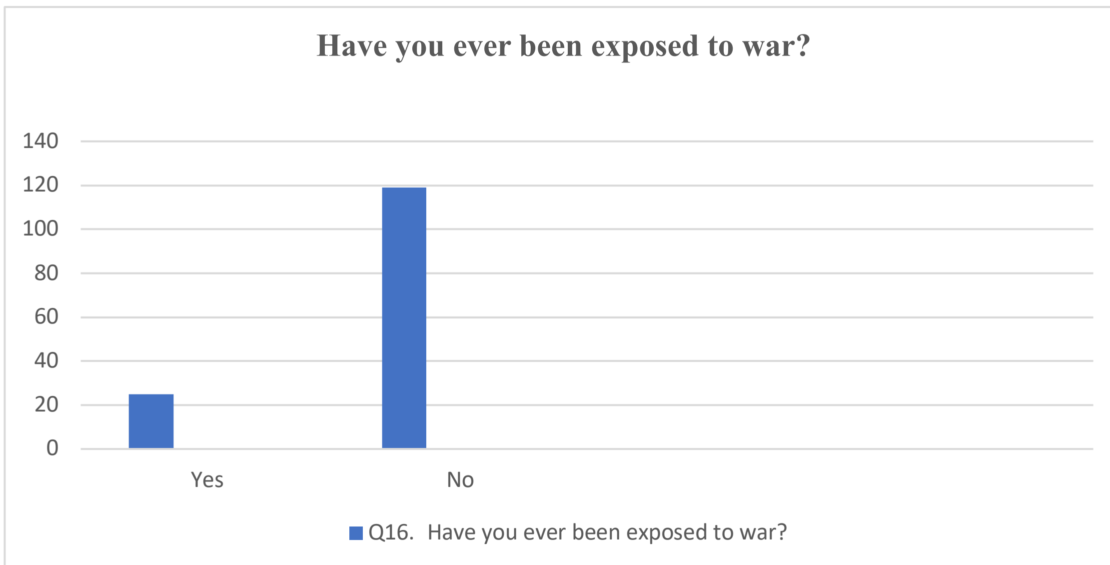
15. Did your parents teach you Arabic? Why or Why not?

Out of the 144 qualifying participants, 111 said their parents and/or community taught them Arabic, while 30 participants were not taught Arabic, and 3 stated their parents did not teach or influence them, but they learned another way. Many stated their motivation for learning Arabic had to do with their religious beliefs, while others stated they didn't learn because their parents wanted them to either assimilate or they were afraid they would be in harm's way in a post-9/11 American society.



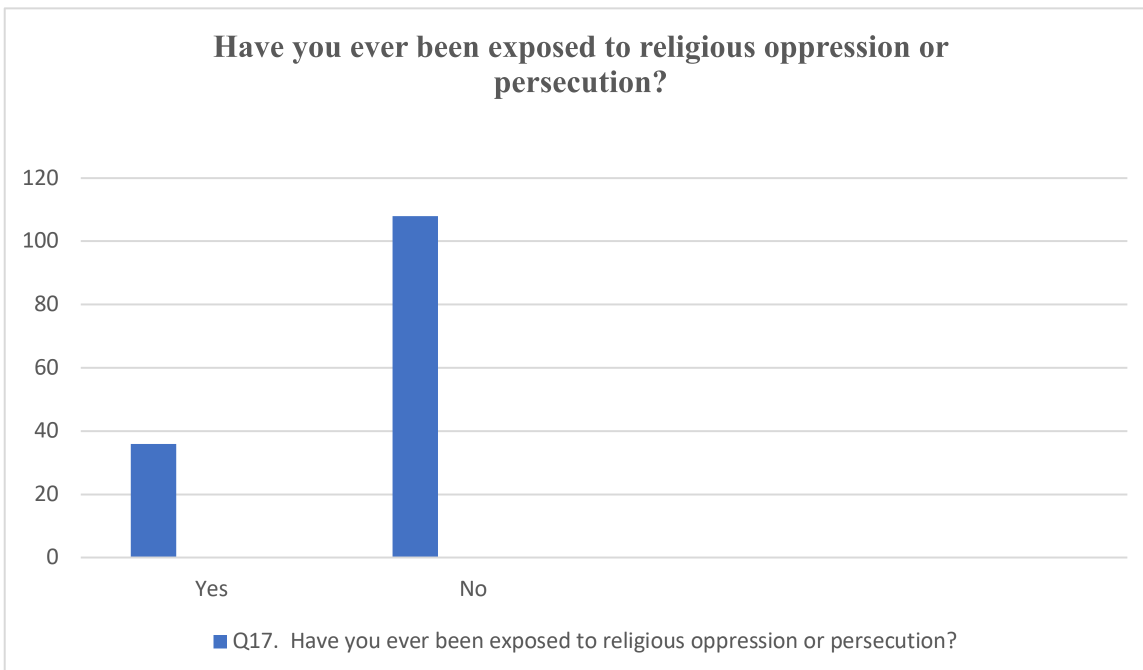
16. Have you ever been exposed to war?

Out of the 144 qualifying participants, 119 answered "no" they had not been exposed to war, while 25 answered "yes." This may be reflective of the number of younger participants.



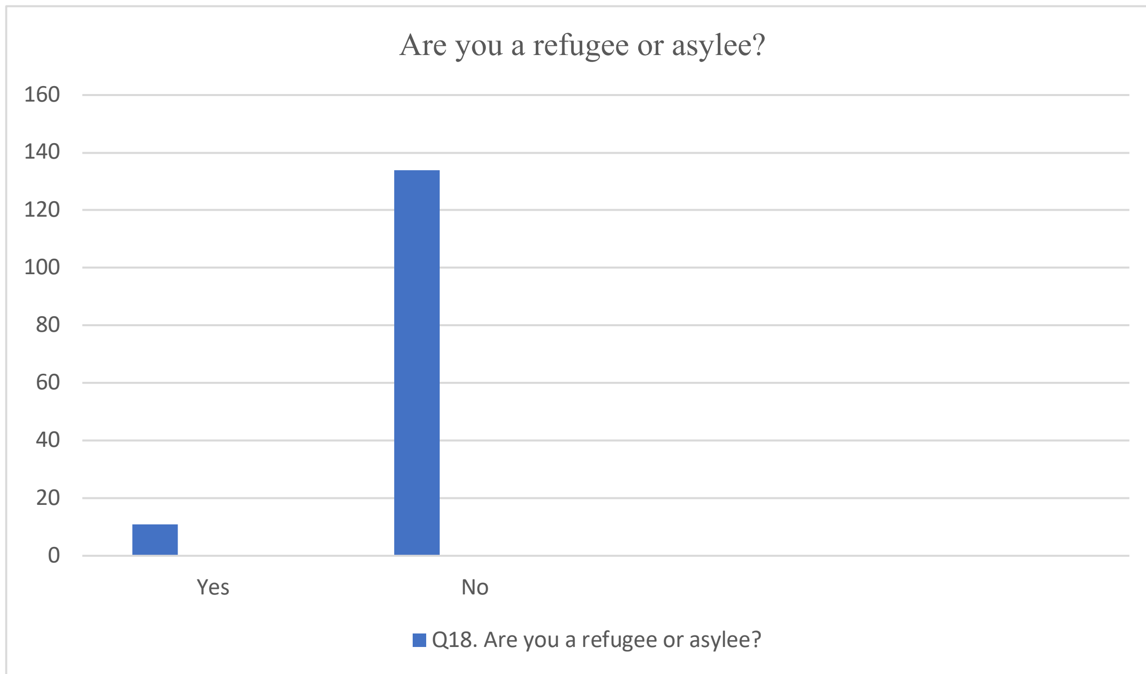
17. Have you ever been exposed to religious oppression or persecution?

Out of the 144 qualifying participants, 108 answered "no" they had not been exposed to religious oppression nor persecution, while 36 answered "yes" to either oppression or persecution or both. Many who answered yes mentioned they had suffered from experiences that ranged in scope from being called names in public to denied work, and a few suffered physical harm. Many who said they had not acknowledged they do not dress in a way where they stand out, so this may be why they are not noticed. While those whose dress signals association with being Muslim almost all had experienced some kind/form of maltreatment from external actors in the broader community.



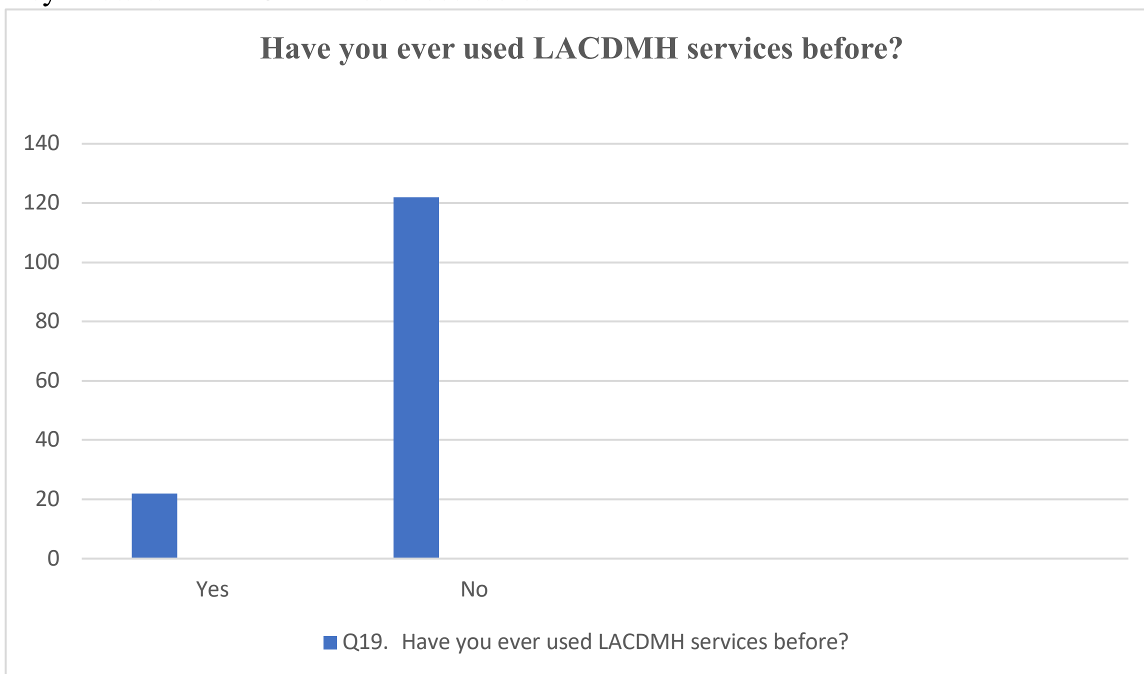
18. Are you a refugee or asylee?

Out of the 144 qualifying participants, 133 answered "no" they were neither refugees nor asylees, while 11 answered "yes" that they were one or the other.



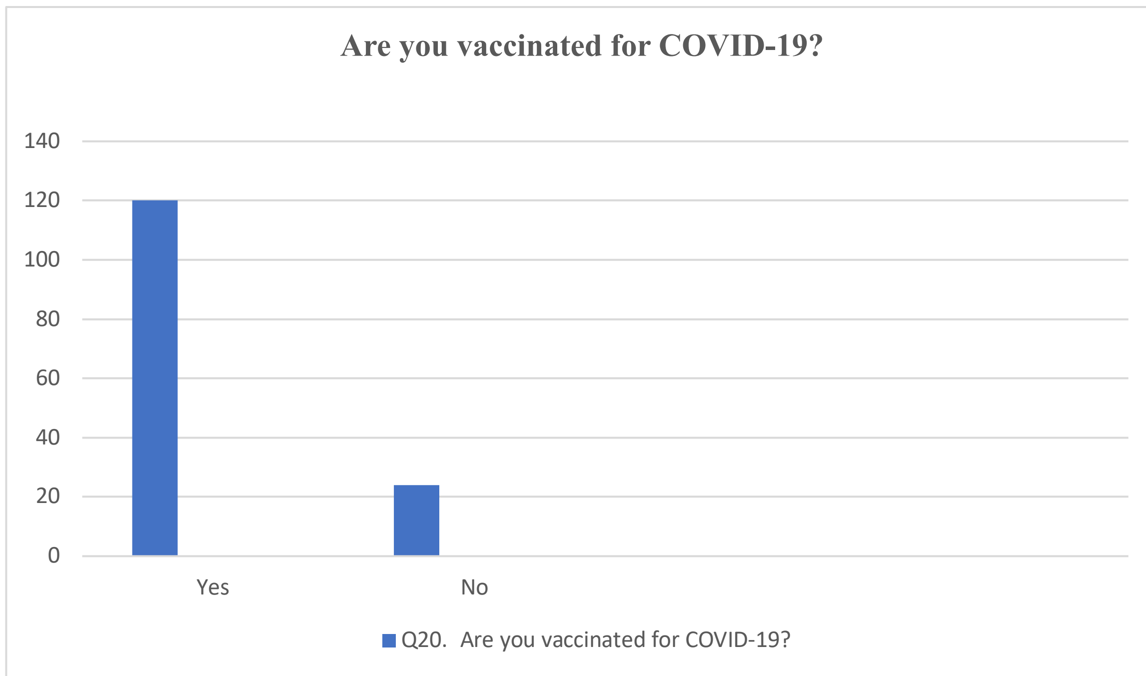
19. Have you ever used LACDMH services before?

Out of the 144 qualifying participants, 122 answered "no" they have never used LACDMH services before, while 22 answered "yes" that they believe they have. Those who have stated they have used LACDMH services before is not a reliable result given that in an earlier answer incorrect answers were given when people thought they knew what LACDMH services were.



20. Are you vaccinated for COVID-19?

Out of the 144 qualifying participants, 120 answered "yes" they have been vaccinated with a COVID vaccination, while 24 answered "no" they have not. This question was added to see if there were any concerns about the depth of trust with the government. This indicates there may be some growing trust.



Patient Health Questionnaire (PHQ-9)
(Over the last two weeks how often have you been bothered by any of the following problems on a scale of 0-3; 0=not at all; 1 =several days; 2= more than half the days; 3=nearly every day)

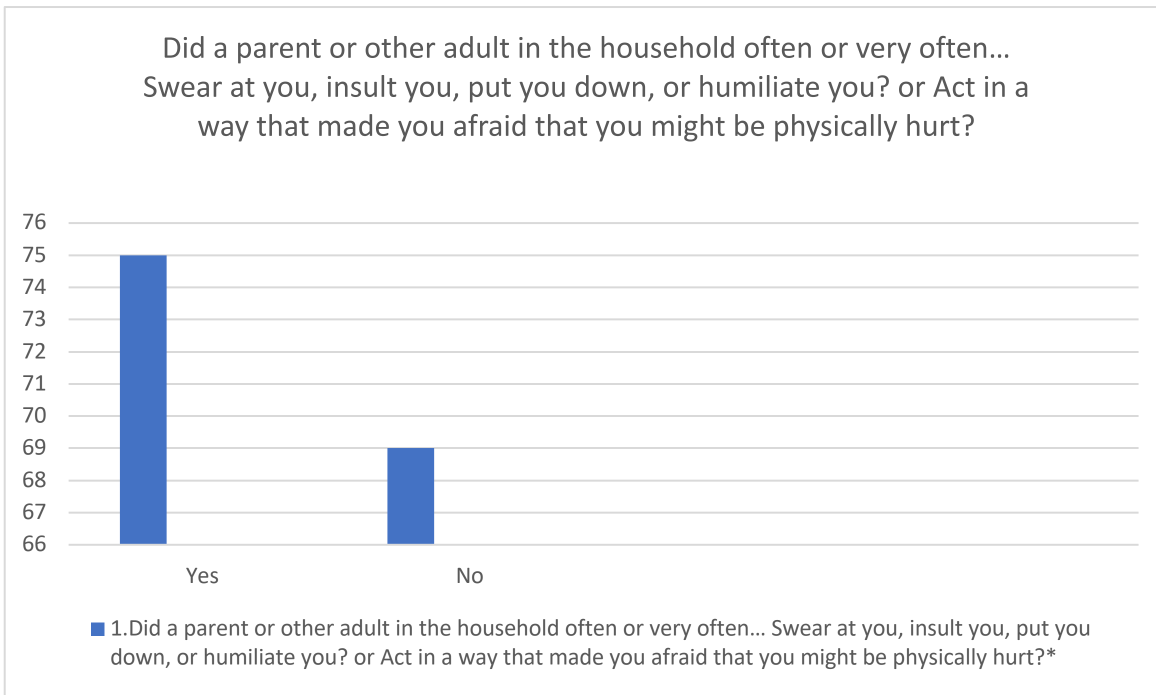
	0 Not at all	0.5	1 Several Days	1.5	2 More than half the days	2.5	3 Nearly every day
Little interest or pleasure in doing things.	53	0	50	3	26	3	9
Feeling down, depressed, or hopeless	62	3	41	3	22	3	10
Trouble falling or staying asleep, or sleeping too much	54	0	33	0	24	5	28
Feeling tired or having little energy	37	0	51	0	33	3	20
Poor appetite or overeating	63	0	42	0	20	3	16

Feeling bad about yourself – or that you are a failure or have let yourself or family down	52	0	57	0	21	0	14
Trouble concentrating on things, such as reading the newspaper or watching television	87	0	27	0	25	0	5
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	106	0	27	0	8	0	3
Thoughts that you would be better off dead, or of hurting yourself.	126	0	15	0	3	0	0
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people (Not difficult at all, somewhat difficult, very difficult, or extremely difficult).	75 Not difficult at all	0	51 Somewhat difficult	0	5 very difficult	0	13 Extremely difficult

Adverse Childhood Experiences Survey (ACES)

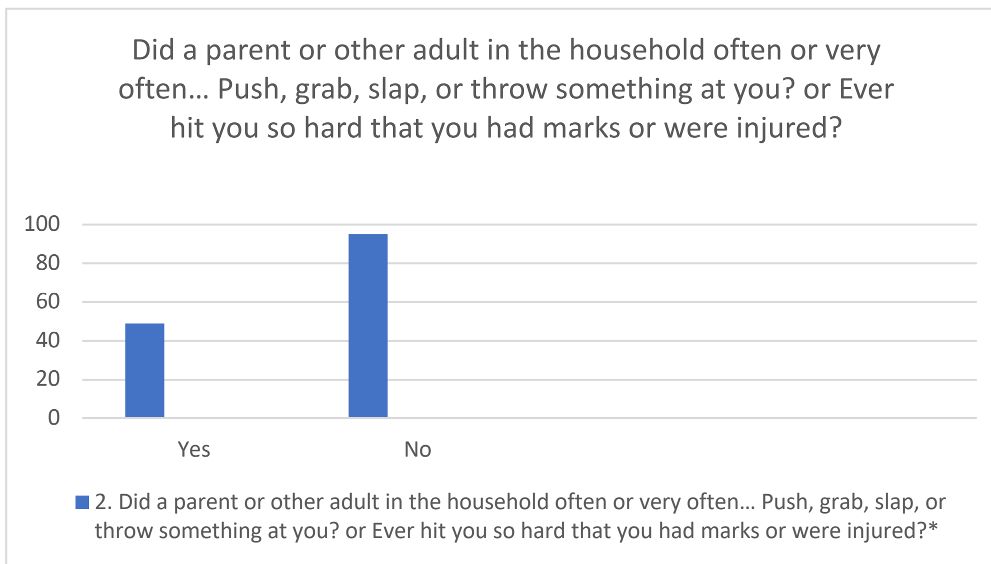
1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

Out of the 144 qualifying participants, 75 answered “yes,”, while 69 answered “no.”



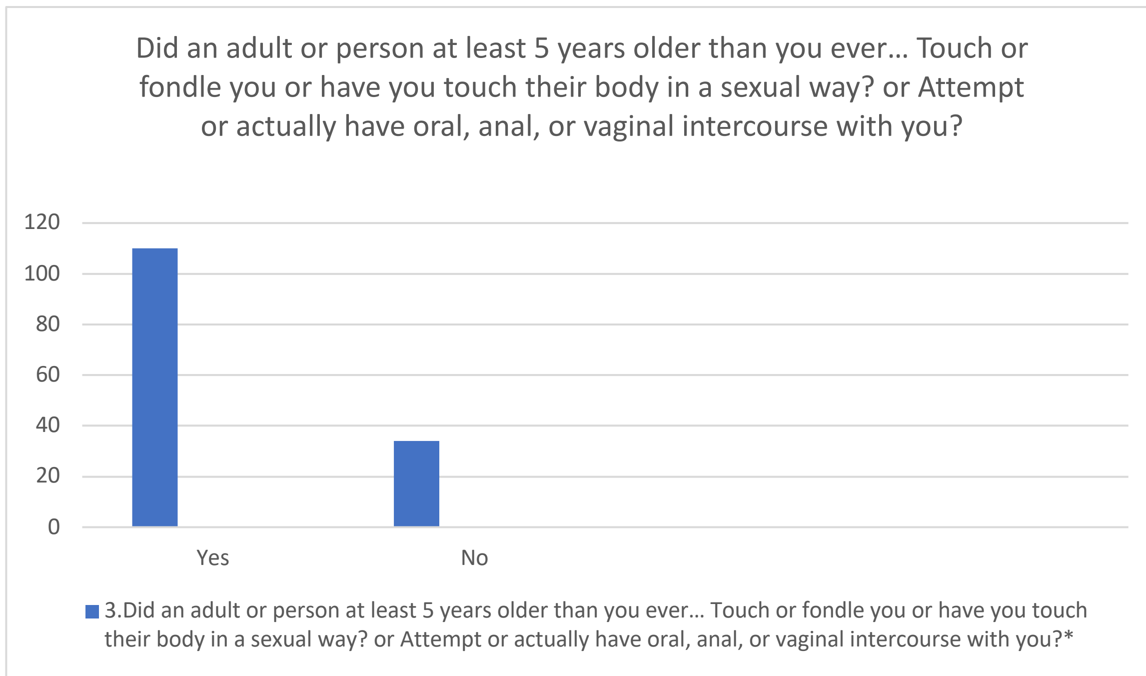
2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

Out of the 144 qualifying participants, 49 answered “yes,”, while 95 answered “no.”



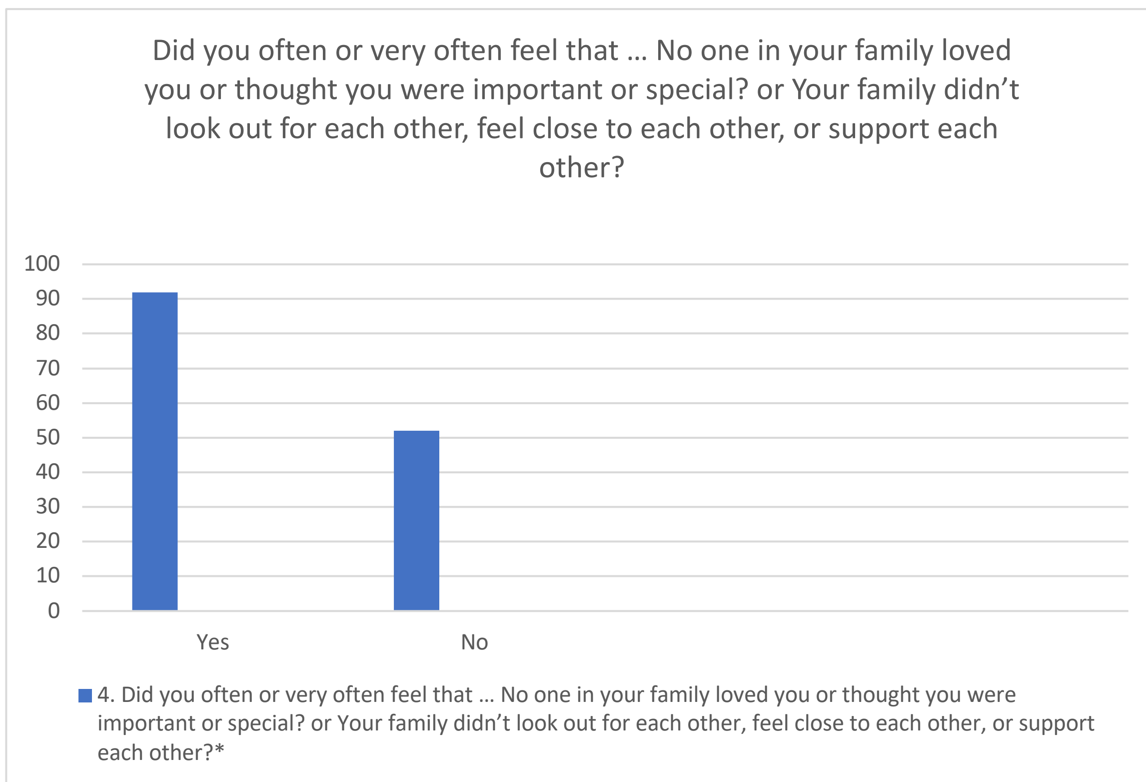
3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

Out of the 144 qualifying participants, 110 answered “yes,”, while 34 answered “no.”



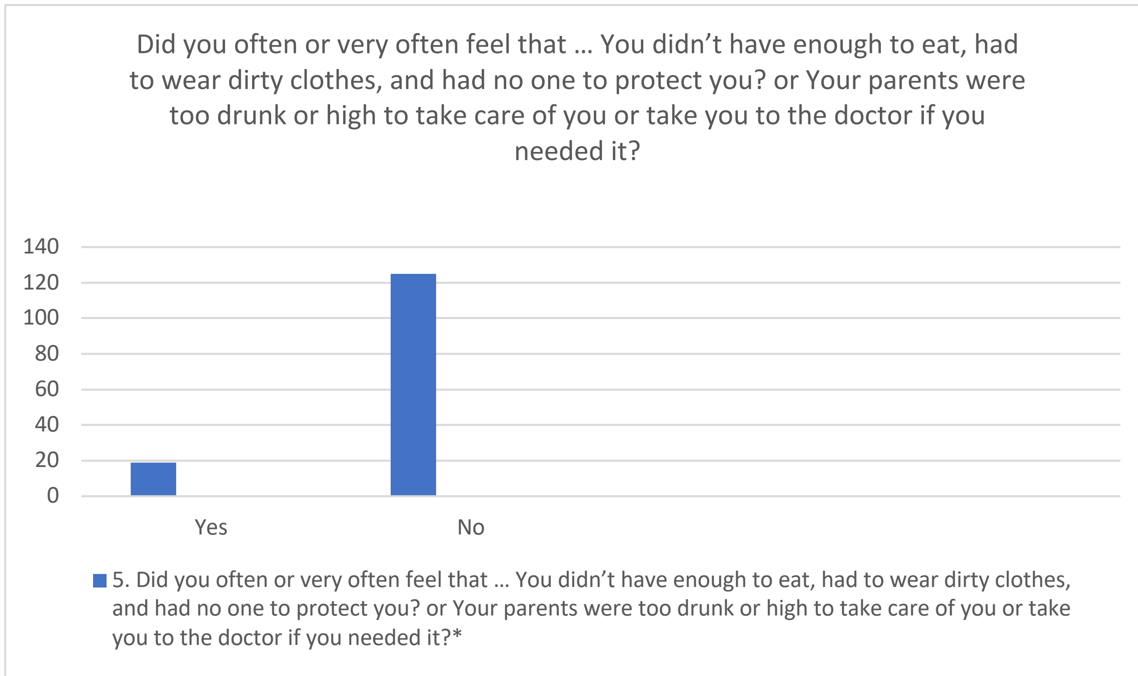
4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   Out of the 144 qualifying participants, 92 answered "yes,", while 52 answered "no."



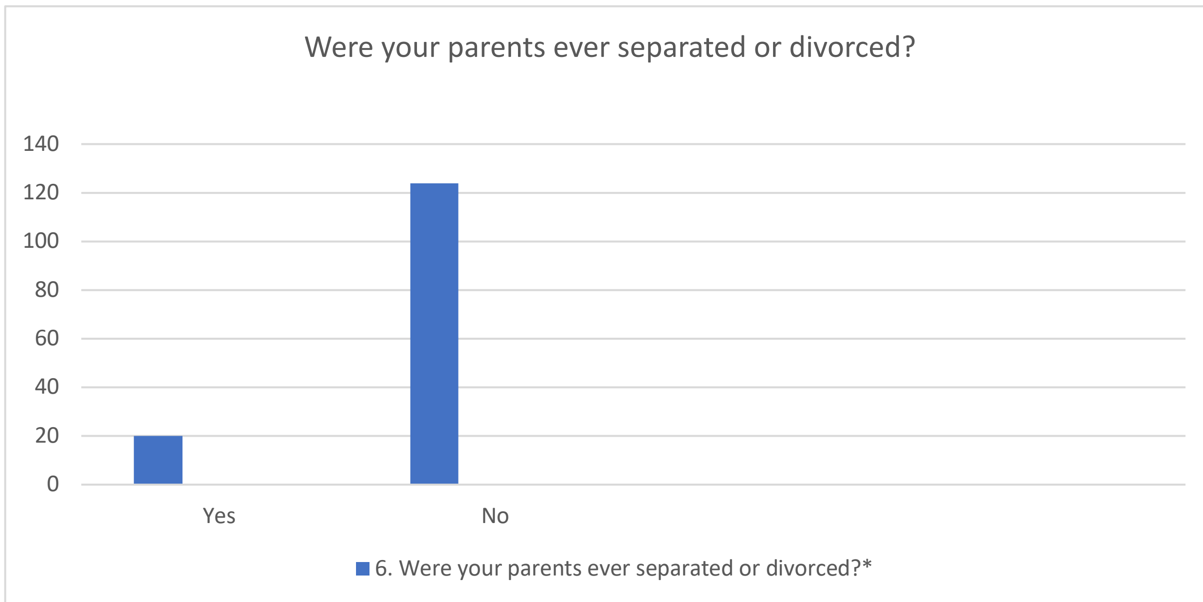
5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Out of the 144 qualifying participants, 19 answered "yes,", while 125 answered "no."



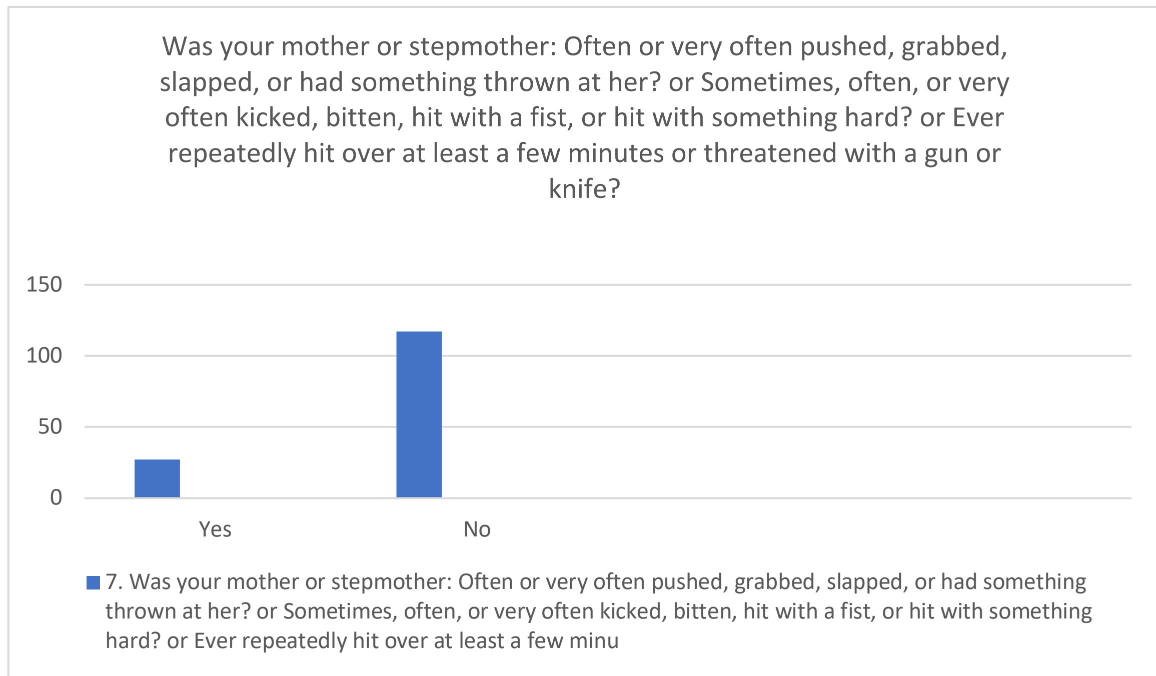
6. Were your parents ever separated or divorced?

Out of the 144 qualifying participants, 20 answered "yes,", while 124 answered "no."



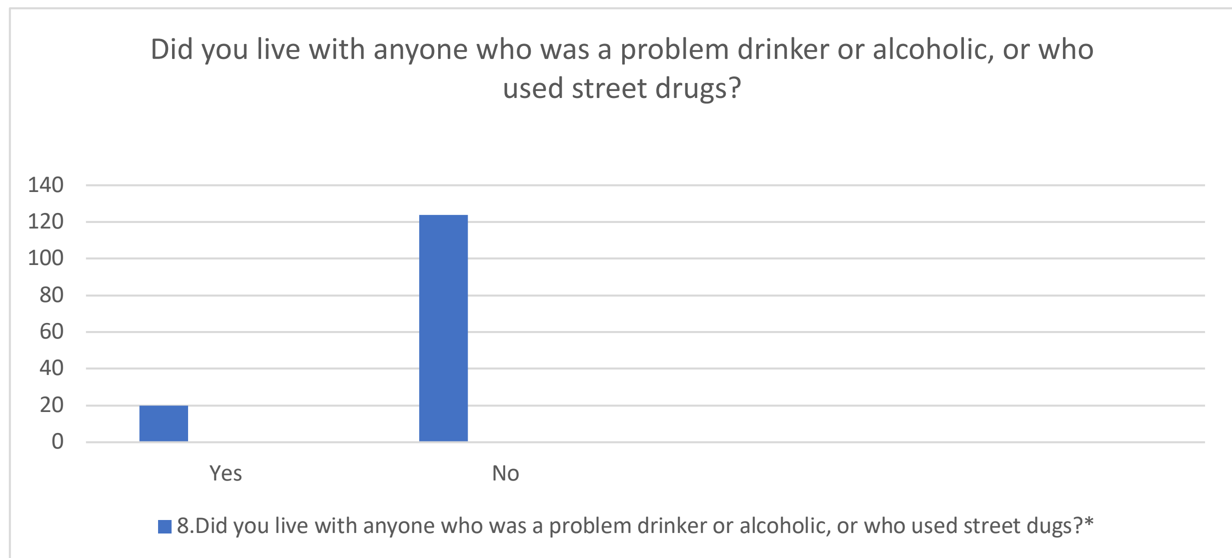
7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Out of the 144 qualifying participants, 27 answered "yes,", while 117 answered "no."



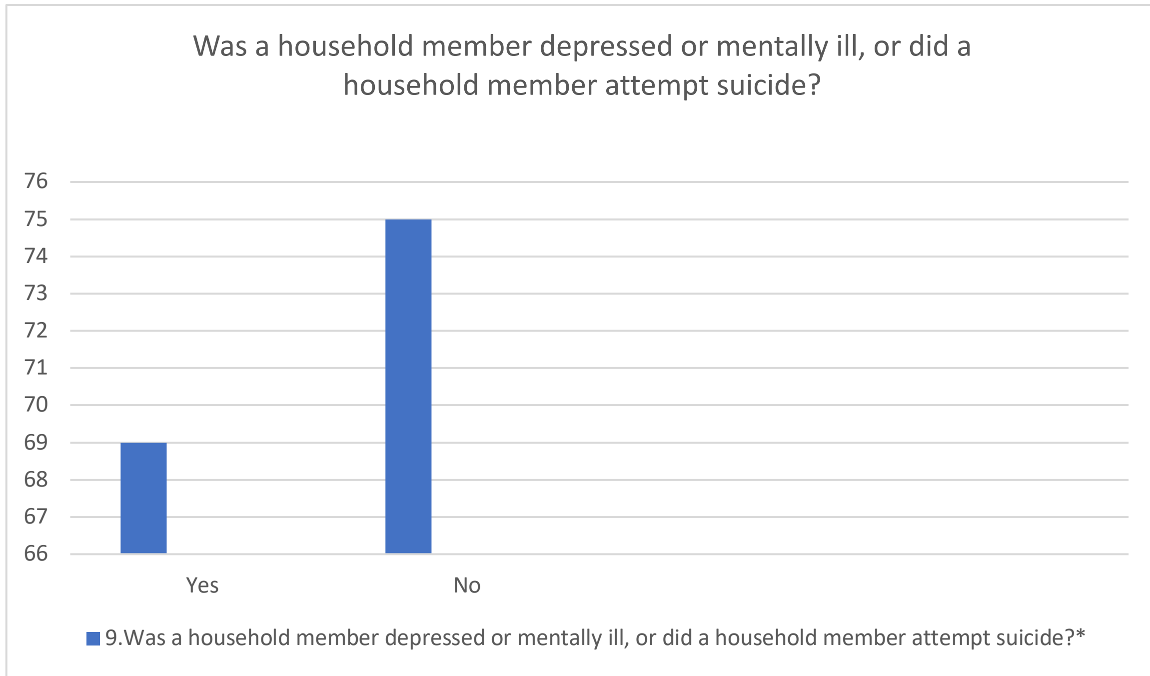
8. Did you live with anyone who was a problem drinker or alcoholic, or who used street dugs?

Out of the 144 qualifying participants, 24 answered “yes,”, while 120 answered “no.”



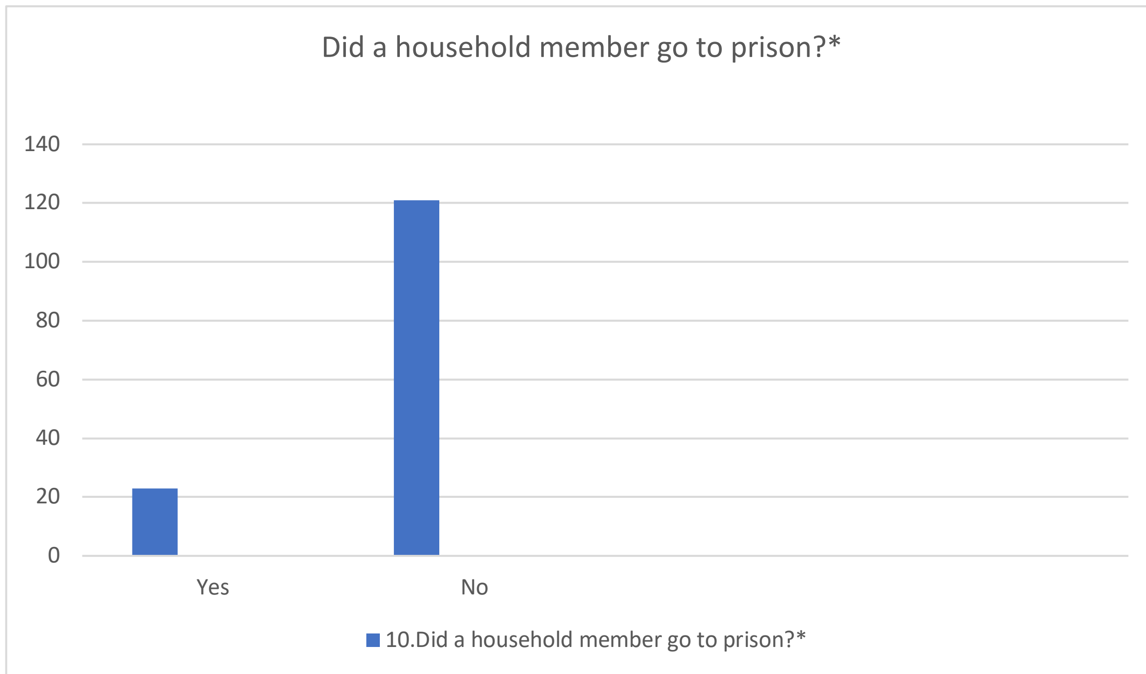
9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

Out of the 144 qualifying participants, 69 answered “yes,”, while 75 answered “no.”



10. Did a household member go to prison?

Out of the 144 qualifying participants, 23 answered "yes,", while 121 answered "no."



Columbia-Suicide Severity Rating Scale (C-SSRS) – Risk Assessment Version

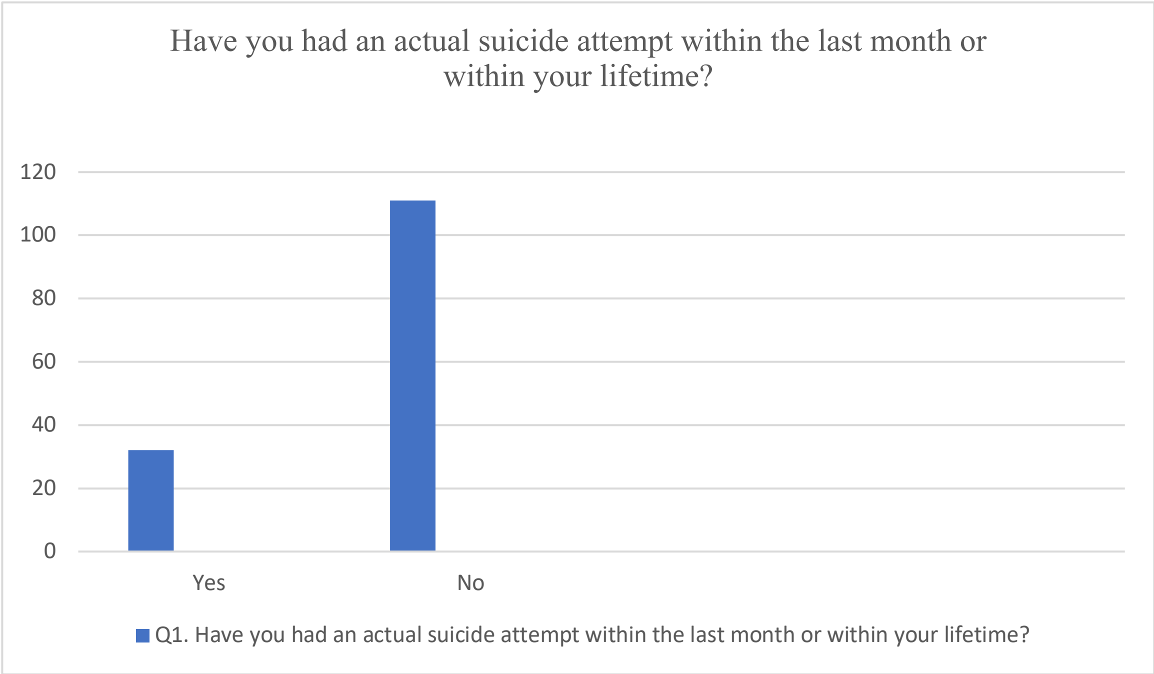
There are 53 possible questions assessing for protective and risk factors utilizing this tool. In the case of this project, I utilized the 53 questions, and added one question to distinguish the person's understanding of morality. The additional question was "Do you think suicide is haram/khati'a (forbidden)?

Some of the questions in this tool assess within the last month or within your lifetime. This is where most answers had something that merits discussion. There were many questions where there were no affirmative responses. Those will be deleted from this report, and only questions where there is a measurable outcome will be reported. A copy of this version (2008) can be found in Appendix (K)

The first category is Suicidal and Self-Injury Behavior (past month or lifetime)

1. Have you had an actual suicide attempt within the last month or within your lifetime?

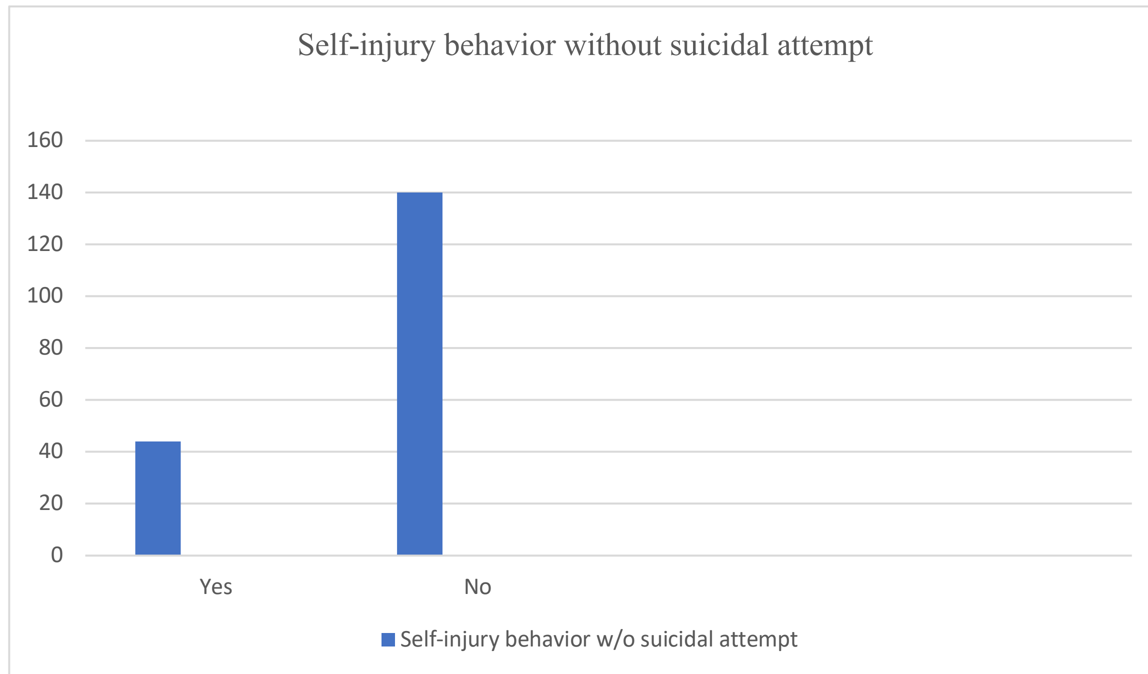
Out of the 144 qualifying participants, 32 answered "yes," they have had an actual suicide attempt either within the last month or within their lifetime, while 111 answered "no." This rate(close to 30%) is higher than the national average of **13.48 per 100,000 individuals (American Foundation for Suicide Prevention)**.



The next three questions were eliminated for no probative value for this project.

a. Self-injury behavior w/o suicidal attempt

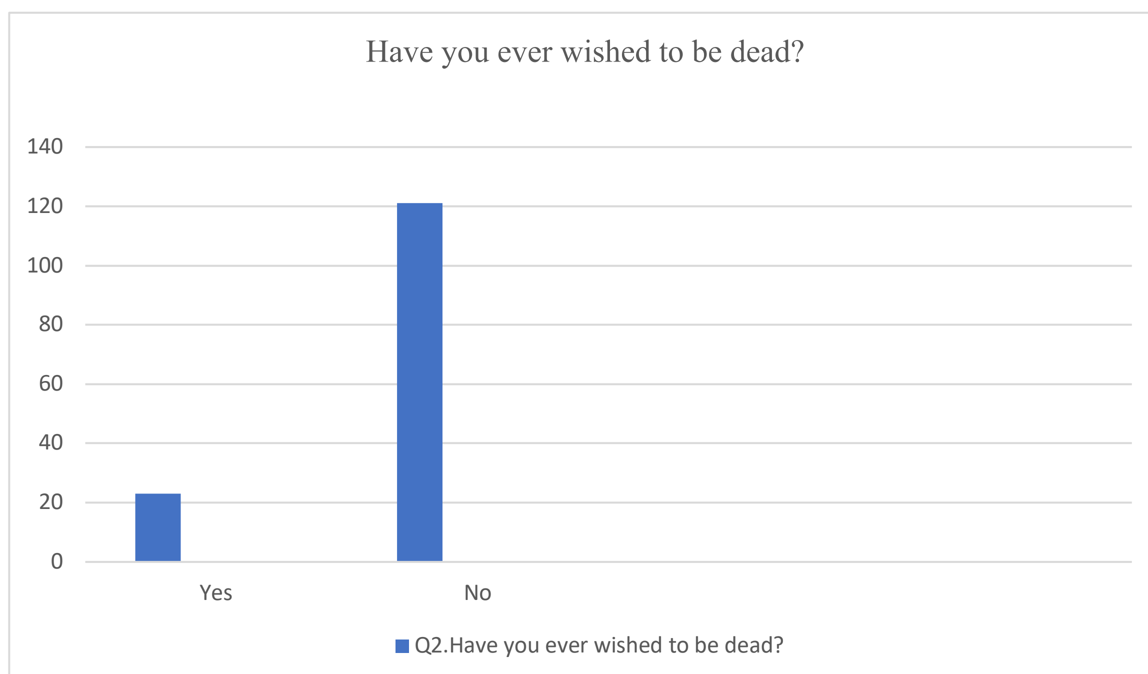
Out of the 144 qualifying participants, 44 answered “yes,” they have been self-injurious without a suicidal attempt, while 140 answered “no.”



The second category Suicide ideation (past month or lifetime)

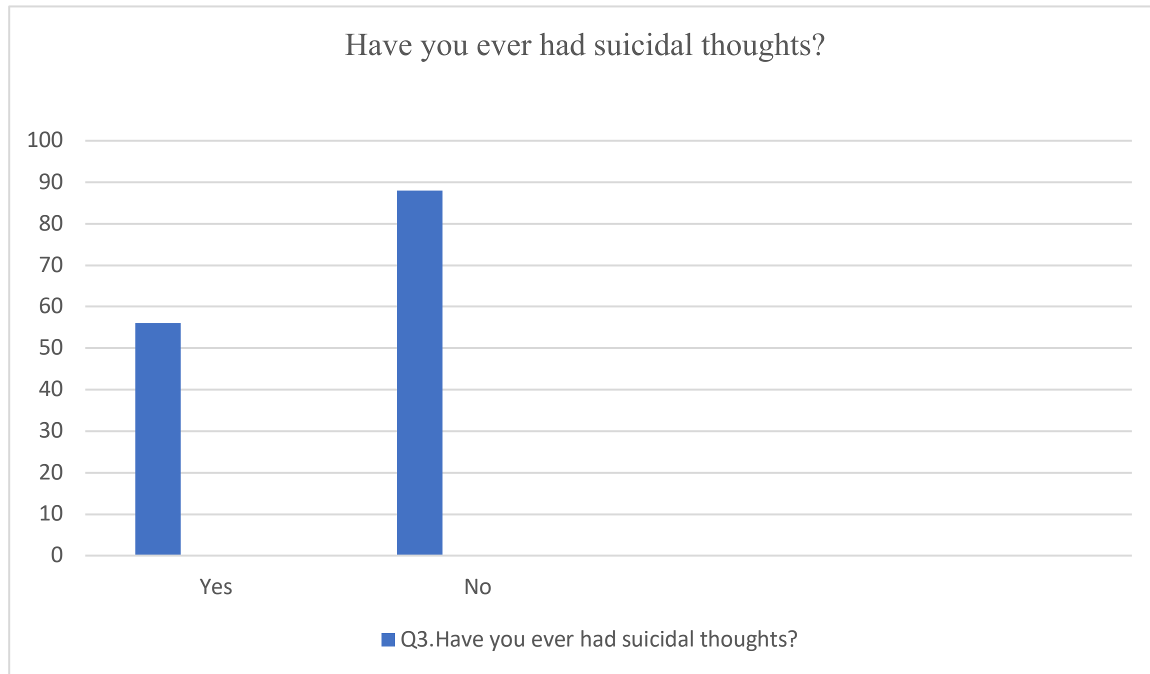
2. Have you ever wished to be dead?

Out of the 144 qualifying participants, 23 answered “yes,” they have wished to be dead, while 121 answered “no.”



3. Have you ever had suicidal thoughts?

Out of the 144 qualifying participants, 56 answered "yes," they have had suicidal thoughts either within the last month or within their lifetime, while 88 answered "no."

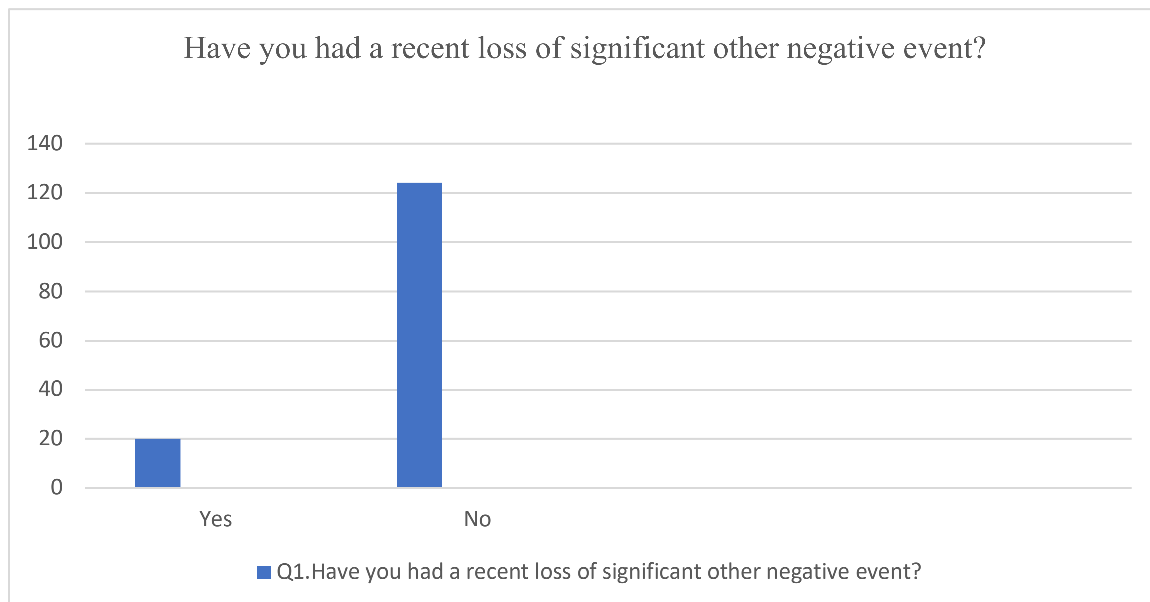


The next three questions were eliminated for no probative value for this project.

Activating Events (Recent)

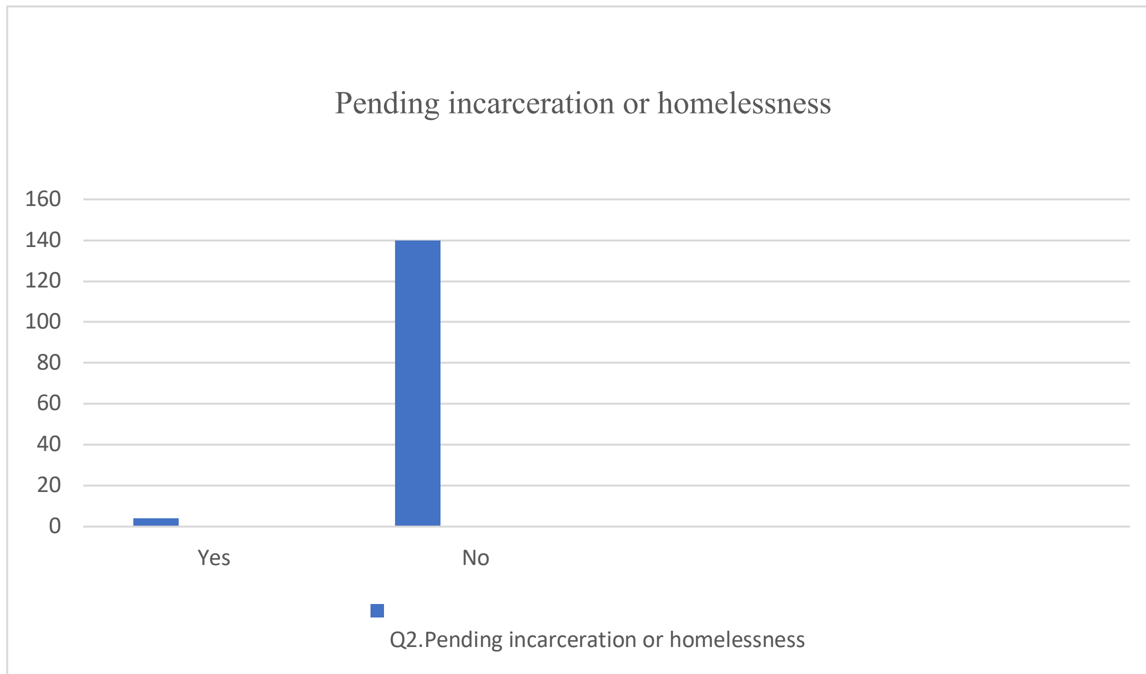
1. Have you had a recent loss of significant another negative event?

Out of the 144 qualifying participants, 20 answered "yes," they have had a recent significant loss or other negative event, while 124 answered "no." Most of these negative events were deaths due to either COVID-19 or war overseas.



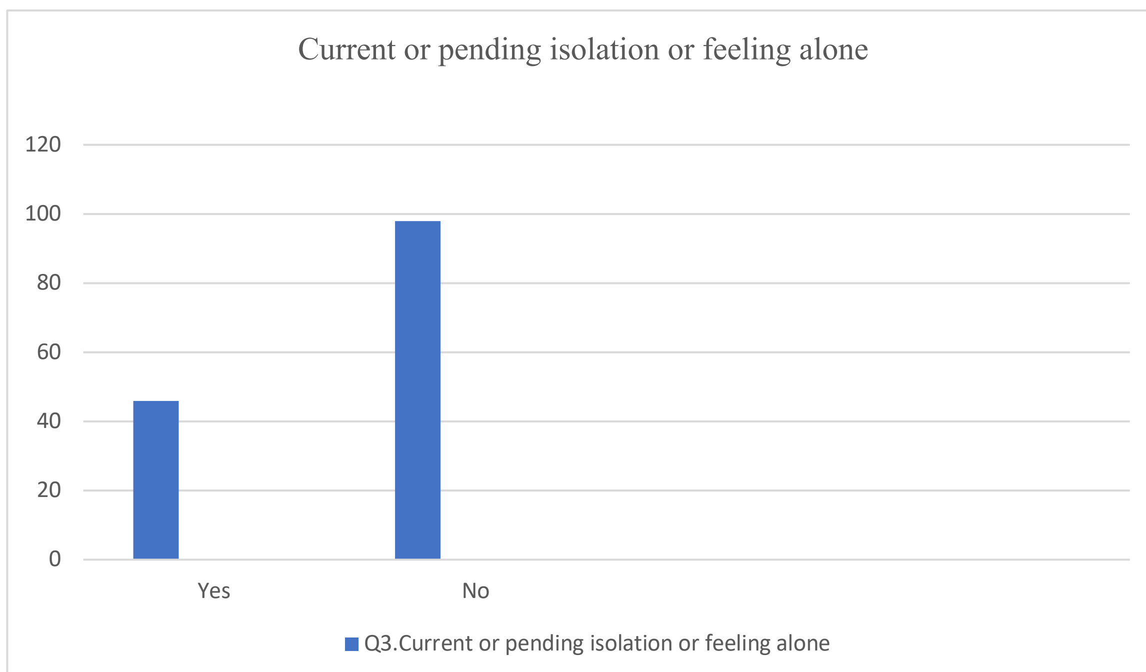
2. Pending incarceration or homelessness

Out of the 144 qualifying participants, 4 answered "yes," they have pending incarceration or homelessness, while 140 answered "no."



3. Current or pending isolation or feeling alone

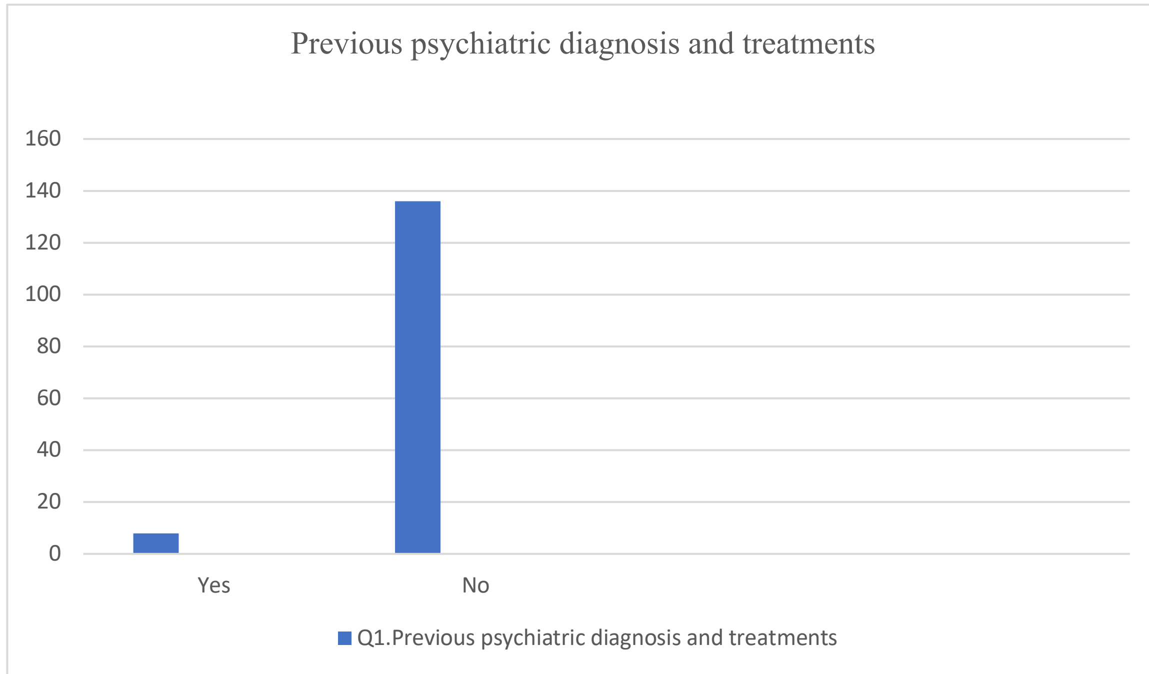
Out of the 144 qualifying participants, 46 answered "yes," they have feelings of pending isolation or feeling alone while 98 answered "no."



Treatment History

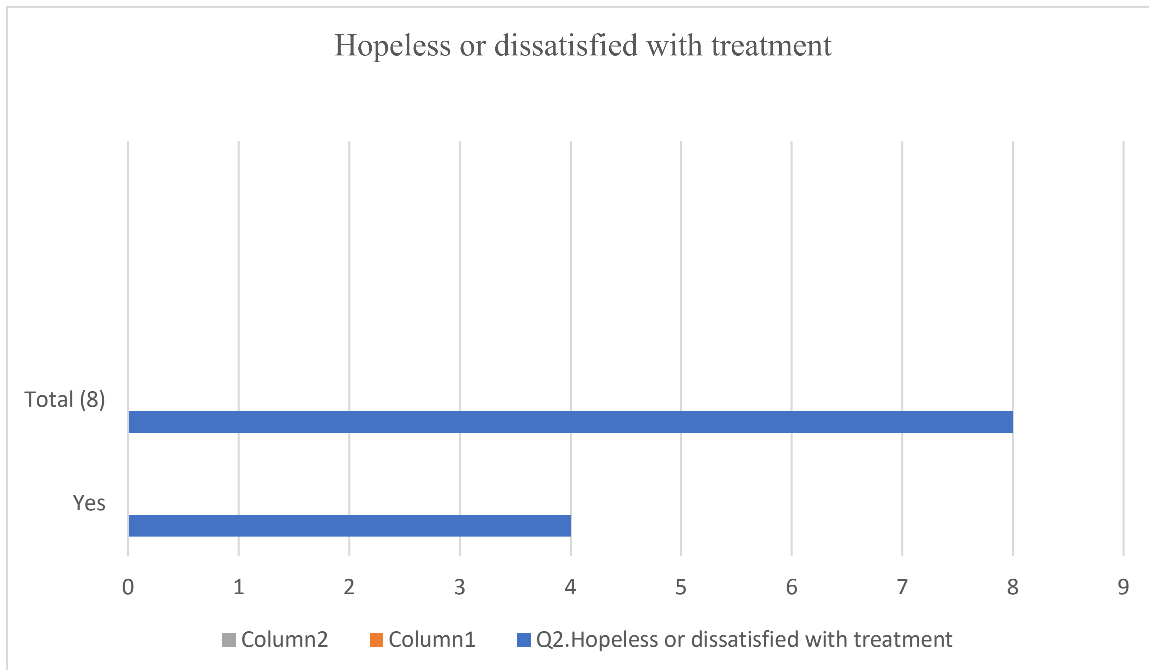
1. Previous psychiatric diagnosis and treatments

Out of the 144 qualifying participants, 8 answered "yes," they have a previous psychiatric diagnosis and treatment, while 136 answered "no."



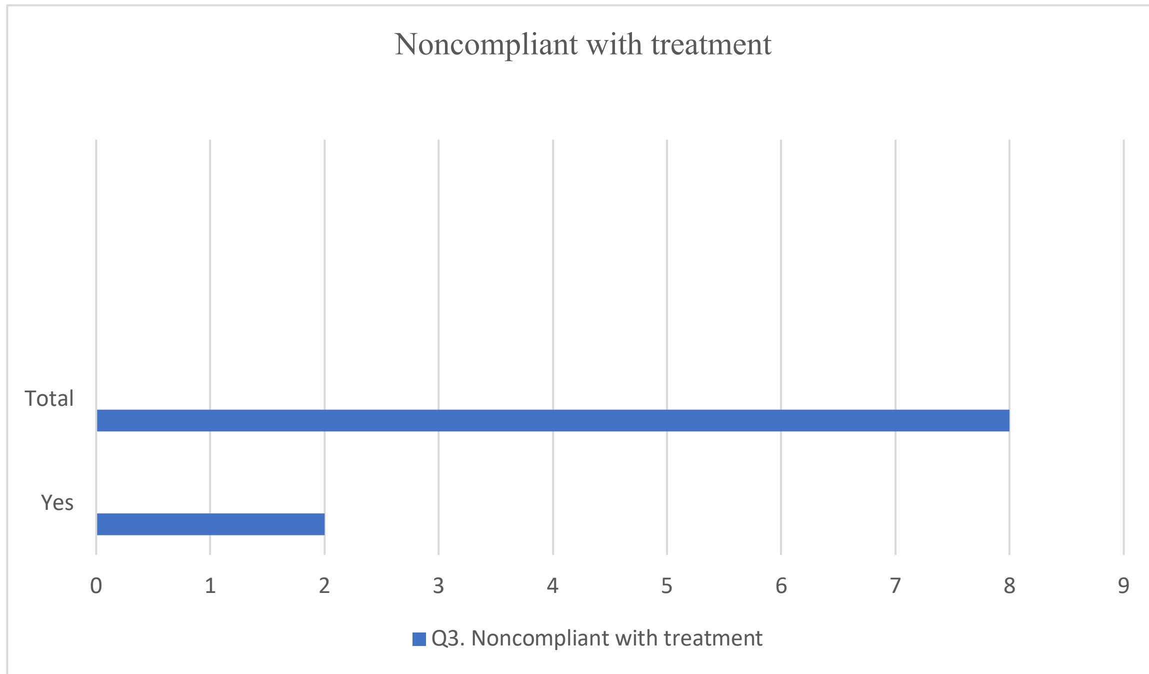
2. Hopeless or dissatisfied with treatment

Of the 8 that answered "yes" to Q1, 4 of the 8 were not satisfied with treatment



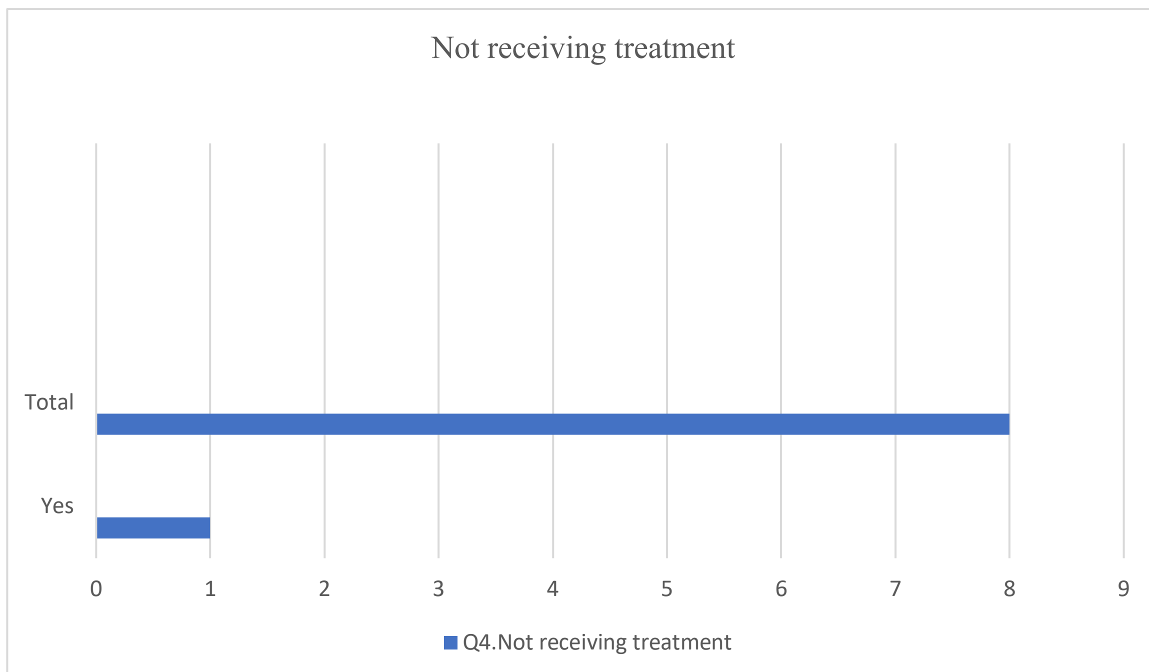
3. Noncompliant with treatment

Of the 8 that answered "yes" to Q1, 2 of the 8 were not satisfied with treatment



4. Not receiving treatment

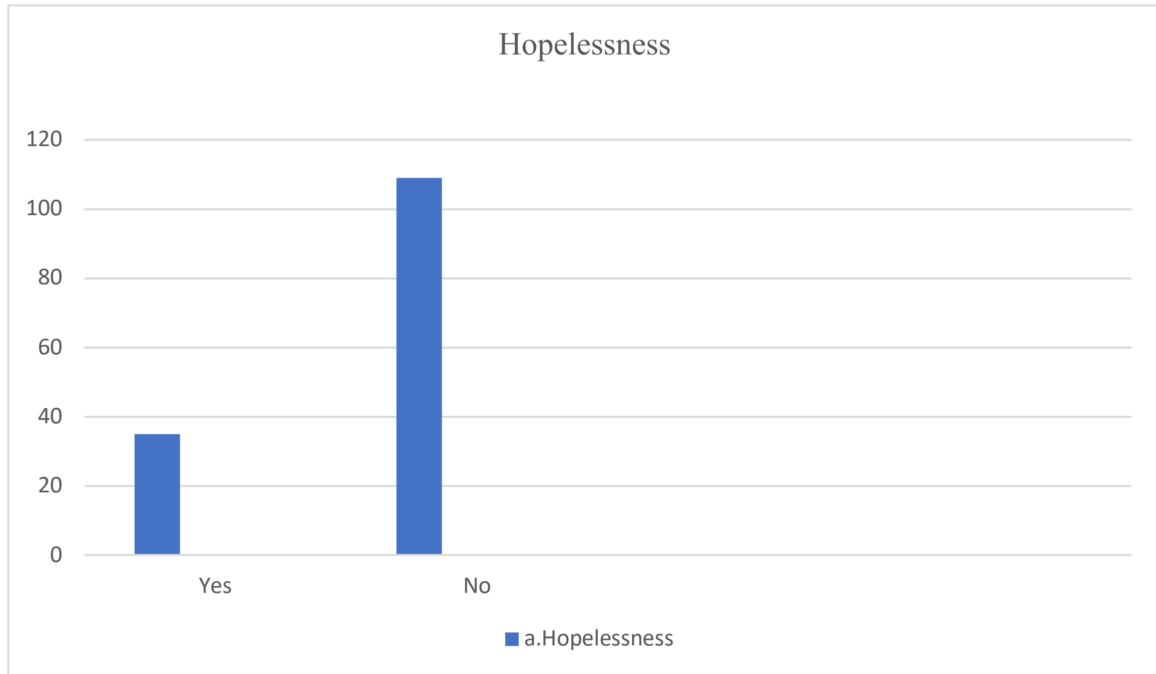
Of the 8 that answered "yes" to Q1, 1 of the 8 were not receiving treatment



Clinical Status (risk factors)

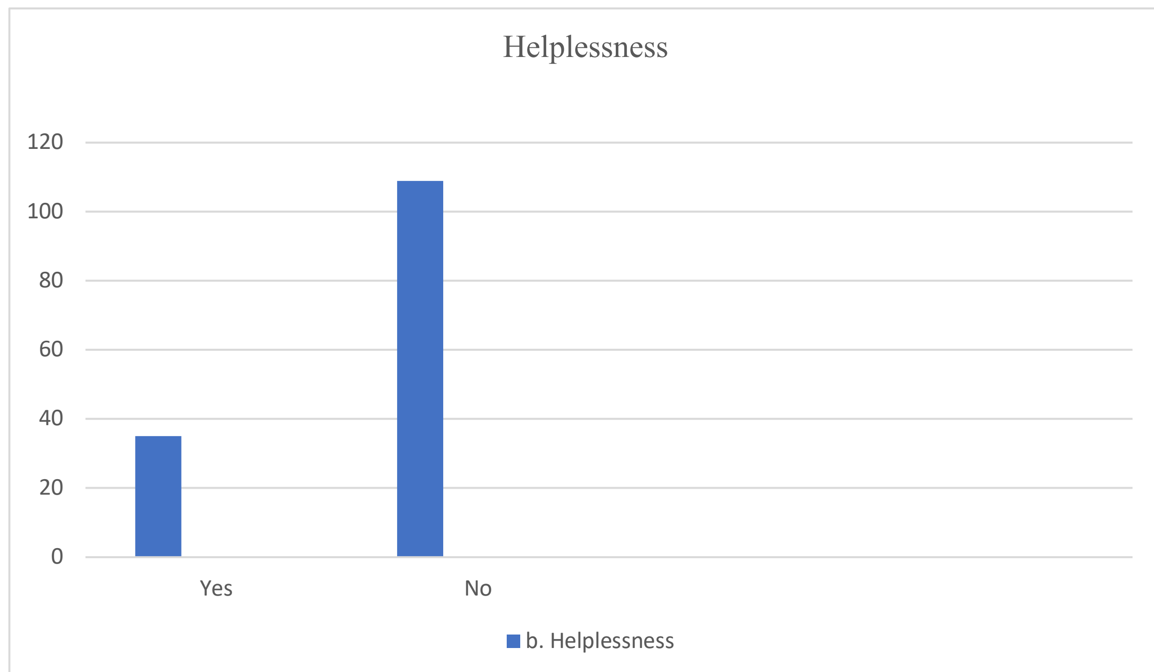
1. In the last month have you felt
    a. Hopelessness

Out of the 144 qualifying participants, 35 answered "yes," they felt hopelessness in the last month, while 109 answered "no" they have not.



b. Helplessness

Out of the 144 qualifying participants, 35 answered "yes," they felt helplessness in the last month, while 109 answered "no" they have not



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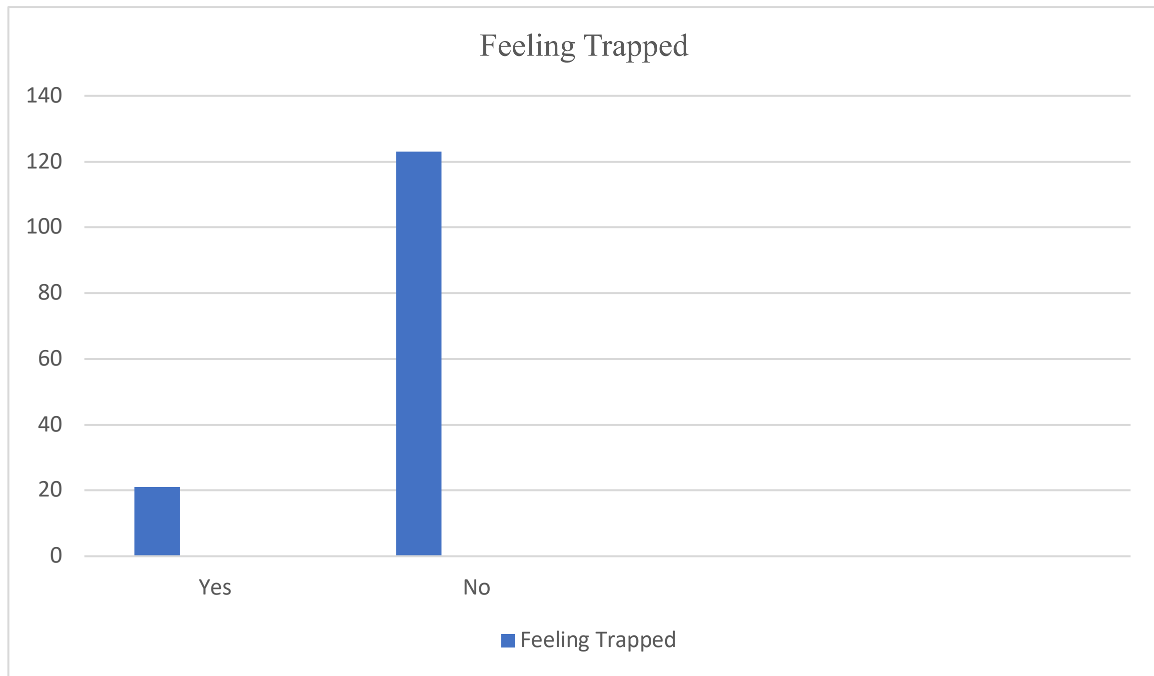
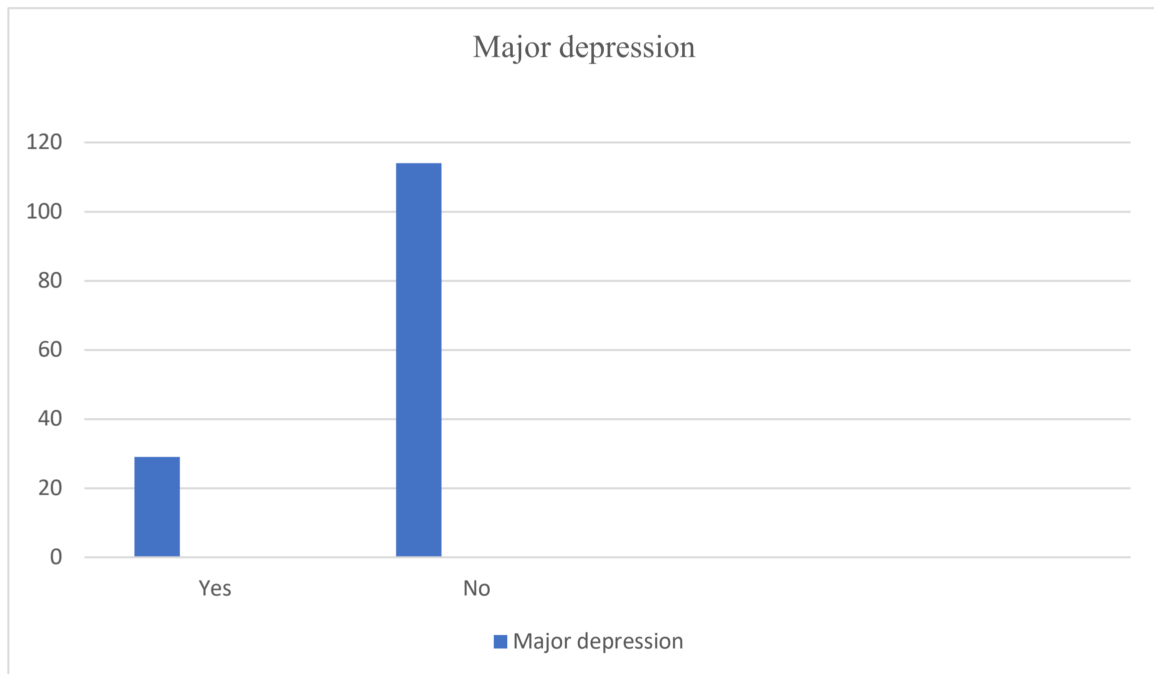
c. Feeling Trapped

Out of the 144 qualifying participants, 21 answered “yes,” they felt trapped in the last month, while 123 answered “no” they have not.



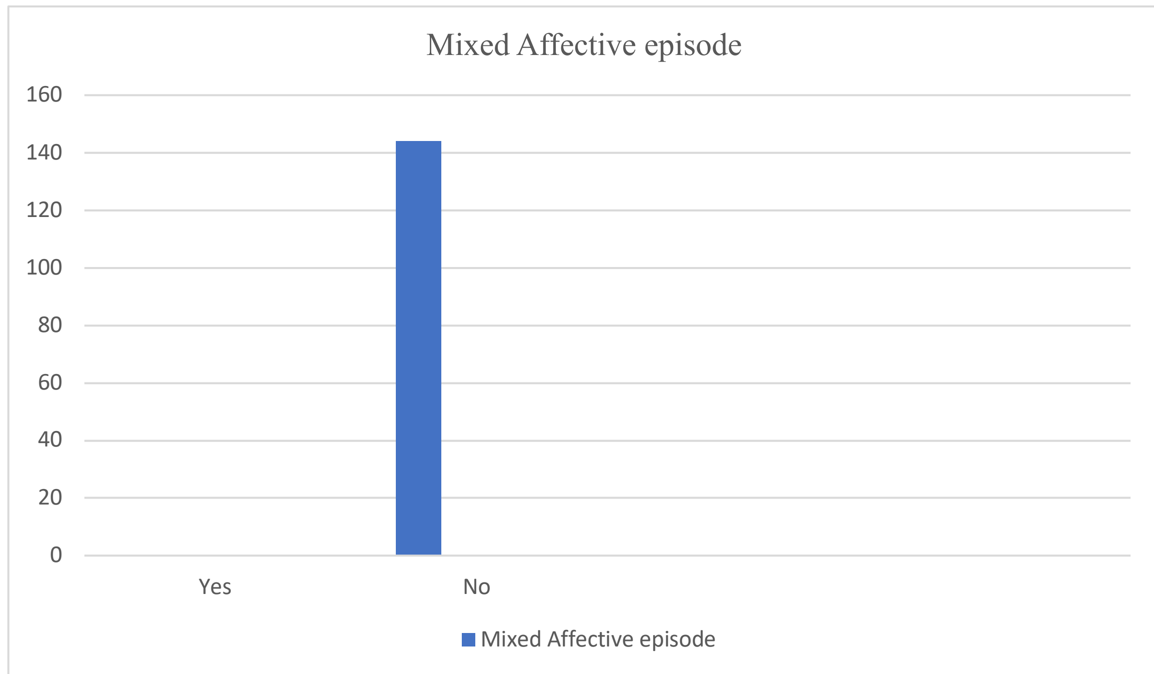
d. Major depression

Out of the 144 qualifying participants, 29 answered “yes,” they felt they had a major depression in the last month, while 114 answered “no” they have not.



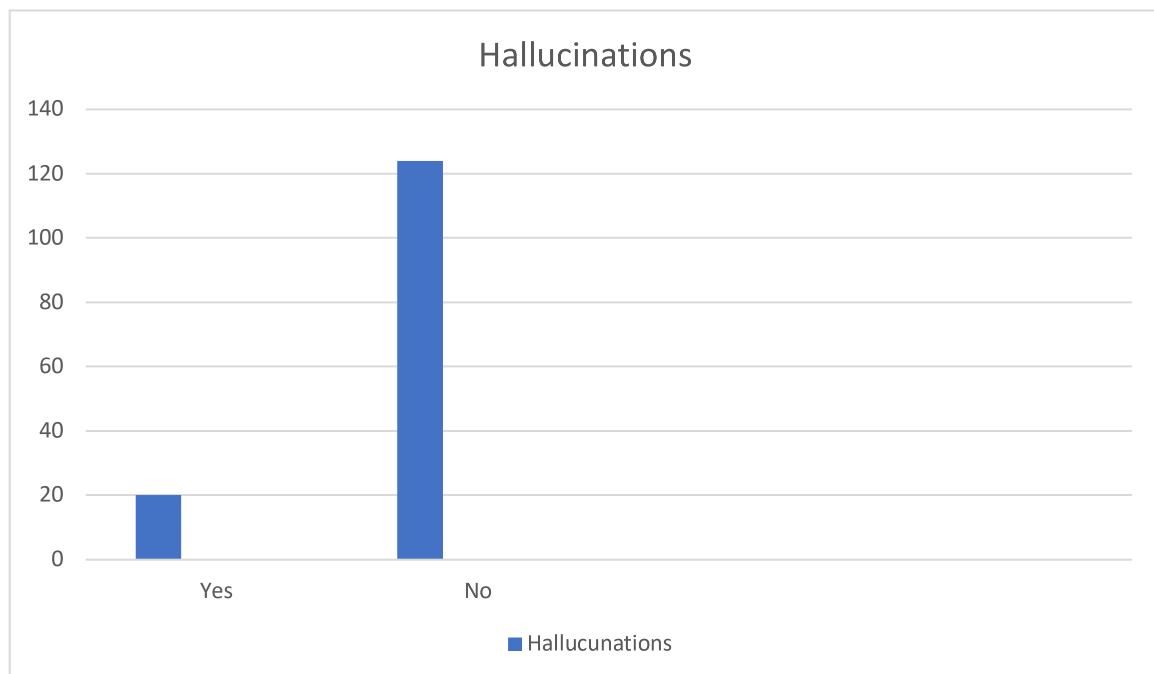
e. Mixed Affective episode

Out of the 144 qualifying participants, 0 answered "yes," in the last month, while 144 answered "no" they have not. This is not something the lay person understands and not helpful to our goal.



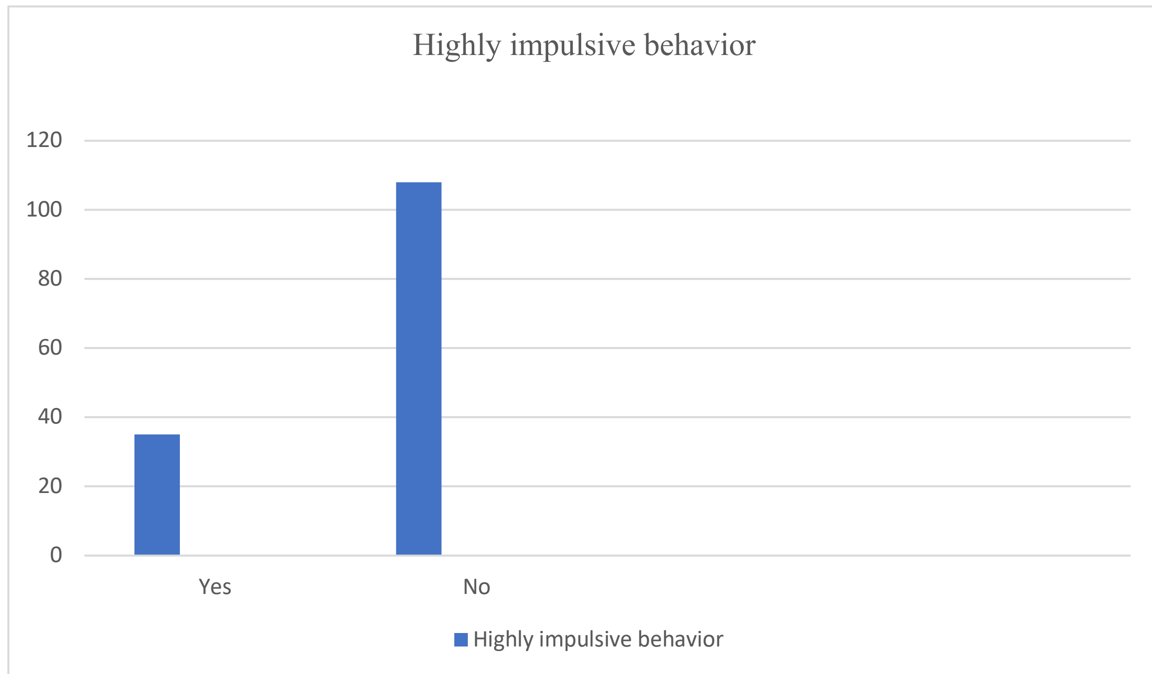
f. Hallucinations

Out of the 144 qualifying participants, 20 answered "yes," they felt they had a hallucination in the last month, while 124 answered "no" they have not.



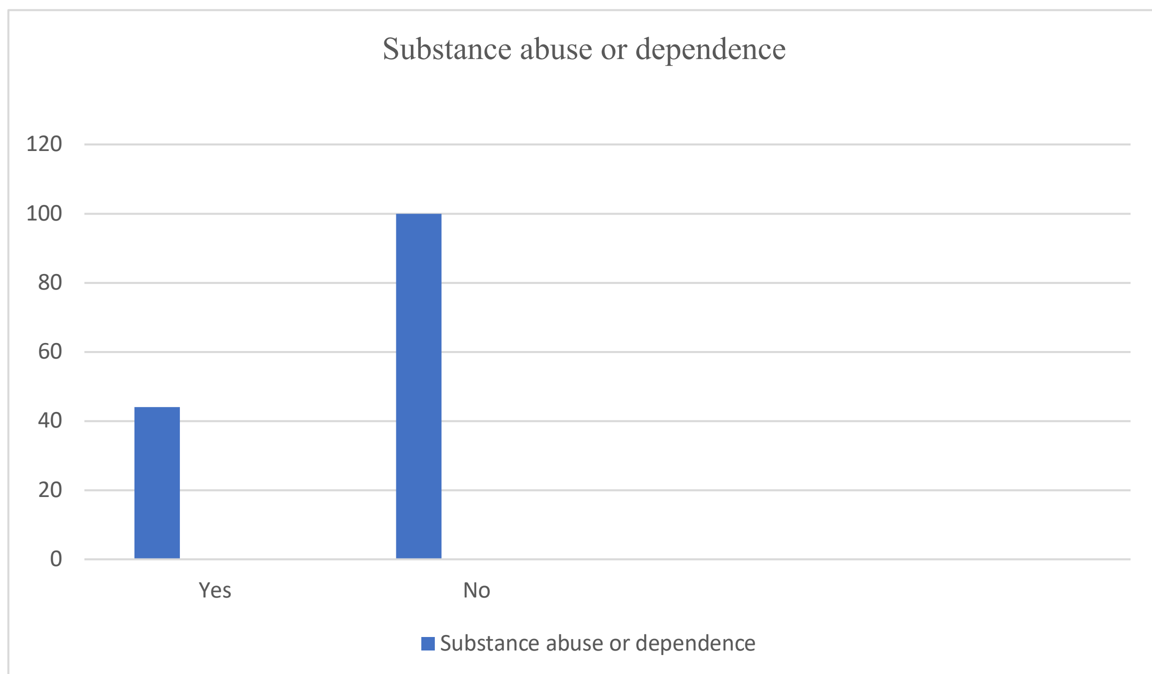
g. Highly impulsive behavior

Out of the 144 qualifying participants, 35 answered "yes," they felt they had highly impulsive behavior in the last month, while 108 answered "no" they have not.



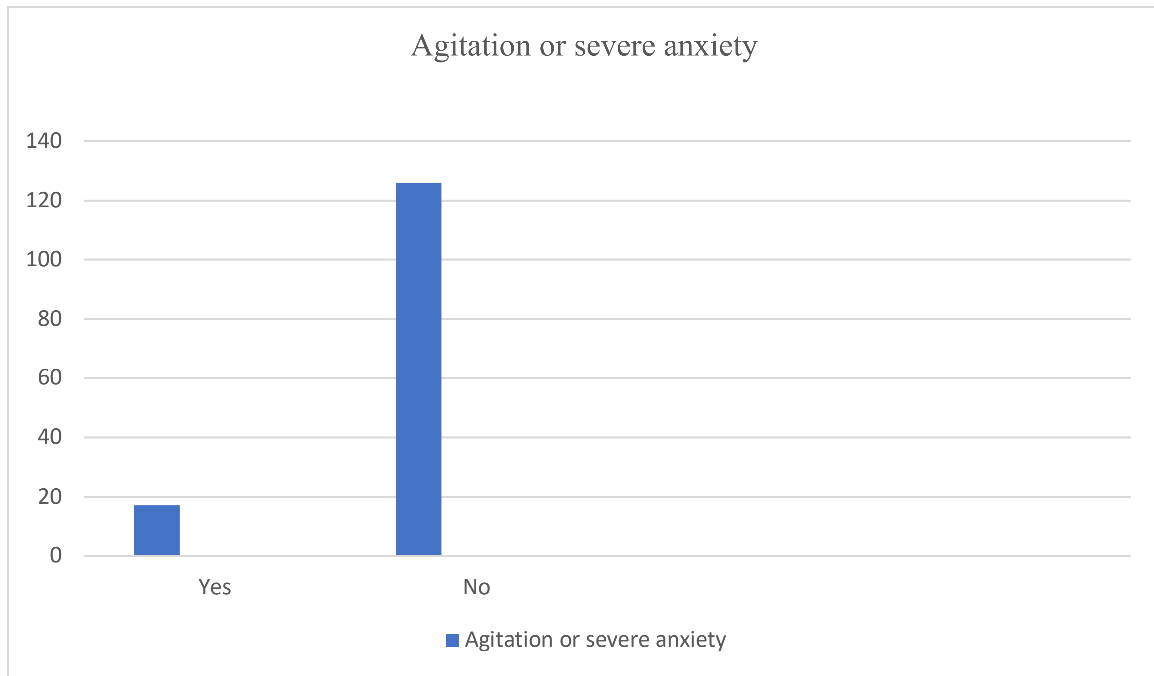
h. Substance abuse or dependence

Out of the 144 qualifying participants, 44 answered "yes," they felt they had an issue with substance abuse or dependence in the last month, while 100 answered "no" they have not.



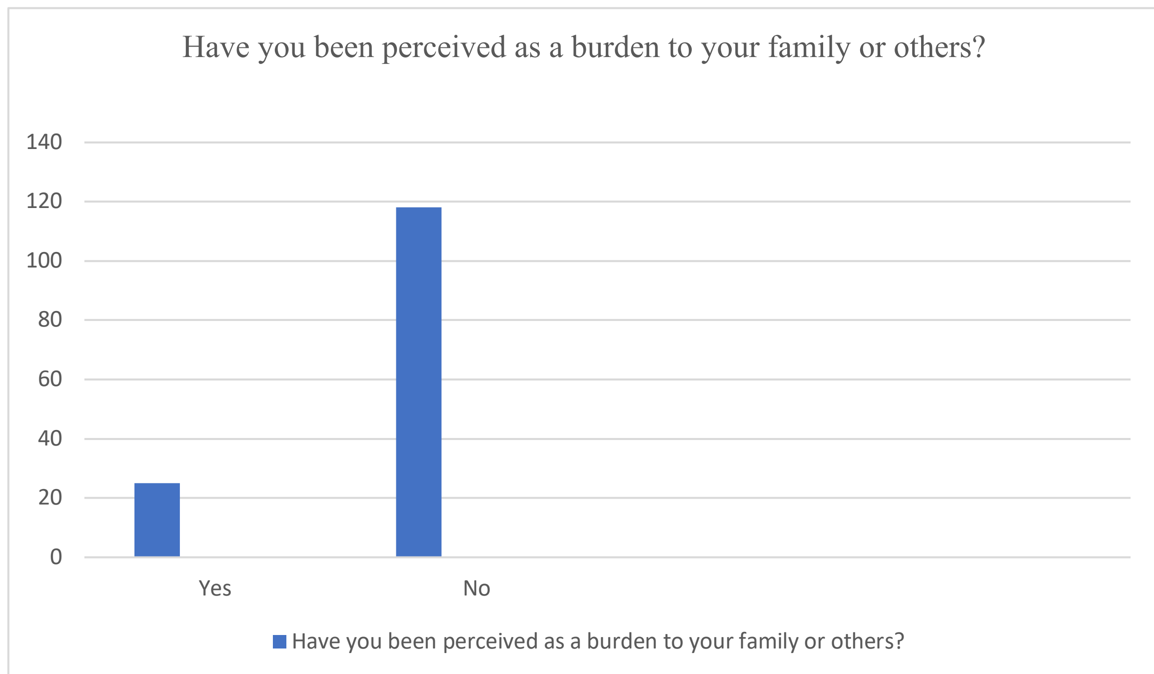
i. Agitation or severe anxiety

Out of the 144 qualifying participants, 17 answered "yes," they felt they had a agitation or severe anxiety in the last month, while 126 answered "no" they have not.



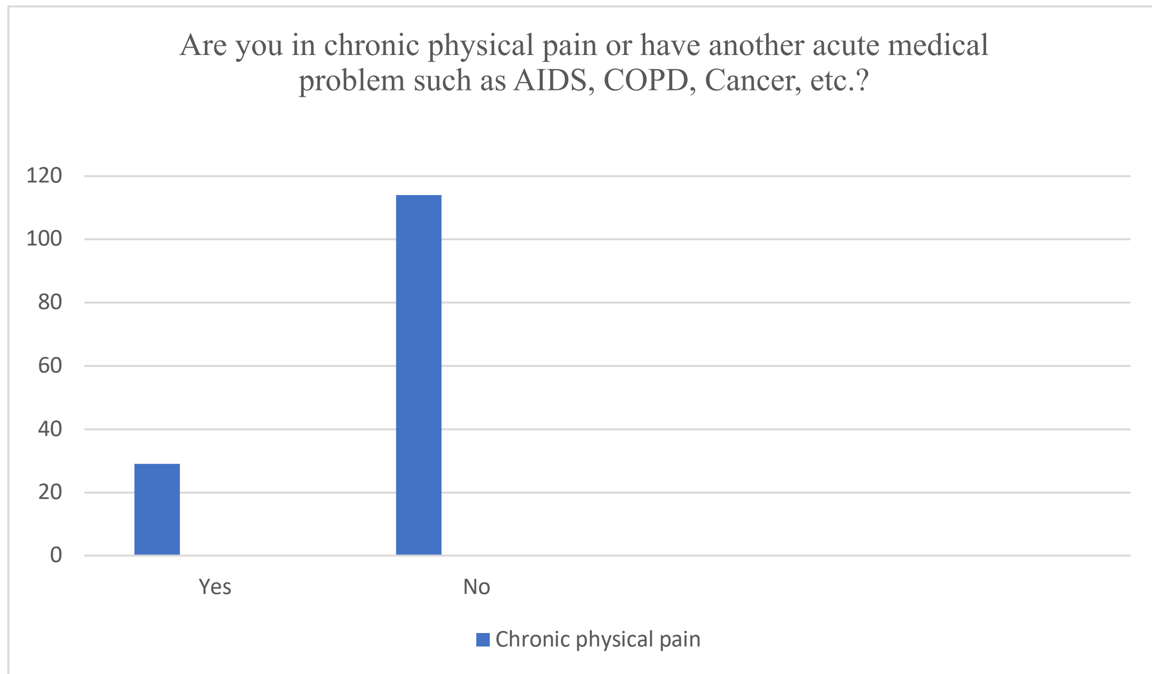
j. Have you been perceived as a burden to your family or others?

Out of the 144 qualifying participants, 25 answered "yes," they felt they have been perceived as a burden to your family or others in the last month, while 118 answered "no" they have not.



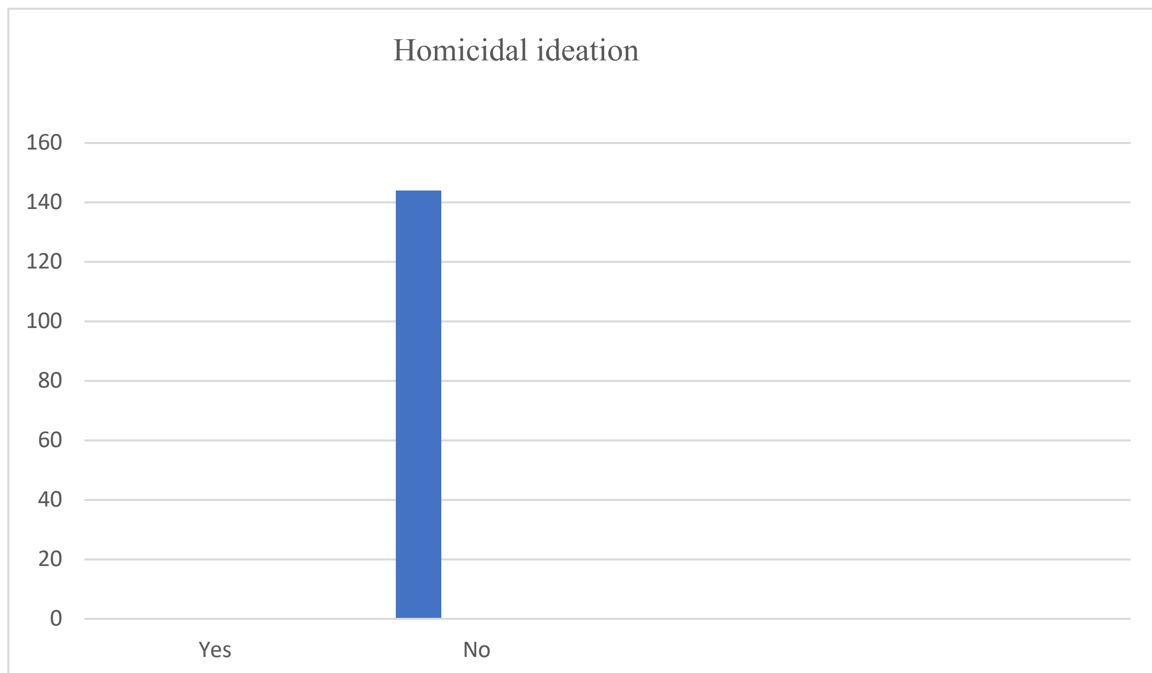
k. Are you in chronic physical pain or have another acute medical problem such as AIDS, COPD, Cancer, etc.?

Out of the 144 qualifying participants, 29 answered “yes,” they have chronic physical pain or have another acute medical problem while 114 answered “no” they have not.



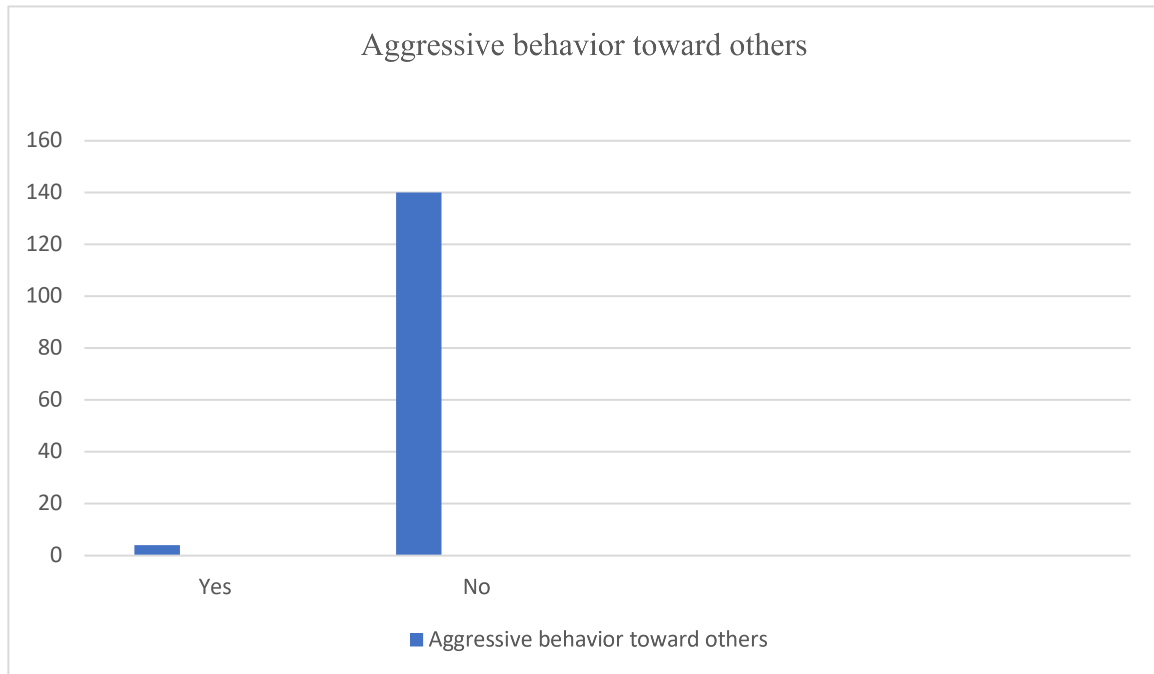
l. Homicidal ideation

Out of the 144 qualifying participants, 0 answered “yes,” and 144 stated they do not have homicidal ideation.



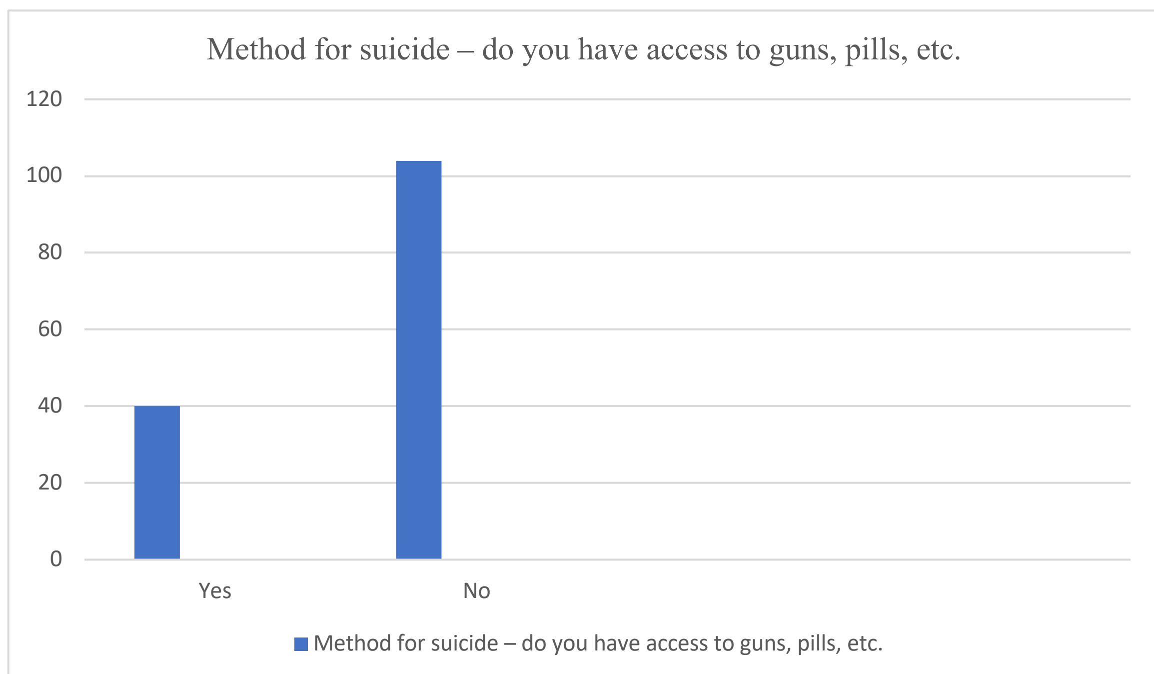
m. Aggressive behavior toward others

Out of the 144 qualifying participants, 4 answered "yes," they felt they have had aggressive behavior toward others in the last month, while 140 answered "no" they have not.



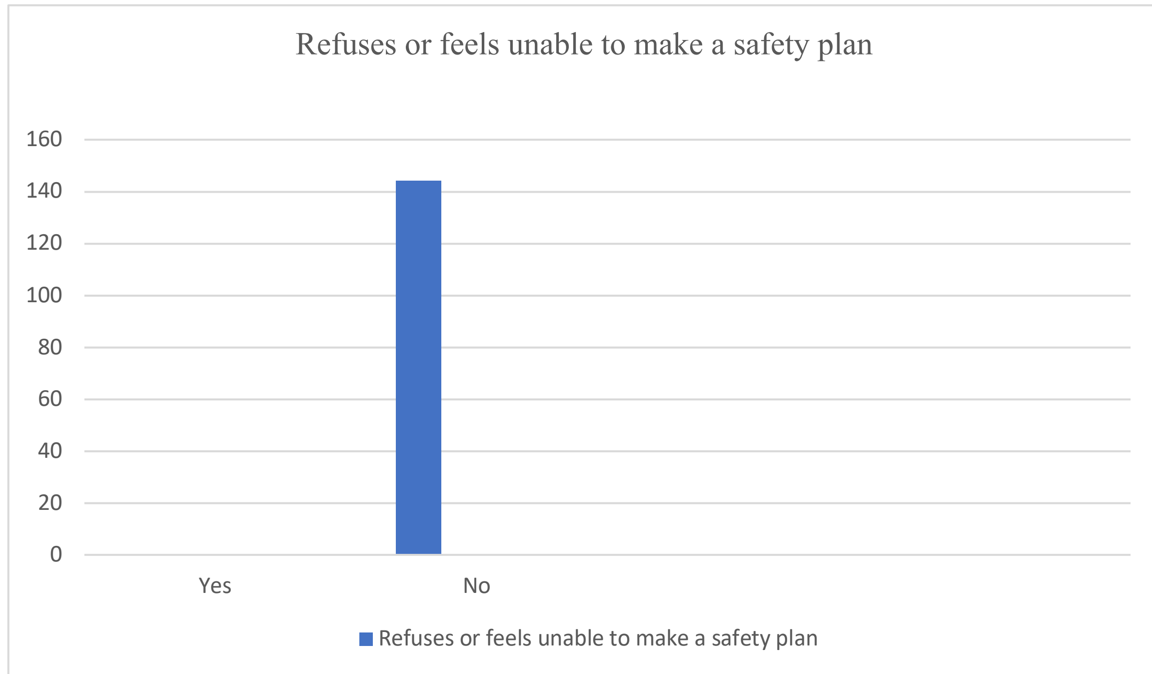
n. Method for suicide – do you have access to guns, pills, etc.

Out of the 144 qualifying participants, 40 answered "yes," they felt they have access to means to complete suicide, while 104 answered "no" they do not.



o. Refuses or feels unable to make a safety plan

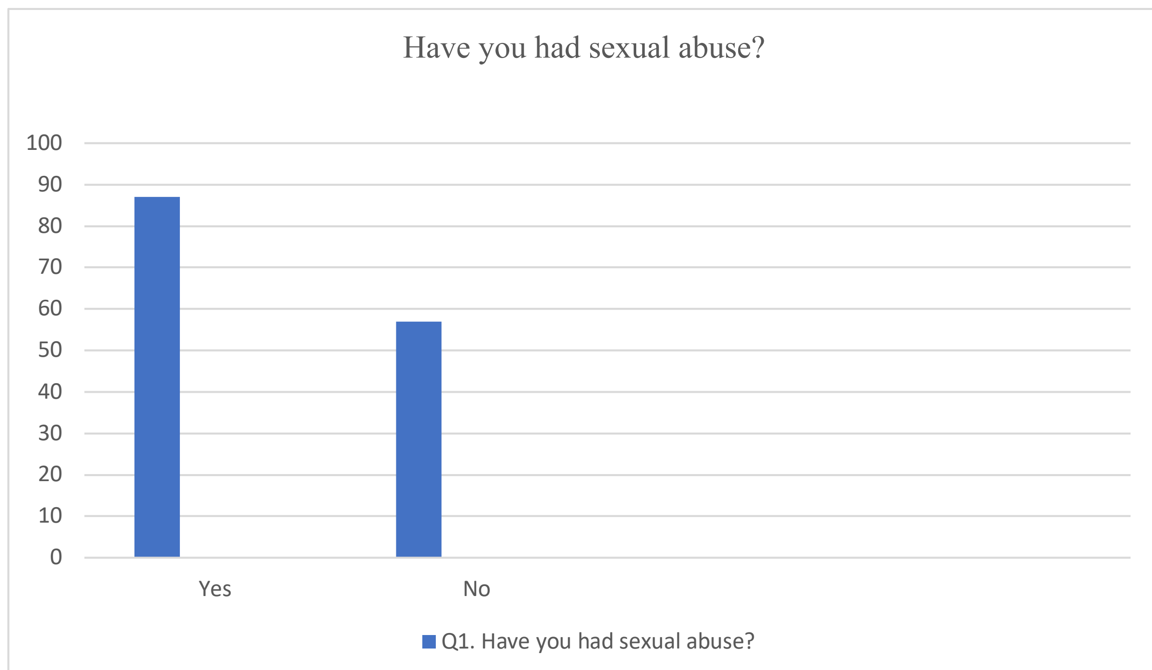
Out of the 144 qualifying participants, 0 answered “yes,” refuse to have a safety plan, while 144 answered “no.”



Within your lifetime

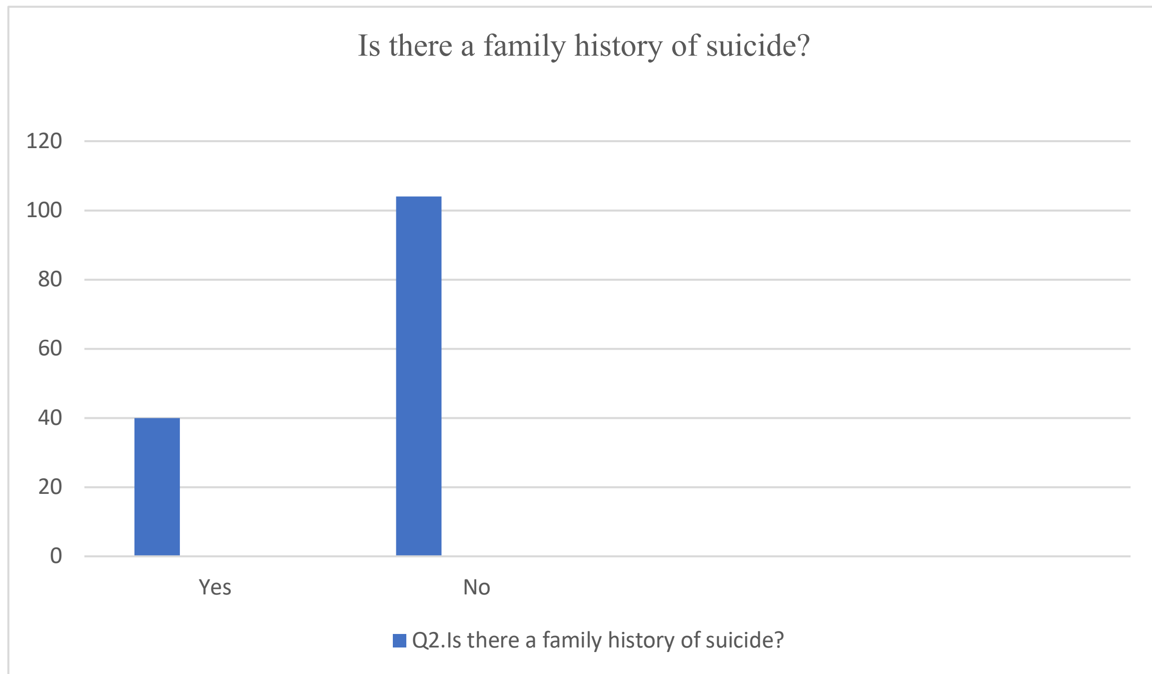
1. Have you had sexual abuse?

Out of the 144 qualifying participants, 87 answered “yes,” they have had sexual abuse within their lifetime, while 57 answered “no.”



2. Is there a family history of suicide?

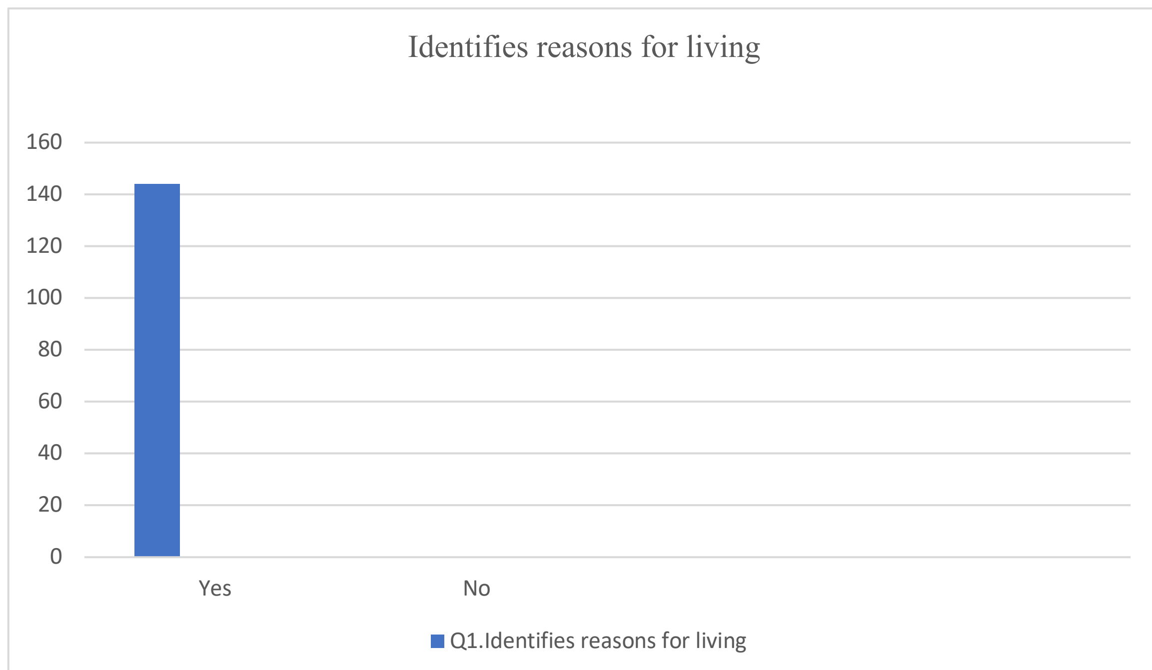
Out of the 144 qualifying participants, 40 answered "yes," there was a history of suicide in their family history within their lifetime, while 104 answered "no." Participants seemed to include not only their nuclear family but also extended level one, e.g., uncles, aunts, cousins, grandparents, in this answer.



Protective Factors

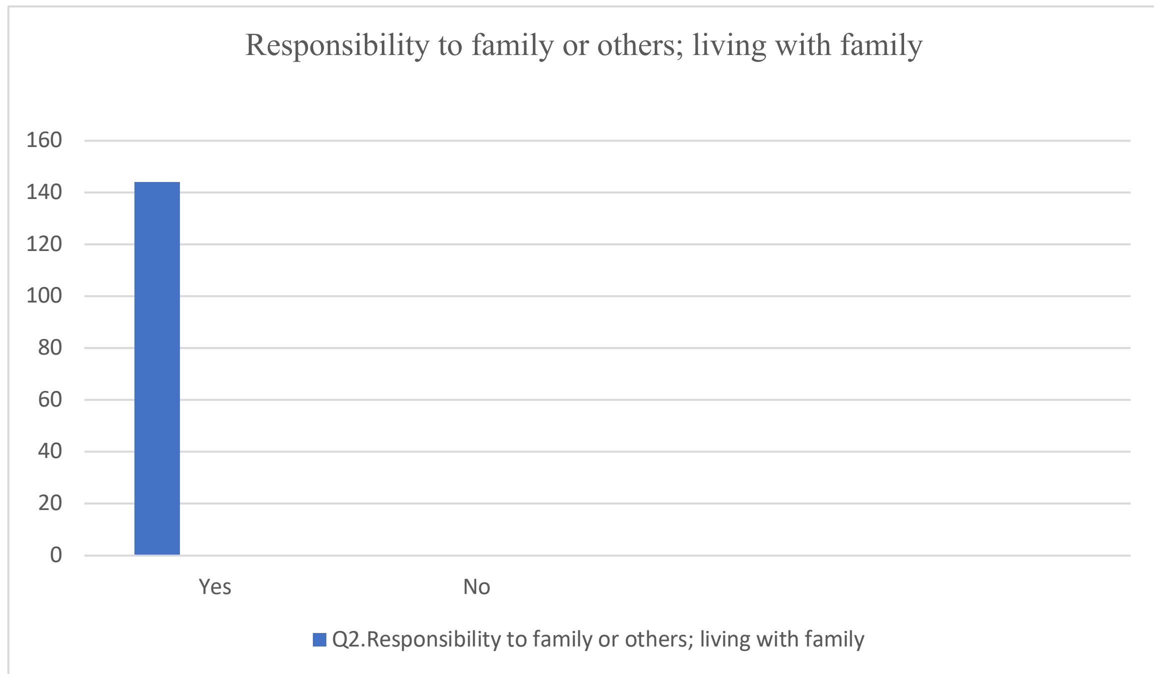
1. Identifies reasons for living

Out of the 144 qualifying participants, 144 answered "yes," they identify reasons for living, while 0 answered "no."



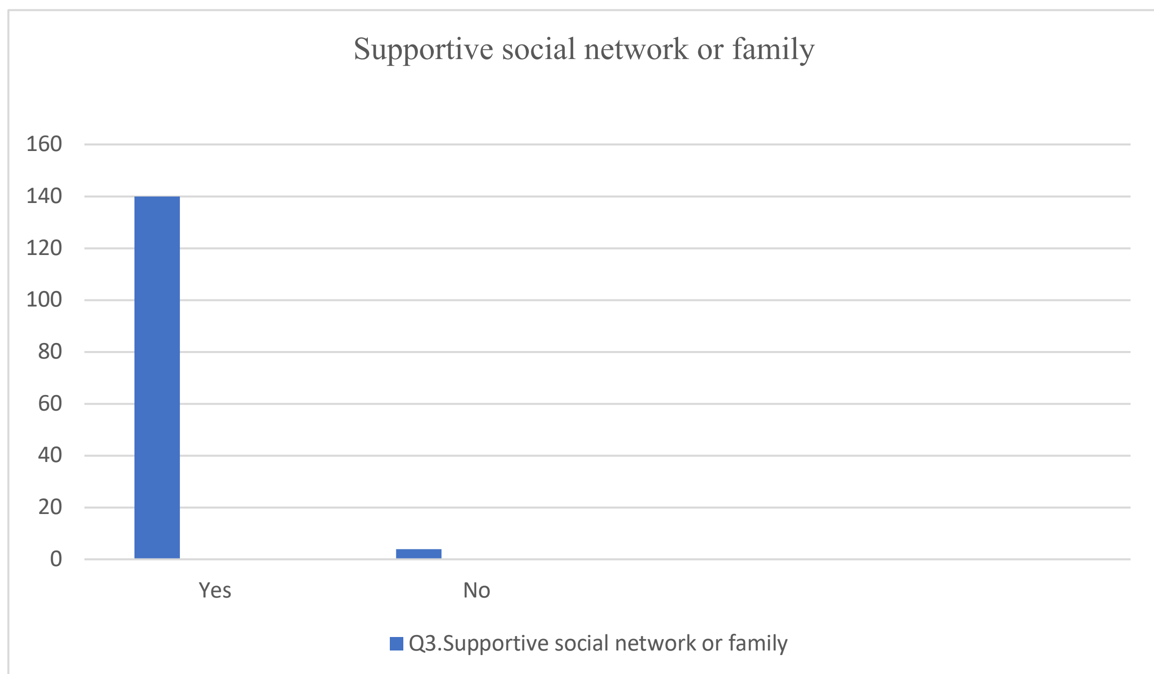
2. Responsibility to family or others; living with family

Out of the 144 qualifying participants, 144 answered “yes,” feel a responsibility to family and may or may not be also living with family, while 0 answered “no.”



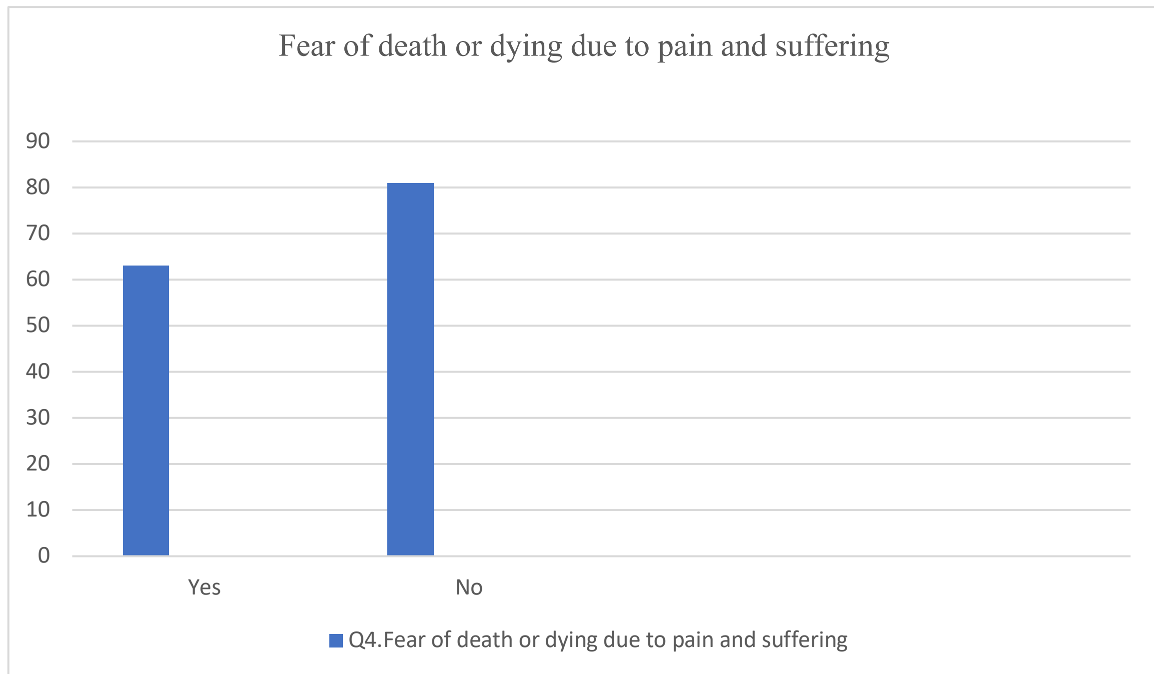
3. Supportive social network or family

Out of the 144 qualifying participants, 140 answered “yes,” they have a supportive social network of family, while 4 answered “no.”



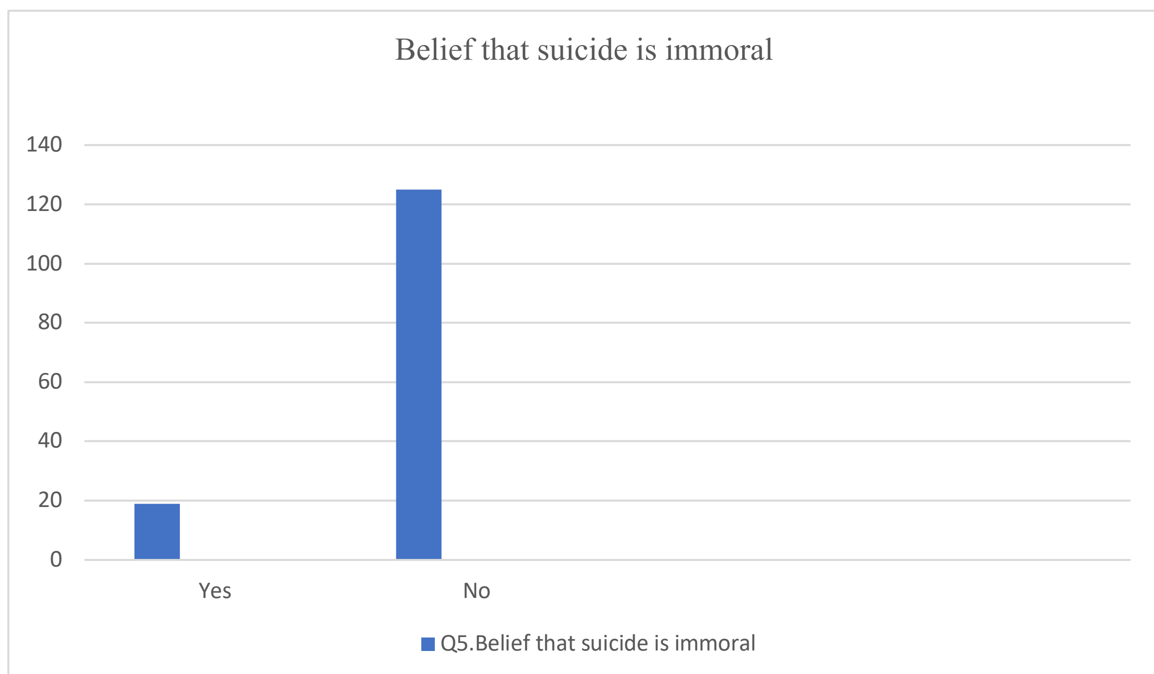
4. Fear of death or dying due to pain and suffering

Out of the 144 qualifying participants, 63 answered "yes," they have a fear of death due to pain and suffering, while 81 answered "no."



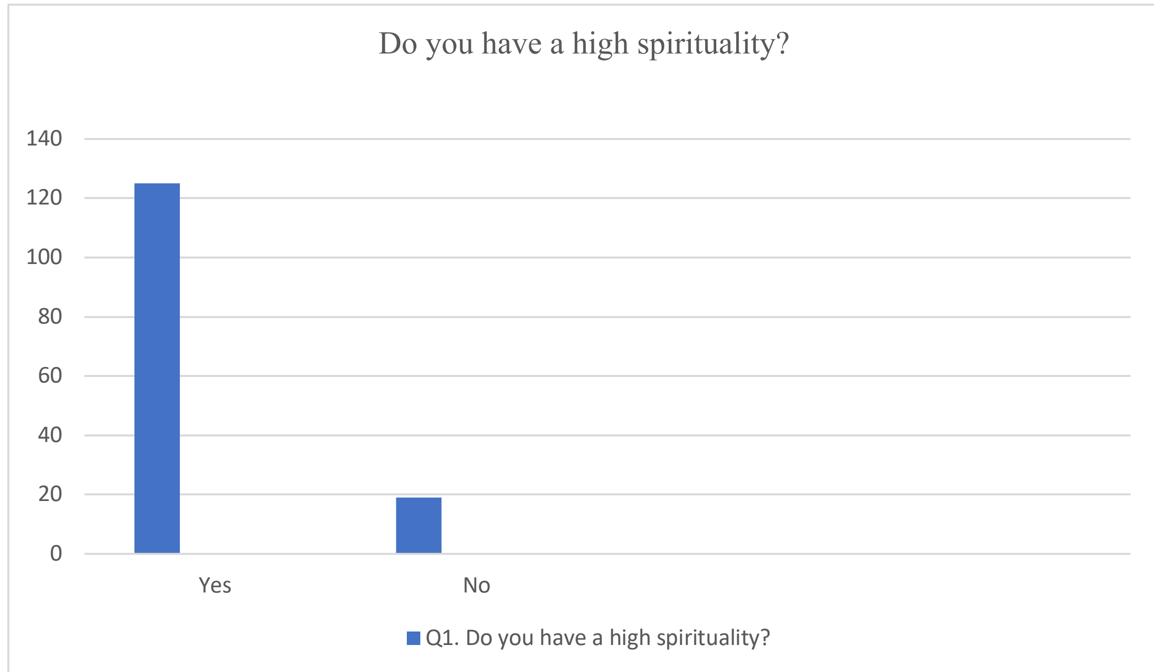
5. Belief that suicide is immoral

Out of the 144 qualifying participants, 19 answered "yes," they believe that suicide is immoral, while 125 answered "no."



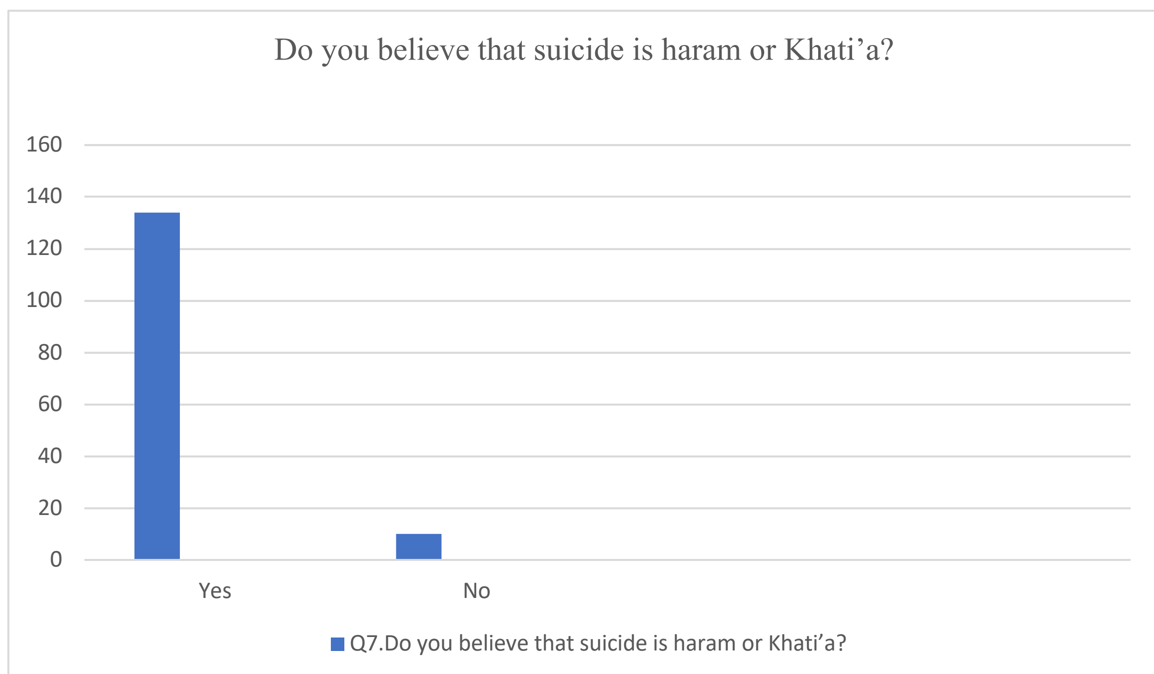
6. Do you have a high spirituality?

Out of the 144 qualifying participants, 125 answered "yes," they have a high spirituality, while 19 answered "no."



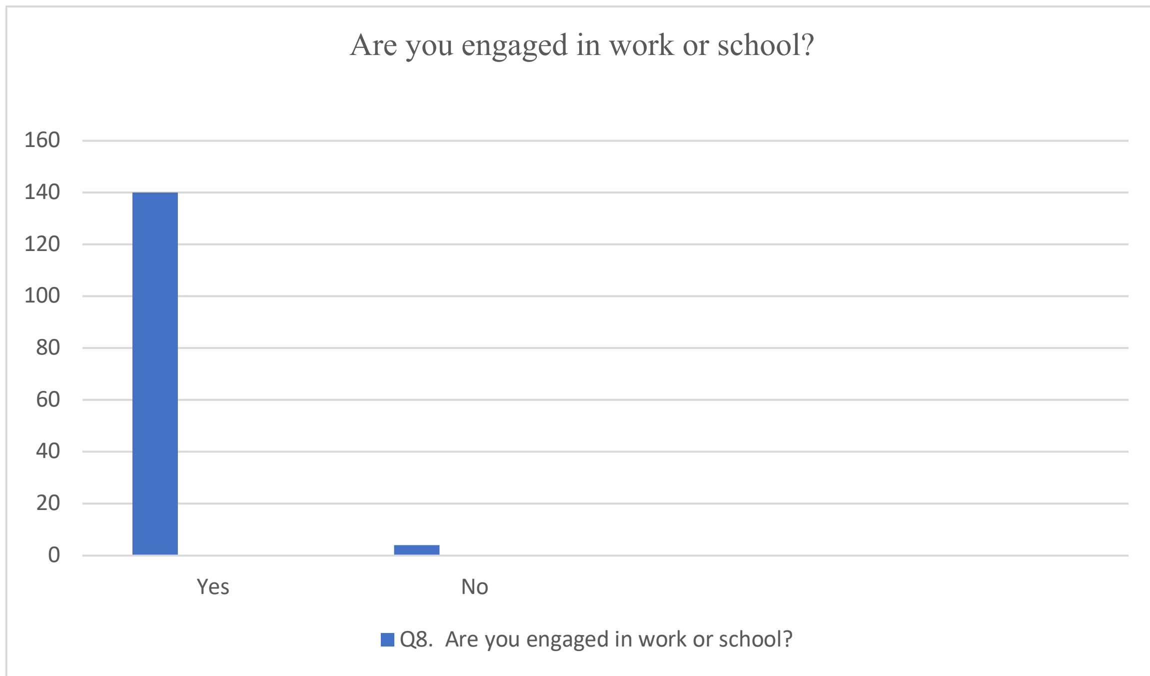
7. Do you believe that suicide is haram or Khati'a?

Out of the 144 qualifying participants, 134 answered "yes," they believe suicide is haram or khati'a, while 10 answered "no."



8. Are you engaged in work or school?

Out of the 144 qualifying participants, 140 answered “yes,” they are engaged in either or both work or school, while 4 answered “no.”



The rest of the C-SSRS assessment questions were not used for this report. They are too personal and do not assist in the goals of this project.

There were two scales (PCL-5 and TSQ) used to measure aspects of acute stress and post-traumatic stress. While there were some individuals with clear PTSD symptomology, there was not a statistically significant group to present utilizing these scales. One of the reasons may be that the first question asks if you have had a traumatic event within the last month. Most did not feel that applied to them. The use of the word “trauma” is so overused that people seem to not understand what it is. Additionally, there is a cultural perspective that seems to suggest that what the American dominant culture would categorize as “stress” or “trauma” for some and especially those who identify more with their country or culture of origin than American culture have very different understandings of these terms, schemas and how to process what we have come to know in the dominant culture to be understood as “trauma.” Interestingly, in interviewing these participants many of them clinically presented with symptoms of acute stress or post-traumatic stress, however, if we meet people where they are, one cannot say they see it that way.

Discussion

There are many interesting results with this project. There are many recommendations for furthering mental wellness that LACDMH can take forward in future projects. The other pieces of information that provide a deeper look at needs are the added scale questions asked beyond the original open-ended questions. The questions surrounding traumas, self-injury, suicide, sexual abuse and substance use all score higher than any national averages. However, this is a small “n,” and geographical sample, so there is not a huge amount of validity or reliability to compare a small sample to a national average. However, it certainly does suggest that a closer look is needed at this population to discern if there need to be more services and outreach provided toward them as an “at-risk” population.

There is no doubt that the geopolitical and socio-political realities that have been permitted to go unchecked by the larger external community has had a physiological, psychological, social, and even at times spiritual affect on this underserved population. This project should elevate the need for wellness services for this group of underserved Los Angeles constituents. As a committee and branch of LACDMH, we should avoid placing the burden on this population to fight for services and rather proactively move in such a manner that the

services are being offered more frequently, culturally appropriately, and linguistically to have a positive impact on the mental well-being for this population.

Conclusion

This project is a beacon on how to proceed forth in how to best serve the Arabic speaking population of LA County. With many suggestions on how to address the mental health needs within this underserved population, there are ideas that can be explored and implemented for years to come. This project also had valuable unintended consequences of promoting current LACDMH services and recruitment of volunteers from this underserved community.

This isn't a project that needs to be repeated at this time. However, many of the lessons learned from this project should be considered for continued action. Among these considerations should be continued MHSA funded capacity building and stigma reducing projects, internal trainings in the DMH on treating the Arabic speaking populations for increased cultural competency and increased evidenced that this population's words have been heard and they can feel seen. Additionally, recruitment and retention of a diverse workforce that includes more Arabic speaking therapists need to be placed in all service areas, but also more often in service areas two, three, four and five. This report confirms that there have been incorrect perceptions about where Arabs and Arabic speaking live in LA County. In fact, they reside in every service area. There are clear opportunities to address marketing and promotion, access to services, volunteer participation and community engagement, and clearly visible representation.

Appendices

Appendix A

Los Angeles County Department of Mental Health
Strategic Communications Division
Underserved Cultural Communities (UsCC)

Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Listening Sessions
Deliverables

Dr. XXXXXXXXXX

June 16, 2021

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Listening Session Guidelines

While surveys and other research methods can be helpful in capturing the reactions and thoughts of people, they often do not accurately capture what people are thinking, feeling or want to share either due to the limitation of closed statements or limited space within the forms and tools used to capture responses, limited time, or simply because people are not fully aware of what they think or feel and/or are able or not to synthesize those thoughts or feelings in a timely manner. Listening sessions allow for people to express themselves while others can observe and capture the thoughts, feelings and verbal and non-verbal expressions.

Having listening sessions in Arabic speaking populations is more culturally endearing than a cold sterile survey. Most Arab cultures believe that most problems can be solved over a cup of tea or coffee. By sitting with Arab people and listening to them, we can learn a better and more culturally appropriate and sensitive path forward in LA county toward serving the mental wellness of the Arabic speaking community. As such, it will be important to highlight particular guidelines to the format of the online listening sessions. This section will discuss these.

I. **Defining the listening sessions**
   a. In this project the listening sessions will consist to two types: a leadership group and eight subsequent community listening sessions. A listening session is not a debate, group therapy, an opportunity to promote individual professional concerns, problem-solving nor conflict resolution.

A. Leadership Listening Session
   a. This listening session is intended to invite leaders within the Arabic speaking community within LA county for the purpose of sharing their insights, views, thoughts and feelings on the services currently provided to the Arabic speaking community, gaps in mental health service delivery, challenges in accessing services, stigma related to mental health for Arabic speaking individuals/ and heritage members of the community, ways to improve mental health service delivery, and suggestions for how to conduct outreach to people who are Arabic speaking or of Arab descent.

B. Community Listening sessions
   a. This listening session is intended to invite community members within the eight service areas of the Arabic speaking community within LA county for the purpose of sharing their insights, views, thoughts and feelings on the services currently provided to the Arabic speaking community, gaps in mental health service delivery, challenges in accessing services, stigma related to mental health for Arabic speaking individuals/ and heritage members of the community, ways to improve mental health service delivery, and suggestions for how to conduct outreach to people who are Arabic speaking or of Arab descent.

II. **Session Guidelines**

A. General guidelines

a. A listening session consists of six to ten people to be effective. It is important to allow for open discussion by skilled facilitators. It should be large enough to have rich and engaged discussions, but not too large where people feel left out of the process. The listening sessions will consist of 10-20 participants between both types of sessions. Therefore, there will be breakout groups consisting of 4-6 participants to generate enough discussion while also listening to all participants.

b. Listening sessions generally are allotted between 45 min – 90 min for discussions. Sessions that last longer usually lose the interest of participants. Therefore, the leadership listening session will incorporate some educational elements on mental wellness, and ice breaker and breaks for participants. The community sessions will be primarily breakout sessions and short on other types of discussions.

c. Homogeneity is important in conducting listening sessions. It provides the appearance of a level playing field allowing participants to feel a sense of safety with people they may never see again. To ensure homogeneity each participant will fill out a qualifying document as seen in Appendix A. The requirements will include acknowledgement of ethnicity, language, and residence.

d. An effort will be made to place people in varying breakout groups with people they do not know to provide enough distance for all to participate freely.

e. All participants will also be given a consent before participating informing each of the risks and benefits of participating in the listening sessions. An example is located in Appendix B.

f. It takes at least 3-4 listening groups to have validity. With each successive group there is more and more validity. When there are no more new ideas a point of saturation has occurred. Saturation is a good indicator that you have heard all the community has to share and the results are considered valid.

g. All participants should not be guided toward answers; however, it is also not unusual for participants to change their answers throughout the session as they hear the ideas of the other members of the group.

B. Leadership Listening Session

a. The leadership listening session will last for six hours.
b. The session will consist of 15-20 members with three to four breakout groups.

C. Community Listening sessions

a. The community listening sessions will last for approximately 2.5 hours.
b. The session will consist of 10-15 members with three breakout groups.

III. **Defining Facilitator and Participant expectations and roles**

a. Facilitator expectations and roles

F. There will be at least four facilitators for the leadership listening sessions, and at least three facilitators for the community listening sessions.

G. Facilitators will provide a safe environment for sharing ideas and ensure that all participants' voices are heard.

H. Most listening sessions consist of eight to ten questions. Eight questions are usually attainable while ten questions are aspirational.

I. Facilitators will illicit the maximum number of ideas from participants in the time allotted, while also recognizing when saturation occurs. If saturation occurs, before the allotted time facilitators will move forward to reach the aspirational 10 questions identified.

J. Facilitators will be culturally attuned and attend a training before the sessions.

K. Three types of questions will be asked during the listening session: engagement, exploration and exit questions.

L. In addition to facilitators, there will be someone to monitor chat, the session leader, a mental health therapist in case someone is triggered during the session, and a technical assistant to assist anyone having technical issues.

b. Participant expectations and roles

F. Participants will be invited to participate through community recruitment through the use of fliers, social media and incentives.

G. Participants will be given a wellness box as an incentive to participate.

H. Participants will fill out a qualifying document as seen in Appendix A and a consent form as attached in Appendix B.

I. Participants will be asked 8-10 questions for their insight and feedback.

J. Participants will receive a resource guide of Arabic resources.

K. Participants are expected to come unprepared and give spontaneous answers to the questions asked and participate from the beginning to the end through an online HIPAA-compliant ZOOM format.

L. All sessions will be recorded to capture what people say and destroyed once the data is retrieved.

M. Participants will be at least 18 years old and not exceed 80 years of age.

N. Participants must be residents of LA county, and either speak Arabic or being of Arab descent.

Listening Session Logistics

There are two types of listening sessions. First, the leadership session. Second, the community sessions. The logistics of both are described below in order of the events themselves.

O. Logistics include human resources (facilitators, observers, notetakers, chat monitor, session leader and participants, therapist, and tech assistant), technology (ZOOM), and administrative tools (qualifying document, informed consent, collected data, resource guide, media and advertisement, slides)
P. Once participants are identified they will be sent a qualifying document (Appendix A) and informed consent (Appendix B). Once these are filled out, they will receive a confirmation email (Appendix C), and a wellness box closer to date of the event.
Q. A spreadsheet of invited participants and their responses will be kept to track of all correspondence. 20% more participants will be invited to ensure numbers are at least what we are targeting.
R. All contractors will arrive at least 30 minutes early to the event, and all participants will be asked to arrive 15 minutes before start time.

Facilitator Training (September 11th, 2021)
Trainers will be trained on the logistics, technology, and ways to ask questions and respond to problematic issues that may arise.

Facilitator Training

11:00 AM Arrive and meet other facilitators and eat lunch

12:00 PM Begin Training/Overview

12:15 PM Agendas for listening sessions

12:30 PM
a. Types of questions, asking questions and responses.
b. Learning how to recognize saturation
c. Aspirational questions
d. Including everyone – no voice left behind

1:00 PM Learning ZOOM technology and breakout sessions

1:15 PM Questions

1:30 PM Depart

Leadership Listening Session (September 25th, 2021)

Preliminary schedule as of June 17th, 2021

As soon as this deliverable is approved invitations will be sent to identified leadership across LA County.

Before the Leadership Listening Session, leaders will be sent a wellness box filled with culturally relevant integrative mental wellness materials. This box will welcome these participants and introduce them to wellness

including a link to a welcome video on YouTube created by Dr. Heather XXXXX. It will be used to incentivize participants and have items worth at least $50 or more.

The Leadership Listening Session will begin at 11:00 AM – 5:00 PM with a one-hour lunch break from 12:00 PM – 1:00 PM. Leadership will be given the opportunity to have lunch delivered to their location, if they choose, to incentivize their participation.

Leadership Listening Session Agenda

11:00 AM- 5:00 PM

Leadership attendees arrive to Zoom session at 10:30 AM to meet and greet one another.

11:00 AM Introduction to the Agenda, schedule and all the facilitators for the day including interpreters. Participants will be notified about the rules of the day, and how to seek help when needed. Dr. XXXXX will lead the listening session. There will be three facilitators for the breakout sessions who are bilingual in English and Arabic. There will be one person to monitor the chat in the main sessions, and one to observe people while others are speaking. And one designated mental health professional for people who may find themselves overwhelmed. Those in roles of observation will take notes to note both the verbal and non-verbal expressions and cues.

11:15 AM ICE Breaker. An ice breaker will be performed to help leaders get to know one another.

11:30 AM Introduction to mental health and wellness. Dr. XXXXX will discuss the purpose of the Leadership Listening Session and a basic understanding of what mental health, and mental illness are to set the tone of the session and orient the participants' thoughts toward the discussions to ensue. Participants will also be able to ask clarifying questions for participation.

12:00 PM- 1:00 PM
Participants can stay online and eat together or depart for lunch for one hour. Participants will also be directed to the LACDMH website where the resource guide will be located to peruse and utilize as needed, or as interested.

1:00 PM
Question #1 As a leader in the Arab community what do you see as the most important mental health issues that need to be addressed? Each leader will be given 2-3 minutes to respond.

1:30 PM
Question #2 What are the mental health services you are aware of in LA County?
Each participant will be given 2-3 minutes to respond.

2:00 PM
Questions #3 Where do you notice gaps or unserved or underserved mental health issues in service delivery to the Arab community? Each participant will be given 2-3 minutes to respond.

2:30 PM
Question #4 What are some challenges or barriers in seeking or accessing mental health services? Each participant will be given 2-3 minutes to respond.

3:00 PM
Question #5 What is the best way to conduct outreach the Arabic community? Each participant will be given 2-3 minutes to respond.

3:30 PM
Question #6 What would it take for you or people you know to access mental health services? Each participant will be given 2-3 minutes to respond.

4:00 PM
Question #7 What would it take for you or people you know to access mental health services? Each participant will be given 2-3 minutes to respond.

4:30 PM
Question # 8 Is there anything else you would like to discuss in the area of mental health and wellness for the Arabic population? Each participant will be given 2-3 minutes to respond.

Aspirational Questions

1. What programs would you like to see more of in your community or service area?

2. Would you like to be more involved in volunteering for LACDMH?

5:00 PM Thank you and depart. A summary of the day will be given, and an explanation of what will happen to the observations and data points collected. Dr. XXXXX will also discuss how to navigate resources at LACDMH. Then participants will depart.

Service Area Listening Session Agendas

11:30 AM- 2:30 PM

11:45 AM People arrive to ZOOM session and check-in

12:00 PM- 12:15 PM Introduction to the Agenda, schedule and all the facilitators for the day including interpreters. Participants will be notified about the rules of the day, and how to seek help when needed. Dr. XXXXX will lead the listening session. There will be three facilitators for the breakout sessions who are bilingual in English and Arabic. There will be one person to monitor the chat in the main sessions, and one to observe people while others are speaking, and one designated mental health professional for people who may find themselves overwhelmed. Those in roles of observation will take notes to note both the verbal and non-verbal expressions and cues.

12:15 PM – 12:30 PM Introduction to mental health and wellness. Dr. XXXXX will discuss the purpose of the Leadership Listening Session and a basic understanding of what mental health, mental illness are to set the tone of the session and orient the participants' thoughts toward the discussions to ensue. Participants will also be able to ask clarifying questions for participation. They will be split into groups of 4-6 participants and move into their assigned breakout rooms.

12:30 PM

Question #1 As a community member what do you see the most prominent issues of mental health within the Arab community? Each participant will be given 2-3 minutes to respond.

12:45 PM
Question #2 What are the mental health services you are aware of in LA County?
Each participant will be given 2-3 minutes to respond.

1:00PM
Questions #3 Where do you notice gaps or unserved or underserved mental health issues in service delivery to the Arab community? Each participant will be given 2-3 minutes to respond.

1:15 PM
Question #4 What are some challenges or barriers in seeking or accessing mental health services? Each participant will be given 2-3 minutes to respond.

1:30 PM
Question #5 What is the best way to conduct outreach the Arabic community? Each participant will be given 2-3 minutes to respond.

1:45 PM
Question #6 What would it take for you or people you know to access mental health services? Each participant will be given 2-3 minutes to respond.

2:00 PM
Question #7 What would it take for you or people you know to access mental health services?
Each participant will be given 2-3 minutes to respond.

2:15 PM
Question # 8 Is there anything else you would like to discuss in the area of mental health and wellness for the Arabic population? Each participant will be given 2-3 minutes to respond.

Aspirational Questions

3. What programs would you like to see more of in your community or service area?

4. Would you like to be more involved in volunteering for LACDMH?

2:30PM Thank you and depart. A summary of the day will be given, and an explanation of what will happen to the observations and data points collected. Dr. XXXXX will also discuss how to navigate resources at LACDMH. Then participants will depart.

Questions for Listening Sessions

1. As a community member what do you see the most prominent issues of mental health within the Arab community?

2 What are the mental health services you are aware of in LA County?

5. Where do you notice gaps or unserved or underserved mental health issues in service delivery to the Arab community?

6. **What are some challenges or barriers in seeking or accessing mental health services?**

7. **What are stigmas related to mental health for the Arab community?**

8. **What are better ways LA County DMH can offer mental health services to the Arab community?**

9. **What is the best way to conduct outreach the Arabic community?**

10. **Is there anything else you would like to discuss in the area of mental health and wellness for the Arabic population?**

11. **What would it take for you or people you know to access mental health services?**

12. **What do you see as the main mental health issues/topics within the Arab community at present? How is this different from 10 years ago? 20 years ago?**

Aspirational Questions

13. **What programs would you like to see more of in your community or service area?**

14. **Would you like to be more involved in volunteering for LACDMH?**

Appendix B

Flyer/Promotional Materials

Embedded within are examples of the flyers for promotion of a master flyer with all the dates, and individual flyers for each service area.

Other promotional materials will be a part of the recruitment process as discussed in the logistics of the listening sessions. These include invitations to leaders and an incentive wellness box for each participant valued at a minimum of $50.

Please see the flyers in the following pages.

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Virtual focus groups for Arabic speaking participants:

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County.

Please reach out to: nafshealertherapy@protonmail.com. Hosted on zoom. MHSA funded.

SEPTEMBER 25TH, 2021

Service Area 1

OCTOBER 9TH, 2021

Service Area 2

OCTOBER 22ND, 2021

Service Area 3

NOVEMBER 6TH, 2021

Service Area 4

NOVEMBER 13TH, 2021

Service Area 5

NOVEMBER 20TH, 2021

Service Area 6

DECEMBER 4TH, 2021

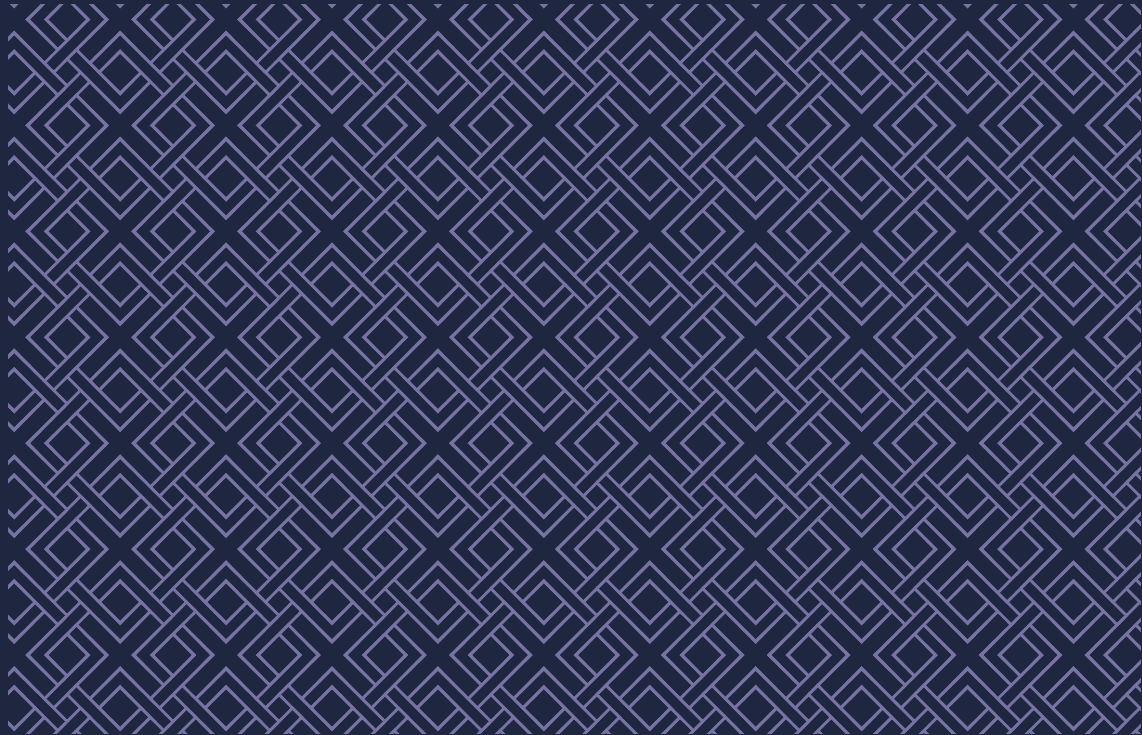
Service Area 7

JANUARY 15H, 2022

Service Area 8

HRL CONSULTING, LLC

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.



SEPTEMBER 25TH, 2021

virtual focus group

for the arabic speaking community

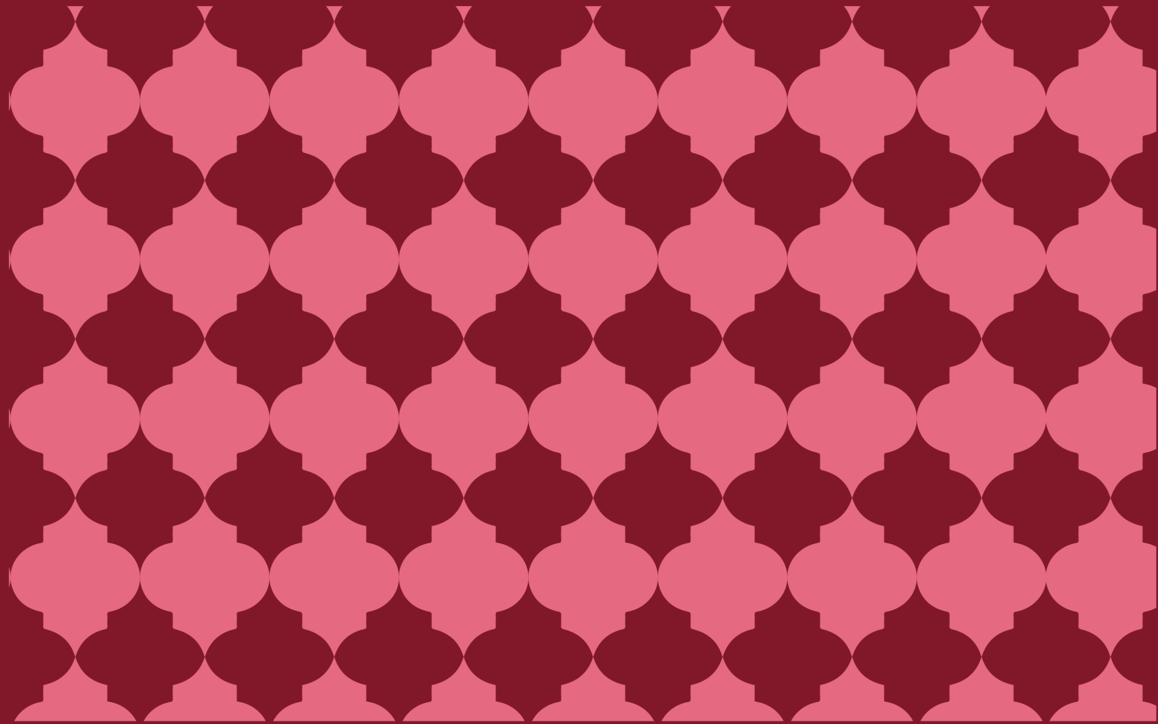
These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 1.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.

WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
hope. recovery. wellbeing.



OCTOBER 9TH, 2021

virtual focus group

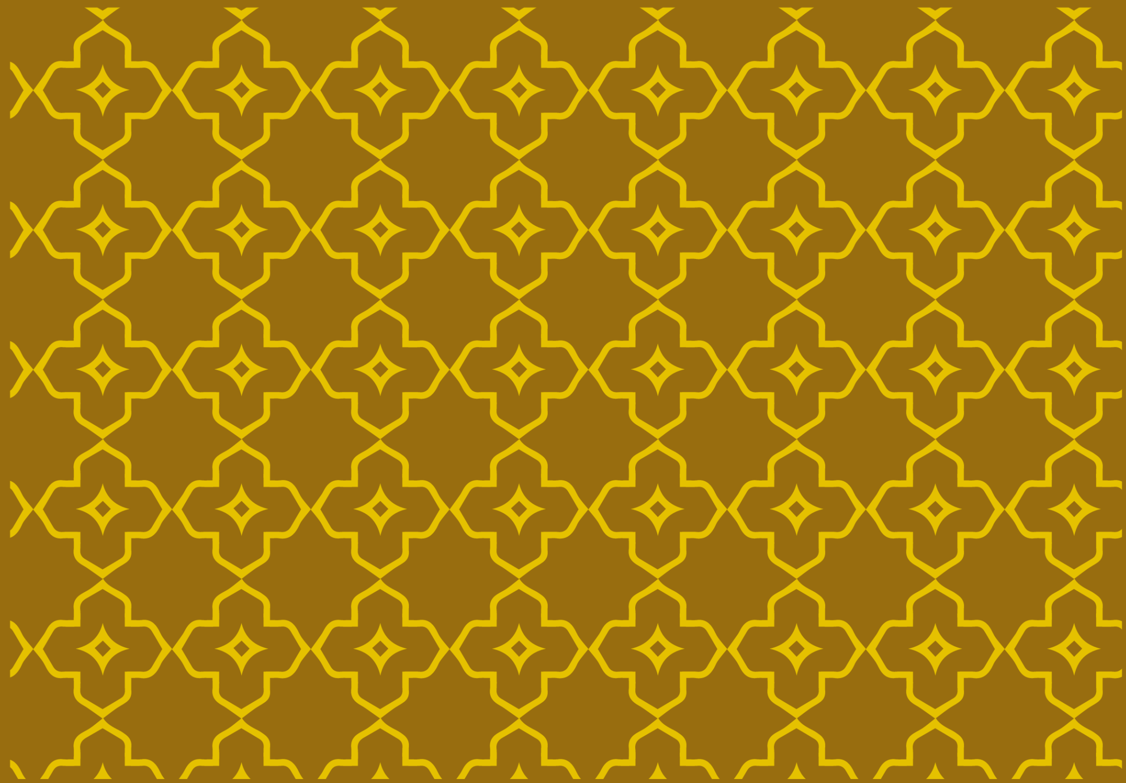
for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 2.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.

WELLNESS • RECOVERY • RESILIENCE



OCTOBER 22ND, 2021

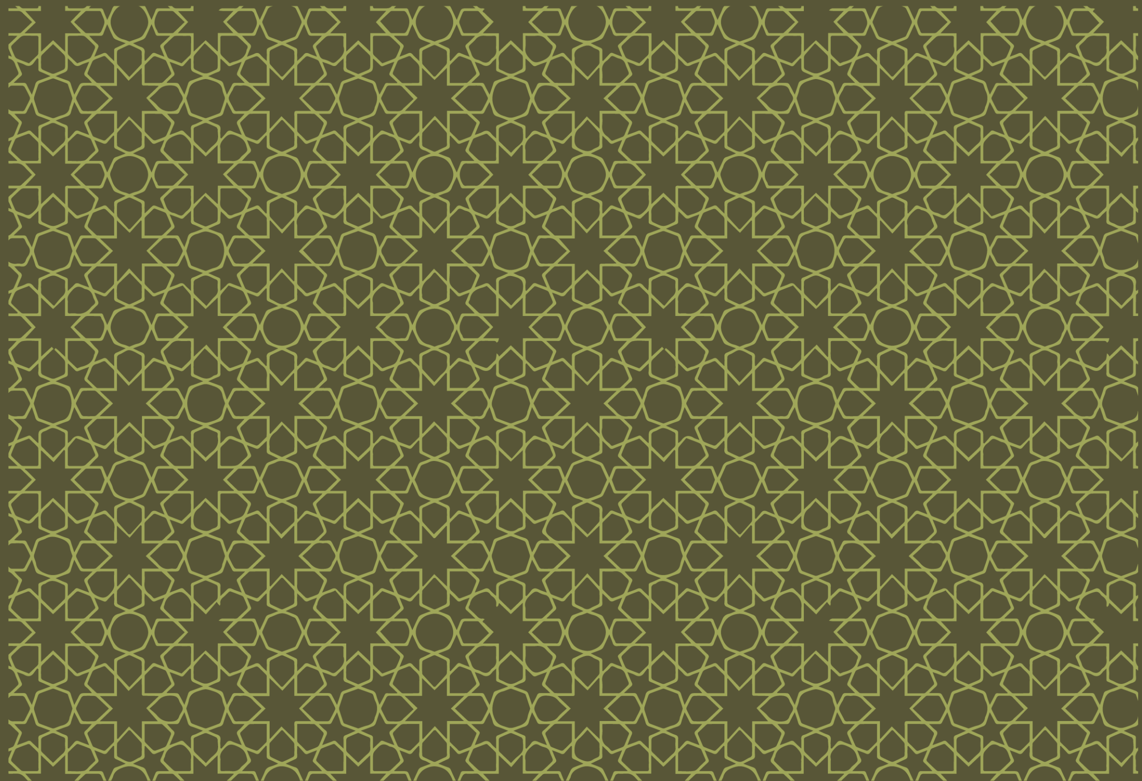
virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 3.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.



NOVEMBER 6TH, 2021

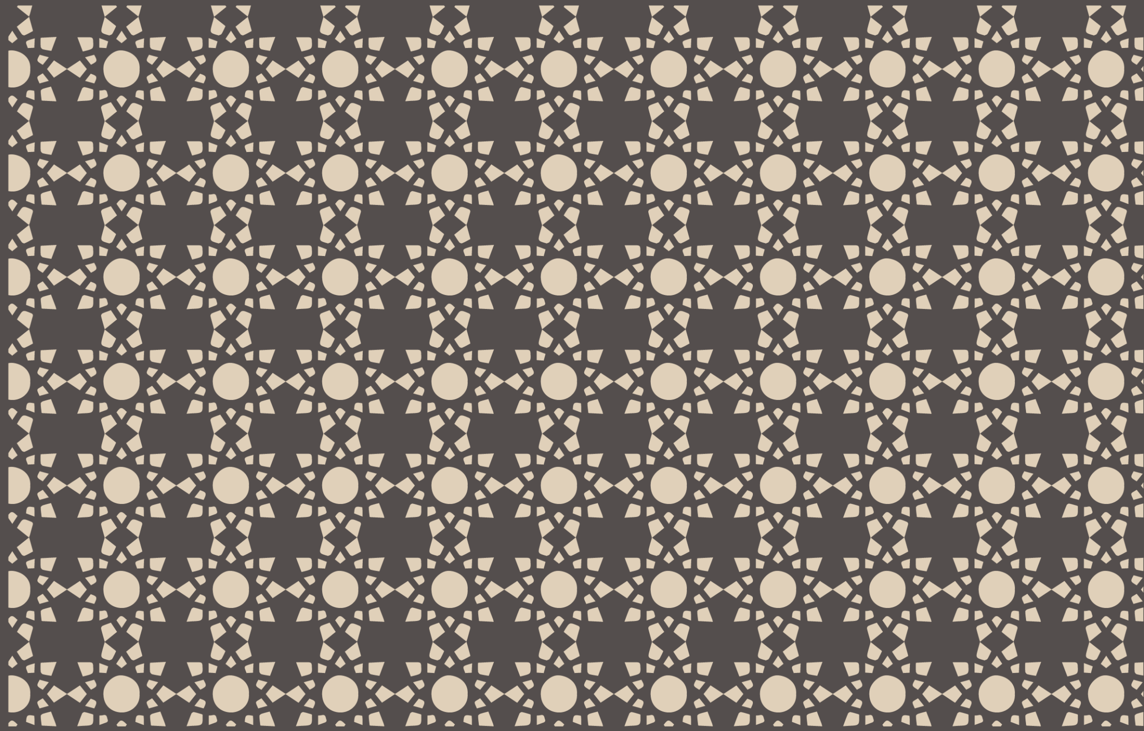
virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 3.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.



NOVEMBER 13TH, 2021

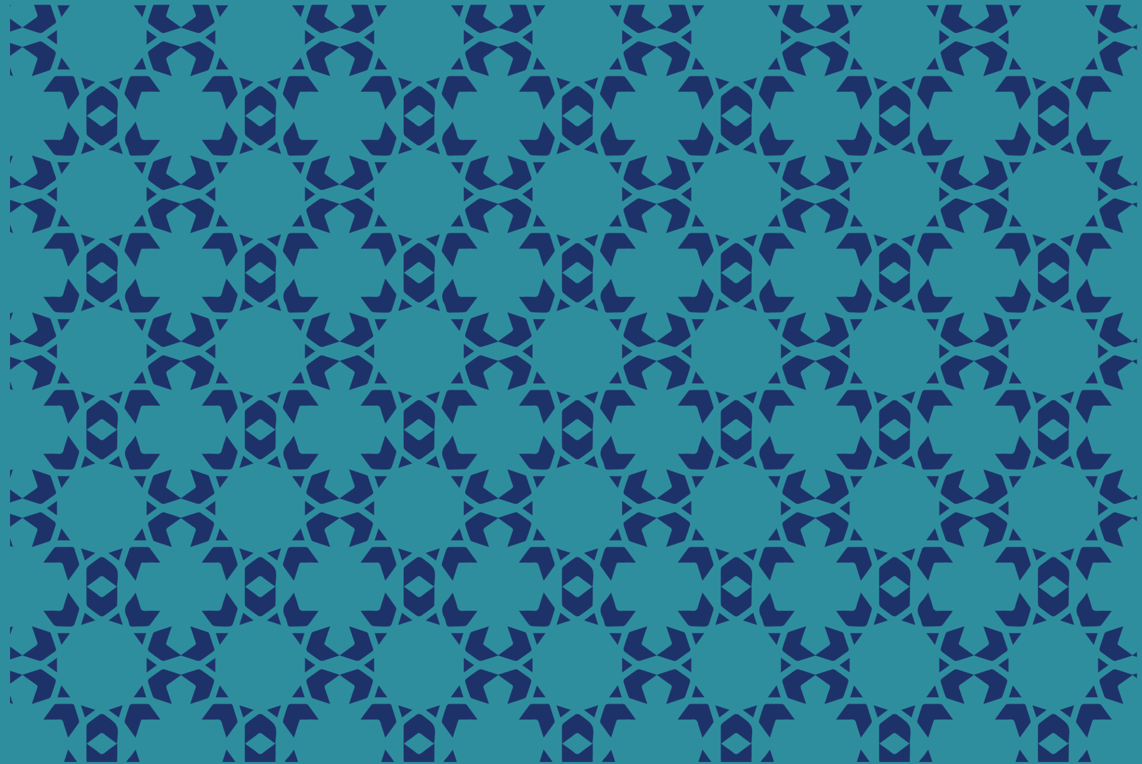
virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 5.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.



NOVEMBER 20TH, 2021

virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 6.

Please reach out to: nafshealertherapy@protonmail.com.

HOSTED ON ZOOM.
mhsa funded.

DECEMBER 4TH, 2021

virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 7.

Please reach out to: nafshealertherapy@protonmail.com.

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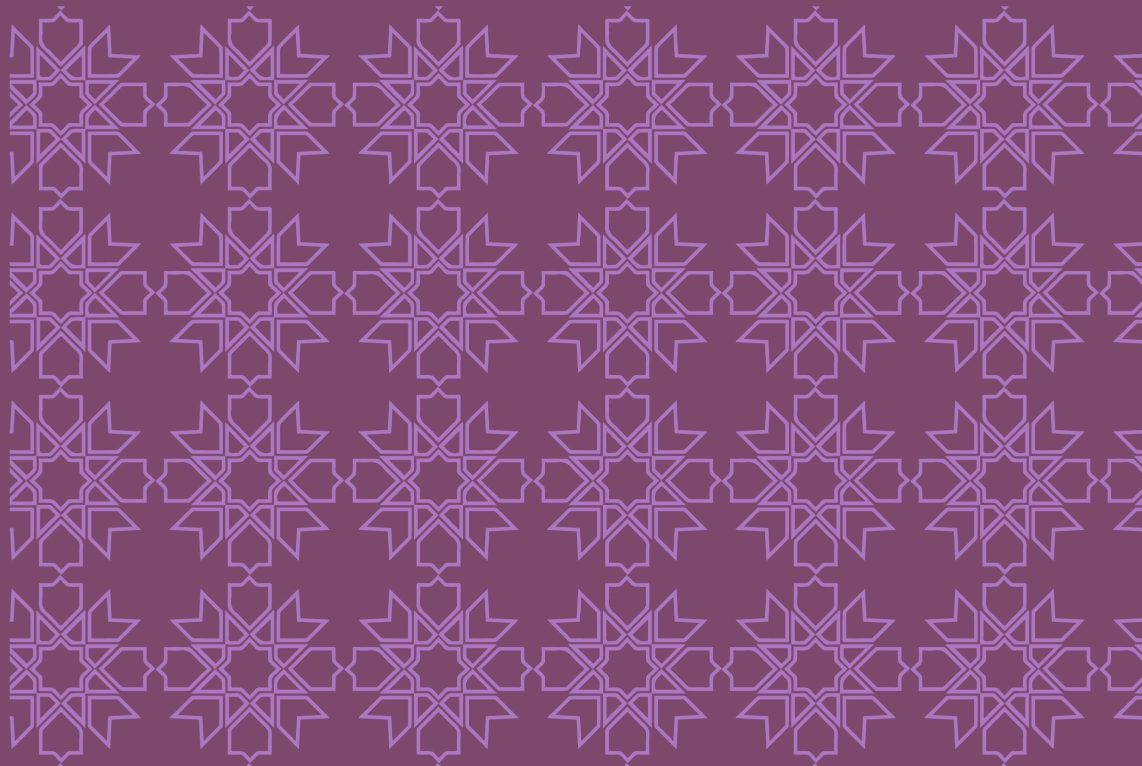

JANUARY 22ND, 2022

virtual focus group

for the arabic speaking community

These events will focus on people who are Arabic speaking and/or Arabic descent to discuss and give feedback on the mental health crisis in the communities of Los Angeles County. This event will be for service area 8.

Please reach out to: nafshealertherapy@protonmail.com.

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Flyers in Arabic

مجموعة التركيز الافتراضية للمجتمع الناطق باللغة العربية:

هذا المساء للمتحدثين باللغة العربية و / أو الأشخاص من أصل عربي لمناقشة أزمة الصحة العقلية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها

يرجى التواصل مع: nafshealertherapy@protonmail.com

استضافة على ZOOM .MHSA funded

SEPTEMBER 25TH, 2021
منطقة الخدمة 1

OCTOBER 9TH, 2021
منطقة الخدمة 2

OCTOBER 22ND, 2021
منطقة الخدمة 3

NOVEMBER 6TH, 2021
منطقة الخدمة 4

NOVEMBER 13TH, 2021
منطقة الخدمة 5

NOVEMBER 20TH, 2021
منطقة الخدمة 6

DECEMBER 4TH, 2021
منطقة الخدمة 7

JANUARY 15H, 2022
منطقة الخدمة 8

SEPTEMBER 25TH, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

هذا المساء للناطقين باللغة العربية و / أو الأشخاص المنحدرين من أصل عربي لمناقشة أزمة الصحة النفسية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها. سيكون هذا الحدث لمنطقة الخدمة 1

يرجى التواصل مع: nafshealertherapy@protonmail.com

استضافة على ZOOM

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OCTOBER 9TH, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

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يرجى التواصل مع: nafshealertherapy@protonmail.com
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WELLNESS • RECOVERY • RESILIENCE

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

OCTOBER 22ND, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

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يرجى التواصل مع: nafshealertherapy@protonmail.com

استضافة على ZOOM

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NOVEMBER 6TH, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

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أزمة الصحة العقلية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها. سيكون
هذا الحدث لمنطقة الخدمة 4

يرجى التواصل مع: nafshealertherapy@protonmail.com
استضافة على ZOOM

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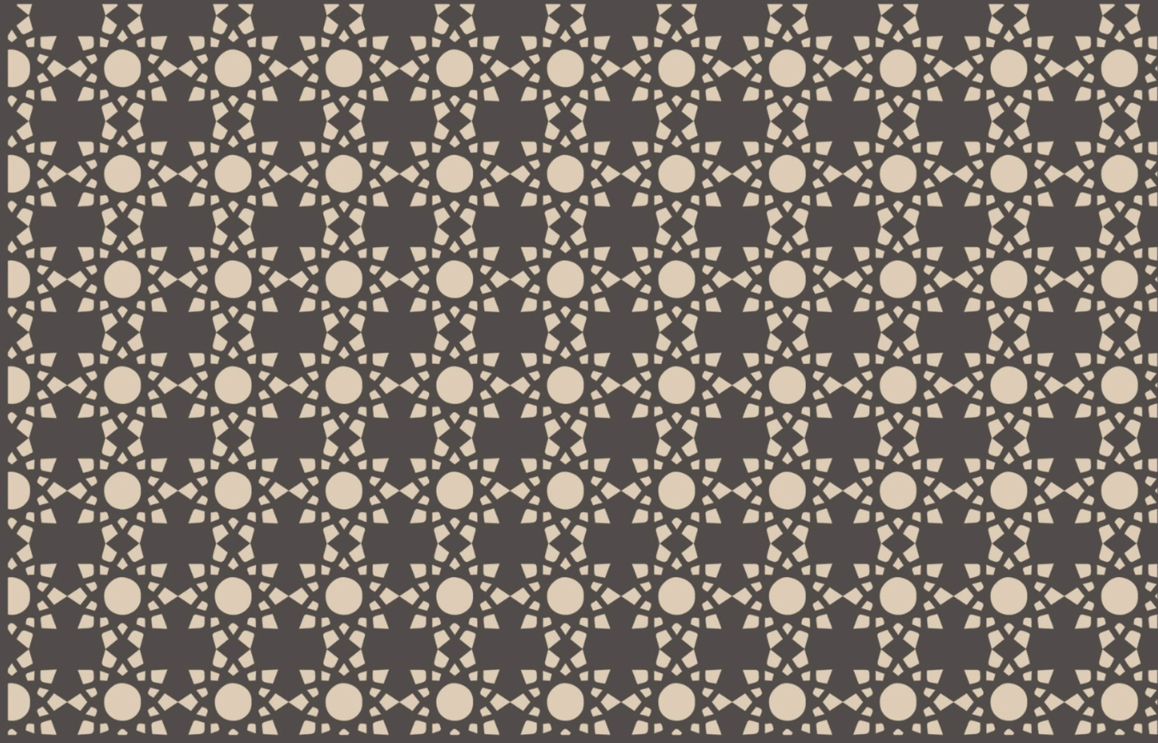

NOVEMBER 13TH, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

هذا المساء للمتحدثين باللغة العربية و / أو الأشخاص من أصل عربي لمناقشة أزمة الصحة العقلية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها. سيكون هذا الحدث لمنطقة الخدمة 5

يرجى التواصل مع: nafshealertherapy@protonmail.com
استضافة على ZOOM
mhsa funded.

NOVEMBER 20TH, 2021

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

هذا المساء للمتحدثين باللغة العربية و / أو الأشخاص من أصل عربي لمناقشة
أزمة الصحة العقلية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها. سيكون
هذا الحدث لمنطقة الخدمة 6

يرجى التواصل مع: nafshealertherapy@protonmail.com
استضافة على ZOOM

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LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
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DECEMBER 4TH, 2021

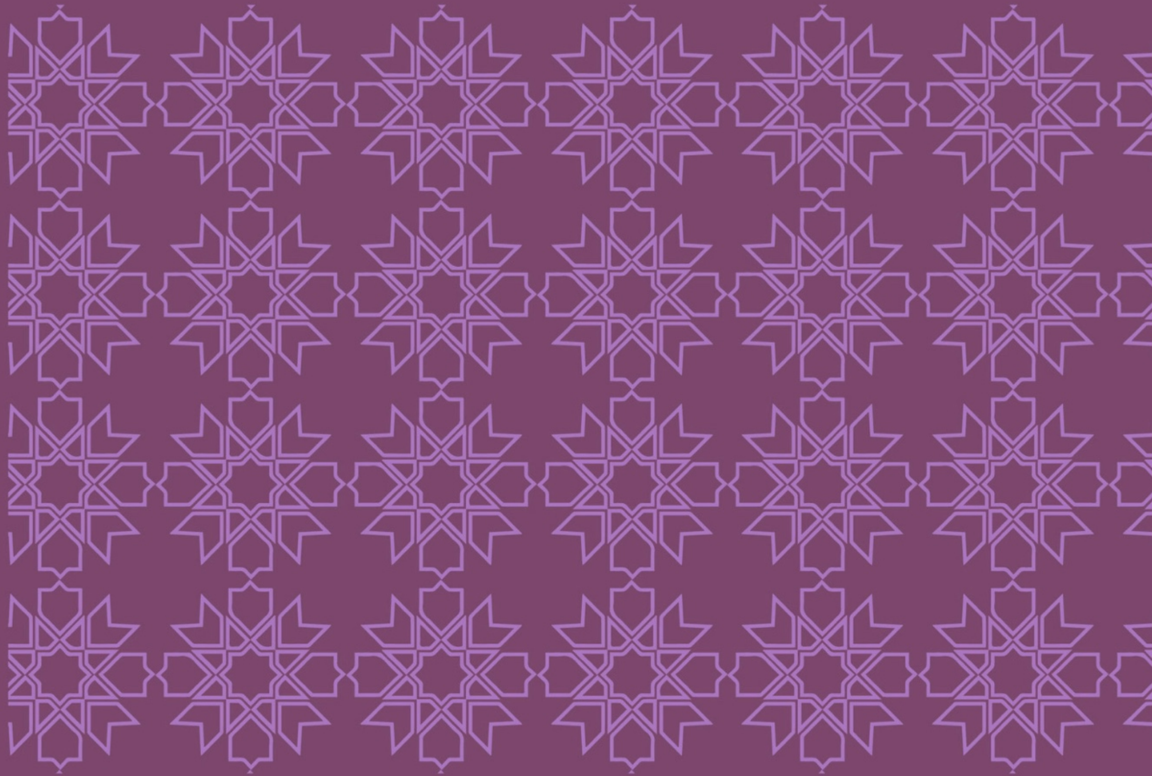
مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

هذا المساء للمتحدثين باللغة العربية و / أو الأشخاص من أصل عربي لمناقشة أزمة الصحة العقلية في مجتمعات مقاطعة لوس أنجلوس والتعليق عليها. سيكون هذا الحدث لمنطقة الخدمة 7

يرجى التواصل مع: nafshealertherapy@protonmail.com
استضافة على ZOOM

mhsa funded.



JANUARY 22ND, 2022

مجموعة التركيز الافتراضية

للمجتمع الناطق باللغة العربية

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يرجى التواصل مع: nafshealertherapy@protonmail.com

استضافة على ZOOM

mhsa funded.

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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Appendix C

Resource Guide Information

Arabic Mental Health Providers List

Services by area.

Service Area 1
SSG PROJECT 180 NORTH
1050 E PALMDALE BLVD SUITE 211 PALMDALE, CA 93550
(661) 208-4699

CHILD AND FAM GUIDANCE CENTER: PALMDALE
40805 10th ST WEST, STE 106 PALMDALE, CA 93551
(661) 265-8627

Service Area 2
CROSS-CULTURAL EXPRESSIONS
Encino, California 91316
(818) 860-1223

TARZANA TREATMENT CENTER
18646 Oxnard Street
Tarzana, CA 91356
(800) 996-1051

Service Area 3
ANTIOCH COUNSELING CENTER
Arcadia, CA 91006
(310) 574-2813

ALMA FAMILY SERVICES: WALNUT
18780 AMAR RD STE 204 WALNUT, CA 91789
Phone: (323) 881-3799

Service Area 4
INSTITUTE FOR MULTICULTURAL COUNSELING AND EDUCATIONAL SERVICES
3580 Wilshire Blvd., Suite 2000
Los Angeles, CA 90010
(213) 381-1250
Hotline: (866) 444-6237

LGBT CENTER
Los Angeles, CA 90038
(323) 957-5280

MAPLE COUNSELING CENTER
9107 Wilshire Blvd.
Beverly Hills, CA 90210
(310) 271-9999

Service Area 5
DIDI HIRSCH
4760 South Sepulveda Blvd., Culver City, CA 90230

STEP UP ON SECOND STREET: DANIEL'S PLACE
1619 SANTA MONICA BLVD SANTA MONICA, CA 90404
(310) 392-5855

Service Area 6
DIDI HIRSCH: INGLEWOOD
323 NORTH PRAIRIE AVE INGLEWOOD, CA 90301
(310) 677-7808

ENKI LPV MENTAL HEALTH CENTER: LA PUENTE
160 SOUTH SEVENTH AVE LA PUENTE, CA 91744
(626) 961-8971

Service Area 7
COMMUNITY FAMILY GUIDANCE CENTER: DOWNEY
8320 IOWA ST STE 201 DOWNEY, CA 90241
(562) 904-4815

OLIVE CREST TREATMENT CENTERS: WRAPAROUND: 17800 WOODRUFF AVE
17800 WOODRUFF AVE BELLFLOWER, CA 90706
(562) 866-8956

Service Area 8
DEL AMO HOSPITAL
23700 CAMINO DEL SOL TORRANCE, CA 90505
(310) 530-1151

SOUTH BAY CHILDREN'S HEALTH CENTER: REDONDO BEACH
410 SOUTH CAMINO REAL REDONDO BEACH, CA 90277
Phone: (310) 316-1212

Services for addiction.

Sober Companions
(866) 676-5688
Los Angeles, California 90067

South Coast Counseling
(949) 430-7191
Los Angeles, California 90011

AION Luxury Addiction Treatment
(561) 325-6909
Los Angeles, California 90011

Elite Care, Inc
(855) 782-1637
Los Angeles, California 90044

The Scott Concierge Luxury Medical Detox
(888) 827-7736
Los Angeles, California 90077

Hotlines.

LA County Hotlines:

LA County DMH (800) 854- 7771
LA County APS (877) 4-R-Seniors
LA County DCFS (800) 540-4000

Someone a little more personal for your needs...

Clinicians.

Hanouf Alahmari
Located: Los Angeles, CA 90025
Contact number: 310-861-7873
Offers online therapy.

Paula Glashausser
Located: Los Angeles, CA 90048
Contact number: 310-943-2889
Offers online therapy.

Hussain Johnee Elhaouli
Located: Los Angeles, CA 90005
Contact number: 626-382-7923
Offers online therapy.

David Ibrahim
Located: Los Angeles, CA 90025
Contact number: 323-366-3016
Offers online therapy.

Daniel D Sadigh
Located: Los Angeles, CA 90024
Contact number: 310-776-6186 x2
Offers online therapy.

Nabil Hanna
Located: Los Angeles, CA 90019
Contact number: 310-435-8869
Offers online therapy.

Abeer A Othman
Located: Los Angeles, CA 90025
Contact number: 818-835-4149
Offers online therapy.

Atwater Village Therapy
Located: Los Angeles, CA 90039
Contact number: 323-716-1253
Offers online therapy.

Norma Kehdi
Located: Los Angeles, CA 90037
Contact number: 213-817-5893
Offers online therapy.

Qutayba Dr. Q Abdullatif
Located: Los Angeles, CA 90049
Contact number: 626-318-8450
Offers online therapy.

Nora Sahakian
Located: Los Angeles, CA 90048
Contact number: 818-291-6229
Offers online therapy.

Dr.Cassidy Blair
Located: Los Angeles, CA 90049
Contact number: 424-888-6124
Offers online therapy.

Evian Mustafa
Located: Los Angeles, CA 90003
Contact number: 562-222-0453
Offers online therapy.

Sarah Megally
Located: Los Angeles, CA 90038
Contact number: 949-849-4807
Offers online therapy.

Samara Aldahwi
Located: Los Angeles, CA 90077
Contact number: 310-868-0836
Offers online therapy.

Maya Boustani
Located: Los Angeles, CA 90034
Contact number: 833-491-1253
Offers online therapy.

Center for Muslim Mental Health and Islamic Psychology
Located: Los Angeles, 90240
Contact number: 424-354-8095
Offers online therapy.

sponsors.

LACDMH Arabic Services:

Mental Health Resource Guide.

Appendix D

Los Angeles County Department of Mental Health
Strategic Communications Division
Underserved Cultural Communities (UsCC)

Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Listening Sessions

Qualifying Document

1.	**I am between the ages of 18 and 80 years old**	**Yes**	**No**
2.	**I am an Arabic speaking person or I am a person of Arab descent.**	**Yes**	**No**
3.	**I live in Los Angeles County**	**Yes**	**No**

4. I live in Service Area (please see the map)

   a. 1
   b. 2
   c. 3
   d. 4
   e. 5
   f. 6
   g. 7
   h. 8

5.	**I am willing to attend my entire assigned session online on ZOOM.**	**Yes**	**No**
6.	**I am willing to share my ideas with others.**	**Yes**	**No**

Service areas of LA County

Appendix E

Los Angeles County Department of Mental Health
Strategic Communications Division
Underserved Cultural Communities (UsCC)

Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Listening Sessions

Informed Consent

You have been asked to participate in a listening session sponsored by the Los Angeles County Department of Mental Health and the Mental Health Services Act. The purpose of the session is to try and understand the Arab community of Los Angeles County and participants views on mental health services. The information learned in the listening sessions will be used to create programming to better serve the Arab population of Los Angeles County.

You can choose whether to participate in the listening sessions and you can also stop at any time. Although the listening session will be recorded, your responses will remain anonymous, and no names will be mentioned in the report.

There are no right or wrong answers to the listening session questions. We want to hear many different viewpoints and would like to hear from everyone, including you. We hope you can be honest even when your responses may not be in agreement with the rest of the group. In respect for each other, we ask that only one individual speak at a time in the group and that responses made by all participants be kept confidential.

The benefits to participating in this listening session are to allow more relevant programming, and access to needed mental healthcare within the Arab community of Los Angeles County. Another benefit is to have your voice heard anonymously. There may even be more benefits.

The risks to participating in this listening session are hearing about ideas or events in the lives of others that may bother or trigger you. You may also uncover difficult feelings of your own. There will be a therapist on site to assist you if needed. There may be more risks. Overall, your risks are low.

I understand this information and agree to participate fully under the conditions stated above:

Signed: ____ Date: ___________________

Appendix F

Saturday, July 10, 2021

Dear ________________,

Thank you for your willingness to participate in our listening session. We would like to hear your ideas and opinions about mental health and the Arab community in Los Angeles County. You will be in a group with 10-15 other participants who are Arabic speaking or of Arab descent. You will then breakout into smaller groups of 4-6 people. Your responses to the questions will be kept anonymous. Please accept this wellness box we have sent you as an incentive to attend the session. Your date, time, along with the ZOOM link for the online sessions are listed below:

You are Confirmed!

Date:

Time:

ZOOM link:

If for any reason you are unable to attend for any reason, please call XXXXXXXXXX. Otherwise, we look forward to seeing you.

Sincerely,

Dr. XXXXXXXXXXXXXX

Appendix G

Questions for Listening Sessions

1. As a community member what do you see the most prominent issues of mental health within the Arab community?

2 What are the mental health services you are aware of in LA County?

15. Where do you notice gaps or unserved or underserved mental health issues in service delivery to the Arab community?

16. What are some challenges or barriers in seeking or accessing mental health services?

17. What are stigmas related to mental health for the Arab community?

18. What are better ways LA County DMH can offer mental health services to the Arab community?

19. What is the best way to conduct outreach the Arabic community?

20. Is there anything else you would like to discuss in the area of mental health and wellness for the Arabic population?

21. What would it take for you or people you know to access mental health services?

22. What do you see as the main mental health issues/topics within the Arab community at present? How is this different from 10 years ago? 20 years ago?

Aspirational Questions

23. What programs would you like to see more of in your community or service area?

24. Would you like to be more involved in volunteering for LACDMH?

Appendix H

Additional Questions
These questions were added in the Phase 2 iteration of this project.

21. Have you ever been self-injurious or had self-harming thoughts?

22. Do you feel comfortable in society why or why not?

23. Did your parents teach you Arabic? Why or Why not?

24. Have you ever been exposed to war?

25. Have you ever been exposed to religious oppression or persecution?

26. Are you a refugee or asylee?

27. Have you ever used LACDMH services before?

28. Are you vaccinated for COVID-19?

Appendix I

https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

Appendix J

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score
While you were growing up, during your first 18 years of life:
1. Did a parent or other adult in the household often ...
Swear at you, insult you, put you down, or humiliate you?
or
Act in a way that made you afraid that you might be physically hurt?
Yes No If yes enter 1 ________
2. Did a parent or other adult in the household often ...
Push, grab, slap, or throw something at you?
or
Ever hit you so hard that you had marks or were injured?
Yes No If yes enter 1 ________
3. Did an adult or person at least 5 years older than you ever...
Touch or fondle you or have you touch their body in a sexual way?
or
Try to or actually have oral, anal, or vaginal sex with you?
Yes No If yes enter 1 ________
4. Did you often feel that ...
No one in your family loved you or thought you were important or special?
or
Your family didn't look out for each other, feel close to each other, or support each other?
Yes No If yes enter 1 ________
5. Did you often feel that ...
You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
or
Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
Yes No If yes enter 1 ________
6. Were your parents ever separated or divorced?
Yes No If yes enter 1 ________
7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
Yes No If yes enter 1 ________
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
Yes No If yes enter 1 ________
9. Was a household member depressed or mentally ill or did a household member attempt suicide?
Yes No If yes enter 1 ________
10. Did a household member go to prison?
Yes No If yes enter 1 ________
Now add up your "Yes" answers: _______ This is your ACE Score

Appendix K

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

© 2008 The Research Foundation for Mental Hygiene, Inc.

RISK ASSESSMENT VERSION

(* elements added with permission for Lifeline centers)

Instructions: Check all risk and protective factors that apply. To be completed following the patient interview, review of medical record(s) and/or consultation with family members and/or other professionals.

	Suicidal and Self-Injury Behavior (Past week)		Clinical Status (Recent)
☐	Actual suicide attempt ☐ Lifetime	☐	Hopelessness
☐	Interrupted attempt ☐ Lifetime	☐	Helplessness*
☐	Aborted attempt Lifetime	☐	Feeling Trapped*
☐	Other preparatory acts to kill self Lifetime	☐	Major depressive episode
☐	Self-injury behavior w/o suicide intent Lifetime	☐	Mixed affective episode
	Suicide Ideation (Most Severe in Past Week)	☐	Command hallucinations to hurt self
☐	Wish to be dead	☐	Highly impulsive behavior
☐	Suicidal thoughts	☐	Substance abuse or dependence
☐	Suicidal thoughts with method (but without specific plan or intent to act)	☐	Agitation or severe anxiety
☐	Suicidal intent (without specific plan)	☐	Perceived burden on family or others
☐	Suicidal intent with specific plan	☐	Chronic physical pain or other acute medical problem (AIDS, COPD, cancer, etc.)
	Activating Events (Recent)	☐	Homicidal ideation
☐	Recent loss or other significant negative event	☐	Aggressive behavior towards others
	Describe:	☐	Method for suicide available (gun, pills, etc.)
		☐	Refuses or feels unable to agree to safety plan
☐	Pending incarceration or homelessness	☐	Sexual abuse (lifetime)
☐	Current or pending isolation or feeling alone	☐	Family history of suicide (lifetime)
	Treatment History		**Protective Factors (Recent)**
☐	Previous psychiatric diagnoses and treatments	☐	Identifies reasons for living
☐	Hopeless or dissatisfied with treatment	☐	Responsibility to family or others; living with family
☐	Noncompliant with treatment	☐	Supportive social network or family
☐	Not receiving treatment	☐	Fear of death or dying due to pain and suffering
	Other Risk Factors	☐	Belief that suicide is immoral, high spirituality
☐		☐	Engaged in work or school
		☐	Engaged with Phone Worker *
			Other Protective Factors
		☐	

Describe any suicidal, self-injury or aggressive behavior (include dates):

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/commit suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it…and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐
INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** ______ (***Type # (1-5)***) ____________ (***Description of Ideation***) Recent - ***Most Severe Ideation:*** ______ (***Type # (1-5)***) ____________ (***Description of Ideation***)	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day	____	____
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous	____	____
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts	____	____

Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of committing suicide?*** (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply	____	____
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others (2) Mostly to get attention, revenge or a reaction from others (3) Equally to get attention, revenge or a reaction from others and to end/stop the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply	____	____

Los Angeles County Department of Mental Health
Strategic Communications Division
Underserved Cultural Communities (UsCC)

SUICIDAL BEHAVIOR *(Check all that apply, so long as these are separate events; must ask about all types)*	**Lifetime**
Actual Attempt: A potentially self-injurious act committed with at least some wish to die, *as a result of act.* Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is ***any*** intent/desire to die associated with the act, then it can be considered an actual suicide attempt. ***There does not have to be any injury or harm***, just the potential for injury or harm. If person pulls trigger while gun is in mouth but gun is broken so no injury results, this is considered an attempt. Inferring Intent: Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred. ***Have you made a suicide attempt?*** ***Have you done anything to harm yourself?*** ***Have you done anything dangerous where you could have died?*** ***What did you do?*** ***Did you______ as a way to end your life?*** ***Did you want to die (even a little) when you_____?*** ***Were you trying to end your life when you _____?*** ***Or Did you think it was possible you could have died from______?*** ***Or did you do it purely for other reasons / without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?*** (Self-Injurious Behavior without suicidal intent) If yes, describe: **Has subject engaged in Non-Suicidal Self-Injurious Behavior?**	**Yes** **No** ☐ ☐ Total # of Attempts **Yes** **No** ☐ ☐
Interrupted Attempt: When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act *(if not for that, actual attempt would have occurred).* Overdose: Person has pills in hand but is stopped from ingesting. Once they ingest any pills, this becomes an attempt rather than an interrupted attempt. Shooting: Person has gun pointed toward self, gun is taken away by someone else, or is somehow prevented from pulling trigger. Once they pull the trigger, even if the gun fails to fire, it is an attempt. Jumping: Person is poised to jump, is grabbed and taken down from ledge. Hanging: Person has noose around neck but has not yet started to hang - is stopped from doing so. ***Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of interrupted
Aborted or Self-Interrupted Attempt: When person begins to take steps toward making a suicide attempt, but stops themselves before they actually have engaged in any self-destructive behavior. Examples are similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else. ***Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of aborted or self-interrupted

Preparatory Acts or Behavior: Acts or preparation towards imminently making a suicide attempt. This can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note). ***Have you taken any steps towards making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away or writing a suicide note)?*** If yes, describe:	**Yes** **No** ☐ ☐ Total # of preparatory acts

	Most Recent Attempt Date:	Most Lethal Attempt Date:
Actual Lethality/Medical Damage: 0. No physical damage or very minor physical damage (e.g., surface scratches). 1. Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). 2. Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). 3. Moderately severe physical damage; *medical* hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). 4. Severe physical damage; *medical* hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). 5. Death	*Enter Code*	*Enter Code*
Potential Lethality: Only Answer if Actual Lethality=0 Likely lethality of actual attempt if no medical damage (the following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over). 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	*Enter Code*	*Enter Code*

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