LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION
CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criteria 1-8

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Director

August 2022

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION
CULTURAL COMPETENCY UNIT

2022 CULTURAL COMPETENCE PLAN UPDATE
EXECUTIVE SUMMARY

The Los Angeles County Department of Mental Health (LACDMH) updates its Cultural Competence Plan annually per the California Department of Health Care Services' (DHCS) Cultural Competence Plan Requirements, Title IX – Section 1810.410 statutes, and the National Standards for Culturally and Linguistically Appropriate Services and Healthcare (CLAS) provisions. The Department utilizes the Cultural Competence Plan as a tool to promote and evaluate system progress in terms of service planning, integration, and delivery toward the reduction of mental health disparities and the enactment of equitable, culturally inclusive, and linguistically appropriate services.

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

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

- Criterion 1: Commitment to Cultural Competence
- Criterion 2: Updated Assessment of Service Needs
- Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
- Criterion 4: Cultural Competency Committee
- Criterion 5: Culturally Competent Training Activities
- Criterion 6: County's Commitment to Growing a Multicultural Workforce
- Criterion 7: Language Capacity
- Criterion 8: Adaptation of Services

The 2022 Cultural Competence Plan Report is based on data and programmatic information for Fiscal Year 20-21.

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE, FY 20-21

Criterion 1

Commitment to Cultural Competence

August 2022

Criterion 1: Commitment to Cultural Competence

The Los Angeles County Department of Mental Health (LACDMH) is the largest county-operated mental health system in the United States, serving over 10 million culturally diverse residents in 13 threshold languages and beyond. LACDMH's provider network is composed of Directly Operated and Contracted programs which serve Los Angeles residents across more than 85 cities and approximately 300 co-located sites. More than 250,000 residents of all ages are served every year. LACDMH strives to reduce the negative impacts of untreated mental illness by providing services based on whole person care, cultural and linguistic responsiveness, equity for all cultural groups, partnerships with communities, integration with social service providers, and openness to sustained learning and on-going improvements. LACDMH believes that wellbeing is possible for all persons and that mental health interventions should address the needs of each constituent. The Department employs a collaborative approach to assist consumers achieve their personal recovery goals such as finding a safe place to live, use time meaningfully, thrive in healthy relationships, access public assistance, overcome crises successfully, and attain wholesome health.

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

In the midst of concerted efforts for survival and wellbeing, uncertainty and distress, grief over lost lives, and disruptions of multiple layers of daily routine, LACDMH remained focused on its mission. Clinical and administrative personnel provided their expertise to overcome the multiplicity of challenges that impinged upon a system of care as large and complex as LACDMH. The Department prioritized the delivery of virtually driven mental health services and supports to care for the most vulnerable individuals and communities experiencing the disproportionate impact of the pandemic. Such disproportionate impact exacerbated mental health conditions, isolation, loneliness, frustration, and despair among others. The Department's efforts to meet COVID-19 needs resulted in several improvements in service delivery, including:

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

- Development of on-line COVID-19-related community informing materials such as wellbeing guidelines and articles, presentations and trainings, messaging, and resources on mental health and beyond to foster hope, wellbeing, recovery, and resiliency in the community.

I. Commitment to Cultural Competence Policy and Procedures

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

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

TYPE	INFRASTRUCTURE DOCUMENTS

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

TYPE	INFRASTRUCTURE DOCUMENTS
	○ SC-6 – Older Adults ○ SC-7 – Assessment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-8 – Treatment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-9 – Access to Care After Discharge from Psychiatric Hospitals and Juvenile Justice Programs
Additional Policies and Procedures Related to Cultural Competence	• Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Access to Care for Veterans and Their Families • Policy No. 200.09 – Culturally and Linguistically Inclusive Services • Policy No. 201.02 – Nondiscrimination of Beneficiaries • Policy No. 305.01 – Mental Health Disorders and Co-Occurring Substance Use • Policy No. 310.01 – HIV and AIDS Clinical Documentation and Confidentiality • Policy No. 311.01 – Integration of Clients' Spiritual Interests in Mental Health Services • Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services
Human Resource Training and Recruitment Policies	• Code of Organizational Conduct, Ethics, and Compliance • Los Angeles County Policy of Equity (CPOE) • Just Culture • Implicit Bias and Cultural Competence • Gender Bias

See Criterion 1 Appendix for detailed information

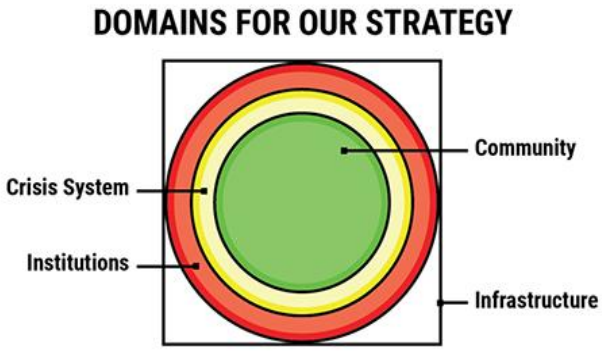
II. County Recognition Value and Inclusion of Racial, Ethnic, Cultural and Linguistic Diversity within the System

Consistent with the Cultural Competence Plan Requirements (CCPR) and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), LACDMH recognizes and values the racial, ethnic, cultural and linguistic diversity of its communities. The vision of the Department is to "build a Los Angeles County unified by shared intention and cross-sector collaboration that helps those suffering from serious mental illness heal, grow and flourish by providing easy access to the right services and the right opportunities at the right time in the right place from the right people." The LACDMH mission is to "optimize the hope, wellbeing and life trajectory of Los Angeles County's most vulnerable through access to care and resources that promote not only independence and personal recovery but also connectedness and community reintegration."

LACDMH's Strategic Plan 2020-2030 guides the System of Care to pursue its mission to optimize hope, wellbeing and life trajectory of Los Angeles County's most vulnerable communities. The means to accomplish this lofty goal require equitable accessibility to mental health services that are culturally and linguistically appropriate. The Strategic Plan is based on core elements that promote independence, personal recovery, social connectedness, and community reintegration. Listed below are the Departments fundamental values and principles, which underscore the importance of cultural competence, equity, and collaborations with consumers as well as the community.

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

Figure 1: Excerpts from the LACDMH Strategic Plan 2020-2030



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

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

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

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

Departmental commitments for equity, anti-racism, cultural-inclusion and linguistic relevance can be found throughout the four domains of the Strategic Plan and its appendices as summarized in the table below.

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

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
Values and Principles		Equitable and culturally competent – where consumers, family members and communities are cared for equitably and services are delivered with cultural humility, respect, and competence.	Anti-Racism, Diversity, and Inclusion- where services are delivered with sensitivity and understanding to the impact of collective racism against Black and other communities of color.	
Community Domain	**Prevention Services** Goal 1A: <u>Early Identification and Engagement</u> Strategy 1A.2	To this end, the navigation, coordination and follow-up across our system must be improved to ensure that individuals of all ages, families and communities get the resources they want and need (Strategy 1A.3). and, every strategy will be viewed through the lens of culture to ensure we are providing outreach and engagement that takes into consideration individuals' *cultural backgrounds and linguistic needs.*	Invest in community access platforms as ideal entry points to resources: Use homes, clinics, parks, libraries, schools, places of worship, community centers and other gathering points in local communities as platforms for providing access to mental health information for children, youth, families and individuals in comfortable, affirming and safe settings.	CR 1, CR 3 and CR 8 CR 2 and CR 3 CR 3, CR 4, and CR 8

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
			Train up the ecosystem of community access platforms to identify needs and coordinate resources to meet them: Provide training to ensure those who work at community-based access points are more knowledgeable about culture, social determinants of health, and the impact of racism on mental health issues. This understanding will improve ability to recognize community members (including children and youth) who may be in need and improve engagement and linkage to appropriate resources	
	Social Support Goal 1B		Expand local community resources for preventing and mitigating stressors: Invest in and expand access to more programs that promote effective coping skills, parenting classes and support for children and teachers, and school-wide interventions to promote a positive mental health climate that values diversity, equity and inclusion	
	Strategy 1B.2		**Support and expand accessible social environments** Collaborate with community leaders and organizations to create Anti-Racist, welcoming, and empowering environments	

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
	Strategy 1B.3		Help individuals to develop and pursue hobbies and interests: Increase opportunities for individual connection to purpose by facilitating educational and employment opportunities for those in treatment, re-entry, or recovery	
	Outpatient Mental Health Care Goal 1C:	Emphasize a whole-person approach to assessment o Integrate individuals' comprehensive needs including behavioral health, physical health and social support during assessments through the lens of their *culture and native language* o For children, include developmental and educational needs"		
	Strategy 1C.1: Assessment and Care Planning	During the assessment process culture and native language must be considered to understand an individuals' comprehensive needs including behavioral health, physical health and social support.		
	Strategy 1C.3: Outpatient Care		Evaluate the system of care to ensure understanding of racism and its impact upon most at-risk children, youth and families engaged with systems of care including the Departments of Children and Family Services and Probation	

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
		And finally, we will find ways to make sure treatment plans are completed in a timely manner and continuously updated; that high-quality care is delivered consistently across communities that are age appropriate and in a culturally competent manner. Services will be designed to do everything possible to guard against crisis, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement *Conduct culturally and linguistically specific outreach to* engage underserved communities in understanding what outpatient services are available to them and how to access care o Expand outpatient clinic hours into the evenings and weekends in order to more effectively engage communities and provide services to enhance accessibility o Support communities in advocating for equity of resources and services		
Crisis System Domain	Goal 2: Intensive Care Strategy 2.1: Real-Time Crisis Response	Build a real-time, robust, well-coordinated, recovery-oriented and client- and family-centered crisis response network	Despite the best efforts of crisis responders and the inpatient and residential treatment network, there are some individuals who continue to experience intensive needs over a longer period, resulting in frequent hospitalization and intensive care. For this population we must examine the role of racism and the disconnect between services and client needs.	CR 3, CR 5, CR 6, and CR 8

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
		○ Integrate high-quality crisis response services into every community and staff them with well-trained, *culturally competent* and caring first responders who work to resolve crises safely, for both youth and adults, and make every attempt to avoid the need for hospitalization		
Institutions Domain	Goal 3: Re-entry initiatives		Goals 1 and 2 of this Strategic Plan propose significant investment and fundamental equitable and just changes to the system of care in LA County that, when fully realized, will dramatically reduce the number of adults and youth with a serious emotional disturbance and mental illness, who when impacted by racism, poverty and inequity fall out of their community and into the institutions of deep isolation, the streets, prolonged or repeated child welfare involvement, juvenile probation and jail. Unfortunately, implementing these interventions will take time during which we must seek to empower and uplift those already living in, or likely to enter, the institutions.	CR 2, CR 7 and CR 8 CR 1, CR 7 and CR 8
	Strategy 3.1 Identifying and Connecting with the Deeply Isolated	Deploy tactics for reaching out to and engaging individuals who are isolated: Assist individuals to return to the community and facilitate opportunities for education, employment, and meaningful connection which is key to stability and successful re-entry ○ Train staff to understand the associated stigmas attached to co-occurring disorders and inter-generational trauma within the cultures represented	Evaluate systemic issues that are impacting disproportionately and promotion of equity within DMH that may be contributing to or enabling isolation Identify co-occurring disorders that may be further isolating individuals: Train staff to understand the associated stigmas attached to co-occurring disorders, impact of	

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
		○ Train front-line and clinical staff in *cultural humility and sensitivity* in order to better demonstrate empathy for increased cultural competency	racism, and inter-generational trauma within the cultures represented	
Infrastructure Domain	Organizational support Goal 4 Strategy 4.2: Process Strategy 4.3: Outcomes	Process consumer grievances, complaints and appeals through the lens of cultural humility and service competency to understand diverse communities that inform the background and mental health needs of individuals ○ Ensure equity in the reviews to help address racial and ethnic disproportionality in access to and delivery/quality of care Improve training and professional development to increase the skills and capabilities of departmental staff ○ Create a true learning organization by building the capacity for staff to manage projects and improve the quality of programs and services ○ Infuse cultural competency training in every new employee orientation ○ Conduct regular and frequent staff trainings to increase their cultural competency, with a focus on staff who	Overhaul processes for recruiting and hiring new staff to increase equity, diversity and enable quicker program development to more competitively attract talented hires Optimize DMH's services from the ground up with the values of Equity, Anti-Racism, Social Justice, Just Culture and continuous quality improvement	CR 1, CR 7 and CR 8 ECR 5, CR 6, and CR 8 CR 2 CR 1 and 7
Infrastructure Domain				

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
		directly engage with clients in outpatient and inpatient settings Collect and utilize data to analyze service utilization by communities of color to address disparities and inequities in the system of care o Conduct cultural competence assessments to better understand the demographic characteristics of communities o Work to improve data collection to track and specify the cultural composition of DMH consumers beyond broad ethnic category labels, e.g., "Latino," in order to provide enhanced culturally specific services and valid, relevant outcomes Translate key documents for DMH consumers into the top 13 threshold languages spoken in L.A. County to capture the elements of culture and equity in service delivery o Ensure critical documents like consent for services, treatment plans and assessments are widely *available in clients' preferred language and capture culturally specific details* that will help enhance the delivery of care		
Addendum B	What We Heard Goal Goals 1A – Prevention Services	Our prevention services in LA County must improve culturally competent outreach and engagement efforts to those experiencing mental health stressors and increase empowering equitable linkage assistance to needed resources.		CR 1, CR 6, and CR 7

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
		Stigma and lack of awareness remains a problem throughout the County. Individuals, families and communities often have difficulty recognizing early signs of mental health challenges. People who work in communities often lack the cultural awareness and training that would help them to recognize and engage individuals in need.		
	Goal IB - Social Support		Black and other diverse communities of color are disproportionally impacted by multi-generational trauma, poverty, and violence. Many family members are stressed and feel they lack the resources required to help their loved ones. Further, many individuals with mental illness find it difficult to maintain their relationships with others and become isolated. Communities of color often lack venues where individuals can safely interact with others free of violence and stigma. In such environments there are often not enough opportunities. Employment and education are currently only a small part of DMH programming, and few consumers experience improvement in these key life domains.	
	1C – Outpatient Mental Health Care	Even when individuals can access the care they need, they rarely experience being active members of the care team. Many individuals and their families find DMH clinics to be unwelcoming or stigmatizing. And there are not enough clinic staff with the appropriate language skills and cultural competence to adequately serve LA County's diverse communities		

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
	Goal 3 – Re-entry Initiatives Goal 4 – Organizational Support		Now, these individuals occupy LA County's institutions at alarming rates. These include not only the institutions of long-term involuntary psychiatric care, but also the insidious institutions of chronic homelessness, criminal justice system involvement and isolation. Black, Latino, and other communities of color occupy these institutions at alarming rates. Whether closed- or open-air, these institutions cut off individuals living with serious mental illness from community. Without community, people cannot flourish and move towards recovery. Our organization was designed and built in a different era to address a different paradigm of need in LA County. Back then the system was designed with little to no sensitivity to race matters and understanding of the impact of social determinants of health. In order to successfully implement this Strategic Plan, we need an overhaul.	
Addendum C	Active Tactics Goal 1A – Prevention Services - *Active Tactics*	"Expanding the Promotores de Salud Mental (Spanish Speaking) and the Mental Health Promoters (Multicultural and Multilingual) Programs: These programs provide specialized mental health prevention services in the community by trained community residents familiar with the language and culture.	The WhyWeRise Campaign (including the We Rise events): A movement to break through barriers, increase diverse voices and defy old assumptions about mental health and the many related social conditions that compound problems and hurt our communities. School-Based Community Access Platforms (SBCAPs): Provide programming and training for students, their families and the school's workforce to address issues related to violence,	CR 8

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
	Goal 4 – Organizational Support – Active Tactics		racism, trauma, and to facilitate healthy dynamics in schools and communities. Increase Cultural and Language Specific Media Resources and Campaigns address racism, diversity, and inclusion. Anti-Racism, Diversity, and Inclusion (ARDI) Division and ARDI Staff Advisory Council: DMH has formed the ARDI division which will include internal issues related to creation of an anti-racist, transparent, and empowering work environment. The ARDI staff advisory council will represent an important bridge between staff and management. The external component of the ARDI division will improve outcomes to maximize resources and increase community participation.	
Addendum D	**Goal 1A - Prevention Services** Goal 1B – Social Support		Increase anti-racism and diversity prevention initiatives to promote pride and resilience in Black, Latino, and other communities of color. Increased number of culturally competent services available Increased opportunities for clients and staff to engage in anti-racism and empowering activities	

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*
	Goal 1C – Outpatient Mental Health Care		Increased equity and access of services to underserved cultural communities Increased number of DMH funded facilities that are welcoming, linguistically, culturally competent, and relevant for the communities they serve	

* Specifications for the CCPR, Criterion 1 - 8

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

A. LACDMH Systemwide Initiatives and Activities that Address Cultural, Linguistic and Equitable Service Delivery and Accessibility

1. ARDI Initiatives and ARDI Division

Key to the provision of anti-racist, equitable, inclusive, and meaningful mental health services is the aim to continuously advance cultural and linguistic effectiveness within the Department. To create an anti-racist culture and address inequities within the work and treatment environments, LACDMH implemented the ARDI Division in June 2021. Such implementation took place in the background of several tragic, racially-fueled events occurring nationally and locally. The Los Angeles County Board of Supervisor's put forth a motion that created the Countywide ARDI Initiative while LACDMH simultaneously expressed commitment and importance of this initiative by forming its own ARDI Division. Two significant internal undertakings laid the foundation for LACDMH's ARDI Division:

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

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

- ***Action Learning Communities (ALC)***

  The primary goal of the ALC was to build an intra-departmental community of LACDMH staff committed to advancing racial equity. ALC members identified various actions needed to address equity issues for Black, Indigenous, and People of Color (BIPOC) communities. The ALC process engaged 54 staff in identifying key issues pertaining to racism and racial equity within the Department and proposing recommendations. With the assistance of an independent consultant, ALC participants reviewed these issues and grouped them into five general categories:
  - Eliminating Workplace Racial Micro-Aggressions and Conflict
  - Culturally Congruent Care/Collaboration/Social Justice
  - Racially Equitable Hiring, Advancement, and Supervision
  - Equitable Pay and Resources/Cross-Departmental Partnerships, Collaboration, and Community Engagement
  - Leadership, Management, and Accountability

- ***Intergroup Dialogues (IGD)***

  IGDs were implemented with LACDMH staff who were interested in creating safe spaces to hold dialogues on matters of race, racism, and specifically anti-Black racism, and to discuss ways of promoting racial equity in LACDMH.

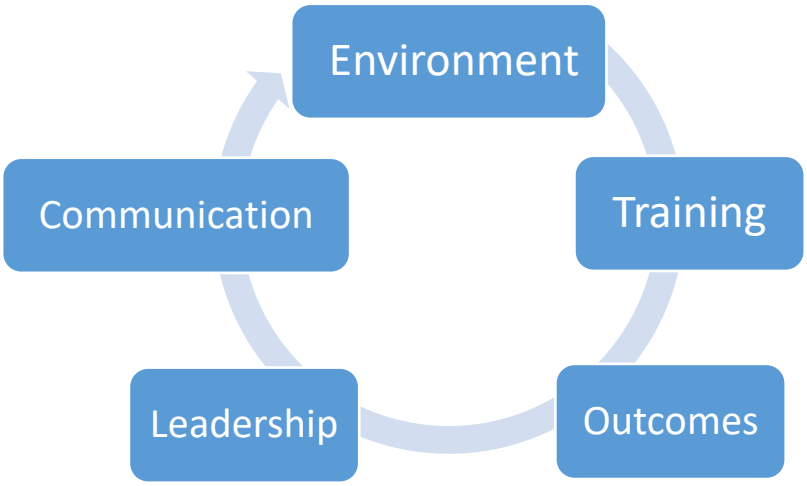
  LACDMH staff who participated in IGDs and/or ALC were organized to develop the action framework to achieve racial equity in LACDMH. The actual framework to achieve racial equity in LACDMH identified six major priorities:

  1) Antiblack racial awareness, acknowledgment, and education to promote intrapersonal growth
  2) Staff well-being and empowerment

3) Hiring, supervision and professional advancement
4) Antiracist, culturally congruent and responsive services
5) Partnerships and collaborations across Los Angeles County, city departments, and community stakeholders
6) Commitment, accountability, and respondent responsiveness of executive management and departmental leadership

The six affinities identified by the ALCs were incorporated into competencies to guide service implementation, coordination, and evaluation strategies for the newly formed ARDI Division. Affinity teams were formed to conduct an analysis of key issues identified by ALC participants, which in turn generated a total of 125 recommendations for the conduction of equity and antiracism work in LACDMH.

LACDMH ARDI Division Domains



The framework of the Division is composed of the five domains illustrated above. Each domain contributes to the Department's overall readiness and responsiveness for sustainable progress in equity and racial justice for the workforce and the communities served.

General Internal Focus Goals

- Promote an anti-racist work environment
- Increase transparency and inclusion in executive decision making
- Define clear pathways and career advancement for culturally diverse staff inclusive of Black, Indigenous, LGBTQ+, and People of Color (POC)
- Create safe spaces to explore impact of racism and oppression at work
- Reduce incidents of work-related racism and inequities
- Provide staff trainings to address impact of systemic oppression, racism and inequities

General External Focus Goals

- Develop, implement, and evaluate programs and services from an anti-racist, culturally competent perspective
- Improve access to care caused by racism, cultural, and linguistic barriers
- Address ongoing issues of systemic oppression in service delivery including poverty, disproportionality of impact and persistent mental illness, social determinants impacting health access and outcomes
- Evaluate outcomes of programs designed to serve specific diverse populations and make recommendations for quality improvement

2. Stakeholder Process and Engagement

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

YourDMH

The purpose of this collaborative and inclusive approach is to develop shared goals of hope, recovery, and wellbeing. Strategically, YourDMH constituents play an active role in identifying funding priorities for services provided under the Mental Health Services Act. The main goal of YourDMH is to engage communities in dialogue and decision-making pertinent to departmental priorities, service delivery models, funding allocations, target populations for various programs and projects, and outcomes. These dialogues produce essential feedback and guidance for the Department to focus on community-driven stakeholder priorities and develop action plans for enhanced service provision with shared goals of hope, recovery, and wellbeing.

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

Many important service expansions and improvements have been informed by YourDMH in alignment with the LACDMH strategic plan. Specifically:

- Reinstituting the Psychiatrist Loan Repayment program which incentivizes recruitment of quality, motivated, and dedicated professionals to serve our consumers and strengthen our staff
- Transforming the Full Service Partnership program to best support consumers with high symptom acuity in their process of recovery and reintegration in the community
- Bolstering the Therapeutic Transportation Van program to provide intensive care resources needed to help individuals in crisis who are falling out of community
- Expanding homeless outreach and mobile engagement (HOME) program to care for and house most vulnerable consumers

Cultural Competency Committee (CCC)

The CCC serves as an advisory group for the infusion of cultural competence in LACDMHs operations. The CCC membership includes the cultural and lived experience perspectives of consumers, family members, peers, advocates, Directly Operated (DO) providers, Contracted providers, and community-based organizations. The Committee considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential members for sustaining its mission. The CCC is led by two Co-Chairs who are community representatives and elected annually by the membership. In the absence of funds to implement projects, the CCC focuses on providing cultural competence-related input for various LACDMH initiatives. The Committee collaborates with the ARDI Division-Cultural Competency Unit's projects. Examples of collaborative projects with a systemwide impact:

- During CY 2014 and 2017, the CCU in partnership with the CCC implemented two workgroups to address the needs of the LGBTQ and physical disabilities communities:
  - "LGBTQ Workgroup" (CY 2014), currently known as the LGBTQIA2S UsCC
  - "Needs of Persons with Physical Disabilities" (CY 2017), currently known as the Access for All UsCC

The addition of these two workgroups to the Underserved Ethnic Populations (UREP) subcommittees propelled the change in their names to the Underserved Cultural Communities subcommittees

- For CY 2019, the Committee reviewed and provided feedback for P&P 200.09 "Culturally and Linguistically Inclusive Services"
- For CY 2021, the CCC partnered with the CCU to implement the "Cultural Traditions and Connections Newsletter."

Underserved Cultural Communities (UsCC) subcommittees

LACDMH has implemented seven (7) UsCC subcommunities that address the mental health needs and concerns of historically unserved, underserved and inappropriately served communities. The UsCC subcommittees work closely with community partners and consumers in order to increase the capacity of the public mental health system and to develop culturally competent recovery-oriented projects specific to the UsCC communities.

The seven UsCC subcommittees include:

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

Every Fiscal Year, each UsCC subcommittee is allotted one-time funding totaling $200,000 to focus on CSS-based capacity-building projects. The membership from each subcommittee generates conceptual ideas for capacity building projects. The UsCC projects are voted via a participatory and consensus-based approach within each subcommittee. Overall, the UsCC capacity building projects aim to increase knowledge about mental illness, increase access to mental health resources, and decrease stigma related to mental illness in the targeted UsCC communities. These projects are not intended for the delivery of mental health services but to increase access to care for unserved, underserved, and inappropriately served populations who are uninsured/uninsurable consistent with the language and cultural needs and demographics of those communities.

Service Area Leadership Teams (SALT)
LACDMH has established Leadership Teams in each of its Service Areas. Each SALT convenes regularly to address priorities specific to their Service Area regarding mental health service delivery, optimal utilization of departmental available resources, and effectiveness of communication between providers and constituents. Collectively, the recommendations from the eight SALT advise the Department on service planning and implementation as well as improvements needed based on their organized feedback. ***See Criterion 1 Appendix, Item for more detailed information.***

Community Leadership Team (CLT)
The CLT is made up of Co-Chairs from two: SALT and UsCC. Members of the CLT work together to discuss and consolidate stakeholder priorities. Once officially endorsed by SALT, UsCC, CCC, and other groups, all recommendations are incorporated into a comparative stakeholder priority list. The purpose of analyzing stakeholder priorities is to identify which priorities have the support of multiple stakeholder groups. CLT meetings take place quarterly and focus on a community planning process that generates input regarding MHSA programs, functioning of the mental health system, and recommendations for improvement of programs as well as strategies to address systemic unmet needs
pursuant to WIC Section 5848(a).

Mental Health Commission (MHC)
State law requires each county to have a Mental Health Board or Commission. The role of the Commission is established in the Welfare and Institutions Code (WIC) Section 5604. LACDMH's MHC was implemented on October 29, 1957. Its role is to review and evaluate the community's mental health needs, services, facilities and special programs. The Commission consists of sixteen members. By law, one member of the Commission must be a member of the Board of Supervisors. WIC Section 5602 sets very specific membership requirements: Fifty percent of the Commission membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. Consumers constitute at least 20% of the total membership. Families of consumers constitute at least 25% of the membership.

In FY 2020-2021, the MHC formed several workgroups to tackle the county's most pressing issues related to mental health. Each work group developed a series of recommendations aimed at the Commission itself, The Department and the Board. The workgroups focused on disparities and inequities across groups, homelessness and integrated culturally competent care. See Criterion 1 Addendum for detailed information.

3. *Multicultural and Multilingual Media Campaigns*

LACDMH designs and implements massive public communications efforts that specifically targeted COVID-19 highly impacted communities during FY 20-21. LACDMH has continued outreaching to Los Angeles County communities to provide support and promote mental health via multiple hyper local/ethnic media outlets. LACDMH Media efforts were supported by Cause Communications, a woman/LGBTQ founded nonprofit organization. Hyper local/ethnic media were used to promote mental health messages. The messaging focused on coping with COVID-19 challenges, supporting frontline workers' mental health, promoting resilience and wellbeing, support via the Department's 24/7 Help Line, online resources offered by LACDMH and partner organizations, virtual wellbeing events, and free subscriptions to Headspace. Examples of hyperlocal targeted media products include digital billboards, Metro and bus line advertisements, radio and TV spots, posters at WIC offices, displays and handouts at commonly frequented community sites. LACDMH's media outreach campaign engages the County's culturally and linguistically diverse communities with placements in English, Spanish, and Chinese newspapers; television programming in English and Spanish; radio programming in English, Spanish, Chinese, Korean, Persian, Armenian, and Vietnamese; WIC offices postings; top outdoor media companies across the County and through social media.

4. *WERISE*

May 2021 marked the fourth consecutive year of the WERISE campaign launched by LACDMH. The Virtual WERISE campaign aimed to connect participants with individual and communal sources of hope, inspiration and healing. In the words of LACDMH's director, Jonathan E. Sherin, M.D., Ph.D., WERISE "drives a heart-forward movement that brings the County together as we all struggle with difficult emotional experiences that are being shared across our collective in an unprecedented way right now."

The RAND Corporation evaluated the 2021 WhyWeRise Mental Health Campaign to reach and impact up a survey that compared the demographic characteristics, attitudes, beliefs, and behaviors of residents who were exposed to the campaign with that of residents who were not. Researchers evaluated all the 2021 campaign elements

inclusive of websites, outdoor ads, television and radio ads, social media posts, and community and digital events.

Key Findings

- The campaign was effective in reaching all major racial/ethnic groups in the county, particularly Spanish-speaking residents, and in reaching sectors with lower incomes and education levels.
- Eighty percent of residents attending campaign events said the events made them feel their mental health is important, and 71 percent said the events gave them new information about how to get help with emotions or mental health. Patterns were similar for television and radio ads and for social media.
- Campaign participants were more likely to agree that they were aware of information and resources offered by LACDMH.
- Awareness of LACDH's Help Line and website was more than twice as high among campaign participants. Website utilization was four times as likely among WhyWeRise-exposed versus unexposed individuals.
- WhyWeRise participants were more likely to agree that they plan to help break down barriers that keep people with mental health challenges from getting treatment and that they have the power to change how communities deal with mental health issues.
- They were also more likely to report that they plan to take action to prevent discrimination against those experiencing mental illness and that they can recognize the signs that someone may be experiencing a mental health problem.

5. Speakers Bureau

This initiative was implemented in April 2020 in response to the COVID-19 pandemic and beyond. It started as a joint effort between the Chief of Psychology Team and the Cultural Competency Unit. Since, the Speakers Bureau has functioned as an organized public communication, clinical and community intervention resource comprised of approximately 90 highly skilled, licensed mental health clinicians who specialize in extensive social media and public speaking delivery. The Speakers Bureau served communities most disproportionally impacted by the COVID-19 pandemic and civil unrest. It supports the reduction of mental health inequities and addresses accessibility to quality mental health information and interventions. Its members are Subject Matter Experts (SME) who are culturally competent and linguistically certified to provide services and interventions in all threshold languages of Los Angeles County, e.g., Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Russian, Spanish, Tagalog, and Vietnamese as well as French, Thai, Urdu, Laotian, and Hindi. Furthermore, the Speakers Bureau intentionally includes specialized cultural representation of several underserved communities such as American Indian and Alaska Native; Asian, Asian American, and Pacific Islander (AAPI); Black and African American; Latino inclusive of Latinx and Central American communities; Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Asexual and Two-Spirit Communities (LGBTQIA2-S); Multi-Racial and Multi-Ethnic; Older Adults; Persons Experiencing Homelessness; Persons with Physical Disabilities; Faith-based and spirituality; and Veterans. Collectively, Speakers Bureau members contribute to over 200 areas of clinical expertise.

6. Faith-based Advocacy Council (FBAC)

This Council empowers the Department's collaboration with faith leaders from various religious affiliations. This council operates under the following values:

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

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

7. LACDMH COVID-19 Webpage

LACDMH supports the wellbeing of Los Angeles County residents and communities. LACDMH published a collection of COVID-19 materials and resources on relevant topics that promote wellbeing and connect the community to up-to-date and reputable sources of information. The webpage is available at https://dmh.lacounty.gov/covid-19-information/. Many of the resources listed are available in the threshold language. Examples include:

1) COVID-19 Mental Health including materials that address mental health and wellbeing needs and concerns
   - Maintaining Health and Stability During COVID-19
   - Staying Connected During Physical Distancing
   - Alleviating Fear and Anxiety During Essential Trips in Public
   - Understanding the Mental Health and Emotional Aspects of COVID-19
   - Coping with the Loss of a Loved One
   - Your Wellbeing on Your Terms brochure

2) Additional COVID-19 materials specific to coping strategies for families, parents, and children; healthcare providers; workers; peer support and the community at large.
3) On-line practical information such as the LACDMH Help Line, Headspace app, iPrevail, suicide prevention, back to school, veterans, grief, and loss, first responders, LGBTQ+, anti-racism, public safety, and holiday season resources.

8. Outreach and Engagement (O&E) Teams

Each of the eight Service Areas has designated staff to conduct community-based outreach and engagement activities focusing on mental health education and linkage. O&E staff are knowledgeable of their respective Service Areas. They effectively network with community-based organizations such as schools, churches, social service providers, and community groups. O&E staff connect LACDMH with communities who may not access mental health services. Utilizing their culturally and linguistically diverse backgrounds, they offer presentations to combat stigma and demystify mental health services. They also coordinate community events and participate in health fairs. O&E staff educate community members on how to access LACDMH available resources.

9. Cultural Competence Trainings

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

- Age groups (Children, TAY, Adults and Older Adults)
- Cultural competence and cultural humility
- Deaf and hard of hearing population
- Evidence Based Practices
- Forensic population
- Gender identity
- Homeless population
- Implicit Bias
- Intellectual and physical disabilities
- Language interpreter series
- Peer support
- Race and ethnicity
- Racism
- Sexual orientation
- Spirituality
- Substance use and co-morbidity
- Trauma-informed services
- Veterans

LACDMH Programs and Activities Focused on Cultural Competence

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

1. Assisted Outpatient Treatment Program (AOT)

Assisted Outpatient Treatment (AOT), also known as Laura's law, was initiated following the 2001 killing of Laura Wilcox by an individual suffering from severe mental illness. Former Assemblywoman Hellen Thomson authored Assembly Bill 1421, thereby establishing Assisted Outpatient Treatment Demonstration Project Act of 2002 (WIC 5345 et seq). OAT serves persons with serious mental illness, history of treatment inconsistency, substantial risk for deterioration, relapse, or detention, all of which could result in grave disability or serious harm to self or others.

2. Community Ambassador Network (CAN)

The CAN program is designed to hire, train and certify community members as "lay" mental health workers in their neighborhoods. Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community

members with resources relevant to their needs. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in most disenfranchised communities. All Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical, and spiritual wellbeing of underserved communities. The CAN Program prioritizes support of communities who self-identify as Black, Asian, Indigenous and People of Color, all of which have been disproportionately impacted by systemic racism and inequality.

3. Enriched Residential Care Program (ERC)

This program was established to facilitate the placement of consumers who require intensive care and supervision at licensed residential facilities. Approved consumer participants receive the financial support necessary to obtain and maintain stable housing including funds for rent, personal and incidental expenses. The program enables LACDMH to subsidize the rent for consumers who live in Board and Care homes and have no income.

4. Full Service Partnerships (FSP)

FSP Programs provide individualized client-driven services and supports. Unique to FSP programs is a low staff-to-client ratio, a 24/7 crisis availability and a team approach based on a partnership between mental health staff and consumers. FSPs have undergone transformation to increase focus on two major groups of clients: children and young adults ranging between 0-20 years of age and adults over the age of 21. The aim of the program is to serve consumers presenting with a severe and persistent mental illness or serious emotional disturbance, and with high levels of need. The foundation of FSP services is doing "whatever it takes" to help individuals on their path to recovery and wellness. The provision of services is based on a team-based and comprehensive approach, and utilization of consumer outcome data to ensure high-quality care. Adult FSP programs assist with housing, employment, education, and integrated services for individuals who have co-occurring mental health and substance use conditions. Services may be provided at consumers' homes or in the community.

5. Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Program

The GENESIS Program offers 100% field-based outpatient comprehensive mental health services for Older Adults who are living with a severe mental illness and are unable to access services due to compromised mobility, frailty, or other challenges. The program provides specialized services to meet the unique needs of consumers who are over the age of 60. Services include individual and family psychotherapy, medication services, mental health education and support, assistance in accessing appropriate level of care, in-home supportive services, housing retention, and linkage to various resources such as Medi-Cal, Medicare, Social Security, and Veteran Administration Benefits.

6. Health Neighborhoods (HN)

Implemented by LACDMH in partnership with the Department of Public Health (DPH) and Department of Health Services (DHS), HN increase health equity and access to

quality services through integrated care and community collaboration. The vision for the HN is to function as a network of diverse stakeholders including mental and public health providers, community and city-based agencies, educational institutions, housing services, social service providers, faith-based groups, and community members. The mission of the Health Neighborhoods is to form a coalition of community partners working to build thriving communities in underserved areas through prevention, improved coordination, and strong support networks. To meet the specific needs of a defined community, HN must remain organic in nature with a shared vision and commitment from the three Health Departments and community stakeholders. The existing HN coalitions in all Service Areas continue to expand and diversify to improve service coordination, collaboration and effective use of resources that support residents and address existing health inequities.

8. Homeless Outreach and Mobile Engagement (HOME)

This specialized program provides field-based outreach, engagement, support, and treatment to individuals who have severe and persistent mental illness, and who are experiencing unsheltered homelessness. Services address basic needs and include clinical assessments; provision of street psychiatry; and linkage to appropriate resources, often related to substance use and housing.

9. Housing and Supportive Services (HSSP) Program

Formally known as the Housing FSP program, the HSSP services focus on individuals experiencing homelessness and mental illnesses who are living in Permanent Supportive Housing (PSH) locations. Services are individualized and may include group psychotherapy, crisis intervention and medication management. HSSP services are part of an integrated service team that includes Intensive Case Management Services (ICMS) and Client Engagement and Navigation Services (CENS).

10. Katie A.

LACDMH, in collaboration with Los Angeles County Department of Children and Family Service (DCFS), provides a variety of mental health services associated with the settlement agreement in the Katie A. class action lawsuit of 2002. These specialized services are provided to children and youth in the county's child welfare system who have open DCFS cases; Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) eligibility; and meet the medical necessity requirement for full scope Medi-Cal. The program offers mental health screening and referral to LACDMH staff who are co-located across the twenty (20) DCFS regional offices. Cases are triaged based on symptom acuity and linked to Directly Operated and Contracted providers with specialty in children's mental health.

11. Linkage programs

The mission of linkage programs is to connect community members to mental health services and other essential social services throughout Los Angeles County. LACDMH has three linkage programs: Jail Transition and Linkage Services, Mental Health Court Linkage, and Service Area Navigation.

- The Jail Transition and Linkage Services program addresses the needs of individuals in collaboration with the judicial system by providing outreach, support,

advocacy, linkage, and interagency collaboration in the courtroom and in prison. Linkage staff work with the MHSA Service Area Navigators and service providers to assist incarcerated individuals in accessing appropriate levels of mental health services and support upon their release from jail. These may include housing, benefits establishment, and other services as indicated individual needs. The goal is to successfully link individuals to community-based services, thereby decreasing the possibilities of re-incarceration and unnecessary emergency/acute psychiatric inpatient services.

- The Mental Health Court Linkage Program operates with two MHSA-funded sub-programs: The Court Liaison and Community Reintegration Programs. The Court Liaison Program which is a problem-solving collaboration between the Department and the Los Angeles County Superior Court. This program has mental health clinicians co-located at courts countywide and serves adults who have mental health conditions, co-occurring disorders, and who are involved with the criminal justice system. The objectives of the program are to increase coordination and collaboration between the criminal justice and mental health systems, improve access to mental health services and supports, and enhance continuity of care. The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants who have a mental health condition including co-occurring substance use. The goal of CRP is to reintegrate clients into the community with the skills and resources necessary to maintain stability and avoid re-arrest. This program also provides admission to two specialized mental health contract facilities for judicially involved individuals with mental health conditions who voluntarily accept treatment in lieu of incarceration.
    - *The Men's Community Re-Entry Program (MCRP)* mission is to reduce recidivism and facilitate community reintegration by treating mental health symptoms and maladaptive behaviors. The program serves justice-involved men 18 to 65 years of age who present with high criminogenic risk factors and moderate acuity of mental illness. Often, MCRP consumers have been fully or partially released from prison. Participation in the program ranges from one to two years. The program uses an evidence-based model to identify the unique needs of each consumer and aims to address criminogenic risk factors that place them at risk for re-offending and recidivism. MCRP staff form working partnerships with jail/prison staff, courts, probation/parole officers, and public defenders.

    - *The Women's Community Reintegration program (WCRP)*
      The main goal is to assist women who have been incarcerated to reintegrate and become successful members of their communities. The program is field-based and aims to reduce recidivism by addressing criminogenic risk factors and promoting mental health. WCRP is Community Health Worker driven along with field psychiatry. WCRP Teams are mostly comprised of Community Health Workers with mental health and incarceration lived experience.

- Service Area Navigation Teams assist individuals and families in accessing mental health and other supportive services. The program is based on the navigators'

ability to network with community-based organizations to strengthen the array of services available to clients of the mental health system. Such networking creates portals of entry in a variety of settings that would make the long-standing goal of "no wrong door" achievable.

12. Maternal Mental Health (MMH) Program

This program provides specialized mental health services tailored to address the unique experiences that parenthood presents. MMH Program is designed to support families who may be currently pregnant, plan to become pregnant, or are post-partum, typically up to a year after the child's birth. Services are tailored to meet specific aspects of cultural competence identified as key for the participant's recovery. For example, MMH has support groups that target the needs of African American and Teen mothers.

13. Mental Health – Law Enforcement Teams (MH-LET)

The program is based on the premise that diversion from arrest/incarceration into community-based treatment facilities connects community members, who have a mental health condition, to the care they need. The goals of this program include: 1) timely access to mental health services to individuals in acute crises who come to the attention of law enforcement through 911 system or patrol; 2) reduce the risk of incarceration of individuals who are in acute crisis when they come into contact with law enforcement; 3) mitigate police use of force; and 4) provide individuals with an immediate clinical assessment and mental health services such as acute inpatient hospitalization, linkage, and intensive case management. The MH-LET teams are composed of one licensed mental health clinician partnered with a law enforcement officer. Together, they respond to 911 calls or patrol car requests for assistance when persons suspected of having a mental condition are involved in an incident. The teams provide crisis intervention including assessment for WIC 5150, de-escalate potentially violent interactions between consumers, family members and police, make appropriate referrals to community agencies, and facilitate hospitalization. The teams decrease the need for inpatient psychiatric hospitalization by providing immediate field-based services. Mental health clinicians have already been assigned to work with 39 of the 46 police departments in Los Angeles County.

14. My Health Los Angeles (MHLA) - Behavioral Health Expansion Program

This program supports mental health prevention services and activities that reduce risk factors associated with the onset of serious mental illness of MHLA participants. The target population is traditionally underserved, mostly monolingual Spanish-speaking individuals who are low income and uninsured. The services are provided at MHLA-contracted Community Partner Clinics. The MHLA Behavioral Health Expansion project contributes to LACDMH's goal of delivering culturally and linguistically competent services by making mental health prevention services and activities available in less stigmatizing community venues.

15. Older Adult (OA) Service Extenders (SE) Program

Service Extenders are volunteers who have been specially trained to provide highly sensitive and culturally appropriate supportive services to Older Adults. They work with multi-disciplinary treatment teams and provide additional support and advocacy.

Service Extenders may assist in making friendly visits to isolated Older Adults, engaging them in community reintegration, and promoting hope and support in their recovery process.

16. Preventing Homelessness and Promoting Health

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

17. Promotores de Salud Mental and United Mental Health Promoters (UMHP) Programs

The UMHP was implemented in November 2020 as an expansion of the Promotores de Salud Program to the African and African American, Asian Pacific Islander, American Indian/Alaska Native, Eastern European/Middle Eastern, LGBTQIA2S, and persons with disabilities. The expansion is based on the premises and accomplishments of the initial Promotores de Salud Program, namely that natural leaders once trained as mental health promoters are successful in bridging gaps between LACDMH and the communities they serve.

Mental Health Promoters function with a solid understanding of their communities, often sharing similar cultural backgrounds including but not limited to race/ethnicity, language, socio-economic status, sexual orientation, and daily-living experiences. They provide leadership, prevention education and linkage services in a culturally and linguistically appropriate manner and facilitate navigation of systemic barriers often experienced by community members who need mental health services. Promoters provide education on topics such as Mental Health Stigma; Stages of Grief and Loss; Domestic Violence Prevention; Drug and Alcohol Prevention; Symptoms and Treatments of Depression; Symptoms and Treatment of Anxiety Disorders; Suicide Prevention; Child Abuse Prevention; and Childhood Disorders, at various community organizations.

18. Outpatient Care Services (OCS) Transitional Age Youth (TAY) Drop-In Centers

These Drop-In Centers are an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who live on the streets or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. Drop-In Centers provides them with a broad array of integrated community-based, clinic-based and wellbeing services and a recovery-focused supportive system of care. They offer basic supports such as showers, meals, clothing, and vouchers as well as linkage and referrals to help the youth work toward stability and recovery. Seeking Safety (SS) groups are offered to address risk factors including trauma, alcohol/drug use, rejection from peers/family, and interpersonal conflict/stress.

19. School Threat Assessment Response Team (START) Program Expansion

The START Program provides comprehensive threat prevention and management services to educational institutions in collaboration with school districts, colleges,

universities, technical schools, and local and Federal law enforcement agencies. The focus of the program is on persons with moderate to high threat levels, either on or off school campuses, and persons exhibiting a pattern of maladaptive behaviors that may be conducive to acts of violence. START staff have formed active partnerships with the educational institutions, law enforcement agencies, local and Federal Bureau of Investigation Office, and other community organizations to prevent and mitigate campus threats in the Los Angeles County. To ensure timely response, all incoming referrals are centralized and tracked from LACDMH headquarters prior to forwarding to the respective supervisors for case assignment. Services include but are not limited to trainings, screenings, assessment, psychoeducation, skill building, faculty consultation on threat management; close monitoring of potentially violent individuals; development of threat management plans and individualized interventions trainings for students and their families; and linkage to a wide range of community resources.

20. Telemental Health Program (TMH)

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

21. Therapeutic Transportation Pilot Program

The goal of this program is to optimize access to mental health services to underserved populations while reducing the use of Los Angeles Fire Department (LAFD) and Los Angeles Police Department (LAPD) resources for mental health emergencies. The program operates 24 hours a day, seven days a week and levers community-driven partnerships to improve outcomes for individuals experiencing mental health emergencies. The Department considers this program to be an effective alternative for dispatching of emergency calls to LAFD and LAPD.

22. Veterans Access Network (VPAN)

VPAN creates connections of hope, wellbeing, and recovery for Los Angeles County veterans and their families. It was developed as a veteran-specialized Prevention and Early Intervention (PEI) program to coordinate resources and services for them and their loved ones. VPAN implements strategies for improved data sharing and coordination of services and creates a more robust process for greater stakeholder involvement for veterans and their families.

23. Wellness Outreach Workers (WOW) Program

LACDMH's WOW volunteers have lived experience and provide peer support in our Directly Operated sites. They work with the treatment teams to assist clients on their path to wellbeing and recovery. The purpose of the WOW program is to promote ongoing peer support to vulnerable adult consumers. Additionally, they facilitate

community reintegration and educate consumers, family members, and community members about mental health care through culturally sensitive treatment options.

24. Whole Person Care (WPC)-Intensive Service Recipient Program (ISR) and Kin Through Peer (KTP)

These field-based programs strive to serve adults 18 years of age and older who have severe and persistent mental illness (SPMI), including co-occurring substance use conditions. Clients eligible for the program must be Medi-Cal-eligible, reside in Los Angeles County, and have had at least two (2) psychiatric inpatient hospitalizations within the last 12 months. Each program offers a wide range of supportive services and referral to community agencies in order to prevent unnecessary psychiatric inpatient hospitalization. Supportive services include crisis; service navigation; benefits establishment, linkage to mental health, physical health, and substance use providers; assistance in obtaining emergency food, clothing, personal hygiene items, and household goods; linkage to housing, educational opportunities, employment, legal assistance, and other social services; and transportation. KTP program fulfills a surrogate "kin" function for clients that need long-term assistance from Community Health Workers (CHW). The CHW's focus on intense relationship-building and long-term sustainable community reintegration to preserve the consumers' healthy well-being.

25. Mental Health Services Act (MHSA) Funded Programs and Initiatives.

LACDMH utilizes the MHSA Plans to advance cultural and linguistic competence within its system of care. The numerous initiatives funded under the MHSA Plans are making a difference in the lives of consumers, their families, and the communities at large. An MHSA update report is produced annually regarding activity under the five MHSA components:

- Community Services and Supports (CSS)
- Prevention Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities/Technology Needs (CFTN)

The annual update details outcomes for MHSA-funded programs and services and is considered an important compliment to the information provided in the 2022 Cultural Competence Plan Report. *See Criterion 1 Appendix for additional information.*

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

Sandra T. Chang, Ph.D. is LACDMH's Ethnic Services Manager (ESM). She is also the Program Manager for the ARDI Division - Cultural Competency Unit (CCU). This organizational structure within the Department allows for cultural competence, equity, and racial justice to be integrated into the Department's quality improvement roles and responsibilities. It also places the ESM and the ARDI Division in a position to actively collaborate with several LACDMH programs and sister Health Departments. In her ESM role, Dr. Sandra Chang has administrative oversight of the departmental Cultural Competency Committee (CCC) and is invested in making the Cultural Competence Plan Requirements (CCPR), the CLAS Standards, and California Reducing Disparities

Report (CRDP) recommendations active components in LACDMH's framework to integrate cultural competence in service planning, delivery, and evaluation.

Examples of how the ESM accomplished these functions during CY 2021:

- Developing and/or a revising departmental policies and procedures (P&P) related to cultural and linguistic competence
- Serving as advisor for the review of policies that include content pertinent to cultural competence. During FY 20-21, the ESM reviewed and provided recommendations on the following:
  - P&P 302.03 – Coordination of Care
  - Culturally Sensitive Services Parameter
- Ensuring inclusion of cultural and linguistic competence in key departmental documents such as the "LACDMH Strategic Plan, 2020-2030: Transforming the Los Angeles County Mental Health System"
- Leading the development of annual Cultural Competence Plans (CCP) Reports
- Serving as departmental lead for cultural competence during the triennial Medi-Cal Reviews and the annual External Quality Review Organization (EQRO) Site Reviews
- Developing reports for the Los Angeles County Board of Supervisors in response to specific Board Motions addressing mental health disparities and COVID-19 disproportionate impact on underserved communities
- Developing and providing trainings on cultural competence, cultural humility, and implicit bias, at various departmental venues and the community at large
- Collaborating with clinical programs in the training of future mental health professionals
  - The ESM provided clinical group supervision to a group of five psychology doctoral students placed at Northeast Mental Health Center
- Providing oversight for the conduction of the cultural competence organizational assessments, informing executive management of outcomes, and addressing knowledge gaps in the workforce
- Implementing initiatives that advance cultural and linguistic competence within the system of care. For example:
  - Dr. Chang is the co-director for LACDMH Speakers Bureau (SB) in collaboration with the ARDI Division Chief, Dr. Jorge Partida Del Toro. During FY 20-21 she strategized the SB infrastructure, recruitment process, and selection of members; inclusion of culture-specific specialties; and development of the SB member directory
  - She also strategized the implementation of the SB Academy to expand the capacity of the bureau, delivered presentations on the SB within LACDMH and stakeholder groups to promote its services, and led the language assistance services and other planning aspects for the 2021 Speaker Bureau Multicultural Community Conference. Additionally, she directed the processing of SB requests while also delivering trainings and presentations as a member

- Overseeing the coordination and delivery of hired vendors for threshold language interpreters, American Sign Language and closed captioning services for consumers, family member and the community at large to participate in departmental stakeholder groups
- Reviewing service utilization data and actively participating in local mental health planning projects that respond to the needs of the county's culturally diverse populations in collaboration with sister health departments
- Promoting knowledge and participation in state cultural competence projects with ESMs from other counties in Southern California
- Providing administrative oversight of the Cultural Competency Committee (CCC) activities
- Providing technical assistance and training to diverse LACDMH programs regarding cultural competence in general, CCPR compliance, and procedures for language translation and interpreter services
- Participating in the Department's Quality Improvement Council meetings as a standing member to provide updates related to the ARDI Division-CCU as well as presentations on the CCC projects and activities
- Representing the unit in various departmental committees such as the Faith-based Advisory Council, UsCC subcommittees, and Service Area Leadership Team meetings
- Collaborating with LACDMH programs/Units to increase the accessibility of mental health services to underserved communities
- Collaborating with the Southern Region ESMs and representing LACDMH in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee
- Serving as the Cultural Competence Lead for the Labor Management Transformation Council which operates under the leadership of the three Health Department directors and Labor Unions

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

1. Development of the annual Cultural Competence (CC) Plan Report, a systemwide report on LACDMH's progress and updates regarding cultural and linguistic competence. The overall goal of the CC Plan is to move all Counties toward more culturally and linguistically competent services and reduce racial/ethnic/cultural and linguistic mental health disparities among unserved, underserved and inappropriately served populations. The ARDI Division-CCU strategically worked with over 40 LACDMH programs to and provided technical assistance in their process of compiling data and information for the report. The CCU writes the CC Plan utilizing the information gathered in accordance with the CCPR areas of focus.

2. Development and implementation of the LACDMH Speakers Bureau (SB) April 2020 as a collaborative effort with the LACDMH Chief of Psychology Team.
   See item 5. on pg. 24 for detailed information.

3. Language Assistance Services for Stakeholder Group Meetings

   During FY 20-21, the ARDI Division-CCU coordinated language assistance services for 23 different stakeholder groups. Most of these efforts required monthly coordination with language interpreter vendors and departmental units. Several of these meetings involved multiple languages and/or a combination of more than one type of accommodation based on requests received from the community. Most language assistance requests involved American Sign Language, closed captioning in real time, and interpreter services for L.A. County threshold languages.

4. Development and review of LACDMH's Policy and Procedure (P&P) pertinent to delivery of cultural and linguistic competent services

   The ARDI Division-CCU was called upon to review departmental policies pertinent to cultural competence. The unit incorporates cultural and linguistic competence content and vets policy revisions with the Cultural Competency Committee. The Unit bases recommendations based on the Cultural Competence Plan Requirements (CCPR) and CLAS Standards.

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

   The mission of the Cultural Intelligence Workgroup is to increase cultural sensitivity, understanding, and humility within three Health Departments to enhance the quality of interpersonal human relationships for all individuals connected to the County of Los Angeles.

   The goals of the CQ Educational Campaign

   - Provide responsive and reflective educational materials to complement the Health Departments' cultural competence, Just Culture, and the Countywide Anti-Racism efforts.
   - Create and facilitate safe spaces for staff from the three Departments to engage in meaningful dialogues about cross-cultural experiences.
   - Enable individual and work teams to embrace cultural intelligence to facilitate systemic changes and improve internal and external service delivery.

   During CY 2021, the workgroup focused on developing educational campaign components for all Health Department employees, which include toolkits, screensavers, a universal poster addressing the four themes specified below,

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

6. Cultural Competence Trainings and Community Presentations pertinent to cultural competence, cultural humility, and implicit bias with LACDMH the community at large

   - New Employee Orientation (NEO)

     The ARDI Division-CCU continued training to new employees on cultural competence and cultural humility during NEO. This introductory training serves the purpose of introducing new employees to the functions of the unit, the CLAS

Standards, the CCPR, County of Los Angeles demographics and threshold languages, and the Department's strategies to reduce mental health disparities.

7. External Quality Review Organization (EQRO) Review

   The ARDI Division-CCU is the lead for the cultural competence and disparities session. In this role, the ESM identifies departmental programs and projects to be featured and coordinates content with the selected key players. The Unit coordinated the collection of reports from twenty-five (25) programs regarding strategies to reduce mental health disparities, consumer utilization data, and cultural competence staff trainings. The Unit also provided guidance to these programs for the proper completion of the information they would be presenting. Additionally, the ESM provided a presentation on the CCU's activities in the Cultural Competence, Disparities and Quality Improvement session.

8. CCC Administrative Oversight

   The ARDI Division-CCU continued providing technical assistance and administrative oversight conducive to the attainment of the Committee's goals and objectives. The Unit's administrative support includes preparation of agendas with CCC co-chairs, meeting minutes, development, and distribution of meeting flyers to promote internal and external meeting participation. The ESM monitored all activities pertaining to the CCC and provided updates on the unit's projects as well as cultural competency initiatives at the State and County levels during CCC meetings. Additionally, the ESM developed and presented the CCC annual report to the Committee, which included demographics regarding the ethnicity, gender, cultural expertise, and languages represented by the membership as well as the goals and activities of the committee. The CCC annual report is included in the Cultural Competence Plan Report.

9. Cultural Traditions and Connections Column

   This project is rooted in the Cultural Competency Committee's (CCC) "Share your Culture" activity, which engaged community members, consumers, family members, peers, and staff in sharing about their cultural background at the time in-person meetings were the norm. With the encroachment of the COVID-19 pandemic, the ARDI Division-CCU in collaboration with the CCC created the on-line Cultural Traditions and Connections Column as a safe space to share, learn, celebrate, and connect our collective cultural experiences. The column is featured in LACDMH's monthly *"Connecting Our Communities Newsletter."*

   The goals of the CTC column include:

   - To honor our personal and communal sense of culture through creative writing, photography, reflections and more. By sharing about our own cultures, we promote cross-cultural learning,understanding, sensitivity, appreciation, and healing for our collective soul.
   - To sustain a virtual space in which everyone can discover, learn about, and nurture the richness of our present experiences and ancestral teachings. Reading heartwarming articles and thought-provoking reflections will expand our horizons, relax our weary minds, draw smilesacross our faces, enhance our knowledge and deepen our compassion for different ways of living.

IV. Budgetary Allocations for Cultural Competence Activities, FY 20-21

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

Cultural Competence-related trainings

- $66,000 for specialized foster care trainings
- $11,600 for juvenile justice trainings
- $28,317.50 for cultural-specific trainings focusing on underserved populations
- $17,245 for interpreter trainings

Language Assistance Services

- $102,235 for language interpreter services, which allow consumers, family members and the community at large to participate in various departmental meetings and conferences
- $8,222 for American Sign Language (ASL) interpreter services provided for consumer, family members and community at large participation in stakeholder meetings
- $76,523 for Closed Captioning in Real Time (CART) services
- $65,708.08 for the translation of documents such as brochures, flyers, and forms
- $101,019 for ASL services offered to consumers from both DO and Contracted providers via the Help Line – ACCESS Center

MHSA Plan-Specific projected budget allocations

A sizable amount of funding is dedicated for cultural competence-related activities under the MHSA Plans. The table below summarizes the projected MHSA-specific budget allocations by plan

- Community Services and Supports (CSS)
- Prevention Early Intervention (PEI)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities/Technology Needs (CFTN)

TABLE 5: SUMMARY OF MHSA PLAN BUDGETARY ALLOCATIONS AND EXPENDITURES, FY 20-21

Programs	Funding
CSS Programs 1. Full Service Partnerships 2. Outpatient Care Services (formerly known as Recovery, Resilience and Integration) 3. Alternative Crisis Services 4. Planning Outreach & Engagement 5. Linkage Services 6. Housing Services	 $302.3 million $636.5 million $139.8 million $7.1 million $28.3 million $35.1 million

Programs	Funding
Total CSS Program Expenditures	**$1,188 million**
PEI Programs 1. Total Gross Expenditures - Suicide Prevention 2. Total Gross Expenditures - Stigma Discrimination Reduction Program 3. Total Gross Expenditures - Prevention 4. Total Gross Expenditures - Early Intervention 5. PEI Administration	 $22.3 million $366.250 $43.6 million $199 million $14.3 million
Total PEI Program Expenditures	**$288 million**
Total Gross Expenditures INN Programs	**$30.2 million**
Total Gross Expenditures WET Programs	**$20.4 million**
Total Gross Expenditures Capital Facilities/Technology Needs	**$3.9 million**

* Data Source: MHSA Annual Update Report FYs 22-23.

CLAS Standards Implementation: Progress at a Glance

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

TABLE 6: CROSSWALK OF LACDMH'S PRACTICES RELATED TO THE CLAS STANDARDS

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
1. Promote effective, equitable, understandable, and respectful quality of care and services	1 - 8	• Departmental mission and vision statements, strategic plan, P&P, providers manual, and parameters that guide clinical care • Implementation of the Anti-Racism, Diversity and Inclusion (ARDI) Division with inclusion of the CCU, Promotores and UMHP program, Speakers Bureau and Spanish Self-Help Group • Implementation of tri-departmental workgroups targeting cultural related service needs, such as cultural and linguistic responsiveness, homelessness, jail diversion, vulnerable youth, and co-occurring disorders • Comprehensive budget allocations for cultural competence activities • Culture and language specific outreach and engagement • Tracking of penetration rates, retention rates and mental health disparities

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Collaborative efforts between the ARDI Division-CCU and the Quality Improvement Unit
2. Governance and leadership promote CLAS	1, 4, 5, and 6	• Well-established Stakeholder Engagement Process • Departmental Strategic Plan • Policies and procedures that guide culturally and linguistically competent service provision • Review and discussions regarding the CLAS standards with departmental leadership, SA QIC, and CCC
3. Diverse governance, leadership and workforce	1, 6, and 7	• Culturally diverse stakeholder process • Utilization of demographical and consumer utilization data in program planning, service delivery, and outcome evaluation • Presence of committees that advocate for the needs of cultural and linguistically underserved populations • Efforts to recruit culturally and linguistically competent staff who represent the communities and cultural groups served • Development of paid employment opportunities for peers and persons with lived experience • Hiring of a LGBTQ+ Services Specialist • Expansion of the Mental Health Promoters Program from a Latino focus to other cultural and language groups as “United Mental Health Promoters Program” • Implementation of the Community Ambassador Program
4. Train governance, leadership and workforce in CLAS	1 and 5	• Accessible cultural competence trainings • Opportunities for Program Managers to request cultural competence trainings needed by their respective staff • Inclusion of the CLAS standards in the cultural competence trainings provided at NEO • Trainings for language interpreters and for the use of language interpreters in mental health settings • Trainings specifically designed for peers and persons with lived experience
5. Communication and language assistance	5 and 7	• Established P&Ps for bilingual certification, language translation and interpretation services, interpreter services for the Deaf and Hard of Hearing community, and culturally and linguistically inclusive services • LACDMH 24/7 Help Line • On-line Provider Directories translated into threshold languages

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Translation of consent forms that require consumer signage in the threshold languages • The ARDI Division-CCU's County wide coordination of language assistance services for consumers, family members, and community members to participate in stakeholder meetings and departmental events • Usage of posters at provider sites which inform the public of the availability of free of cost language assistance services
6. Availability of language assistance	7	• Monitoring the LACDMH 24/7 Help Line's language assistance operations • Hiring and retention of bilingual certified staff • Mechanisms for Contracted providers to establish contracts with language line vendors • Language accommodations via the ARDI Division - CCU for consumers, family members and community members to participate in LACDMH's Cultural Competency Committee, UsCC, SALT and other stakeholder meetings
7. Competence of individuals providing language assistance	6 and 7	• Bilingual certification testing • Offering of trainings for language interpreters (beginning and advance levels) • Offering of trainings on medical terminology in several threshold languages • Addressing service quality issues reported by users
8. Easy to understand materials and signage	1, 3, and 7	• Translation of consent forms, program brochures and fliers in the threshold languages • Partnering with the community for the creation of brochures that are culturally meaningful and linguistically appropriate
9. CLAS goals, policies, and management accountability	1	• On-going evaluation of consumer satisfaction outcomes • Program-specific reporting on service utilization and strategies that address mental health disparities

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
10. Organizational assessments	3 and 8	• Monitoring the impact of cultural and language-specific outreach and engagement activities • Partnering with the community to identify capacity-building projects for underserved cultural communities • Conducting cultural competence assessments related to CCPR • Conducting program-based needs assessments • Conducting workforce/discipline – specific needs assessments • Conducting program outcome evaluations and reporting on the progress made in service accessibility, and improvements in penetration and retention rates
11. Demographic data	2, 4, and 8	• Compiling and reporting of the Los Angeles County demographics, consumer utilization data by ethnicity/race, age group, language, gender, and SA • Monitoring of consumer utilization data to identify emerging cultural and linguistic populations • Compiling and tracking of penetration rates, retention rates and mental health disparities • The ESM advocates and participates in data dashboard meetings to expand consumer demographical data (i.e., gender identity, physical disabilities, and tribal affiliation) • The ESM connects with CCC and UsCCs to obtain their recommendations on LACDMH's efforts to expand consumer demographical information
12. Assessments of community health assets and needs	3 and 8	• Presence of Committees that advocate for the needs of cultural groups, underserved populations, and faith-based communities • Funding for capacity building projects for underserved populations • Expansion of programs such as Community Mental Health Promoters • Monitoring the use of innovative programs by the community, such as tele psychiatry services • Monitoring the effectiveness of medication practices
13. Partnerships with community	1, 3, and 4	• Media campaigns to increase access to mental health services and decrease stigma in partnership with community-based organizations

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Presence of various stakeholder committees such as "YourDMH", CCC, UsCC subcommittees, Faith-based Advocacy Council • Provision of stipends and scholarships for consumers and family members to attend stakeholder meetings and conferences • Collaborations with agencies that specialize in services to Veterans • Implementation of Health Neighborhoods and other innovation programs based on partnerships with community-based organizations • Partnerships and collaborations with the faith-based communities • Partnerships and collaborations with other county departments for specialized programs such as Whole Person Care
14. Conflict and grievance resolution processes	8	• Development of online Patient's Rights Office apps • Monitoring of consumer and family satisfaction with services received • Monitoring of beneficiary requests for change of provider • Monitoring the quality of services provided by the LACDMH 24/7 Help Line and contracted language lines • Monitoring of grievances, appeals and request for State Fair Hearings
15. Progress in implementing and sustaining the CLAS standards	1	• The Cultural Competence Plan is accessible to LACDMH clinical and administrative programs, the Executive Management Team, various stakeholders such as the CCC, UsCC subcommittees, and SA QICs. Additionally, it is posted in the departmental Cultural Competency Unit webpage • On-going stakeholder process and other committee meetings monthly meetings with the community • Cultural Competence Organizational Assessment

Criterion 1 Appendix

1. Link to LACDMH policies and procedures
   https://secure2.compliancebridge.com/lacdmh/public/index.php?fuseaction=app.main&msg

2. Link to LACDMH Strategic Plan 2020-2030
   https://dmh.lacounty.gov/about/lacdmh-strategic-plan-2020-2030/

3. Examples of SALT activities for FY 20-21

SALT Info for 2022
CC Plan- FY 20-21 fina

4. Link to WhyWeRise Report
   https://www.rand.org/pubs/research_reports/RRA875-3.html

5. Link to MHSA report, FY 22-23
   1120630_MHSAAnnualUpdateFY2022-23.pdf (lacounty.gov)

5. Link to MHC Annual Report, FY 20-21
   1117512_FY2021MHCAnnualReport.pdf (lacounty.gov)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE, FY 20-21

Criterion 2

Updated Assessment of Services Needs

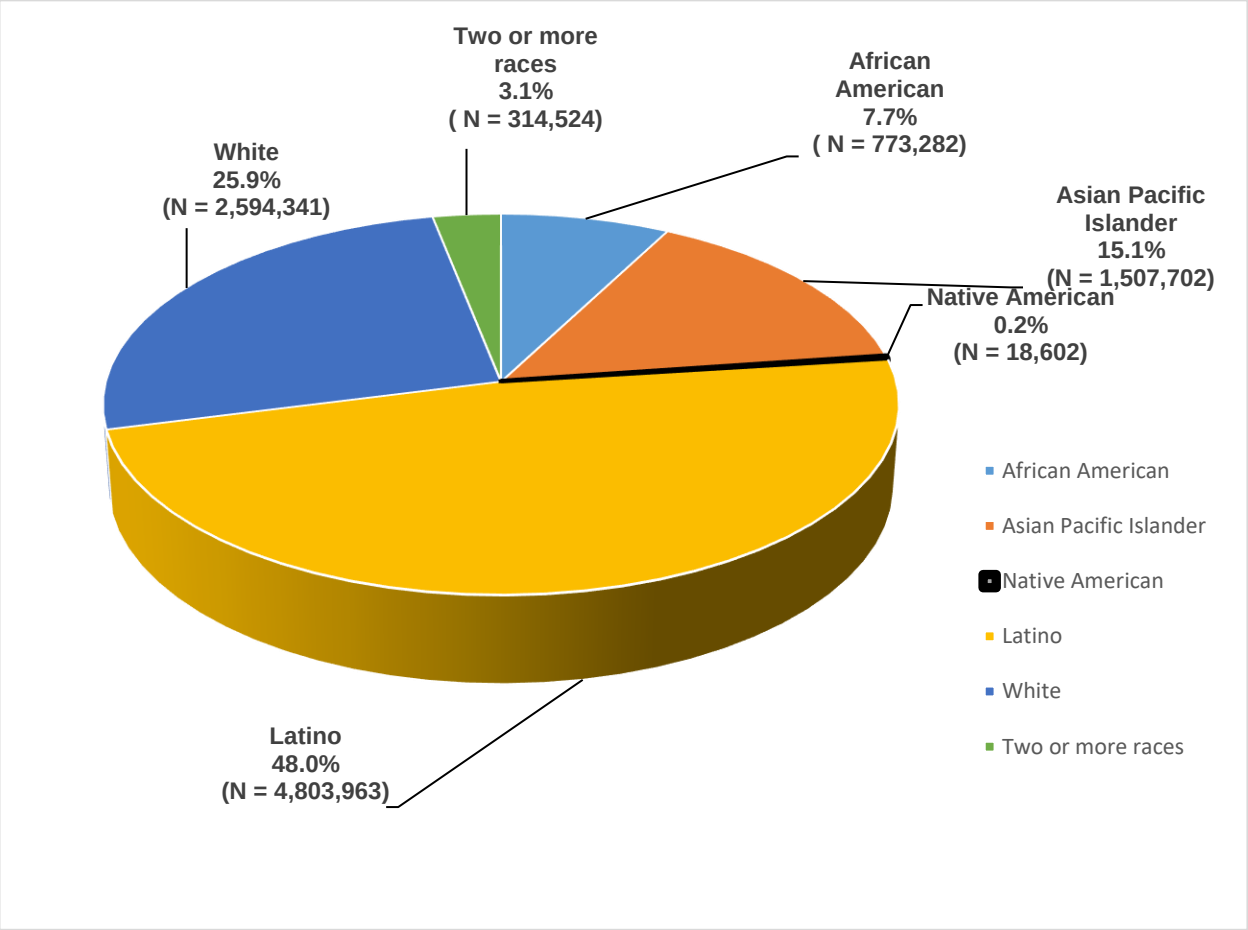
August 2022

Criterion 2: Updated Assessment of Services Needs

I. General Population: County Total Population

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

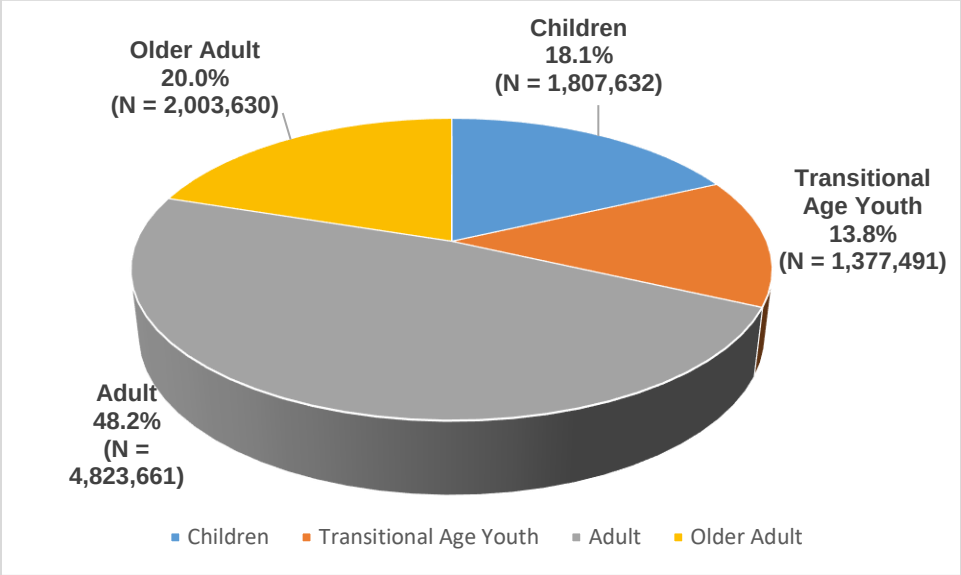
FIGURE 1: POPULATION BY RACE AND ETHNICITY
CY 2020
(N = 10,012,414)



Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2021.

Figure 1 shows population by Race and Ethnicity. Latinos are the largest group at 48.0%, followed by Whites at 25.9%, Asian/Pacific Islanders (API) at 15.1%, African Americans at 7.7%, persons with Two or More Races at 3.1%, and American Indian/Alaska Native at 0.2%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2020
(N = 10,012,414)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Figure 2 shows population by Age Group. Adults make up the largest group at 48.2%, followed by Children at 18.1%, Older Adults at 20.0%, and Transition Age Youth (TAY) at 13.8%.

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TABLE 1: POPULATION BY RACE, ETHNICITY AND SERVICE AREA
CY 2020

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	62,383	16,691	218,503	1,471	103,725	15,273	418,046
Percent	14.9%	4.0%	52.3%	**0.35%**	24.8%	3.7%	100.0%
SA 2	79,672	260,898	867,861	3,504	918,778	77,926	2,208,639
Percent	3.6%	11.8%	39.3%	0.16%	41.6%	3.5%	100.0%
SA 3	54,476	546,511	802,885	2,877	304,911	41,922	1,753,582
Percent	3.1%	**31.2%**	45.8%	0.16%	17.4%	2.4%	100.0%
SA 4	62,046	191,774	520,983	2,300	306,752	36,686	1,120,541
Percent	5.5%	17.1%	46.5%	0.21%	27.4%	3.3%	100.0%
SA 5	33,383	91,873	105,216	952	395,198	38,168	664,790
Percent	5.0%	13.8%	**15.8%**	**0.14%**	**59.4%**	**5.7%**	100.0%
SA 6	235,154	24,396	703,549	1,513	32,713	18,944	1,016,269
Percent	**23.1%**	**2.4%**	69.2%	0.15%	**3.2%**	1.9%	100.0%
SA 7	38,727	128,944	950,243	2,800	140,197	20,138	1,281,049
Percent	**3.0%**	10.1%	**74.2%**	0.22%	10.9%	**1.6%**	100.0%
SA 8	207,441	246,615	634,723	3,185	392,067	65,467	1,549,498
Percent	13.4%	15.9%	41.0%	0.21%	25.3%	4.2%	100.0%
Total	773,282	1,507,702	4,803,963	18,602	2,594,341	314,524	10,012,414
Percent	7.7%	15.1%	48.0%	0.19%	25.9%	3.1%	100.0%

Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Differences by Race and Ethnicity

The highest percentage of African Americans was in SA 6 (23.1%) compared to SA 7 (3.0%) with the lowest percentage.

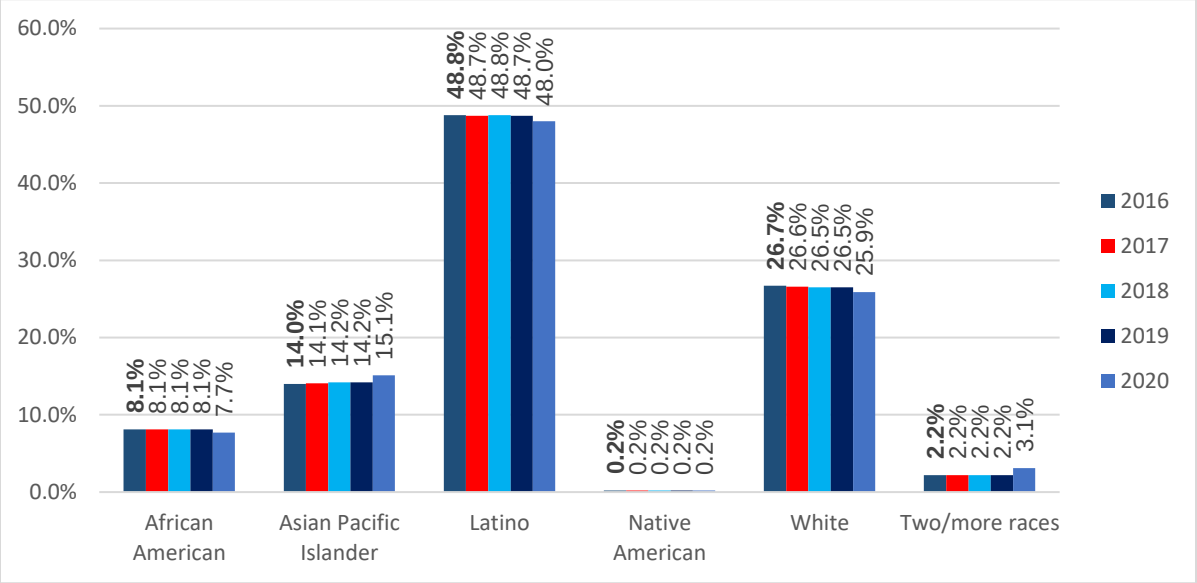
The highest percentage of Asian/Pacific Islanders was in SA 3 (31.2%) compared to SA 6 (2.4%) with the lowest percentage.

The highest percentage of Latinos was in SA 7 (74.2%) compared to SA 5 (15.8%) with the lowest percentage.

The highest percentage of Native Americans was in SA 1 (0.35%) compared to SA 5 (0.14%) with the lowest percentage.

The highest percentage of Whites was in SA 5 (59.4%) compared to SA 6 (3.2%) with the lowest percentage.
The highest percentage of Two or More Races was in SA 5 (5.7%) compared to SA 7 (1.6%) with the lowest percentage.

FIGURE 3: POPULATION PERCENT CHANGE BY RACE AND ETHNICITY CY 2016–2020



Note: The "Two or More Races" ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

The percentage of African Americans (AA) in the County has decreased by 0.4 percentage points (PP) over the past five years. AA represented 8.1% of the total population in CY 2016 and 7.7% of the population in CY 2020.

The percentage of Asian/Pacific Islanders (API) in Los Angeles County has increased by 1.1 PP over the past five years. API represented 14.0% of the total population in CY 2016 and represented 15.1% in CY 2020.

The percentage of Latinos in Los Angeles County has decreased by 0.8 PP over the past five years. Latinos represented 48.8% of the total population in CY 2016 and represented 48.0% in CY 2020.

The percentage of Native Americans (NA) in Los Angeles County has remained the same over the past five years. NA represented 0.2% of the total population in CY 2016` and in CY 2020.

The percentage of Whites in Los Angeles County has decreased by 0.8 PP over the past five years. Whites represented 26.7 of the total population in CY 2016 and represented 25.9% in CY 2020.

The percentage of Two or More Races in Los Angeles County has increased 0.9 PP over the past five years. Two or More Races category represent 2.2% of total population in CY 2016 and represented 3.1% in CY 2020.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2020

Service Area (SA)	Age Group						
	0-18	**19-20**	**21-25**	**26-59**	**60-64**	**65+**	**Total**
SA 1	117,822	13,744	35,965	181,543	24,533	44,439	418,046
Percent	**28.2%**	3.3%	8.6%	**43.4%**	5.9%	10.6%	100.0%
SA 2	472,604	56,891	145,662	1,063,968	146,961	322,553	2,208,639
Percent	21.4%	2.6%	6.6%	48.2%	**6.7%**	14.6%	100.0%
SA 3	370,559	52,150	123,848	811,066	116,403	279,556	1,753,582
Percent	21.1%	3.0%	7.1%	46.3%	6.6%	15.9%	100.0%
SA 4	187,437	25,004	62,831	628,240	63,906	153,123	1,120,541
Percent	16.7%	**2.2%**	**5.6%**	**56.1%**	5.7%	13.7%	100.0%
SA 5	106,191	24,964	41,338	339,179	42,130	110,988	664,790
Percent	**16.0%**	**3.8%**	6.2%	51.0%	6.3%	**16.7%**	100.0%
SA 6	277,605	37,949	88,026	469,180	49,235	94,274	1,016,269
Percent	27.3%	3.7%	**8.7%**	46.2%	**4.8%**	**9.3%**	100.0%
SA 7	311,204	39,128	100,194	596,356	70,881	163,286	1,281,049
Percent	24.3%	3.1%	7.8%	46.6%	5.5%	12.7%	100.0%
SA 8	344,534	42,658	106,815	734,129	99,836	221,526	1,549,498
Percent	22.2%	2.8%	6.9%	47.4%	6.4%	14.3%	100.0%
Total	2,187,956	292,488	704,679	4,823,661	613,885	1,389,745	10,012,414
Percent	21.9%	2.9%	7.0%	48.2%	6.1%	13.9%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

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Differences by Age Group

The highest percentage of individuals between 0 and 18 years old was in SA 1 (28.2%) compared to SA 5 (16.0%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old was in SA 5 (3.8%) compared to SA 4 (2.2%) with the lowest percentage.

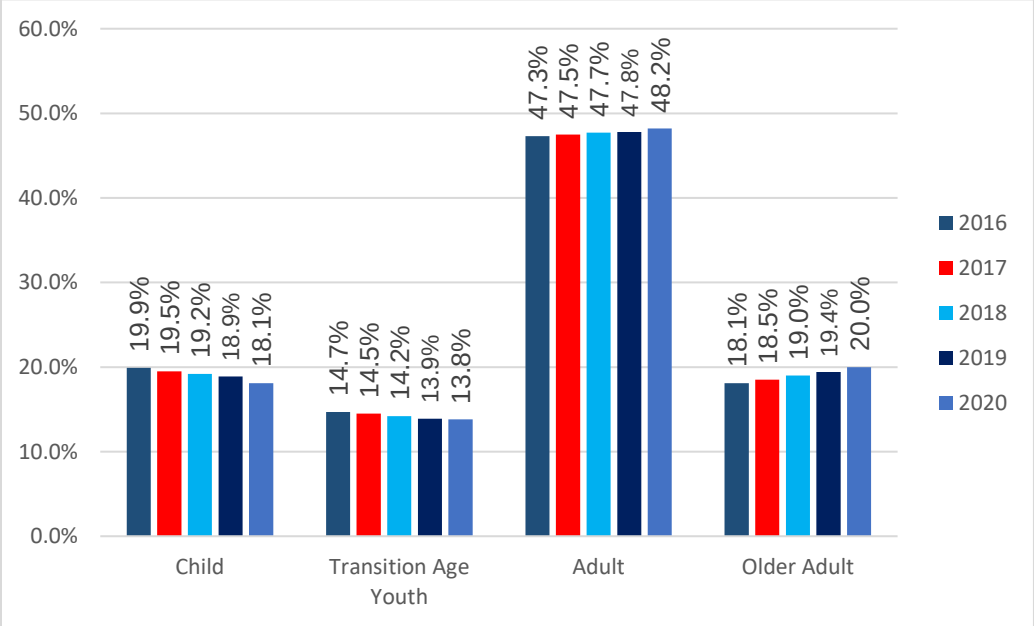
The highest percentage of individuals between 21 and 25 years old was in SA 6 (8.3%) compared to SA 4 (5.6%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (56.1%) compared to SA 1 (43.4%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 2 (6.7) compared to SA 6 (4.8%) with the lowest percentage.

The highest percentage of individuals 65+ years old was in SA 5 (16.7%) compared to SA 6 (9.3%) with the lowest percentage.

FIGURE 4: POPULATION PERCENT (PP) CHANGE BY AGE GROUP CY 2016–2020



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

The percentage of Children in the County has decreased by 1.8 PP over the past five years. Children represented 19.9% of the total population in CY 2016 and 18.1% in CY 2020.
The percentage of Transition Age Youth (TAY) in the County has decreased by 0.9 PP over the past five years. TAY represented 14.7% of the total population in CY 2016 and 13.8% in CY 2020.

The percentage of Adults in the County increased by 0.9 PP over the past five years. Adults represented 47.3% of the total population in CY 2016 and 48.2% in CY 2020.

The percentage of Older Adults in the County has increased by 1.9 PP over the past five years. Older Adults represented 18.1% of the total population in CY 2016 and 20.0% in CY 2020.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2020

Service Area (SA)	Male	Female	Total
SA 1	206,513	211,533	418,046
Percent	49.4%	50.6%	100.0%
SA 2	1,093,609	1,115,030	2,208,639
Percent	49.5%	50.5%	100.0%
SA 3	854,807	898,775	1,753,582
Percent	48.7%	51.3%	100.0%
SA 4	579,602	540,939	1,120,541
Percent	**51.7%**	**48.3%**	100.0%
SA 5	321,775	343,015	664,790
Percent	**48.4%**	**51.6%**	100.0%
SA 6	497,397	518,872	1,016,269
Percent	48.9%	51.1%	100.0%
SA 7	629,722	651,327	1,281,049
Percent	49.2%	50.8%	100.0%
SA 8	758,117	791,381	1,549,498
Percent	48.9%	51.1%	100.0%
Total	4,941,542	5,070,872	10,012,414
Percent	49.4%	50.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Difference by Gender

The highest percentage of Males was in SA 4 (51.7%) compared to SA 5 (48.4%) with the lowest percentage.

The highest percentage of Females was in SA 5 (51.6%) compared to SA 4 (48.3%) with the lowest percentage.

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

TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY RACE AND ETHNICITY, AND SERVICE AREA
CY 2020

Service Area (SA)	African American	Asian/Pacific Islander	Latino	American Indian/ Alaska Native	White	Two or More Races	Total
SA 1	18,463	2,866	61,123	391	19,252	3,758	105,853
Percent	17.4%	2.7%	57.7%	**0.37%**	18.2%	3.55%	100.0%
SA 2	12,305	36,061	181,524	393	113,820	8,389	352,492
Percent	3.5%	10.2%	51.5%	0.11%	32.3%	2.38%	100.0%
SA 3	7,165	78,334	145,762	269	29,341	3,279	264,150
Percent	2.7%	**29.7%**	55.2%	0.10%	11.1%	1.24%	100.0%
SA 4	14,079	48,124	156,058	705	49,623	7,033	275,622
Percent	5.1%	17.5%	56.6%	0.26%	18.0%	2.55%	100.0%
SA 5	3,944	12,307	15,097	55	42,643	4,003	78,049
Percent	5.1%	15.8%	**19.3%**	**0.07%**	**54.6%**	**5.13%**	100.0%
SA 6	72,496	8,912	244,064	640	8,146	5,933	340,191
Percent	**21.3%**	**2.6%**	71.7%	0.19%	**2.4%**	1.74%	100.0%
SA 7	5,023	12,815	194,100	293	11,777	1,244	225,252
Percent	**2.2%**	5.7%	**86.2%**	0.13%	5.2%	**0.55%**	100.0%
SA 8	45,637	35,397	146,196	503	36,691	8,066	272,490
Percent	16.7%	13.0%	53.7%	0.18%	13.5%	2.96%	100.0%
Total	179,112	234,816	1,143,924	3,249	311,293	41,705	1,914,099
Percent	9.4%	12.3%	59.8%	0.2%	16.3%	2.18%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Differences by Race and Ethnicity

The highest percentage of African Americans (AA) living at or below 138% FPL was in SA 6 (21.3%) compared to SA 7 (2.2%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 9.4% self-identified as AA.

The highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL was in SA 3 (29.7%) compared to SA 6 (2.6%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 12.3% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (86.2%) compared to SA 5 (19.3%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 59.8% self-identified as Latino.

The highest percentage of American Indian/Alaska Native (NA) living at or below 138% FPL was in SA 1 (0.37%) compared to SA 5 (0.07%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 0.20% self-identified as NA.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (54.6%) compared to SA 6 (2.4%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 16.3% self-identified as White.

The highest percentage of Two or More Races living at or below 138% FPL was in SA 5 (5.1%) compared to SA 7 (0.6%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 2.2% self-identified as having Two or More Races.

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TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA CY 2020

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	41,522	3,151	8,168	38,759	4,708	9,545	105,853
Percent	**39.2%**	3.0%	7.7%	**36.6%**	4.4%	9.0%	100.0%
SA 2	101,739	8,986	23,317	155,875	17,942	44,633	352,492
Percent	28.9%	2.5%	**6.6%**	44.2%	**5.1%**	12.7%	100.0%
SA 3	76,701	7,300	18,588	108,499	13,132	39,930	264,150
Percent	29.0%	2.8%	7.0%	41.1%	5.0%	**15.1%**	100.0%
SA 4	68,809	6,008	15,916	133,992	12,709	38,188	275,622
Percent	25.0%	**2.2%**	5.8%	48.6%	4.6%	13.9%	100.0%
SA 5	12,683	2,633	8,684	38,944	3,753	11,352	78,049
Percent	**16.3%**	**3.4%**	**11.1%**	**49.9%**	4.8%	14.5%	100.0%
SA 6	132,218	10,962	27,983	130,861	13,035	25,132	340,191
Percent	38.9%	3.2%	8.2%	38.5%	**3.8%**	**7.4%**	100.0%
SA 7	82,474	6,221	15,933	88,518	9,350	22,756	225,252
Percent	36.6%	2.8%	7.1%	39.3%	4.2%	10.1%	100.0%
SA 8	88,503	7,368	19,003	114,143	13,036	30,437	272,490
Percent	32.5%	2.7%	7.0%	41.9%	4.8%	11.2%	100.0%
Total	604,649	52,629	137,592	809,591	87,665	221,973	1,914,099
Percent	31.6%	2.7%	7.2%	42.3%	4.6%	11.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

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Differences by Age Group

The highest percentage of individuals between 0 and 18 years old estimated to be living at or below 138% FPL was in SA 1 (39.2%) compared to SA 5 (16.3%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old estimated to be living at or below 138% FPL was in SA 5 (3.4%) compared to SA 4 (2.2%) with the lowest percentage.

The highest percentage of individuals between 21 and 25 years old estimated to be living at or below 138% FPL was in SA 5 (11.1%) compared to SA 2 (6.6%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old estimated to be living at or below 138% FPL was in SA 5 (49.9%) compared to SA 1 (36.6%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old estimated to be living at or below 138% FPL was in SA 2 (5.1%) compared to SA 6 (3.8%) with the lowest percentage.

The highest percentage of individuals age 65 years old and overestimated to be living at or below 138% FPL was in SA 3 (15.1%) compared to SA 6 (7.4%) with the lowest percentage.

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TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2020

Service Area (SA)	Male	Female	Total
SA 1	47,952	57,901	105,853
Percent	45.3%	54.7%	100.0%
SA 2	160,021	192,471	352,492
Percent	45.4%	54.6%	100.0%
SA 3	118,267	145,883	264,150
Percent	44.8%	55.2%	100.0%
SA 4	129,083	146,539	275,622
Percent	**46.8%**	**53.2%**	100.0%
SA 5	34,599	43,450	78,049
Percent	**44.3%**	**55.7%**	100.0%
SA 6	154,097	186,094	340,191
Percent	45.3%	54.7%	100.0%
SA 7	100,570	124,682	225,252
Percent	44.6%	55.4%	100.0%
SA 8	122,631	149,859	272,490
Percent	45.0%	55.0%	100.0%
Total	867,220	1,046,879	1,914,099
Percent	45.3%	54.7%	100.0%

Note: Bold values represent highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Differences by Gender

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (46.8%) compared to SA 5 (44.3%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 5 (55.7%) compared to SA 4 (53.2%) with the lowest percentage.

TABLE 7: PRIMARY LANGUAGES[1] OF ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY SERVICE AREA AND THRESHOLD LANGUAGE CY 2021

Service Area	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	406	360	63	74	55,140	97	224	58	144	50	34,541	404	212	91,773
Percent	0.44%	0.39%	0.07%	0.08%	**60.08%**	0.11%	0.24%	0.06%	0.16%	0.05%	**37.64%**	0.44%	0.23%	100.00%
SA 2	3,131	26,737	121	482	111,830	4,175	3,776	1,160	2,244	4,373	139,655	5,536	3,452	306,672
Percent	1.02%	**8.72%**	0.04%	0.16%	**36.47%**	**1.36%**	**1.23%**	0.38%	0.73%	**1.43%**	**45.54%**	**1.81%**	**1.13%**	100.00%
SA 3	1,089	1,235	502	11,607	73,737	281	2,359	15,803	19,406	163	93,792	2,928	9,199	232,101
Percent	0.47%	0.53%	0.22%	**5.00%**	**31.77%**	0.12%	**1.02%**	**6.81%**	**8.36%**	0.07%	**40.41%**	1.26%	**3.96%**	100.00%
SA 4	805	3,565	308	2,700	71,134	697	16,200	1,387	5,668	2,422	128,561	4,252	1,548	239,247
Percent	0.34%	1.49%	**0.13%**	**1.13%**	**29.73%**	0.29%	**6.77%**	0.58%	2.37%	**1.01%**	**53.74%**	1.78%	0.65%	100.00%
SA 5	700	376	48	603	42,624	3,317	990	2,004	2,284	850	10,974	306	597	65,673
Percent	1.07%	0.57%	0.07%	0.92%	**64.90%**	**5.05%**	1.51%	3.05%	3.48%	1.29%	**16.71%**	0.47%	0.91%	100.00%
SA 6	202	46	83	187	83,054	203	1,367	762	1,993	66	209,418	411	468	298,260
Percent	0.07%	0.02%	0.03%	0.06%	**27.85%**	0.07%	0.46%	0.26%	0.67%	0.02%	**70.21%**	0.14%	0.16%	100.00%
SA 7	1,243	479	281	406	47,032	93	1,482	674	1,390	107	141,323	1,726	895	197,131
Percent	0.63%	0.24%	0.14%	0.21%	**23.86%**	0.05%	**0.75%**	0.34%	0.71%	0.05%	**71.69%**	0.88%	0.45%	100.00%
SA 8	1,684	263	2,945	302	102,124	441	3,310	790	1,670	254	116,562	4,080	2,533	236,958
Percent	0.71%	0.11%	**1.24%**	0.13%	**43.10%**	0.19%	**1.40%**	0.33%	0.70%	0.11%	**49.19%**	1.72%	**1.07%**	100.00%
Total	9,260	33,061	4,351	16,361	586,675	9,304	29,708	22,638	34,799	8,285	874,826	19,643	18,904	1,667,815
Percent	0.56%	1.98%	0.26%	0.98%	**35.18%**	0.56%	1.78%	1.36%	2.09%	0.50%	52.45%	1.18%	1.13%	100.00%

Note: [1]Data reported only for LACDMH threshold languages. "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Arabic is a Countywide threshold language. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

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

A percentage of 97.0% (N = 1,667,815) of the population (N = 1,718,291) living at or below 138% FPL spoke a LACDMH threshold language. Among these, 35.2% (N = 586,675) were English-speaking, 52.5% were Spanish-speaking (N = 874,826) and the remaining 12.4% spoke other LACDMH threshold languages.

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

SA 1 reported two (2) threshold languages: English (60.1%) and Spanish (37.6%).

SA 2 reported eight (8) threshold languages: Armenian (8.7%), English (36.5%), Farsi (1.4%), Korean (1.2%), Russian (1.4%), Spanish (45.5%), Tagalog (1.8%) and Vietnamese (1.1%).

SA 3 reported seven (7) threshold languages: Cantonese (5.0%), English (31.8%), Korean (1.0%), Mandarin (6.8%), Other Chinese (8.4%), Spanish (40.4) and Vietnamese (3.40%).

SA 4 reported seven (7) threshold languages: Armenian (1.5%), Cantonese 1.1%), English (29.7%), Korean (6.8%), Other Chinese (2.4%), Russian (1.0%), and Spanish (53.7%).

SA 5 reported three (3) threshold languages: English (64.9%), Farsi (5.1%), and Spanish (16.7%).

SA 6 reported two (2) threshold languages: English (27.9%) and Spanish (70.2%).

SA 7 reported three (3) threshold languages: English (23.9%), Korean (0.75%), and Spanish (71.7%).

SA 8 reported five (5) threshold languages: Cambodian (1.2%), English (43.1%), Korean (1.4%), Spanish (49.2%), and Vietnamese (1.1%).

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TABLE 8: ESTIMATED PREVALENCE OF SERIOUS EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE AND ETHNICITY, AND SERVICE AREA CY 2020

Service Area (SA)	African American	Asian/Pacific Islander	Latino	American Indian/ Alaska Native	White	Two or More Races	Total
SA 1	3,213	461	10,146	183	3,966	744	18,713
Percent	17.2%	**2.5%**	54.2%	**0.98%**	21.2%	4.0%	100.0%
SA 2	2,141	5,806	30,133	184	23,447	1,661	63,371
Percent	3.4%	9.2%	47.5%	0.29%	37.0%	2.6%	100.0%
SA 3	1,247	12,612	24,196	126	6,044	649	44,874
Percent	2.8%	**28.1%**	53.9%	0.28%	13.5%	1.4%	100.0%
SA 4	2,450	7,748	25,906	329	10,222	1,393	48,047
Percent	5.1%	16.1%	53.9%	0.69%	21.3%	2.9%	100.0%
SA 5	686	1,981	2,506	26	8,784	793	14,777
Percent	4.6%	13.4%	**17.0%**	**0.17%**	**59.4%**	**5.4%**	100.0%
SA 6	12,614	1,435	40,515	299	1,678	1,175	57,715
Percent	**21.9%**	**2.5%**	70.2%	0.52%	**2.9%**	2.0%	100.0%
SA 7	874	2,063	32,221	137	2,426	246	37,967
Percent	**2.3%**	5.4%	**84.9%**	0.36%	6.4%	**0.6%**	100.0%
SA 8	7,941	5,699	24,269	235	7,558	1,597	47,299
Percent	16.8%	12.0%	51.3%	0.50%	16.0%	3.4%	100.0%
Total	31,165	37,805	189,891	1,517	64,126	8,258	332,763
Percent	9.4%	11.4%	57.1%	0.46%	19.3%	2.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each Ethnic Group and across the Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2019 and CY 2020. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2021.

Differences by Race and Ethnicity

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

The highest rate of prevalence of SED and SMI among the African American (AA) group was in SA 6 (21.9%) compared to SA 7 (2.3%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Asian/Pacific Islander (API) group was in SA 3 (28.1%) compared to SA 6 (2.5%) with the lowest percentage.

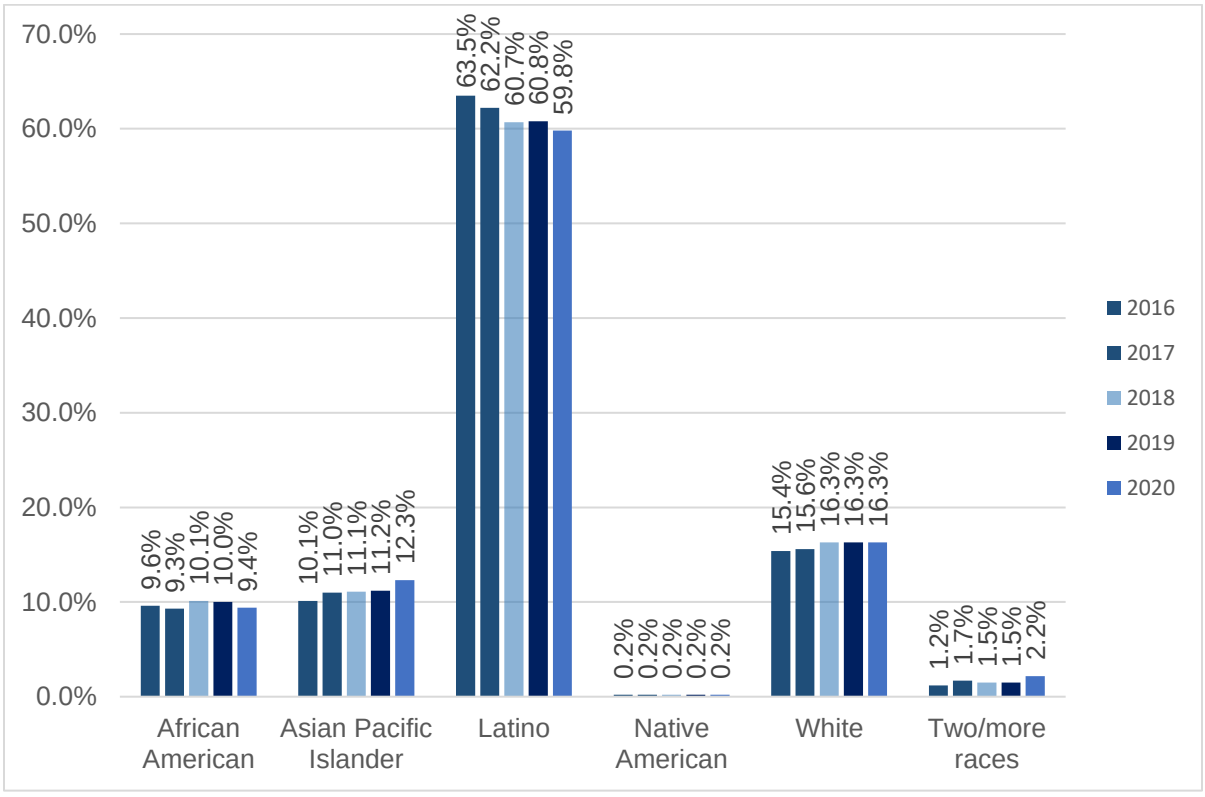
The highest rate of prevalence of SED and SMI among the Latino group was in SA 7 (84.9%) compared to SA 5 (17.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Native American (NA) group was in SA 1 (0.98%) compared to SA 5 (0.17%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the White group was in SA 5 (59.4%) compared to SA 6 (3.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among the Two or More Races group was in SA 5 (5.4%) compared to SA 7 (0.6%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE AND ETHNICITY
CY 2016–2020



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

The percentage of African Americans living at or below 138% FPL has decreased by 0.2% from 9.6% in CY 2016 to 9.4% in CY 2020.
The percentage of Asian/Pacific Islanders (API) living at or below 138% FPL has increased by 2.2% from 10.1% in CY 2016 to 12.3% in CY 2020.

The percentage of Latinos living at or below 138% FPL has decreased by 3.7% from 63.5% in CY 2016 to 59.8% in CY 2020.

The percentage of American Indian/Alaska Natives living at or below 138% FPL has remained unchanged at 0.2% from CY 2016 to CY 2020.

The percentage of Whites living at or below 138% FPL has increased by 0.9% from 15.4% in CY 2016 to 16.3% in CY 2020.

The percentage of category Two or More Races living at or below 138% FPL increased by 1.0 from 1.2% in CY 2016 to 2.2% in CY 2020.

TABLE 9: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2020

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA 1	3,654	1,144	2,793	5,543	330	401	13,864
Percent	**26.4%**	8.3%	20.1%	**40.0%**	2.4%	2.9%	100.0%
SA 2	8,953	3,262	7,974	22,290	1,256	1,875	45,610
Percent	19.6%	7.2%	17.5%	48.9%	**2.8%**	4.1%	100.0%
SA 3	6,750	2,650	6,357	15,515	919	1,677	33,868
Percent	19.9%	7.8%	18.8%	45.8%	2.7%	**5.0%**	100.0%
SA 4	6,055	2,181	5,443	19,161	890	1,604	35,334
Percent	17.1%	**6.2%**	**15.4%**	**54.2%**	2.5%	4.5%	100.0%
SA 5	1,116	956	2,970	5,569	263	477	11,350
Percent	**9.8%**	8.4%	**26.2%**	49.1%	2.3%	4.2%	100.0%
SA 6	11,635	3,979	9,570	18,713	912	1,056	45,866
Percent	25.4%	**8.7%**	20.9%	40.8%	**2.0%**	**2.3%**	100.0%
SA 7	7,258	2,258	5,449	12,658	655	956	29,233
Percent	24.8%	7.7%	18.6%	43.3%	2.2%	3.3%	100.0%
SA 8	7,788	2,675	6,499	16,322	913	1,278	35,475
Percent	22.0%	7.5%	18.3%	46.0%	2.6%	3.6%	100.0%
Total	53,209	19,104	47,056	115,772	6,137	9,323	250,601
Percent	21.2%	7.6%	18.8%	46.2%	2.4%	3.7%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group and across all SAs. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2019 and 2020. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

Differences by Age Group

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

The highest rate of prevalence of SED and SMI in Age Group 0-18 was in SA 1 (26.4%) compared to SA 5 (9.8%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 19-20 was in SA 6 (8.7%) compared to SA 4 (6.2%) with the lowest percentage.

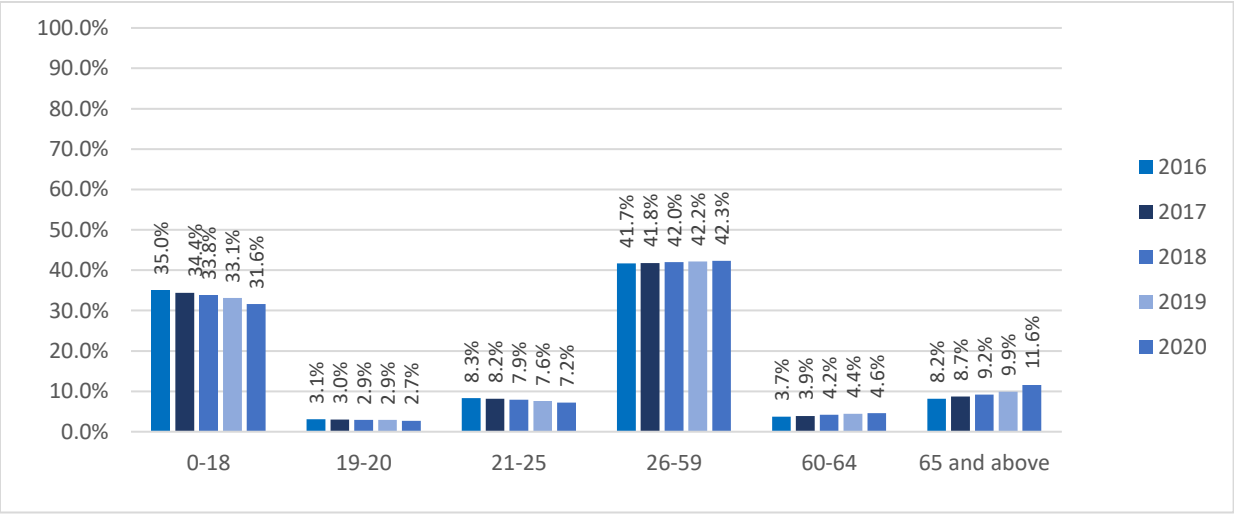
The highest rate of prevalence of SED and SMI in Age Group 21-25 was in SA 5 (26.2%) compared to SA 4 (15.4%) the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 26-59 was in SA 4 (54.2%) compared to SA 1 (40.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 60-64 was in SA 2 and SA (2.8%) compared to SA 6 (2.0%).

The highest rate of prevalence of SED and SMI in Age Group 65 and older was in SA 3 (5.0%) compared to SA 6 (2.3%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2016–2020



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2021.

The percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL decreased by 3.4 PP from 35.0% in CY 2016 to 31.6% in CY 2020.

The percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL decreased by 0.4 PP from 3.1% in CY 2016 and to 2.7% in CY 2020.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 1.1 PP from 8.3% in CY 2016 to 7.2% in CY 2020.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL increased by 0.6 PP from 41.7% in CY 2016 to 42.3% in CY 2020.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.9 PP from 3.7% in CY 2016 to 4.6% in CY 2020.

The percentage of individuals age 65 and older and estimated to be living at or below 138% FPL increased by 3.4 PP from 8.2% in CY 2016 to 11.6% in CY 2020.

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TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA CY 2020

Service Area (SA)	Male	Female	Total
SA 1	7,001	10,885	17,886
Percent	39.1%	60.9%	100.0%
SA 2	23,363	36,185	59,548
Percent	39.2%	60.8%	100.0%
SA 3	17,267	27,426	44,693
Percent	38.6%	61.4%	100.0%
SA 4	18,846	27,549	46,395
Percent	**40.6%**	**59.4%**	100.0%
SA 5	5,051	8,169	13,220
Percent	**38.2%**	**61.8%**	100.0%
SA 6	22,498	34,986	57,484
Percent	39.1%	60.9%	100.0%
SA 7	14,683	23,440	38,123
Percent	38.5%	61.5%	100.0%
SA 8	17,904	28,173	46,078
Percent	38.9%	61.1%	100.0%
Total	126,614	196,813	323,427
Percent	39.1%	60.9%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence of mental illness for Los Angeles County are provided by CHIS for the population living at or below 138% FPL, CY 2019 and CY 2020. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2021.

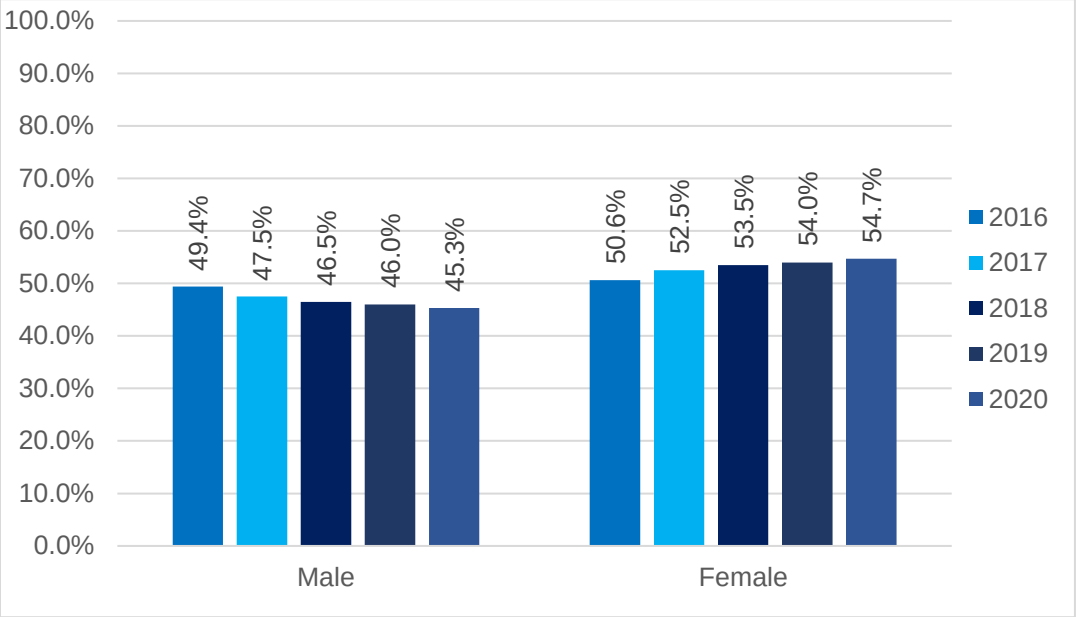
Differences by Gender

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

The highest rate of prevalence of SED and SMI among Males was in SA 4 (40.6%) compared to SA 5 (38.2%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 5 (61.8%) compared to SA 4 (59.4%) with the lowest percentage.

FIGURE 7: ESTIMATED PERCENT CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2016–2020



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2021.

The percentage of Males living at or below 138% FPL decreased by 4.1% PP from 49.4% in CY 2016 to 45.3% in CY 2020.

The percentage of Females living at or below 138% FPL increased by 4.1% from 50.6% in CY 2016 to 54.7% in CY 2020.

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II. Medi-Cal Population Service Needs

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

TABLE 11: POPULATION ENROLLED IN MEDI-CAL BY RACE AND ETHNICITY CY 2021

CY 2021	African American	Asian/Pacific Islander	Latino	American Indian/ Alaska Native	White	Not Reported	Total
Jan-Oct Average	404,603	385,506	2,386,900	5,020	525,480	389,312	4,096,820
Percent	9.9%	9.4%	58.3%	0.1%	12.8%	9.5%	100.0%

Note: Race/ethnicity categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded on December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Race and Ethnicity

Table 11 presents the Los Angeles County Medi-Cal enrolled population by racial categories averaged across monthly estimates for CY 2021. The Latino group had highest Medi-Cal enrollment (58.3%), followed by the White group (12.8%), African American group (9.9%), Asian/Pacific Islander group (9.4%), and American Indian/Alaska Native (AI/AN) group (0.1%). A sizeable proportion (9.5%) did not report a specific race/ethnicity.

TABLE 12: POPULATION ENROLLED IN MEDI-CAL BY AGE GROUP CY 2021

CY 2021	Age Group				
	0-18	19-44	45-64	65+	Total
Jan-Oct Average	1,318,031	1,481,100	845,292	452,398	4,096,820
Percent	32.2%	36.2%	20.6%	11.0%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Age Group, and Sex.
Downloaded on December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Age Group

Table 12 presents the Medi-Cal enrolled population by Age Group. The Age Group with the highest percentage of Medi-Cal enrollees were individuals ages 19 to 44

(36.2%), followed by Youth ages 0 to 18 (32.2%), Adults ages 45 to 64 (20.6%), and Older Adults ages 65 and above (11.0%).

TABLE 13: Population Enrolled in Medi-Cal by Gender
CY 2021

CY 2021	Gender		
	Female	Male	Total
Jan-Oct Average	2,196,796	1,900,024	4,096,820
Percent	53.6%	46.4%	100.0%

Note: Gender categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Age Group, and Sex. Downloaded on December 28, 2021. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Gender

Table 13 presents the monthly Medi-Cal enrolled population by Gender. Females had higher representation (53.6%), followed by Males (46.4%).

TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY RACE AND ETHNICITY
CY 2021

CY 2021	African American	Asian/Pacific Islander	Latino	American Indian/ Alaska Native	White	Not Reported	Total
Jan-Oct Average	65,950	70,933	393,839	879	118,758	68,130	718,488
Percent	9.2%	9.9%	54.8%	0.1%	16.5%	9.5%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2019 and CY 2020. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded on December 28, 2021.Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Race and Ethnicity

Table 14 compares the prevalence of estimated SED and SMI among Medi-Cal enrolled population by race and ethnicity. The Latino group had is the highest estimated SED/SMI (54.8%), followed by the White group (16.5%), Asian/Pacific Islander group

(9.9%), African American group more (9.2%), American Indian/Alaska Native (AI/AN) group (0.1%) and ethnic group not reported (9.5%).

TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP
CY 2021

CY 2021	Age Group				
	0-18	19-44	45-64	65+	Total
Jan-Oct Average	434,950	319,918	78,612	19,001	852,481
Percent	51.0%	37.5%	9.2%	2.2%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2019 and CY 2020. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded on December 28, 2021.Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Age Group

Table 15 compares the prevalence of estimated SED and SMI among Medi-Cal enrolled population by Age Group. The 0-18 Age Group has the highest estimated SED/SMI (51.0%), followed by the 19-44 Age Group (37.5%), 45-64 Age Group (9.2%). The 65 and above Age Group had the least estimated SED/SMI (2.2%).

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TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY GENDER
CY 2021

CY 2021	Gender		
	Female	Male	Total
Jan-Oct Average	388,833	324,904	713,737
Percent	54.5%	45.5%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2019 and CY 2020. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded on December 28, 2021. Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Gender

Table 16 compares the prevalence of SED and SMI Medi-Cal enrolled population by gender. Females had the highest estimated SED/SMI (54.5%), followed by Males (45.5%).

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TABLE 17: PRIMARY LANGUAGE OF POPULATION ENROLLED IN MEDI-CAL THRESHOLD LANGUAGE CY 2021

Language	Jan-Oct Average	Average %
English	2,358,716	57.65%
Spanish	1,375,105	33.61%
Armenian	79,238	1.94%
Missing/Unknown	57,671	1.41%
Mandarin	49,447	1.21%
Cantonese	43,628	1.07%
Korean	35,007	0.86%
Vietnamese	30,350	0.74%
Farsi	15,074	0.37%
Russian	14,268	0.35%
Tagalog	9,861	0.24%
Cambodian	8,670	0.21%
Arabic	6,108	0.15%
Other Non-English	5,847	0.14%
Other Chinese	2,613	0.06%
Total	4,091,603	100.00%

Note: 1The totals were suppressed for the Mien and Unknown categories, which may affect the overall total. "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. "Other Chinese" no longer meets the definition of a threshold language. The "Other non-English" category met the criteria of a threshold language and was included in this table. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County, Month of Eligibility, Primary Language. Downloaded on December 28, 2021.

Table 17 presents the Medi-Cal enrolled population by primary language. The primary language with the highest percentage of Medi-Cal enrollees was English (57.6%), followed by Spanish (33.6%), Armenian (1.9%), Unknown (1.4%), Mandarin (1.2%), Cantonese (1.1%), Korean (0.9%), Vietnamese (0.7%), Farsi (0.4%), Russian (0.4%), Tagalog (0.2%), Cambodian (0.2%), Arabic (0.2%), Other Non-English (0.1%) and Other Chinese (0.1%). The remaining languages represented under 0.1%.

Consumers Served in Outpatient Programs

TABLE 18: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE AND ETHNICITY AND SERVICE AREA FY 20–21

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Total
SA 1	6,083	178	5,077	124	3,736	850	1,830	17,878
Percent	34.0%	**1.0%**	28.4%	0.69%	20.9%	**4.8%**	**10.2%**	100.0%
SA 2	3,326	1,215	16,032	140	9,620	1,160	6,976	38,469
Percent	8.6%	3.2%	41.7%	**0.36%**	25.0%	3.0%	18.1%	100.0%
SA 3	2,781	2,359	11,841	170	4,317	756	10,860	33,084
Percent	8.4%	**7.1%**	35.8%	0.51%	13.0%	2.3%	**32.8%**	100.0%
SA 4	5,967	1,807	13,274	206	4,775	642	5,527	32,198
Percent	18.5%	5.6%	41.2%	0.64%	14.8%	2.0%	17.2%	100.0%
SA 5	1,669	333	1,784	44	3,000	267	1,672	8,769
Percent	19.0%	3.8%	**20.3%**	0.50%	**34.2%**	3.0%	19.1%	100.0%
SA 6	16,566	425	15,770	637	2,200	659	7,219	43,476
Percent	**38.1%**	**1.0%**	36.3%	**1.47%**	**5.1%**	**1.5%**	16.6%	100.0%
SA 7	1,762	786	15,135	186	2,571	719	8,031	29,190
Percent	**6.0%**	2.7%	**51.8%**	0.64%	8.8%	2.5%	27.5%	100.0%
SA 8	9,636	1,858	10,986	226	5,268	1,103	6,207	35,284
Percent	27.3%	5.3%	31.1%	0.64%	14.9%	3.1%	17.6%	100.0%
Total	30,438	6,855	59,791	1,063	23,937	3,914	32,412	158,410
Percent	19.2%	4.3%	37.7%	0.67%	15.1%	2.5%	20.5%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes Null (N= 83), Out of LA and Out of State (N = 2,527). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, March, 2022.

Differences by Race and Ethnicity

Table 18 presents the unduplicated count of consumers served in outpatient programs by Race and Ethnicity and Service Area (SA).

The highest percentage of African American consumers served in outpatient programs was in SA 6 (38.1%) as compared to SA 7 (6.0%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander consumers served in outpatient programs was in SA 3 (7.1%) as compared to SA 1 and SA 6 (1.0%) with the lowest percentage.

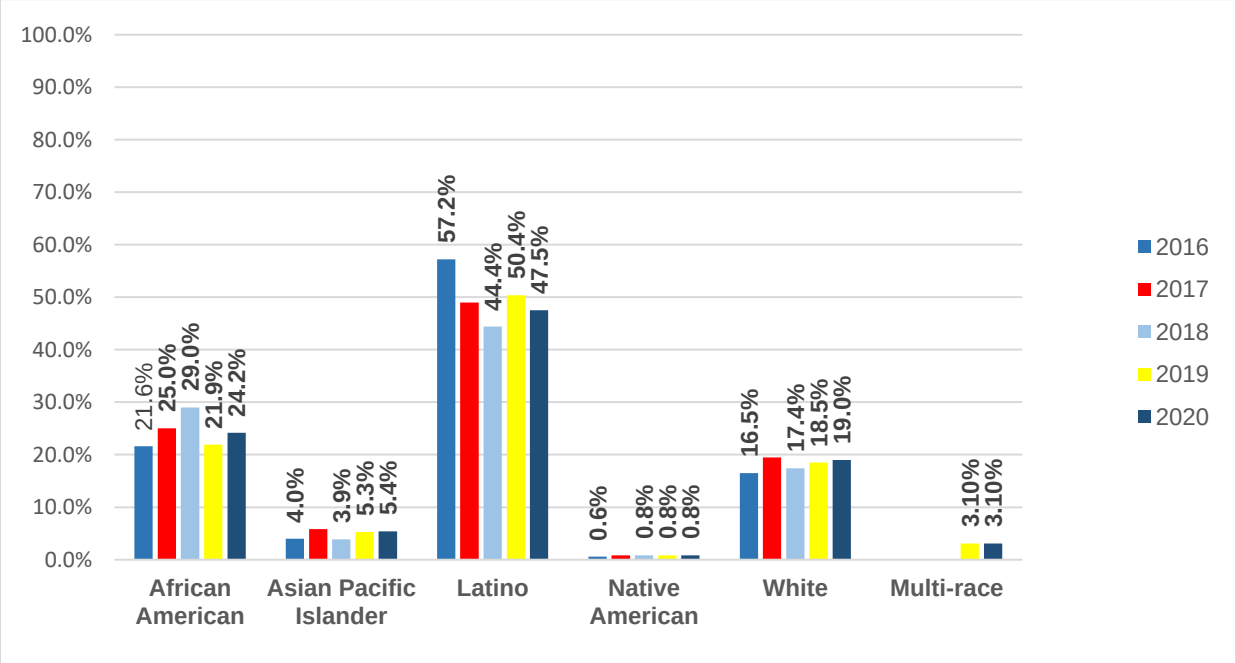
The highest percentage of Latino consumers served in outpatient programs was in SA 7 (51.8%) as compared to SA 5 (20.3%) with the lowest percentage.

The highest percentage of American Indian/Alaska Native consumers served in outpatient programs was in SA 6 (1.5%) as compared to SA 2 (0.4%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (34.2%) as compared to SA 6 (5.1%) with the lowest percentage.

The highest percentage of Two or More Races served in outpatient programs was in SA 1 (4.8%) as compared to SA 6 (1.5%) with the lowest percentage.

FIGURE 8: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE AND ETHNICITY TREND FY 16–21



Data Source: LACDMH, IS-IBHIS, March 2022

The percentage of African Americans (AA) served in outpatient programs increased by 2.6% from 21.6% to 24.2% between FY 16-17 and FY 20-21.

The percentage of Asian/Pacific Islanders (API) served in outpatient programs increased by 1.4% from 4.0% to 5.4% between FY 16-17 and FY 20-21.

The percentage of Latinos served in outpatient programs decreased by 9.7% from 57.2% to 47.5% between FY 16-17 and FY 20-21.

The percentage of American Indian/Alaska Native served in outpatient programs increased by 0.2% from 0.6% to 0.8% from FY 16-17 and FY 20-21.

The percentage of Whites served in outpatient programs increased by 2.5% from 16.5% to 19.0% between FY 16-17 and FY 20-21.

The percentage of Two or More Races served in outpatient programs remained the same at 3.1% between FY 19-20 and FY 20-21.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP AND SERVICE AREA FY 20–21

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	5,544	3,174	7,512	1,648	17,878
Percent	31.0%	17.8%	42.0%	9.2%	100.0%
SA 2	9,777	8,332	15,761	4,599	38,469
Percent	25.4%	21.7%	41.0%	12.0%	100.0%
SA 3	10,227	8,379	11,533	2,945	33,084
Percent	30.9%	**25.3%**	34.9%	8.9%	100.0%
SA 4	6,708	5,682	15,250	4,558	32,198
Percent	20.8%	17.6%	47.4%	14.2%	100.0%
SA 5	1,382	1,269	4,591	1,527	8,769
Percent	**15.8%**	**14.5%**	**52.4%**	**17.4%**	100.0%
SA 6	11,391	8,669	18,676	4,740	43,476
Percent	26.2%	19.9%	43.0%	10.9%	100.0%
SA 7	9,629	7,037	10,128	2,396	29,190
Percent	**33.0%**	24.1%	**34.7%**	**8.2%**	100.0%
SA 8	8,861	6,553	15,576	4,294	35,284
Percent	25.1%	18.6%	44.1%	12.2%	100.0%
Total	39,749	30,414	67,457	20,790	158,410
Percent	25.1%	19.2%	42.6%	13.1%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Table excludes Null (N= 83), Out of LA and Out of State (N = 2,527). Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, March 2022.

Differences by Age Group

Table 19 shows the unduplicated count of consumers served in outpatient programs by Age Group and Service Area (SA).

The highest percentage of Children (0-15 years old) served was in SA 7 (33.0%) compared to SA 5 (15.8%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 3 (25.3%) when compared to SA 5 (14.5%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (52.4%) compared to SA 7 (34.7%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (17.4%) compared to SA 7 (8.2%) with the lowest percentage.

TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 20–21

Service Area (SA)	Gender					
	Male	Female	Transgender (M to F)	Transgender (F to M)	Unknown	Total
SA 1	8,427	9,432	6	13		17,878
Percent	**47.1%**	**52.8%**	0.0%	0.1%	0.0%	100.0%
SA 2	18,503	19,879	28	50	9	38,469
Percent	48.1%	51.7%	0.1%	0.1%	0.0%	100.0%
SA 3	16,389	16,662	12	16	5	33,084
Percent	49.5%	50.4%	0.0%	0.0%	0.0%	100.0%
SA 4	17,023	15,086	62	19	8	32,198
Percent	**52.9%**	**46.9%**	0.2%	0.1%	0.0%	100.0%
SA 5	4,490	4,266	4	9		8,769
Percent	51.2%	48.6%	0.0%	0.1%	0.0%	100.0%
SA 6	21,983	21,430	20	30	13	43,476
Percent	50.6%	49.3%	0.0%	0.1%	0.0%	100.0%
SA 7	14,267	14,881	17	20	5	29,190
Percent	48.9%	51.0%	0.1%	0.1%	0.0%	100.0%
SA 8	17,489	17,711	34	41	9	35,284
Percent	49.6%	50.2%	0.1%	0.1%	0.0%	100.0%
Total	81,011	77,132	114	120	33	158,410
Percent	51.1%	48.7%	0.1%	0.1%	0.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Table excludes Null (N= 83), Out of LA and Out of State (N = 2,527). Data Source: LACDMH-IS-IBHIS, March, 2022.

Differences by Gender

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

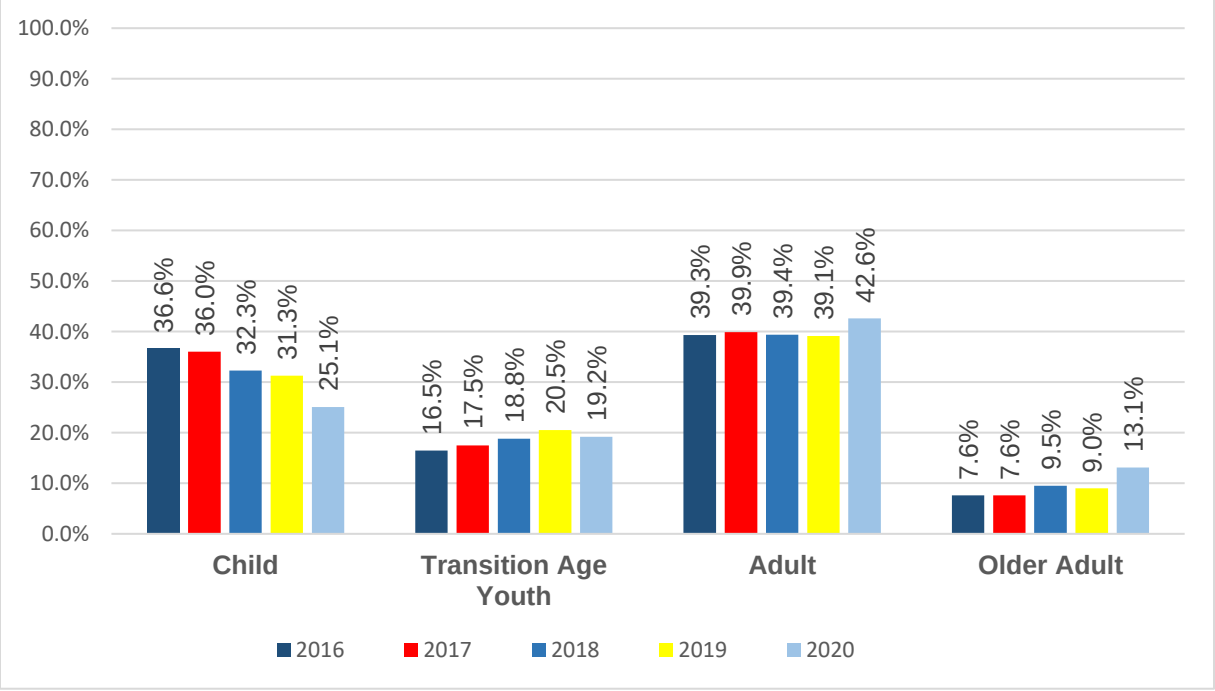
The highest percentage of Males served in outpatient programs was in SA 4 (52.9%) compared to SA 1 (47.1%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 2 (52.8%) compared to SA 4 (46.9%) with the lowest percentage.

The highest percentage of Transgender (M to F) persons served in outpatient programs was in SA 4 (0.2%) compared to SA 1, SA 3 and SA 6 (0.04%) with the lowest percentage.

The highest percentage of Transgender (F to M) persons served in outpatient programs was in SA 1, SA 2, SA 4, SA 5, SA 6, SA 7 and SA 8 (0.1%) compared to SA 3 (0.0%) with the lowest percentage.

FIGURE 9: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP TREND FY 16–21



Data Source: LACDMH, IS-IBHIS, March 2022

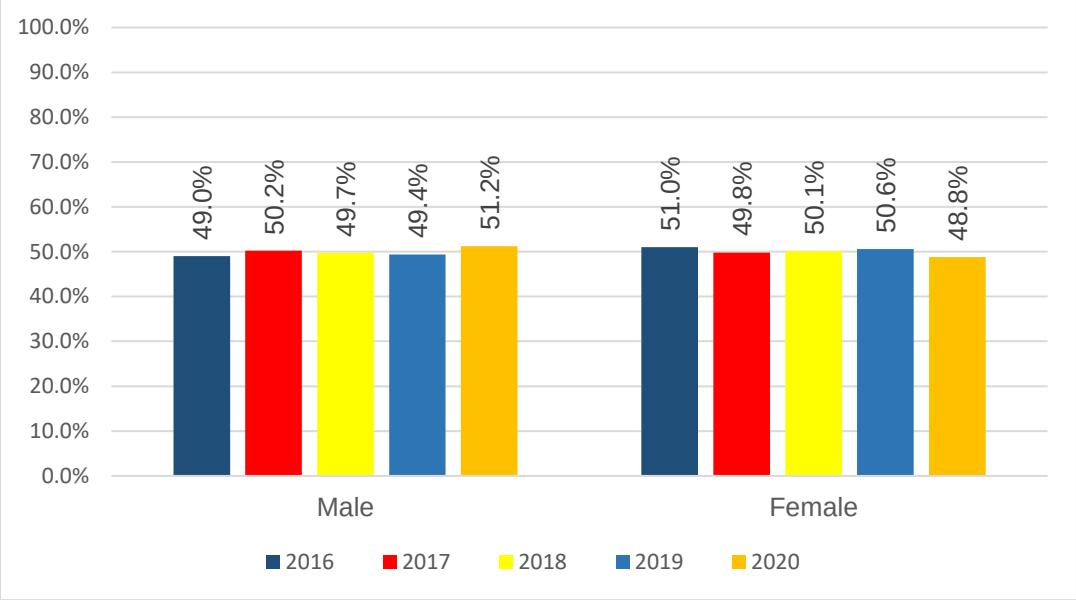
The percentage of Children served in outpatient programs decreased by 11.5% from 36.6% to 25.1% between FY 16-17 and FY 20-21.

The percentage of TAY served in outpatient programs increased by 2.7% from 16.5% to 19.2% between FY 16-17 and FY 20-21.

The percentage of Adults served in outpatient programs decreased by 3.3% from 39.3% to 42.6% between FY 16-17 and FY 20-21.

The percentage of Older Adults served in outpatient programs increased by 5.5% from 7.6% to 13.1% between FY 16-17 and FY 20-21.

FIGURE 10: PERCENT CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER TREND FY 16–21



Data Source: LACDMH, IS-IBHIS, March 2022.

The percentage of Males in outpatient programs increased by 2.2% from 49.0% to 51.2% between FY 16 -17 and FY 20-21.

The percentage of Females served in outpatient programs decreased by 2.2% from 51.0% to 48.8% between FY 16 -17 and FY 20-21.

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

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other Non-English	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	4	10	1	1	16,491	9	2	1	1	2	8	1,118	6	0	17,654
Percent	0.02%	0.06%	0.01%	0.01%	**93.41%**	0.05%	0.01%	0.01%	0.01%	0.01%	0.05%	**6.33%**	0.03%	0.00%	100.00%
SA 2	74	1,093	18	5	30,741	457	93	6	11	9	174	4,682	80	67	37,510
Percent	0.2%	2.9%	0.0%	0.0%	**82.0%**	1.2%	0.2%	0.0%	0.0%	0.0%	0.5%	**12.5%**	0.2%	0.2%	100.0%
SA 3	26	61	65	439	25,766	14	69	399	63	14	6	4,426	32	350	31,730
Percent	0.1%	0.2%	0.2%	1.4%	**81.2%**	0.0%	0.2%	1.3%	0.2%	0.0%	0.0%	**13.9%**	0.1%	1.1%	100.0%
SA 4	10	162	59	77	25,303	34	469	33	16	4	130	4,726	60	54	31,137
Percent	0.0%	0.5%	0.2%	0.2%	**81.3%**	**b**	1.5%	0.1%	0.1%	0.0%	0.4%	**15.2%**	0.2%	0.2%	100.0%
SA 5	12	5		2	7,830	126	16	2	2	3	27	452	3	1	8,481
Percent	0.1%	0.1%	0.0%	0.0%	**92.3%**	1.5%	0.2%	0.0%	0.0%	0.0%	0.3%	**5.3%**	0.0%	0.0%	100.0%
SA 6	3	7	11	18	36,341	19	53	17	0	8	7	6,140	9	12	42,645
Percent	0.01%	0.02%	0.03%	0.04%	**85.22%**	0.04%	0.12%	0.04%	0.00%	0.02%	0.02%	**14.40%**	0.02%	0.03%	100.00%
SA 7	20	17	84	20	22,494	10	48	30	14	1	2	5,849	24	23	28,636
Percent	0.07%	0.06%	0.29%	0.07%	**78.55%**	0.03%	0.17%	0.10%	0.05%	0.00%	0.01%	**20.43%**	0.08%	0.08%	100.00%
SA 8	15	8	501	10	29,610	9	70	20	6	5	6	3,959	65	97	34,381
Percent	0.04%	0.02%	1.46%	0.03%	**86.12%**	0.03%	0.20%	0.06%	0.02%	0.01%	0.02%	**11.52%**	0.19%	0.28%	100.00%
Total	135	1,115	705	486	126,026	542	696	425	99	26	324	22,434	230	510	153,753
Percent	0.1%	0.7%	0.5%	0.3%	**82.0%**	0.4%	0.5%	0.3%	0.1%	0.0%	0.2%	**14.6%**	0.1%	0.3%	100.0%

Note: “Threshold Language” means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Table excludes Null (83) Out of State and Out of County N = 2,527. Another 8935 consumers had primary languages that were “Unknown”. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, March 2022.

Table 21 shows the primary language of consumers served in outpatient programs by Service Area (SA) and threshold language.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 126,026 (82.0%) English speaking consumers were served followed by 22,434 (14.6%) Spanish speaking consumers. The remaining 5,293 (3.4%) consumers served spoke other LACDMH threshold languages. A total 27,727 (18.0%) of the consumers served reported a primary language other than English.

SA 1 (93.41 %) had the highest percentage of English-speaking consumers, as compared to SA 7 (78.55%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for consumers served in all SAs. The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (20.43%) and the lowest percentage was in SA 5 (5.3%).

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

- SA 1: Spanish (6.33%)
- SA 2: Armenian (2.9%), Farsi (1.2%), Russian (0.5%), Spanish (12.5%), Tagalog and (0.2%), and Vietnamese (0.2%)
- SA 3: Cantonese (1.4%), Korean (0.2%), Mandarin (1.3%), Spanish (13.9%), and Vietnamese (1.1%)
- SA 4: Armenian (0.5%), Cantonese (0.2%), Korean (1.5%), Other Chinese (0.1%), Russian (0.4%), Spanish (15.2%), and Tagalog (0.2%)
- SA 5: Farsi (1.5%) and Spanish (5.3%)
- SA 6: Spanish (14.4%)
- SA 7: Korean (0.17%) and Spanish (20.43%)
- SA 8: Cambodian (1.46%), Korean (0.2%), Spanish (11.52%), and Vietnamese (0.28%)

B. Needs Assessment/Analysis of Disparities

Demographic profile of Los Angeles County is presented in the next section. This includes total population and population living at or below 138% FPL distribution by race/ethnicity, age group and gender in CY 2020 and consumers served in FY 20-21. The needs assessment section further analyzes the demographic distribution of the outpatient consumers served in the County Service Areas for FY 20-21 and compares it with population enrolled in Medi-Cal estimated with Severe Emotional Disturbance (SED) and Serious Mental Illness (SMI) to assess the unmet need for mental health services in the County.

Disparity by Race and Ethnicity

TABLE 22: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED POPULATION WITH SED AND SMI
FY 20-21

	African American	Asian/Pacific Islander	Latino	American Indian/Alaska Native	White	Unreported	Total
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	69,950	70,933	393,839	879	118,758	68,130	722,489
Outpatient Consumers Served	30,438	6,855	59,791	1,063	23,937	32,412	154,496
Total Disparity	39,512	64,078	334,048	+184	94,821	35,718	567,993

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County. Downloaded on December 28, 2021.

Table 22 shows unmet need among ethnic groups at the county level

Among African Americans (AA), there was an estimated unmet service need for 39,512 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 30,348 while the estimated Medi-Cal Enrolled Population with SED and SMI was 69,950.

Among Asian/Pacific Islanders there was an estimated unmet service need for 64,078 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 6,855 while the estimated Medi-Cal Enrolled Population with SED and SMI was 64,078.

Among Latinos there was an estimated unmet service need for 334,048 Medi-Cal Enrolled Latino individuals as the number of unduplicated consumers served was 56,791 while the estimated Medi-Cal Enrolled Population with SED and SMI was 393,839.

Among American Indian/Alaska Natives, there was an estimated unmet service need for 184 Medi-Cal Enrolled Native American individuals as the number of unduplicated consumers served was 1.063 while the estimated Medi-Cal Enrolled Population with SED and SMI was 879.

Among Whites there was an estimated unmet service need for 94,821 Medi-Cal Enrolled White individuals as the number of unduplicated consumers served was 23,937 while the estimated Medi-Cal Enrolled Population with SED and SMI was 118,758.

Among Unreported ethnicity, there was an estimated unmet service need for 35,718 Medi-Cal Enrolled Unreported ethnicity individuals as the number of unduplicated consumers served was 32,412 while the estimated Medi-Cal Enrolled Population with SED and SMI was 68,130.

Disparity by Language

TABLE 23: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED POPULATION WITH SED AND SMI BY LANGUAGE ESTIMATED FY 20–21

Language	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
English	412,775	126,026	-286,749
Spanish	240,643	22,434	-218,209
Armenian	13,867	1,115	-12,752
Mandarin	8,653	425	-8,228
Cantonese	7,635	486	-7,149
Korean	6,126	696	-5,430
Vietnamese	5,311	510	-4,801
Farsi	2,638	542	-2,096
Russian	2,497	324	-2,173
Tagalog	1,726	230	-1,496
Cambodian	1,517	705	-812
Arabic	1,069	135	-934
Other Non-English	1,023	26	-997
Other Chinese	457	99	-358
Total	705,938	153,753	-552,185

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates “no disparity”. A “+” number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County. Downloaded on December 28, 2021.

Table 23 shows that among the Outpatient consumers in Los Angeles County. The threshold language with the highest unmet need was Spanish with an estimated 286,479 (unduplicated) Spanish speaking individuals in need of services. The least disparity was Other Chinese with an estimated 358 (unduplicated) individuals in need of services.

Overall, at the county level, there was an estimated unmet service need based on language for 552,185 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 153,185 while the estimated Medi-Cal Enrolled Population with SED and SMI was 705,938.

Disparity by Age Group

TABLE 24: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY AGE GROUP ESTIMATED WITH SED AND SMI FY 20–21

	Age Group				
CY 2021	**0-18**	**19-44**	**45-64**	**65 and above**	**Total**
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	434,950	319,918	78,612	19,001	852,481
Outpatient Consumers Served	54,941	53809	39640	10,016	158,410
Total Disparity	380,009	266,109	38,972	8,985	694,071

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County. Downloaded on December 28, 2021.

Table 24 shows that among the Outpatient consumers in Los Angeles County. The age group with the highest unmet need is 0-18 with an estimated 380,009 (unduplicated) individuals in need of services. The age group with the least unmet need 65 and above with an estimated 8,895 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 694,071 Medi-Cal Enrolled individuals as the number of unduplicated consumers served across age groups was 158,410 while the estimated Medi-Cal Enrolled Population with SED and SMI was 852,481.

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Disparity by Gender

TABLE 25: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY GENDER ESTIMATED WITH SED AND SMI FY 20–21

CY 2021	Female	Male	Total
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	388,833	324,904	713,737
Outpatient Consumers Served	77,132	81,011	158,143
Total Disparity	311,701	243,893	555,594

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligible Tables by County. Downloaded on December 28, 2021.

Table 25 shows unmet need among gender at the county level. Among females there was an estimated unmet service need for 311,701 Medi-Cal Enrolled females individuals as the number of unduplicated consumers served was 77,132 while the estimated Medi-Cal Enrolled Population with SED and SMI was 388,833.

Among males there was an estimated unmet service need for 243,893 Medi-Cal Enrolled males individuals as the number of unduplicated consumers served was 81,011 while the estimated Medi-Cal Enrolled Population with SED and SMI was 324,893.

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

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

TABLE 26: ESTIMATED COUNTYWIDE TOTAL POPULATION BY RACE AND ETHNICITY TREND CY 2018-2020

Race/Ethnicity	Countywide Estimated Total Population					
	2018		2019		2020	
	N	%	N	%	N	%
African American	835,568	8.1%	835,191	8.1%	773,282	7.7%
Asian /Pacific Islander	1,454,863	14.2%	1,457,731	14.2%	1,507,702	15.1%
Latino	5,011,365	48.8%	4,993,673	48.7%	4,803,963	48.0%
Native American	23,716	0.2%	23,720	0.2%	18,602	0.2%
White	2,723,137	26.5%	2,719,729	26.5%	2,594,341	25.9%
Two or More Races	230,184	2.2%	230,193	2.2%	314,524	3.1%
Total	10,278,834	100.0%	10,260,237	100.0%	10,012,414	100.0%

The African American population decreased by 62,286 between CY 2018 and CY 2020, from 835,568 to 773,282 (percent decreased 8.1% of the total population.) The African American population decreased by 61,909 between CY 2019 and CY 2020, from 835,191 to 773,282 (percent decreased by 0.4 from 8.1% to 7.7% of the total population.)

The Asian/Pacific Islander population decreased by 52,839 between CY 2018 and CY 2020, from 1,454,863 to 1,507,702 (percent increased by 0.9% from 14.2% to 15.1% of the total population.) The Asian/Pacific Islander population decreased by 49,971 between CY 2019 and CY 2020, from 1,457,731 to 1,507,702 (percent increased by 0.9 from 14.2% to 15.1% of the total population.)

The Latino population decreased by 207,402 between CY 2018 and CY 2020, from 5,011,365 to 4,803,963 (percent decreased by 0.8% 48.8% to 48.0% of the total population.) The Latino population decreased by 189,710 between CY 2019 and CY 2020, from 4,993,673 to 4,803,963 (deceased by 0.7% from 48.7% to 48.0% of the total population.)

The American Indian/Alaska Native population decreased by 5,114 between CY 2018 and CY 2020, from 23,716 to 18,602 (percent remained at 0.2% of the total population.) The Native American population decreased by 5,118 from 23,720 to 18,602 between CY 2019 and CY 2020 (percent remained the same at 0.2% of the total population.)

The White population decreased by 128,796 between CY 2018 and CY 2020, from 2,723,137 to 2,594,341 (percent decreased by 0.6% from 26.5% to 25.9% of the total population.) The White population decreased by 125,388 between CY 2019 and CY 2020, from 2,719,729 to 2,594,341 (percent decreased by 0.6% from 26.5% to 25.9% of the total population.)

The Two or More Races population increased by 84,340 from CY 2018 and CY 2020 from 230,184 to 314,524 (percent increased by 0.9% from 2.2% to 3.1% of the total population). The Two or More Races population increased by 84,331 (0.9) from CY 2019 and CY 2020 from 230,193 to 314,524 (percent increased by 0.9 from 2.2% to 3.1% of the total population.)

TABLE 27: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE AND ETHNICITY TREND
CY 2018-2020

Race/Ethnicity	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2018		2019		2020	
	N	%	N	%	N	%
African American	228,375	10.1%	213,465	10.0%	179,112	9.4%
Asian/Pacific Islander	249,736	11.1%	238,106	11.2%	234,816	12.3%
Latino	1,368,985	60.7%	1,297,085	60.8%	1,143,924	59.8%
Native American	5,255	0.2%	5,038	0.2%	3,249	0.2%
White	368,507	16.3%	348,173	16.3%	311,293	16.3%
Two or More Races	33,208	1.5%	32,374	1.5%	41,705	2.2%
Total	2,254,066	100.0%	2,134,242	100.0%	1,914,099	100.0%

The African American population living at or below 138% FPL decreased by 49,263 between CY 2018 and CY 2020, from 228,375 to 179,112 (percent decreased by 0.7% from 10.1% to 9.4% of the total 138% FPL population.) The African American population decreased by 3,290 between CY 2019 and CY 2020, from 213,465 to 179,112 (percent decreased 0.6% from 10.0 to 9.4 of the total 138% FPL population.).

The Asian/Pacific Islander population living at or below 138% FPL decreased by 14,920 between CY 2018 and CY 2020, from 249,736 to 234,816 (percent increased by 1.2% from11.1% to 12.3% of the total 138% FPL population.) The Asian/Pacific Islander population decreased by 3,290 between CY 2019 and CY 2020, from 238,106 to 234,816 (percent increased by 1.1% from 11.2% to 12.3% of the total 138% FPL population.)

The Latino population living at or below 138% FPL decreased by 225,061 between CY 2018 and CY 2020, from 1,368,985 to 1,143,924 (percent decreased by 0.9% from 60.7%

to 59.8% of the total 138% FPL population). The Latino population decreased by 153,161 between CY 2019 and CY 2020, from 1,297,085 to 1,143,924 (percent decreased by 1.0% from 60.8% to 59.8% of the total 138% FPL population).

The American Indian/Alaska Native population living at or below 138% FPL decreased by 2,006 between CY 2018 and CY 2020, from 5,255 to 3,249 (percent remained the same at 0.2% of the total 138% FPL population.) The Native American population decreased by 1,789 between CY 2019 and CY 2020, from 5,038 to 3,249 (percent remained at 0.2% of the total 138% FPL population).

The White population living at or below 138% FPL decreased by 57,214 between CY 2018 and CY 2020, from 368,507 to 311,293 (percent remained at 16.3% of the total 138% FPL population.) The White population decreased by 36,880 between CY 2019 and CY 2020, from 348,173 to 311,293 (percent remained the same at 16.3% of the total 138% FPL population).

The Two or More Races population increased by 8,497 from CY 2018 and CY 2020 from 33,208 to 41,705 (percent increased by 0.7% from 1.5% to 2.2 of the total population.)
The Two or More Races population decreased by 9,331 from CY 2019 and CY 2020 from 32,374 to 41,705 (percent increased 1.5% to 2.2% of the total population.)

TABLE 28: ESTIMATED COUNTYWIDE TOTAL POPULATION BY AGE GROUP TREND CY 2018-2020

Age Group	Countywide Estimated Total Population					
	2018		2019		2020	
	N	%	N	%	N	%
0-18	2,380,526	23.2%	2,329,975	22.7%	2,187,956	21.9%
19-20	304,749	3.0%	300,201	2.9%	292,488	2.9%
21-25	747,746	7.3%	732,995	7.1%	704,679	7.0%
26-59	4,897,871	47.7%	4,904,764	47.8%	4,823,661	48.2%
60-64	600,998	5.8%	618,685	6.0%	613,885	6.1%
65 and older	1,346,944	13.1%	1,373,617	13.4%	1,389,745	13.9%
Total	10,278,834	100.0%	10,260,237	100.0%	10,012,414	100.0%

The Age Group 0-18 decreased by 192,570 between CY 2018 and CY 2020, from 2,380,526 to 2,187,956 (percent increased by 1.3 from 23.2% to 21.9%). The Age Group

0-18 decreased by 142,019 between CY 2019 and CY 2020, from 2,329,975 to 2,187,956 (percent decreased by 0.8% from 22.7% to 21.9%).

Age Group 19-20 decreased by 12,261 between CY 2018 and CY 2020, from 304,749 to 292,488 (percent decreased by 0.1% from 3.0% to 2.9%). The Age Group 19-20 decreased by 7,713 between CY 2019 and CY 2020, from 300,201 to 292,488 (percent remained the same at 2.9%).

Age Group 21-25 decreased by 43,067 between CY 2018 and CY 2020, from 747,746 to 704,679 (percent decreased by 0.3% from 7.3% to 7.0%). The Age Group 21-25 decreased by 28,316 between CY 2019 and CY 2020, from 732,995 to 704,679 (percent decreased by 0.1% from 7.1% to 7.0%).

Age Group 26-59 increased by 74,210 between CY 2018 and CY 2020, from 4,897,871 to 4,823,661 (percent increased by 0.5% from 47.7% to 48.2%). The Age Group 26-59 decreased by 81,103 between CY 2019 and CY 2020, from 4,904,764 to 4,823,661 (percent increased by 0.4% from 47.8% to 48.2%).

Age Group 60-64 increased by 12,887 between CY 2018 and CY 2020, from 600,998 to 613,885 (percent increased by 0.3% from 5.8% to 6.1%). The Age Group 60-64 population decreased by 4,800 between CY 2019 and CY 2020, from 618,685 to 613,885 (percent increased by 0.1% from 6.0% to 6.1%).

Age Group 65 and older increased by 42,801 between CY 2018 and CY 2020, from 1,346,944 to 1,389,745 (percent increased by 0.8% from 13.1% to 13.9%). The Age Group 65 and older increased by 16,128 between CY 2019 and CY 2020, from 1,373,617 to 1,389,745 (percent increased by 0.5% from 13.4% to 13.9%).

TABLE 29: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP TREND CY 2018-2020

Age Group	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2018		2019		2020	
	N	%	N	%	N	%
0-18	760,978	33.8%	707,071	33.1%	604,649	31.6%
19-20	66,182	2.9%	60,915	2.9%	52,629	2.7%
21-25	177,416	7.9%	162,265	7.6%	137,592	7.2%
26-59	947,137	42.0%	900,114	42.2%	809,591	42.3%
60-64	93,912	4.2%	93,028	4.4%	87,665	4.6%
65 and above	208,441	9.2%	210,849	9.9%	221,973	11.6%
Total	2,254,066	100.0%	2,134,242	100.0%	1,914,099	100.0%

Table 29 presents the estimated total population living at or below 138% FPL by Age Group for CY 2018, CY 2019, and CY 2020.

Age Group 0-18 living at or below 138% FPL decreased by 156,329 between CY 2018 and CY 2020, from 760,978 to 604,649 (percent decreased by 2.2% from 33.8% to 31.6% of the total 138% FPL population.) The Age Group 0-18 living at or below 138% FPL decreased by 102,422 between CY 2019 and CY 2020, from 707,071 to 604,649 (percent decreased by 1.5% from 33.1% to 31.6%).

Age Group 19-20 living at or below 138% FPL decreased by 13,553 between CY 2018 and CY 2020, from 66,182 to 52,629 (percent decreased by 0.2% from 2.9% to 2.7% of the total 138% FPL population.) The Age Group 19-20 living at or below 138% FPL decreased by 8,286 between CY 2019 and CY 2020, from 60,915 to 52,629 (percent decreased by 0.2% from 2.9% to 2.7%).

Age Group 21-25 living at or below 138% FPL decreased by 39,824 between CY 2018 and CY 2020, from 177,416 to 137,592 (percent decreased by 0.7% from 7.9% to 7.2% of the total 138% FPL population.) The Age Group 21-25 living at or below 138% FPL decreased by 24,673 between CY 2019 and CY 2020, from 162,265 to 137,592 (percent decreased by 0.4% from 7.6% to 7.2%).

Age Group 26-59 living at or below 138% FPL decreased by 137,546 between CY 2018 and CY 2020, from 947,137 to 809,591 (percent increased by 0.3% from 42.0% to 42.3% of the total 138% FPL population.) The Age Group 26-59 living at or below 138% FPL decreased by 90,523 between CY 2019 and CY 2020, from 900,114 to 809,591 (percent increased by 0.1% from 42.2% to 42.3%).

Age Group 60-64 living at or below 138% FPL decreased by 6,247 between CY 2018 and CY 2020, from 93,912 to 87,665 (percent increased by 0.4% from 4.2% to 4.6% of the total 138% FPL population.) The Age Group 60-64 living at or below 138% FPL decreased by 5,363 between CY 2019 and CY 2020, from 93,028 to 87,665 (percent increased by 0.2% from 4.4% to 4.6%).

Age Group 65 and older living at or below 138% FPL increased by 13,532 between CY 2018 and CY 2020, from 208,441 to 221,973 (percent increased by 2.4% from 9.2% to 11.6% of the total 138% FPL population.) The Age Group 65 and older living at or below 138% FPL increased by 11,124 between CY 2019 and CY 2020, from 210,849 to 221,973 (percent increased by 1.7% from 9.9% to 11.6%).

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TABLE 30: ESTIMATED COUNTYWIDE TOTAL POPULATION BY GENDER TREND
CY 2018-2020

Gender	Countywide Estimated Total Population					
	2018		2019		2020	
	N	%	N	%	N	%
Male	5,067,739	49.3%	5,060,057	49.3%	4,941,542	49.4%
Female	5,211,095	50.7%	5,200,180	50.7%	5,070,872	50.6%
Total	10,278,834	100.0%	10,260,237	100.0%	10,012,414	100.0%

Table 30 presents the estimated countywide total population by gender for CY 2018, CY 2019, and CY 2020.

The Male population decreased by 126,197 between CY 2018 and CY 2020, from 5,067,739 to 4,941,542 (percent increased by 0.1% from 49.3% to 49.4%). The Male population decreased by 118,515 between CY 2019 and CY 2020 from 5,060,057 to 4,941,542 (percent increased by 0.1% from 49.3% to 49.4%).

The Female population decreased by 140,223 between CY 2018 and CY 2020, from 5,211,095 to 5,070,872 (percent decreased by 0.1% from 50.7% to 50.6%). The Female population decreased by 129,308 between CY 2019 and CY 2020, from 5,200,180 to 5,070,872 (percent decreased 0.1% from 50.7% to 50.6%).

TABLE 31: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER TREND
CY 2018-2020

Gender	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2018		2019		2020	
	N	%	N	%	N	%
Male	1,048,535	46.5%	981,510	46.0%	867,220	45.3%
Female	1,205,531	53.5%	1,152,732	54.0%	1,046,879	54.7%
Total	2,254,066	100.0%	2,134,242	100.0%	1,914,099	100.0%

Table 38 presents the estimated total population living at or below 138% FPL by gender for CY 2018, CY 2019, and CY 2020.

The Male population living at or below 138% FPL decreased by 181,315 between CY 2018 and CY 2020, from 1,048,535 to 867,220 (percent decreased by 1.2% from 46.5% to 45.3%). The Male population living at or below 138% FPL decreased by 114,290 between

CY 2019 and CY 2020, from 981,510 to 867,220 (percent decreased by 0.7% from 46.0% to 45.3%).

The Female population living at or below 138% FPL decreased by 158,652 between CY 2018 and CY 2020, from 1,205,531 to 1,046,879 (percent increased by 1.2% from 53.5% to 54.7%). The Female population living at or below 138% FPL decreased by 105,853 between CY 2019 and CY 2020, from 1,152,732 to1,046,879 (percent increased by 0.7% from to 54.0% to 54.7%).

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

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

TABLE 32: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY RACE AND ETHNICITY AND SERVICE AREA FY 20–21

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	American Indian/ Alaska. Native	White	Two or More Races	Unreported	Total
SA 1	4,163	144	3,698	91	2,810	643	1,121	12,670
Percent	32.9%	**1.1%**	29.2%	0.72%	22.2%	**5.1%**	**8.8%**	100.0%
SA 2	2,029	886	10,630	110	6,652	792	4,084	25,183
Percent	8.1%	3.5%	42.2%	**0.44%**	26.4%	3.1%	16.2%	100.0%
SA 3	1,370	1,612	7,043	113	2,534	447	6,186	19,305
Percent	7.1%	**8.4%**	36.5%	0.59%	13.1%	2.3%	**32.0%**	100.0%
SA 4	3,850	1,234	8,565	146	2,996	406	3,163	20,360
Percent	18.9%	6.1%	42.1%	0.72%	14.7%	2.0%	15.5%	100.0%
SA 5	1,011	216	1,180	30	2,097	181	1,068	5,783
Percent	17.5%	3.7%	**20.4%**	0.52%	**36.3%**	3.1%	18.5%	100.0%
SA 6	10,941	304	9,916	412	1,276	409	4,385	27,643
Percent	**39.6%**	**1.1%**	35.9%	**1.49%**	**4.6%**	**1.5%**	15.9%	100.0%
SA 7	1,043	556	9,363	129	1,611	458	4,410	17,570
Percent	**5.9%**	3.2%	**53.3%**	0.73%	9.2%	2.6%	25.1%	100.0%
SA 8	6,184	1,538	7,262	143	3,625	751	3,691	23,194
Percent	26.7%	6.6%	31.3%	0.62%	15.6%	3.2%	15.9%	100.0%
Total	24,039	5,835	45,870	832	19,250	3,202	22,200	121,228
Percent	19.83%	4.81%	37.84%	0.69%	15.88%	2.64%	18.31%	100.00%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes Null (N= 69), Out of LA and Out of State (N = 1,630). Total reflects an unduplicated count of consumers served. Total reflects unduplicated count of consumers served with the SAs. Data Source: LACDMH-IS-IBHIS, March, 2022.

Differences by Race and Ethnicity

The highest percentage of African American MHSA consumers served in outpatient programs was in SA 6 (39.6%) compared to SA 7 (5.9%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander (API) MHSA consumers served in outpatient programs was in SA 3 (8.4%) compared to SA 1 and SA 6 (1.0%) with the lowest percentage.

The highest percentage of Latino MHSA consumers served in outpatient programs was in SA 7 (53.3%) compared to SA 5 (20.4%) with the lowest percentage.

The highest percentage of American Indian/Alaska Native MHSA consumers served in outpatient programs was in SA 6 (1.49%) compared to SA 2 (0.44%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (36.3%) compared to SA 6 (4.6%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (36.3%) compared to SA 6 (4.6%) with the lowest percentage.

The highest percentage of Two or more races MHSA consumers served in outpatient programs was in SA 1 (5.1%) compared to SA 6 (1.6%) with the lowest percentage.

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TABLE 33: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 20–21

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	2,873	1,947	6,394	1,456	12,670
Percent	22.7%	15.4%	50.5%	11.5%	100.0%
SA 2	5,889	5,007	10,837	3,450	25,183
Percent	23.4%	19.9%	43.0%	13.7%	100.0%
SA 3	5,667	4,379	7,151	2,108	19,305
Percent	**29.4%**	22.7%	**37.0%**	10.9%	100.0%
SA 4	3,835	3,423	9,823	3,279	20,360
Percent	18.8%	16.8%	48.2%	16.1%	100.0%
SA 5	866	804	2,945	1,168	5,783
Percent	**15.0%**	**13.9%**	**50.9%**	**20.2%**	100.0%
SA 6	6,005	4,932	12,968	3,738	27,643
Percent	21.7%	17.8%	46.9%	13.5%	100.0%
SA 7	5,116	4,004	6,763	1,687	17,570
Percent	29.1%	**22.8%**	38.5%	**9.6%**	100.0%
SA 8	5,054	3,804	10,889	3,447	23,194
Percent	21.8%	16.4%	46.9%	14.9%	100.0%
Total	27,201	21,600	54,795	17,429	121,025
Percent	22.5%	17.8%	45.3%	14.4%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Table excludes Null (N= 69), Out of LA and Out of State (N = 173). Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, March, 2022.

Differences by Age Group

The highest percentage of Children MHSA consumers 0-15 years old was in SA 3 (29.4%) compared with SA 5 (15.0%) with the lowest percentage.

The highest percentage of TAY MHSA consumers 16-25 years old was in SA 7 (22.8%) compared with SA5 (13.9%) with the lowest percentage.

The highest percentage of Adult MHSA consumers 26-59 years old was in SA 5 (50.9%) compared with SA 3 (37.0% with the lowest percentage.

The highest percentage of Older Adult MHSA consumers 60 years old and over was in SA 5 (20.2%) compared with SA 7 (9.6%) with the lowest percentage.

TABLE 34: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 20–21

Service Area (SA)	Male	Female	Trans (M to F)	Trans (F to M)	Unknown	Total
SA 1	5,742	6,914	5	9		12,670
Percent	**45.3%**	**54.6%**	0.0%	0.1%	0.0%	100.0%
SA 2	11,753	13,375	17	31	7	25,183
Percent	46.7%	53.1%	0.1%	0.1%	0.0%	100.0%
SA 3	9,212	10,072	10	8	3	19,305
Percent	47.7%	52.2%	0.1%	0.0%	0.0%	100.0%
SA 4	10,431	9,869	41	14	5	20,360
Percent	**51.2%**	**48.5%**	0.2%	0.1%	0.0%	100.0%
SA 5	2,893	2,880	4	6		5,783
Percent	50.0%	49.8%	0.1%	0.1%	0.0%	100.0%
SA 6	13,320	14,284	17	18	4	27,643
Percent	48.2%	51.7%	0.1%	0.1%	0.0%	100.0%
SA 7	8,240	9,302	10	13	5	17,570
Percent	46.9%	52.9%	0.1%	0.1%	0.0%	100.0%
SA 8	10,825	12,315	23	26	5	23,194
Percent	46.7%	53.1%	0.1%	0.1%	0.0%	100.0%
Total	57,572	63,225	110	96	22	121,025
Percent	47.6%	52.2%	0.1%	0.1%	0.0%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Table excludes Null (N= 69), Out of LA and Out of State (N = 1,630). Total reflects unduplicated count of consumers served with the SAs. Data Source: LACDMH-IS-IBHIS, March 2022.

Differences by Gender

The highest percentage of Male MHSA consumers served in outpatient programs was SA 4 (51.2%) compared with SA 1 (45.3%) with the lowest percentage.

The highest percentage of Female MHSA consumers served in outpatient programs was SA 1 (54.6%) compared with SA 4 (48.5%) with the lowest percentage.

TABLE 35: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY THRESHOLD LANGUAGE AND SERVICE AREA FY 20–21

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other Non - English	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	4	10	1	1	11,647	7	1	1	1	2	6	846	6		12,533
Percent	0.03%	0.08%	0.01%	0.01%	**92.93%**	0.06%	0.01%	0.01%	0.01%	0.02%	0.05%	**6.75%**	0.05%	0.00%	100.00%
SA 2	56	780	17	3	19,956	397	61	5	7	7	82	3,298	69	34	24,772
Percent	0.23%	**3.15%**	0.07%	0.01%	**80.56%**	**1.60%**	**0.25%**	0.02%	0.03%	0.03%	**0.33%**	**13.31%**	**0.28%**	**0.14%**	100.00%
SA 3	19	35	48	337	14,602	7	55	290	43	6	3	2,854	27	234	18,560
Percent	0.10%	0.19%	0.26%	**1.82%**	**78.67%**	0.04%	**0.30%**	**1.56%**	0.23%	0.03%	0.02%	**15.38%**	0.15%	**1.26%**	100.00%
SA 4	10	137	38	40	15,858	26	344	24	10	2	65	3,229	46	29	19,858
Percent	0.05%	**0.69%**	0.19%	**0.20%**	**79.86%**	0.13%	**1.73%**	0.12%	0.05%	0.01%	0.33%	**16.26%**	0.23%	**0.15%**	100.00%
SA 5	10	4		2	5,152	102	11	2		1	16	336	2		5,638
Percent	0.18%	0.07%	0.00%	0.04%	**91.38%**	**1.81%**	0.20%	0.04%	0.00%	0.02%	0.28%	**5.96%**	0.04%	0.00%	100.00%
SA 6	2	7	10	7	22,946	9	41	8		4	3	4,190	6		27,233
Percent	0.01%	0.03%	0.04%	0.03%	**84.26%**	0.03%	0.15%	0.03%	0.00%	0.01%	0.01%	**15.39%**	0.02%	0.00%	100.00%
SA 7	14	11	81	12	13,530	3	25	22	9	1		3,621	20		17,349
Percent	0.08%	0.06%	0.47%	0.07%	**77.99%**	0.02%	0.14%	0.13%	0.05%	0.01%	0.00%	**20.87%**	0.12%	0.00%	100.00%
SA 8	12	5	483	8	19,295	8	61	15	6	4	4	2,712	56	90	22,759
Percent	0.05%	0.02%	**2.12%**	0.04%	**84.78%**	0.04%	**0.27%**	0.07%	0.03%	0.02%	0.02%	**11.92%**	0.25%	**0.40**%	100.00%
Total	110	935	657	372	96,981	498	543	331	72	24	164	17,226	208	354	118,475
Percent	0.09%	0.79%	0.55%	0.31%	81.86%	0.42%	0.46%	0.28%	0.06%	0.02%	0.14%	14.54%	0.18%	0.30%	100.00%

Note: “Threshold Language” means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Table excludes Null (66) Out of State and Out of County N = 1. A total of 1,605 consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 23. Another 1,468 consumers had primary languages that were “Unknown” Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Total reflects unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, March 2022.

Table 35 shows that Spanish and English are the most common languages in all of the Service Areas among the MHSA consumers. English was the most commonly spoken language at 81.9% followed by Spanish at 14.4% of languages spoken. The following information highlights the threshold languages spoken among the MHSA population by Service Area.

SA 1 has two (2) threshold languages: English (92.5%) and Spanish (7.2%).

SA 2 has seven (7) threshold languages: Armenian (3.2%), English (80.6%), Farsi (1.6%), Korean (0.3%), Russian (0.3%), Spanish (13.3%), Tagalog (0.3%) and Vietnamese (0.1%).

SA 3 has six (6) threshold languages: Cantonese (1.8%), English (78.7%), Korean (0.3%), Mandarin (1.6%), Spanish (15.4%), and Vietnamese (1.3%).

SA 4 has seven (7) threshold languages: Armenian (0.7%), Cantonese (0.2%), English (79.9%), Korean (1.7%), Other Chinese (0.05%), Russian (0.3%), Spanish (16.3%).

SA 5 has three (3) threshold languages: English (91.4%), Farsi (1.8%), and Spanish (6.0%).

SA 6 has two (2) threshold languages: English (84.3%) and Spanish (15.4%).

SA 7 has two (2) threshold languages: English (78.0%) and Spanish (20.9%).

SA 8 has five (5) threshold languages: Cambodian (2.1%), English (84.8%), Korean (0.3%), Spanish (12.0%) and Vietnamese (0.4%).

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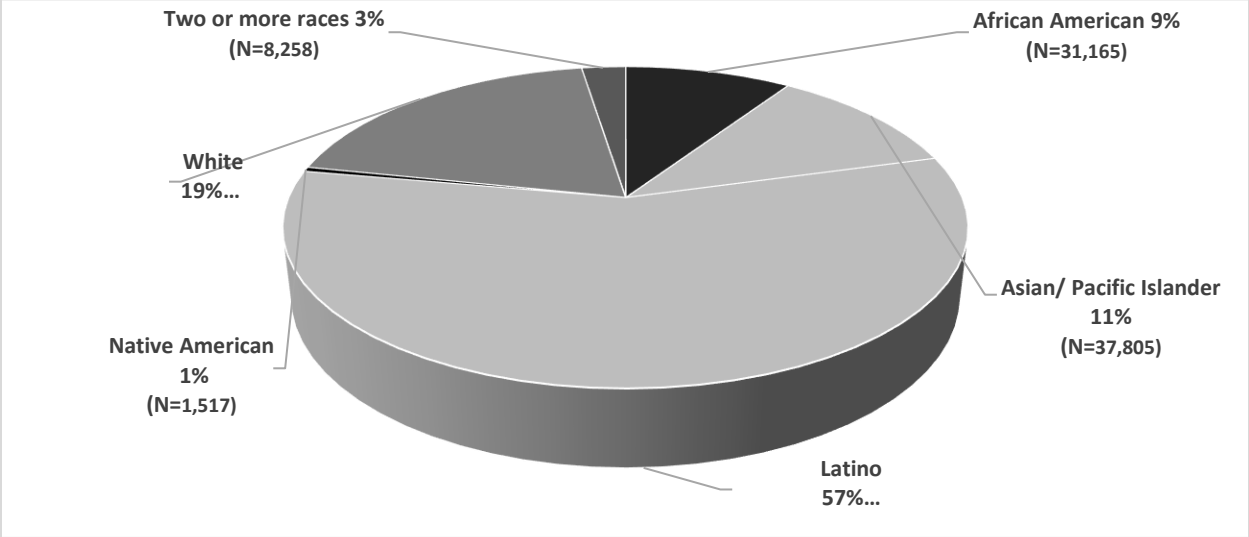
Analysis of Disparities

FIGURE 11: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE AND ETHNICITY CY 2020



Estimated prevalence of mental illness by Race/Ethnicity for Los Angeles County is provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2019 and CY 2021.
Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2021.

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

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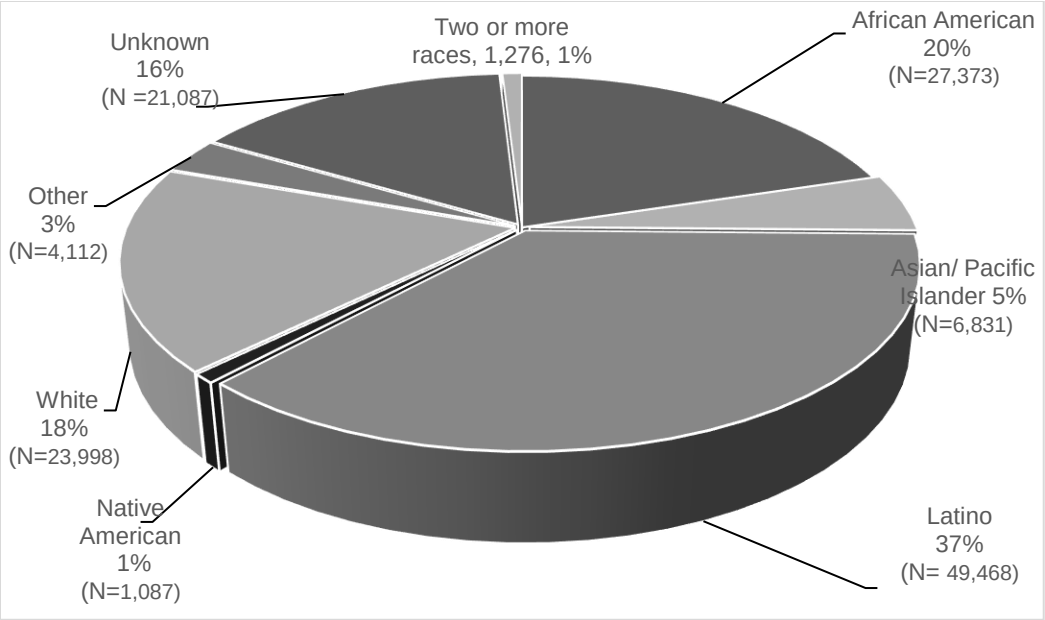
FIGURE 12: CSS CONSUMER POPULATION BY RACE AND ETHNICITY FY 22–23



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

Figure 12 shows the CSS enrolled population by Race and Ethnicity. Latinos are the largest group at 36%, followed by African Americans at 20%, Whites at 18%, Asian/Pacific Islanders at 5%, Other at 3%, Native Americans at 1.0% and Two or More Races at 1%. Unknown/Not specified Race/Ethnicity is at 14%.

Figures 11 and 12 indicate the following:

African Americans constitute 9% of the population in need of services at or below 138% FPL and constitute 20% of the CSS consumers.

Asian/Pacific Islanders constitute 11% of the population in need of services at or below 138% FPL and constitute 5% of the CSS consumers.

Latinos constitute 57% of the population in need of services at or below 138% FPL and constitute 37% of the CSS consumers.

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

Whites constitute 19% of the population in need of services at or below 138% FPL and constitute 18% of the CSS consumers.

Two or more races constitute 3% of the population in need of services at or below 138% FPL and constitute 1.0% of CSS consumers.

FIGURE 13: NEEDS ASSESSMENT SUMMARY FOR CSS PROGRAMS: PERCENTAGE COMPARISON FOR THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) AND CONSUMERS SERVED BY RACE AND ETHNICITY FY 20–21

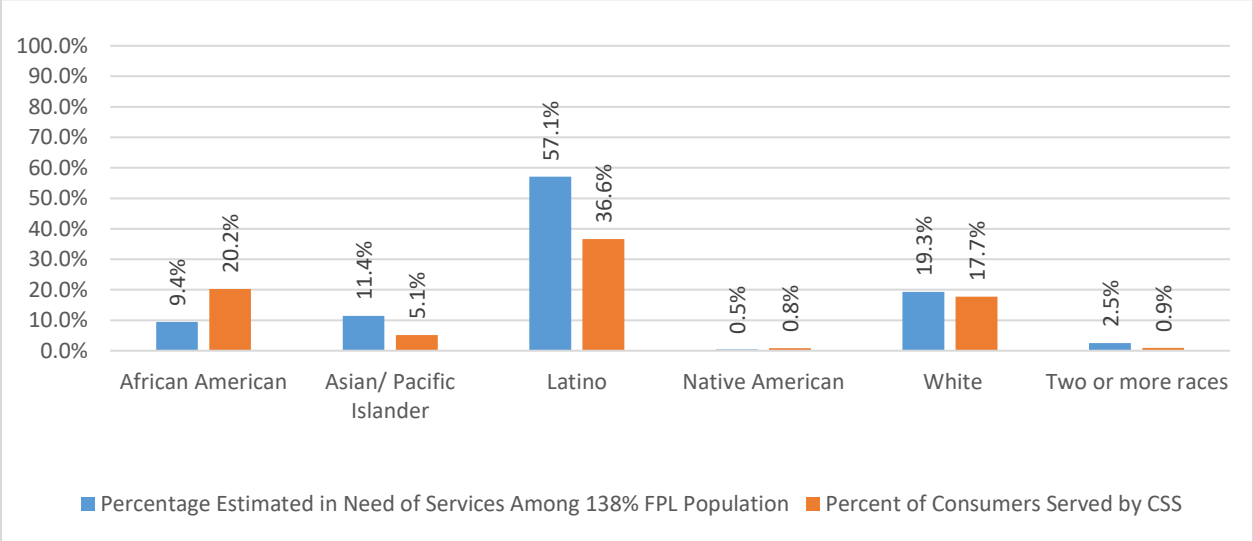


Figure 13 compares the information in Figures 11 and 12.

The percentage of African Americans receiving CSS services was the highest at 20.0% when compared with their population at or below 138%, FPL estimated in need of services at 9.0%.

The percentage of Asian/Pacific Islanders receiving CSS services was 5.0% when compared with their population at or below 138%, FPL estimated in need of services at 11.0%.

The percentage of Latinos receiving CSS services was 36.6% when compared to their population at or below 138%, FPL estimated in need of services at 57.0%.

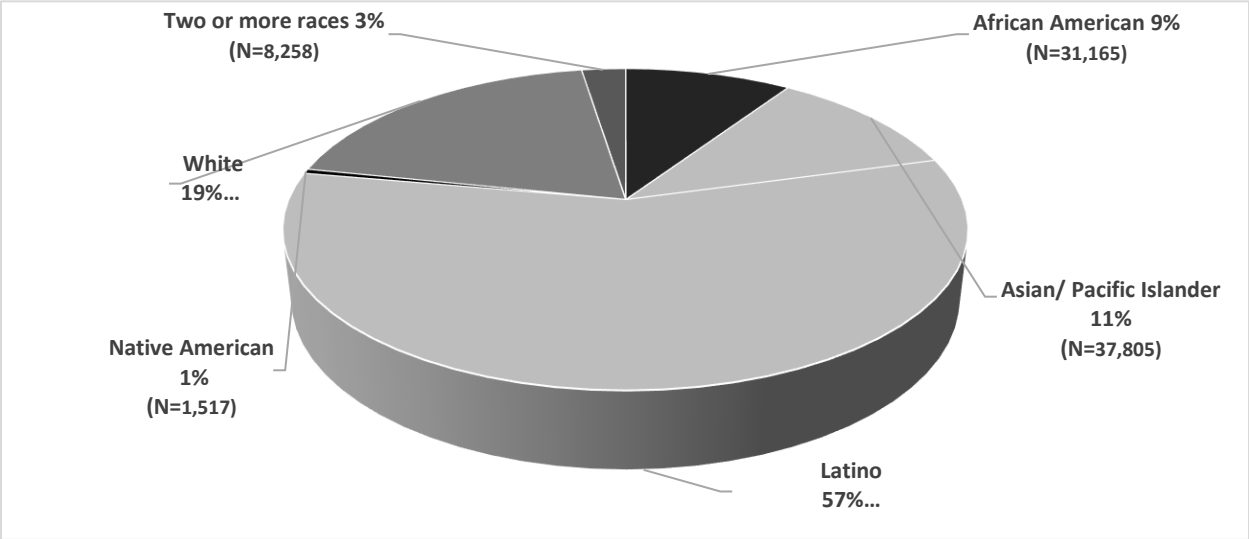
The percentage of Native Americans receiving CSS services was 1.0% when compared with their population of Native Americans at or below 138%, FPL estimated in need of services at 1.0%.

The percentage of Whites receiving CSS services was 19.3% when compared with their population at or below 138%, FPL estimated in need of services at 17.7%.

The percentage of Two or More Races receiving CSS services was 0.9% when compared with their population at or below 138%, FPL estimated in need of services at 2.5%.

Prevention and Early Intervention (PEI) Plan

FIGURE 14: ESTIMATED POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE AND ETHNICITY CY 2020



Estimated prevalence of mental illness by Race/Ethnicity for Los Angeles County is provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2019 and CY 2021. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2021.

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

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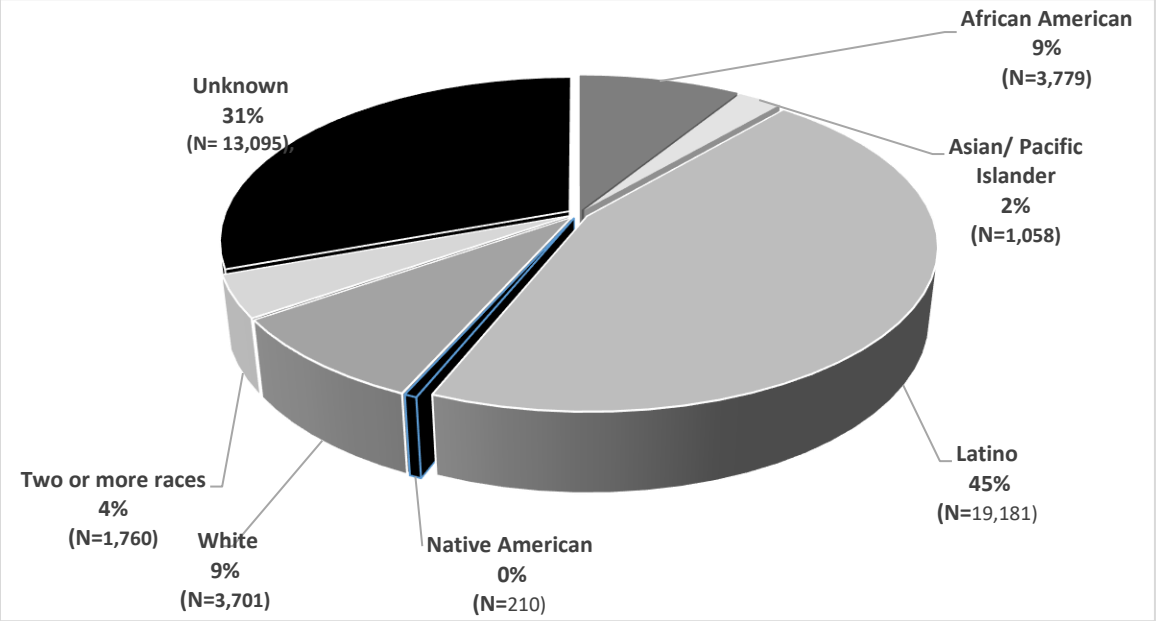
FIGURE 15: PEI CONSUMER POPULATION BY RACE AND ETHNICITY FY 22-23



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 22-23.

Figure 15 shows the PEI enrolled population by Race and Ethnicity. Latinos are the largest group at 45.0%, followed by African Americans at 9.0%, Whites at 9.0%, Asian/Pacific Islanders at 2.0%, and American Indian/Alaska Native at 0.3%.

Figures 14 and 15 indicate the following:

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

Asian/Pacific Islanders constitute 11.0% of the population in need of services at or below 138% FPL and constitute 2.0% of the PEI consumers.

Latinos constitute 57.0% of the population in need of services at or below 138% FPL and constitute 45.0% of the PEI consumers.

American Indian/Alaska Natives constitute 1.0% of the population in need of services at or below 138% FPL and constitute 0.49% of the PEI consumers.

Whites constitute 19.0% of the population in need of services at or below 138% FPL and constitute 9.0% of the PEI consumers.

FIGURE 16: NEEDS ASSESSMENT SUMMARY FOR PEI PROGRAMS: PERCENTAGE COMPARISON FOR THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) AND CONSUMERS SERVED BY RACE AND ETHNICITY FY 19-20

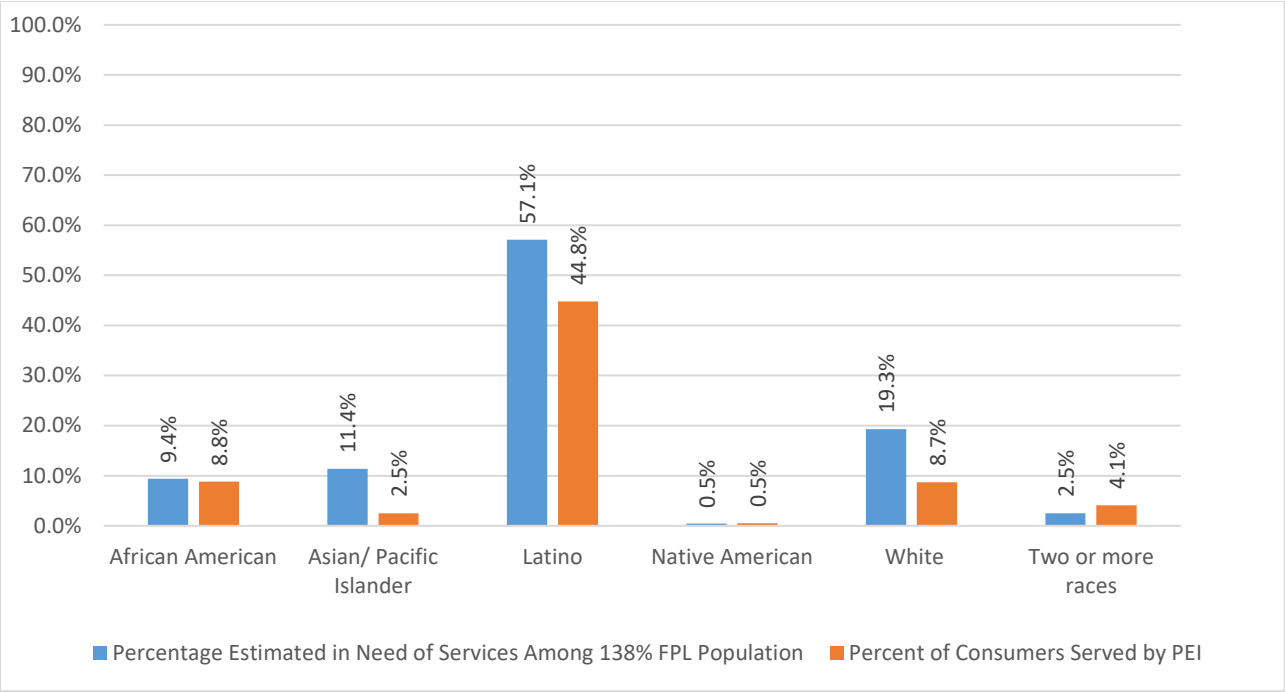


Figure 16 compares the information in Figures 14 and 15.

The percentage of African Americans receiving PEI services was 8.8% when compared with their population at or below 138% FPL estimated in need of services at 9.4%.

The percentage of Asian/Pacific Islanders receiving PEI services was 2.5% when compared with their population at or below 138% FPL estimated in need of services at 11.4%.

The percentage of Latinos receiving PEI services was the highest at 44.8% when compared to their population at or below 138% FPL estimated in need of services at 57.1%.

The percentage of American Indian/Alaska Natives receiving PEI services was 0.5% when compared with their population at or below 138% FPL estimated in need of services at 0.5%.

The percentage of Whites receiving PEI services was 8.7% when compared with their population at or below 138% FPL estimated in need of services at 19.3%.

The percentage of Two or More Races receiving PEI services was 4.1% when compared with their population at or below 138% FPL estimated in need of services at 2.5%.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criterion 3

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

August 2022

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

Identified unserved/underserved target population (with disparities)

I. List of Target Populations with Disparities

Based on FY 20-21 data, the Los Angeles County Department of Mental Health (LACDMH) target populations with mental health disparities include the following:

Medi-Cal population

By ethnicity

- African American - Countywide disparity
- Asian Pacific Islander (API) - Countywide disparity
- Latino - Countywide disparity
- White - Countywide disparity
- Unreported - Countywide disparity

By language

- Arabic - Countywide disparity
- Armenian - Countywide disparity
- Cambodian - Countywide disparity
- Cantonese - Countywide disparity
- English - Countywide disparity
- Farsi - Countywide disparity
- Korean - Countywide disparity
- Mandarin - Countywide disparity
- Other Chinese - Countywide disparity
- Other Non-English - Countywide disparity
- Russian - Countywide disparity
- Spanish - Countywide disparity
- Tagalog - Countywide disparity
- Vietnamese - Countywide disparity

By age group

- Age 0-18 - Countywide disparity
- Age 19-44 - Countywide disparity
- Age 45-64 - Countywide disparity
- Age 65+ - Countywide disparity

By gender

- Male - Countywide disparity
- Female - Countywide disparity

II. Identified disparities within the CCPR target populations

A. Community Services and Support (CSS) Plan

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

By ethnicity

- African American - Countywide disparity
- Asian Pacific Islander (API) - Countywide disparity
- Latino - Countywide disparity
- White - Countywide disparity
- Unreported - Countywide disparity

By language

- Arabic - Countywide disparity
- Armenian - Countywide disparity
- Cambodian - Countywide disparity
- Cantonese - Countywide disparity
- English - Countywide disparity
- Farsi - Countywide disparity
- Korean - Countywide disparity
- Mandarin - Countywide disparity
- Other Chinese - Countywide disparity
- Other Non-English - Countywide disparity
- Russian - Countywide disparity
- Spanish - Countywide disparity
- Tagalog - Countywide disparity
- Vietnamese - Countywide disparity

By age group

- Age 0-18 - Countywide disparity
- Age 19-44 - Countywide disparity
- Age 45-64 - Countywide disparity
- Age 65+ - Countywide disparity

By gender

- Male - Countywide disparity
- Female - Countywide disparity

B. Workforce, Education, and Training (WET)

By ethnicity

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

- Middle Eastern

By age group

- Children
- TAY
- Adults
- Older Adults

By language

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

C. Prevention Early Intervention (PEI) Priority Populations with Disparities

Underserved Cultural Populations

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

Individuals Experiencing Onset of Serious Psychiatric Illness

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

Children/Youth in Stressed Families

- Young Children
- Children
- TAY

Trauma-exposed

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

Children/Youth at Risk for School Failure

- Young Children
- Children

- TAY

Children/Youth at Risk of or Experiencing Juvenile Justice

- Children
- TAY

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

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

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

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

    Examples:
    - Specialized trainings were offered such as "COVID-19 and Similar Infections Diseases Outbreaks," "Suicide Prevention and COVID" and "COVID-19 Online Mental Health Workshop Series (Korean)"
    - CalWORKs and GROW services were accessible throughout the COVID-19 pandemic and mental health services were offered Countywide via telehealth
    - For all clinical sites, Personal Protective Equipment (PPE) was provided to all staff and community members who requested it and all COVID-19 recommendations/restrictions set forth by the Los Angeles (LA) County Department of Public Health (DPH) were implemented and adhered to
    - United Mental Health Promoter (UMHP) Program continued the process of adapting workshops to be responsive to COVID-related mental health and well-being issues. These workshops were also tailored to priority populations including Latino, Black and African Heritage (including Ethiopian), American Indian/Alaska Native, Korean, Chinese, Cambodian and Filipino. Additionally, Promoters staffed vaccine sites and conducted outreach to support mental health and vaccination efforts
    - TAY Drop-In Centers abided by all health mandates presented by DPH and implemented a hybrid model (online and in-person) at all Drop-In Centers to minimize any disruption in services
    - TAY Navigation Team provided PPE to all staff who requested, and any COVID-19 restrictions put into place by the shelters were adhered to when staff were visiting their clients
    - FSP services continued to provide services via telehealth and in the field with the use of PPE. The FSP services ensured that clients and staff took necessary precautions to reduce the risk of COVID-19 transmission in the context of providing in-person services
    - Health Neighborhood (HN) program received regular updates regarding COVID-19 by HN DPH representative

- Olive View Urgent Care Center (UCC) maintained all staff onsite at least half time and enhanced its telehealth program. All visitors were screened for COVID symptoms, and any visitors who were positive for symptoms received ongoing services via telephone (for non-holdable clients) or in front of the facility, including involuntary holds as needed
- Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Older Adult Program modified its service delivery system to prioritize providing field-based services for Older Adults most in need of in-person services. The program increased tele-mental health services through implementation of virtual platforms to protect the health and safety of Older Adults
- Faith-Based Advocacy Council (FBAC) leadership disseminated COVID-19 guidance, teleconferences, and critical information released by DPH to its membership and congregants
- Enriched Residential Care Program (ERC) has provided extensive technical assistance, training and supports to ERC operators along with DHS, DPH, and Community Care Licensing throughout the pandemic. This includes assisting them with accessing PPE, COVID testing, COVID vaccines, weekly webinars, weekly COVID surveys and follow-up technical assistance and guidance
- Women's Community and Re-Entry Program (WCRP) utilizes VSee technology and assists clients with learning how to use their phones for such visual communications. WCRP ensures that all clients have the appropriate PPE to receive services as well. WCRP provides safe COVID protocols and requirements for transportation, jail pick-up to their shelter, and temporary or permanent housing situation
- Men's Community Re-Entry Program (MCRP) collaborated with Sheriff's Department to conduct COVID tests before releasing individuals from jail into the community. MCRP conducts LACDMH's COVID-19 Symptom Screening questionnaire at onset of enrollment and subsequent contact with a client to determine if the client is presenting with any symptoms. LACDMH's symptom screening was also conducted for staff who called out due to illness. MCRP submits COVID Incident Report (CIR) to Human Resources (HR) and follows the CIR guidance returned by HR. In addition, MCRP requests COVID test kits from LACDMH pharmacy services in accordance with LACDMH policy
- Assisted Outpatient Treatment Program (AOT) continued to see clients in the field. AOT provided tele-services whenever necessary, or possible, for clients as well as their families. AOT conducted meetings and consultations via Microsoft Teams and provided PPE for clients upon request. AOT provided direct services in Spanish, Mandarin, Cantonese, and Tagalog. Support staff were also available to assist in Arabic, Armenian, French and German
- Whole Person Care (WPC)'s COVID-19 responsiveness includes:
  - WPC consulted with the Health and Safety Unit addressing COVID-19 issues
  - Field-based staff offered clients hygiene supplies and COVID-19 information to effectively isolate in case of severe symptoms

- At clinical program level, all general field-based program operations were re-deployed from street outreach work and directed to engage in office or telework mode. Staff members were asked to immediately identify their most vulnerable clients (aged 50+) and prioritize housing needs and available resources; obtain contact information of clients to maintain outreach and engagement via phone and provide need assessment, triaging and if needed, crisis intervention. Additionally, tele-psychiatry was made available for phone consultations and medication supportive services

- Veteran Peer Access Network (VPAN) staff continues to provide field-based services during the pandemic. VPAN Support Line was created specifically with veterans' unique needs in mind at the onset of the pandemic. The support line is staffed by Disaster Services Workers (DSW) and volunteers who are veterans or military family members
- Innovation 2 - Community Ambassadors (INN 2 – CAN) served the most disadvantaged and marginalized communities in LA County, including those communities disproportionately impacted by the COVID-19 pandemic. Since community members have more trusted relationships with their peers, such as Community Ambassadors (CAs), they can respond to community suffering resulting from oppression, job loss and other stressors brought by systemic inequities and the COVID-19 pandemic.
  - INN 2 - CAs helped drive a collective self-help model, using the inherent strengths of the community to promote healing, recovery, and community empowerment. The INN 2 - CAN focused on providing services and supports to existing communities and extended services and supports to communities that continue to be disproportionately impacted by the COVID-19 pandemic, or that are otherwise marginalized
  - Based on available funding and community resources, referrals and linkage for rental assistance, utility payments, food, clothing, shelter, and essential needs, etc. were provided
  - Linkage to ongoing needed supports and services, including but not limited to mental health, housing, and employment
- Katie A. provided the following services in response to the COVID-19 pandemic:
  - LACDMH and contractors transitioned from in-person to virtual platforms for the continued provision of specialty mental health services to youth and families
  - LACDMH required contractors to offer in-person services to children and youth at high-risk
  - To assist families in accessing their educational, vocational, and mental health needs, LACDMH allocated funds to contractors for the procurement of laptops, tablets, phones, internet access, PPE, etc.
  - LACDMH and contractors were trained to address the novel, clinical and behavioral implications of the COVID-19 virus and its stressors. Additionally, during this time, LACDMH staff were deployed as Disaster

Services Workers (DSWs) to assist with efforts to house the homeless, operate the LACDMH Warm Line and assist with unaccompanied minors
- Prevention & Early Intervention (Older Adults)'s outreach and engagement activities were conducted by virtual platforms
- Homeless Outreach and Mobile Engagement (HOME) Teams were equipped with PPE for use by staff and clients. The teams collaborated with other departments to access testing and vaccinations
- Directly Operated clinics adopted a hybrid model of in-person and virtual services. Kiosks were set up to provide services that observed the COVID-19 safety measures
- Telemental Health Program promoted use of telehealth in order to continue serving clients during COVID-19 with minimal disruptions

31. Equity Related Practices

Examples:

- DMH/DHS Collaboration sites include communities where there are high concentrations of historically underserved individuals such as High Desert, Martin Luther King (MLK), and Long Beach. To maximize the capacity of bilingual clinicians, group interventions have been implemented (e.g., the MLK Diabetes and Cancer Support group, Roybal Wellness Education Group in Chinese). The program consults closely with DHS and DPH partners to determine service gaps in the community and address them as best they can. One example was enlisting DMH Anti Stigma and Discrimination (ASD) staff and Mental Health Promoters to offer groups at the Curtis Tucker site and at the Community Wellness Center led by DPH
- CalWORKs Programs and GROW Administration promote equity in service planning and delivery by ensuring that mental health services are provided countywide. Administrative staff works closely with providers to ensure services are delivered consistent with the program's goals and objectives
- Maternal Mental Health (MMH) program developed an array of community partnerships to ensure and promote equity in service planning, delivery, and evaluation. The partnerships were developed with cultural and ethnic specific community-based organizations that work closely with underserved and marginalized communities in LA County. Through these cultural/ethnic specific partnerships, community education efforts and culturally specific mental health strategies were developed to better reach and provide mental health education to the targeted populations
- My Health LA (MHLA) Behavioral Health Expansion Project was designed and implemented to address mental health disparities in historically underserved communities. The mission is to add mental health prevention-based services via 52 Community Provider health clinics which are already providing medical services throughout Los Angeles area communities via the DHS program
- TAY Drop-In Centers promote equity in service planning, delivery, and evaluation in all eight (8) SAs in LA County. Language capacity is based on the language needs of the community being served. All centers are required to be Americans with Disability Act (ADA) compliant and accessible by the

local public transportation service. Participants are asked to provide feedback on services received and ideas for additional support services. Monthly meetings are held with contractors to address service provision, participant complaints and training needs

- Prevent Homelessness Promote Health $(PH)^2$ program receives referrals from all eight (8) SAs in Los Angeles (LA) County. Every referral that is submitted to $(PH)^2$ is vetted to ensure it meets program criteria of 1) risk of returning to homelessness, due to 2) acute mental health condition. Then, it is assigned to an officer of the day. Clinical staff rotate days of the week performing officer of the day duties
- FSP programs ensure that services are provided in each of the County's threshold languages by hiring multilingual staff or by the use of interpreter/translator services to communicate with clients. The FSP services have also developed and are in the process of updating their brochures in other languages to ensure clients are aware of their services and how to access them
- Health Neighborhood (HN) recruits participants from throughout the Service Area (SA) that represent community service providers for health, mental health, public health, substance use, education, child welfare, faith-based and other community resources. Effective recruitment and multicultural participation help ensure that the voices of the SA communities are represented and heard
- Olive View UCC is a walk-in program. At the facility, all are welcome, and visitors voluntarily choose to come. The program manager is actively involved in a wide range of community partnerships to promote the program and help minimize any barriers to service. The program manager was also actively involved in Action Learning Community (ALC) process (which later became the Anti-Racism, Diversity and Inclusion, or "ARDI" Staff Advisory Council) and regularly includes topics of equity and inclusion in all staff activities. Staff actively addressed issues of equity, diversity and inclusion in the welcoming process, the screening and assessment process, and in ongoing client advocacy
- Equity is the center of the GENESIS Older Adult Program's implementation and delivery of mental health services for homebound older adults unable to access mental health services in a traditional outpatient clinic. Furthermore, it is an essential factor and is displayed through the partnership and collaboration with other county departments such as Adult Protective Services (APS), older adult community and contracted agencies. To foster equity and accessibility, the program provides services that are culturally and linguistically appropriate in the following languages: English, Spanish, Russian, Farsi, and Tagalog. For languages not represented by the program's diverse staffing, the GENESIS Older Adult Program collaborates with contracted and community agencies capable of providing field-based specialty services to meet the cultural and linguistic needs for the older adult population
- FBAC reached out to diverse faith community leaders, clergy, and outreach workers to invite participation in monthly meetings and activities. The group

conducted periodic surveys and sought input for program planning, delivery, and evaluation

- ERC works to promote equity by providing housing resources for some of the County's most vulnerable residents with serious mental illness and often co-occurring substance use and physical health conditions. This program targets underserved populations experiencing or at risk of homelessness. ERC was formed to ensure that the critical housing resources are able to stay in operation so that the County continues to provide safe and stable placements for clients who would be at high risk of homelessness if they don't have these resources
- AOT assesses clients in their personal environment. AOT links clients to age appropriate, bilingual, and culturally sensitive providers who can best assist them in addressing their needs
- WPC utilizes field-based services to meet consumers "where they are" regardless of mental health functioning, socio-economic level, social-cultural integration, and other factors that may contribute to disparities. By physically traveling to consumers, staff reduced barriers in accessing services
- VPAN strives to hire veterans or military family members to workforce. Up to 90% of staff are veterans. VPAN Support Line is staffed by volunteers who are also veterans or military family members. VPAN also hires bilingual staff to ensure multiple language capacities
- TAY Navigation Team's supervisors ensure that cultural similarities are taken into account when matching staff to clients. Additionally, they revised the Enhanced Emergency Shelter Program (EESP) Gatekeeper Screening Form which is used to place young people into the Enhanced Emergency Shelters. TAY Navigation Team added questions around gender identity and pronouns
- INN 2 Providers hire ethnically and linguistically diverse staff reflective of the community they serve. University of California, San Diego collected outcomes on a monthly basis to makes sure LACDMH and providers were promoting equity within the communities served
- Katie A. works to ensure that there is access to mental health services for Child Welfare and Probation impacted youth in all areas of LA County, including underserved areas such as Service Area 6 (South Los Angeles) and Service Area 1 (Antelope Valley). Through monitoring and training of providers, the division ensures that services are culturally relevant, trauma-informed, and linguistically appropriate
- MCRP addresses the risks for recidivism by removing treatment barriers. It is discussed at the time of intake, treatment, and termination of services. Some of these obstacles might be related to discrimination; intellectual and physical disabilities; language deficits and comprehension; lack of housing and transportation; poverty; unfair treatment due to criminal background, culture or race; housing/employment denials due to mental illness or physical disability; social rejection; lack of education. In addition, case management services are used to promote equity as well as to advocate for the client when discriminated/mistreated by housing, education, employment, financial

assistance, and/or other systems. Case consultations are also implemented to plan the delivery of services and address any obstacles to responsivity

- In the Prevention & Early Intervention (Older Adults) program, equity is the center of program implementation and delivery. To foster equity and accessibility, the program provides services that are culturally and linguistically appropriate. Educational materials are carefully researched to ensure cultural factors are incorporated. Furthermore, the materials are presented in various threshold languages
- HOME Program is designed to promote equity in its inherent form and function by providing services in vivo on the streets where the individuals reside. The team is comprised of staff from a variety of racial and ethnic backgrounds and languages to provide services in a culturally and linguistically competent way. If individuals need support around access to care and mobility needs, the team will obtain equipment and care to promote ability to access services. The team also provides services via telehealth for therapy, psychiatric appointments, and for court appearances
- Telemental Health Program provides remote medication support to areas of need throughout LA County, thereby making mental health access more equitable

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

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	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health Departments	13. Culture-Specific Capacity Building Projects	14. Policies & Procedures	15. New Technologies	16. Service Accessibility	17. Language Assistance Services	18. Integrated Supportive Services	19. Interagency Collaboration	20. Investments in Learning	21. Multi-Cultural Staff Development	22. Integrated Services (Physical/ Mental Health & Substance Use)	23. Specific Ethnic/Language Groups	24. Provider Communication/Support	25. School-based services	26. Trainings/Case Consultation	27. Utilization of Community Knowledge & Feedback	28. Workforce Assessment	29. Health Department Collaboration	30. COVID-19 Responsiveness
1)	Assisted Outpatient Treatment Program				X	X	X		X		X	X				X	X	X		X		X	X	X	X		X	X			X
2)	CalWORKs		X							X	X		X																		X
3)	DMH/DHS Collaboration Program		X	X		X							X		X					X		X	X		X				X	X
4)	Enriched Residential Care Program				X											X				X			X		X		X	X			X
5)	Faith-Based Advocacy Council	X	X	X	X								X									X						X			X
6)	Full Service Partnership	X	X			X	X		X		X	X					X	X	X	X		X	X		X		X	X			X
7)	GENESIS			X							X												X				X				X
8)	Health Neighborhoods	X			X	X		X			X		X		X		X			X	X	X	X		X	X	X	X		X	X
9)	HOME Teams	X			X						X				X		X		X	X		X	X				X				X
10)	Housing and Supportive Services				X						X									X			X		X		X			X	
11)	INN2/ Community Ambassador	X						X										X		X	X	X		X			X	X	X		X
12)	Katie A.		X	X	X						X				X	X				X					X		X				X
13)	My Health LA (MHLA)	X			X			X									X						X					X			X

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health Departments	13. Culture-Specific Capacity Building Projects	14. Policies & Procedures	15. New Technologies	16. Service Accessibility	17. Language Assistance Services	18. Integrated Supportive Services	19. Interagency Collaboration	20. Investments in Learning	21. Multi-Cultural Staff Development	22. Integrated Services (Physical/ Mental Health & Substance Use)	23. Specific Ethnic/Language Groups	24. Provider Communication/Support	25. School-based services	26. Trainings/Case Consultation	27. Utilization of Community Knowledge & Feedback	28. Workforce Assessment	29. Health Department Collaboration	30. COVID-19 Responsiveness
14)	Maternal Mental Health	X		X	X		X				X																X				X
15)	Men's Community Re-Entry Program		X			X			X		X						X		X	X		X			X		X	X		X	X
16)	Older Adult Service Extenders																					X									X
17)	Olive View UCC	X		X	X			X							X		X	X		X			X	X				X	X	X
18)	Outreach & Engagement (O&E)	X			X															X					X			X			X
19)	Preventing Homelessness & Promoting Health			X	X	X				X	X						X	X		X		X	X				X				X
20)	Prevention Early Intervention (Older Adults)	X			X																										X
21)	Promotores de Salud & UMHP	X	X		X	X		X		X	X		X		X	X	X			X	X	X	X	X	X	X	X	X	X	X	X
22)	Spanish Support Groups	X	X		X			X		X	X					X	X		X	X		X		X	X	X	X				X
23)	TAY Drop-in Centers	X			X						X											X	X					X			X
24)	TAY Navigation Team	X	X		X	X					X									X							X				X
25)	Telemental Health Program														X	X	X															X
26)	Training Unit	X	X	X	X			X		X	X					X						X	X	X								X

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health Departments	13. Culture-Specific Capacity Building Projects	14. Policies & Procedures	15. New Technologies	16. Service Accessibility	17. Language Assistance Services	18. Integrated Supportive Services	19. Interagency Collaboration	20. Investments in Learning	21. Multi-Cultural Staff Development	22. Integrated Services (Physical/ Mental Health & Substance Use)	23. Specific Ethnic/Language Groups	24. Provider Communication/Support	25. School-based services	26. Trainings/Case Consultation	27. Utilization of Community Knowledge & Feedback	28. Workforce Assessment	29. Health Department Collaboration	30. COVID-19 Responsiveness
27)	Underserved Cultural Communities (UsCC), MHSA	X	X	X	X	X	X	X	X		X	X		X			X	X	X	X	X	X		X	X		X	X			X
28)	Veteran Peer Access Network			X	X	X		X			X				X	X	X		X	X	X	X	X		X		X	X			X
29)	Wellness Outreach Workers																					X									
30)	Whole Person Care	X		X	X						X		X			X	X	X	X	X	X	X	X		X		X				X
31)	Women's Community Re-Entry	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X

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

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

Given the significant number of technical terms used by each program, a glossary of acronyms has been developed to guide the reading of this information.
(See the Criterion 3 Attachment 1: Acronyms)

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

Assisted Outpatient Treatment Program (AOT)
Also known as Laura's Law, the AOT program was initiated following the 2001 killing of Laura Wilcox by an individual suffering from severe mental illness. Former Assemblywoman Hellen Thomson authored Assembly Bill 1421 establishing Assisted Outpatient Treatment Demonstration Project Act of 2002 (WIC 5345 et seq). The Act identifies persons with serious mental illness, history of treatment inconsistency, and substantial deterioration and/or detention risk under WIC 5150, all of which could be mitigated by provision of appropriate services. As of 2022, AOT further identifies individuals in need of AOT services in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to self or others.

AOT utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to communities. For example, AOT provides the following services:

- Bilingual and culturally aware staff
- Interpreter services to ensure participation of clients' family members
- Trainings for underserved communities to increase the awareness of the program
- Field-based services to eliminate the barriers of transportation and other barriers to care
- Consultations with community partners including emergency rooms and Urgent Care Centers (UCCs) staff for the purpose of identifying underserved clients to refer to the AOT program and address local needs for access to care

All AOT's services are rendered with consideration of clients' culture, environment, identities, and needs in line with LACDMH's provision of culturally and linguistically competent services.

AOT staff is multidisciplinary and multiracial, with many cultural and language capabilities. Fifty- nine percent (59%) of AOT's clients served in FY 20-21 were people of color.

Furthermore, AOT staff meet with clients where they are geographically (i.e., at home, parks, sidewalks). AOT staff approach their engagement with clients by being persistent and "relentless" to encourage the client to accept mental health services being offered to them. Program staff use a non-traditional approach to engage clients who present with symptoms of mental health deterioration and need services to ensure their safety and recovery. The ethos of AOT is that no client is left behind which shows the program's endeavors to link all clients to necessary services. AOT can petition in mental health court to mandate specific clients to receive mental health treatment.

Assisted Outpatient Treatment Program (AOT)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and Outcomes**
1) Community education to increase mental health awareness and decrease stigma	Presentations to various community stakeholders such as National Alliance for Mental Illness (NAMI), Law Enforcement Agencies, DHS, Jails, DCFS and Hospitals.	Ongoing	Increased number of referrals to AOT program improved relationships with these agencies.
2) Consultation with gatekeepers	Advocacy for continuity of care and stabilization during involuntary hospitalizations with Countywide Resource Management (CRM)/International Classification of Diseases (ICD) staff. Communication/consultation with Service Area (SA) Navigators about specific client needs. Communication/Consultation with ICD/CRM for securing ERS placement for clients. Consult with ICD/CRM AOT Liaison to support client specific cultural and linguistic needs.	Ongoing	Improved outcomes from hospital stay with more appropriate discharge plan Assignment to an appropriate FSP Increased utilization of ERS placement Improved client outcomes due to the rendering of services that are culturally and linguistically appropriate
3) Countywide Full Service Partnership (FSP) Networks to increase	When available, a client is assigned to an FSP provider based on client's cultural and linguistic needs.	Ongoing	Clients successfully graduate to a lower level of care.

Assisted Outpatient Treatment Program (AOT)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and Outcomes**
linguistic/cultural access			
4) Designation and tracking ethnic targets for FSP	AOT electronically tracks all referrals in terms of demographics including language and ethnicity Ethnic demographics are entered into SRTS for FSP assignment.	Ongoing	Assignments to appropriate levels of care. Provides information for the hiring of staff for both our outreach and engagement and FSP levels of care.
5) Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"	Homelessness is never a condition for enrollment into AOT program.	Ongoing	40 % of AOT's clients, at any given time, are homeless. 60% of clients are housed and most are with families.
6) Implementation of new technologies to enhance the Department's service delivery	Outreach and Engagement staff utilize County issued cellphones to facilitate the access to medication support services, enrollment into FSP, ERS etc. via tele-mental health.	Ongoing	Clients were provided with medications and successfully enrolled in services.
7) Augmentation of mental health service accessibility to underserved populations	100% field-based services which eliminates access to care barriers. All services are rendered to unserved/underserved populations.	Ongoing	All clients must be non-compliant with treatment to qualify for AOT services. AOT monitors clients' engagement in FSP services for a minimum of 6 months.
8) Coordination of language interpreter and closed-captioning services in real time services for consumer, family member, and community member	Hiring and assignment of bilingual staff to provide cultural and linguistically appropriate services Utilization of Language Line during outreach and engagement whenever necessary	Ongoing	Clients can express their thoughts, feelings and needs in their preferred languages Clients understand the program/court hearings Staff provide ongoing communication with the client and family during treatment

Assisted Outpatient Treatment Program (AOT)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and Outcomes**
participation in clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings	Request for interpreter services for court proceedings for client/family		
9) Interagency Collaboration	Ongoing collaboration and consultation with courts, hospitals, Law Enforcement, Public Defenders, County Council, UCCs and other community agencies.	Ongoing	Increased referrals Better treatment outcomes Access to care Consistent adherence to court mandates
10) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Department wide trainings Discussions in Staff meetings	Ongoing	Increased staff competency in understanding diverse cultural norms and expectations.
11) Integration of physical health, mental health, and substance use services	AOT makes referrals for eating disorder, substance abuse and any specialty program needed by clients FSP arrange for primary care visits	Ongoing	Graduation from these specialty programs including FSP.
12) Programs that target specific ethnic and language groups	AOT refers/utilizes FSPs that specialize in specific age, ethnic and language groups.	Ongoing	Monitoring the level of engagement and graduation from FSP services.
13) Provider communication and support	Quarterly provider meeting Trainings to providers on AOT services Ongoing daily support via FSP coordinator	Ongoing	Monthly and quarterly submission of AOT client measures entered into the AOT database.

Assisted Outpatient Treatment Program (AOT)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and Outcomes**
14) Utilization of the community knowledge, feedback, and capacity to promote health and wellbeing	AOT holds quarterly oversight committee meetings which involve community, agency, and court stakeholders.	Ongoing	The program has incorporated many of the committee's suggestions.

CONSUMERS SERVED BY AOT
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Outreach & Engagement	140	116	185	34	2	Not reported -7 Identified as other -6 multi-Race-18	M (338)/ F (163)		2		2	Spanish, Cantonese, Mandarin, Tagalog
FSP	53	41	75	9		Not reported -2 Identified as other -2 Multi-race- 6	M (123)/ F (61)		1		1	Spanish, Armenian, Russian, Teochew, Mandarin, Korean, Samoan, Khmer, Tagalog, Vietnamese, Hindi, Farsi, Armenian, Finnish, Bengal
ERS	2	4	2	1		Multi-Race-1	M (5)/ F (5)					Gathering from ICD

California Work Opportunity and Responsibility for Kids (CalWORKs) and General Relief Opportunities for Work (GROW) Mental Health Supportive Services Programs

CalWORKs and GROW Mental Health Supportive Services programs are funded by the Department of Public Social Services (DPSS). CalWORKs and GROW recipients are eligible to receive Specialized Mental Health Supportive Services as part of their Welfare-to-Work (WtW) plan to assist them in removing mental health barriers to employment and moving toward self-sufficiency.

Countywide, the CalWORKs program has 52 provider sites and the GROW program has 17 provider sites including Directly Operated and Contracted agencies. CalWORKs and GROW recipients are screened by DPSS and referred to a CalWORKs Provider or a GROW clinical assessor for a mandatory clinical assessment. This assessment identifies mental health barriers to employment and mental health needs warranting a clinical referral.

Mental health services for CalWORKs recipients include:

- Crisis intervention
- Individual and family assessment and treatment
- Individual, group, and collateral treatment services
- Specialized vocational assessments
- Supported Employment – Individual Placement and Support
- Life Skills support groups
- Parenting effectiveness
- Medication management services
- Case management, brokerage, linkage and advocacy
- Rehabilitation, support, vocational rehabilitation and employment services
- Field-based services
- Home visits
- Community outreach, including the following:
  - Educational presentations in local DPSS offices where potential CalWORKs consumers may be present
  - Outreach to community agencies including churches, community centers, and other local social service agencies

The goal of these outreach activities is to provide education on CalWORKs mental health services available to the community. Outreach activities are also conducted with potential employers in the community to provide education and awareness of the abilities of CalWORKs mental health consumers to facilitate employment opportunities.

Mental health treatment services for GROW recipients include:

- Emergency and crisis intervention
- Individual and group psychotherapies
- Medication management services
- Vocational/employment services

More information on CalWORKs and GROW is available at the following link: https://dmh.lacounty.gov/calworks-grow/

CalWORKs and GROW services at each clinic are required to reflect the specific cultural and linguistic needs of each Service Area and community in which the clinic is located. CalWORKs and GROW Mental Health Supportive Services are currently available in twenty (20) languages countywide in addition to English.

CalWORKs and GROW Mental Health Supportive Services are delivered to reflect the specific cultural and linguistic needs of each community they serve. CalWORKs Programs and GROW administration team maintain the responsibility of ensuring all agencies provide culturally competent mental health services for all CalWORKs and GROW participants. In addition, CalWORKs and GROW providers conduct outreach and education activities within their Service Areas and communities to educate people about CalWORKs or GROW and help potential participants learn about the availability of mental health services to address their mental health barriers to employment and self-sufficiency. These outreach activities occur at DPSS offices, community colleges, and other locations where CalWORKs or GROW participants receive other services.

CalWORKs and GROW services are offered countywide via telehealth. Referrals are made with the intention of ensuring all clients have immediate access to care. This countywide referral process is not limited to service area boundaries and helps to ensure clients have access to services that are consistent with their cultural and linguistic needs.

CalWORKs and GROW			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
1) Development and translation of public informing materials that address mental health education	• CalWORKs and GROW administrations participate in special projects in collaboration with DPSS to develop and translate public information material addressing mental health awareness and education. For example, bilingual CalWORKs and GROW Administration staff developed and translated/interpreted a presentation on mental health awareness, recognizing mental health issues and seeking professional help that was made available to	• The Job Club presentation and translation were completed in October 2020. • Bilingual staff continue to provide interpretation and translation services within the Department on an ongoing basis.	• The Job Club presentation continues to be utilized in English and Spanish and Job Club trainings conducted by DPSS for CalWORKs recipients.

CalWORKs and GROW			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
	CalWORKs recipients participating in Job Club. • Bilingual CalWORKs and GROW Administration staff also provide translation/interpretation services for Department use. For instance, a bilingual CalWORKs/GROW Administration staff assisted the Office of Administrative Operations – Quality, Outcomes, and Training Division in translating the annual Consumer Perception Survey (CPS) in Korean. This survey was sent to clients/caregivers to receive feedback about LACDMH outpatient services.		
2) Evidence-Based Practices (EBPs)/ Community-Defined Evidence Practices (CDEs) for ethnic populations	• Individual Placement and Support (IPS), an evidence-based practice that assists individuals with Severe and Persistent Mental Illness (SPMI) in obtaining and maintaining employment has been utilized by LACDMH CalWORKs Directly Operated (DO) and Contracted sites countywide to support all CalWORKs participants toward their employment goals.	Ongoing	• CalWORKs Programs Administration collects and analyzes IPS data for all CalWORKs Providers and creates reports based on findings. • In addition, CalWORKs Programs Administration develops and conducts trainings for CalWORKs Providers to ensure that all CalWORKs participants have access to IPS services.
3) Field-based services	• CalWORKs Providers countywide provide field-	Ongoing	• CalWORKs Programs Administration collects

CalWORKs and GROW			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
	based services to all CalWORKs participants, as needed, in order to assist participants in staying engaged in treatment. In addition, employment specialists conduct IPS job development activities in communities where CalWORKs participants reside and/or are seeking employment. • Job development activities are not limited to service area boundaries and help ensure CalWORKs participants have access to employers and job opportunities that are consistent with employment, cultural and linguistic needs.		and monitors data on the frequency of job development activities for all CalWORKs Providers and conducts job development trainings to ensure Providers conduct job development activities in the field that are consistent with clients' specific employment, cultural and linguistic needs.
4) Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health	• The CalWORKs and GROW Programs employ multilingual and multicultural case management and clinical staff to provide treatment services countywide. • DPSS staff who make referrals to LACDMH Directly-Operated and Contracted clinics have continuously updated listings of all clinics and their language capabilities to ensure that participants are appropriately referred if a specific language need is identified.	Ongoing	• CalWORKs Programs and GROW Administration monitors accessibility of culturally competent mental health services for CalWORKs and GROW participants.
5) COVID-19 responsiveness at clinical and administrative program level	• To ensure CalWORKs and GROW services were accessible throughout the COVID-19 pandemic, mental health services were offered countywide via telehealth.	Ongoing	• CalWORKs Programs and GROW Administration continue to monitor the availability of telehealth and in-

CalWORKs and GROW			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
	• Referrals were managed at an administrative level and coordinated with the intention of ensuring all clients have immediate access to care. • The countywide referral process was not limited to service area boundaries and helped to ensure clients had access to services which were consistent with their cultural and linguistic needs		person services for all CalWORKs and GROW providers. • CalWORKs Programs and GROW Administration collects and monitors data on referrals to ensure immediate access to care and the availability of services consistent with participants' cultural and linguistic needs.

CONSUMERS SERVED BY CALWORKS AND GROW
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Your Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
CalWORKs and GROW Mental Health	206	317	490	2	9	71	M (110)/ F (985)	n/a	n/a	n/a	n/a	English, Spanish, Armenian, Russian, Cantonese, Vietnamese, Chinese

Child Welfare Division - Katie A.

LACDMH, in collaboration with LA County Department of Children and Family Service (DCFS), provides a variety of mental health services associated with the settlement agreement in the Katie A. class action lawsuit (2002). These services are targeted to children and youth in the county's Child Welfare system that have open DCFS cases, Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) eligibility, and meet the medical necessity requirement for full scope Medi-Cal. The program

includes the mental health screening of all children and youth with open Child Welfare cases and the triaging of those who screen positive to LACDMH staff who are co-located in each DCFS regional office. Cases are triaged based on acuity and linked to Directly Operated and Contracted children's mental health providers.

Key program components include:

- Specialized Foster Care (SFC) Program (co-located)
- Medical Hubs
- Wraparound Program
- Family Preservation (FP)
- Intensive Field Capable Clinical Services (IFCCS)
- Intensive Services Foster Care (ISFC)
- Multidisciplinary Assessment Teams (MAT)
- Community Treatment Facility (CTF)
- Qualified Individual (QI)
- Short Term Residential Therapeutic Program (STRTP)
- Specialized Linkages Services Unit (SLSU)

Katie A. reviewed the service data and analyzed with a specific focus on unique client counts, gender, language, and ethnicity to determine client and staffing needs within a Service Area (SA). For example, SA 6 has a high density of youth who have monolingual Spanish-speaking parents and a greater need for Spanish-speaking clinicians. As another example, SA 3 has a high density of Asian Pacific Islander (API) clients compared to other Service Areas and a need for clinicians who speak API languages such as Cantonese. Overall, LACDMH utilizes data to identify clients' ethnic and language backgrounds to collaborate with service providers to ensure that there is recruitment, hiring, and training of staff who will address the cultural and linguistic needs of all clients and their families within the SA.

Katie A's projects contribute to LACDMH's provision of culturally and linguistically competent services by ensuring specialty mental health services such as Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) are provided in a timely manner and in the language spoken at home to children, youth, and families in the Child Welfare system, Probation and/or in the community. Data is analyzed to ensure that specific populations are provided with services to meet their specific needs and staff practice cultural humility in their service delivery. Through various collaborative projects and trainings, the Child Welfare Division (CWD) assures that staff are incorporating the Integrated Core Practice Model (ICPM) in their practice when servicing children, youth, and families.

Also, Katie A's projects/activities increase access to mental health services and decrease disparities by providing guidance and informational material to various referral portals, contractors, County Departments, mental health resources for parents and youth. Additionally, field-based services facilitate access to care for youth and families by

rendering services at the home, school, and/or community - the preferred location selected by the youth and family.

Further, CWD in collaboration with its County partners, works to ensure that there is access to mental health services for Child Welfare and Probation impacted youth in all areas of LA County. Through continuous coaching, case consultation, technical assistance, monitoring, and training of providers, CWD works to ensure that services delivered are culturally relevant, trauma-informed, and that linguistic needs are met for all youth.

Katie A.			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Development and translation of public informing materials that address mental health education	Developed informational materials (webinar/brochures/flyers) in English and Spanish to guide youth, parents, resources parents and families in accessing specialty mental health services, including Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS).	Informational materials were shared with Department of Children and Family Services (DCFS) and Department of Health Services (DHS) partners for distribution to parents, resources parents and families in December 2020. Training was delivered to DCFS and Foster and Kinship Care Education in January 2021.	Informational materials were included in placement packets provided by DCFS for distribution to resource families. Specialty Mental Health Services recorded webinars were shared with DCFS, DHS and Foster and Kinship Care Education for on-demand access and distribution.
2) Co-location with other county departments	Specialized Foster Care (SFC) and the Countywide Medical Hub programs are both DMH co-located programs that serve children and youth entering the child welfare system. SFC is co-located with DCFS. The Medical Hubs are co-located with Department of Health Services (DHS), DCFS, and Department of Public Health (DPH). Services provided for both programs include triage, assessment, crisis	Ongoing – Services are provided on-site/in person, field-based and via telehealth. During the COVID-19 pandemic, most specialty mental health services were provided via telehealth. However, the Department required that intensive field-based programs deliver services to high-risk youth in-person in their home, school, and/or community setting.	Both SFC and Medical Hubs procedures are outlined in the guidelines. For FY 20-21, SFC and the Medical Hubs received over 25, 000 referrals.

Katie A.			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	intervention, specialty mental health services as needed and linkage to ongoing treatment.		
3) Community education to increase mental health awareness and decrease stigma	Developed a training curriculum and webinars on Specialty Mental Health Services for Children and Youth intended for parents, resource parents, and youth, and DCFS partners to help raise mental health awareness, decrease stigma, and increase access to mental health services.	Delivered training to Department of Children and Family Services (DCFS), Department of Health Services (DHS) and Kinship Care Education program in January 2021.	A recorded webinar was developed for on-demand access. Foster and Kinship Care Education program incorporates training curriculum as part of resource parent education.
4) Field-based services	Specialty Mental Health Services (SMHS) are rendered through Specialized Foster Care, Wraparound, Intensive Field Capable Clinical Services, and Intensive Services Foster Care in the home and/or community.	Ongoing - During the COVID-19 pandemic, most specialty mental health services were delivered via telehealth. However, intensive field-based programs were required to deliver services to high-risk youth in person in their home, school, and/or community setting.	For FY 20-21, during the COVID-19 pandemic, approximately 20% of high-risk children and youth accepted in-person, mental health services.
5) Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	The Child Welfare Division established practice parameters and procedural guidelines for Specialized Foster Care (SFC), Multidisciplinary Assessment Teams (MAT), Intensive Services Foster Care (ISFC), Short Term Residential Therapeutic Programs (STRTPs), Medical Hubs (MH), Family	Ongoing – the Guidelines are revised as needed.	Each program is responsible for the quality and timelines of delivery of mental health services through monitoring, technical reviews, and coaching staff and contractors.

Katie A.			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	Preservation (FP), Wraparound, and Intensive Field Capable Clinical Services (IFCCS). Guidelines address responsiveness to referrals in accordance with LACDMH Access to Care Policy 302.07.		
6) Implementation of new technologies to enhance the Department's service delivery	SFC and the Medical Hubs worked in collaboration with LACDMH to implement VSEE to enhance the provision of telehealth services during the COVID-19 pandemic.	Ongoing – SFC and Medical Hub staff participated in VSEE training and developed a workflow.	For FY 20-21, 50% of staff participated in VSEE training. Newly hired staff are required to participate in the training.
7) Interagency Collaboration	During FY 20-21, CWD continued to collaborate with the Office of Child Protection (OCP), Department of Children & Family Services (DCFS), Department of Health Services (DHS) and Probation to focus on improving mental health services to youth and families. Trainings and curriculums were developed in collaboration with various county departments, as well as brochures/flyers regarding specialty mental health services and how to access mental health services.	CWD staff participated in ongoing meetings with DCFS regarding: • Domestic Violence-Child Welfare Committee meetings. • Youth hospital discharge planning meetings. • Crisis response protocols for non-hospitalized youth in need of stabilization and ongoing treatment. • Review Treatment Foster Care services and benefits to youth with Foster Family Agencies. • Develop Therapeutic Foster Care (TFC) training protocol for resource parents in collaboration with	Trainings are tracked by Training Coordinators. Monthly meetings are tracked using sign-in sheets. Reports to DMH Deputy and Program Managers are provided monthly on the various activities.

Katie A.			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
		DCFS and resource parents. • Collaborated with DCFS to develop and deliver training to DCFS staff, DMH staff and FFA providers. • System of Care Meeting	
8) Provider communication and support	Provider meetings were held monthly for Wraparound, Intensive Field Capable Clinical Services (IFCCS), Intensive Services Foster Care (ISFC), Short Term Residential Therapeutic Programs (STRTPs), Specialized Foster Care (SFC), and Medical Hubs. During the meetings, the agenda focused on updates on services rendered, to address new policies, and provide training and coaching information. Developed and provided weekly support calls to providers to address delivery of services, engaging youth, and families, etc.	During FY 20-21, program specific provider meetings were held via Skype and/or Microsoft TEAMS. Questions and answers were created to address concerns. LACDMH staff rotated into the offices to provide support as needed.	Attendance registration was provided at the monthly provider meetings. Questions and answers were distributed to providers. Support calls are tracked to review progress and utilization.
9) Trainings/case consultation	CWD offers regular training and coaching support to LACDMH staff and contractors. Case consultations, coaching sessions, and trainings include cultural componence and help reflect on mental health practices that can improve accessibility to services.	Trainings are offered on a regular basis to LACDMH staff and contractors. Individualized coaching sessions are offered when requested by a contractor. Additionally, booster trainings on specific topics are developed when	CWD maintains a database to track all training and coaching sessions offered to LACDMH staff and contractors.

Katie A.			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	All trainings that are developed and/or acquired through outside vendors are reviewed to ensure that the content of trainings address cultural humility as well as cultural disparities.	requested and scheduled accordingly. All trainings transitioned to virtual platforms to ensure that continual training opportunities were accessible to all LACDMH staff and contractor.	

CONSUMERS SERVED BY KATIE A.
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Katie A. Class (Some clients identified in more than one category in the FY.)	2,354	4,373	8,508	247	62	Multiple Ethnicity: 1,113 Other Ethnicity: 5,561	M (10,961)/ F (11,199)	10	3	0	2	All of the threshold languages represented in the LA County community

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

The DMH/DHS Collaboration Program is a Mental Health Services Act (MHSA) PEI-funded program in which LACDMH staff are located on a full-time basis within the DHS Ambulatory Care Network (ACN), working alongside the medical providers in the Primary Care or Family Medicine clinics. LACDMH staff provides short-term, early intervention, specialty mental health services within medical settings as a means of improving access for individuals who may experience stigma in seeking services in traditional mental health clinics. The program focuses on integrated care, requiring collaboration between the

mental health and health care providers in the co-management of individuals referred by primary care providers to LACDMH staff.

The Collaboration Program utilizes disparities data from the Quality Assurance (QA) division in the planning of strategies to make services culturally and linguistically accessible by specific groups (e.g., MLK Diabetes and Cancer Support group in both English and Spanish; Roybal Wellness Education Group in Chinese). The program makes every effort to fill vacancies with culturally/linguistically congruent staff, based on this data. To fill language gaps, all staff are competent in using the Language Line.

The DMH/DHS Collaboration Program has contributed to LACDMH's provision of culturally and linguistically competent services. For example, the DMH/DHS Collaboration Program publishes its patient brochures in English, Spanish, and Chinese. The program's clinicians provide and deliver culturally and linguistically appropriate services to consumers where possible, and where not, the staff are comfortable using the Language Line for triage and linkage to culturally and linguistically congruent services elsewhere in the County.

The DMH/DHS Collaboration Program was specifically designed to bring early intervention mental health services into primary care settings in order to provide early identification and treatment of mental health conditions before they increase in severity. Seeking treatment in a traditional mental health clinic is often stigmatizing for members from culturally diverse backgrounds. Due to fear of stigmatization, individuals in need of services may not seek mental health services in a timely manner, or may wait until their symptoms are debilitating, thereby requiring a more intensive approach. By delivering services in medical settings, the whole person may be treated and care among providers can be better coordinated. Accessing mental health services in a medical setting is highly desirable to many persons and in fact, many consumers prefer to wait to be seen by mental health staff in a familiar DHS location rather than be referred elsewhere for a timelier appointment. The role of the primary care provider in endorsing mental health providers and interventions is essential and can increase compliance with mental health treatment goals.

DMH/DHS COLLABORATION			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
Pertinent to the 30 Countywide strategies, the DMH/DHS Collaboration Program endorses the following: • Co-location with other county departments (DHS)	The DMH/DHS Collaboration Program provides integrated mental health care alongside DHS providers who are providing for our shared patients' medical needs.	The Collaborative Care model gives patients expanded access to mental health and support resources, along with appropriate referrals and linkage, alongside their medical provider's services.	Annual Outcome Measure Application (OMA) Reports show a robust percentage score change in patients' scores on the Generalized Anxiety Disorder (GAD)7 and/or Patient Health

DMH/DHS COLLABORATION			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
• Consultation to gatekeepers • Interagency Collaboration • Integration of physical health, mental health, and substance use services • Provider communication and support	The DHS providers prescribe psychotropic medication where appropriate, with DMH consulting psychiatrists' support. Substance use treatment services are provided or linked by the DHS Behavioral Health Integration (BHI) staff.	The Collaboration has actively participated in designing the work flows and referral/treatment logic so that services are value-added and non-redundant.	Questionnaire (PHQ)-9. Ongoing modifications are being made to Collaboration Program workflows to accommodate the services of the BHI team, without duplicating services.
• Development and translation of public informing materials that address mental health education	A Wellness Education group for the Chinese consumers at the Roybal site, designed by the clinician and Medical Case Worker, provides non-stigmatizing outreach to the community.	The group is held biannually at Roybal, and the PHQ-4/PHQ-9 is given and reviewed to identify mental health needs. Prevention or treatment services are offered to attendees as appropriate.	The group is conducted in Mandarin and Cantonese and offers a non-stigmatizing way to educate about overall health and to outreach and identify persons needing mental health treatment who face cultural barriers to seeking it out. The DHS PCPs are becoming aware of the group and make referrals.
• Interagency Collaboration	At the Mid Valley site, the clinicians are co-facilitating a disease management group focusing on diabetes. The group alternates weekly in English and Spanish.	Launched in July 2019, initial attendance was low but consistent (5-10/session).	Strategies for improving registration and attendance numbers were in discussion in January 2020. The group was suspended during this FY.
• Implementation of new departmental policies and procedures that	At the High Desert site, the team is part of an effort to increase access to mental health services for perinatal	Engagement by DMH clinics and DHS providers has been robust. Patients are	Women's Clinic providers report that this pathway is a "relief" due to being

DMH/DHS COLLABORATION			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
improve the quality and timeliness of delivering mental health services	women by creating a new cross-referral workflow between DHS Women's Health medical providers, the Collaboration Program team, and two (2) directly operated LACDMH clinics with staff trained in providing maternal mental health services.	being referred by DHS, triaged by the Collaboration Program, and then linked to care either within the program or to a full-service clinic.	able to link their perinatal patients with mental health services on a reliable basis. The workflow has minimal issues which are easily resolved due to the clear communication lines that have been established.
• Multi-lingual/multi-cultural staff development and support • Outreach and Engagement (O&E) efforts • Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity	Clinicians across the program were trained in supporting Gender Affirming Treatment and writing letters supporting same. The focus includes cultural issues, biases, and trauma around LGBTQ+ healthcare.	Approximately 2/3 of the program clinicians were trained by the close of FY 20-21.	Clinicians talk about this service at DHS ACN meetings, specifically how DMH clinicians can support patients seeking appropriate treatment. Clinicians have received referrals for letters and supportive therapy with the Collaboration program.

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CONSUMERS SERVED BY DMH/DHS COLLABORATION
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Collaboration Program Clinical Services	165	136	643	46	4	Unreported: 138	M (339)/ F (834)	1	0	0	0	Spanish, English, Mandarin

Enriched Residential Care (ERC) Program

ERC Program provides rental payments for clients with high symptom acuity who may need support to maintain housing in Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs), also known as Board and Care Homes and Assisted Living Facilities. These unlocked facilities are licensed through the State and provide 24-hour care and supervision, medication management, three (3) meals per day and assistance with activities of daily living. This program also supports efforts across the County to preserve the stock of this valuable housing resource since many of these facilities across the County have been closed due to underfunding, causing housing instability for highly vulnerable individuals for whom it may be challenging to find new housing without these resources.

To the extent possible, ERC ensures that placement options are accessible to the clients they serve. This includes collecting information about each facility, which is collected and available to service providers making placements through the Mental Health Resource Locator and Navigator (MHRLN). This system offers real time vacancy information for facilities in all geographic areas of LA County, including the level of care available in each facility and language capacity. The data available to the community through this system ensures that providers have the tools necessary to make culturally competent placements. ERC also collects data about clients and enrollments to ensure that the population served is reflective of LACDMH clients and the homeless population, which has an over-representation of the Black/African American community and is promoting equity and prioritizing housing stability.

ERC projects aim to promote culturally competent services by ensuring that clients presenting with acute symptoms obtain stable and supported housing. By providing trainings to community-based facilities and by collaborating broadly with system partners,

the ERC is able to promote high quality of care that is sensitive to the needs of residents with serious mental illness. ERC maintains constant contact with clinical staff to ensure clients served by ERC are continuously connected to appropriate mental health services and reduce barriers to care to prevent eviction/homelessness.

ERC ensures housing and quality of life for individuals at risk of homelessness or in need of higher levels of care. ERC ensures that clients can reside in the community and are supported in ways that promote recovery and stabilization.

Enriched Residential Care (ERC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Community education to increase mental health awareness and decrease stigma	Coordinates trainings for facility administrators and staff to promote increased understanding and competency around serving clients with serious mental illness. Trainings have included: harm reduction, trauma informed care, interventions for individuals with psychotic disorders, de-escalation and managing psychiatric emergencies, among others.	The webinars ran through FY 20-21. Similar trainings will likely be implemented through the Licensed Adult Residential Care Association (LARCA) which has been seeded by LACDMH.	Administrators were able to receive continuing education units (CEUs) for attending trainings and attendance was recorded.
2) Implementation of new technologies to enhance the Department's service delivery	ERC participated in distributing telehealth tablets to over 100 licensed residential facilities across the County to ensure individuals were able to maintain connections with their healthcare providers via telehealth despite barriers related to COVID-19.	These tablets remain at the facilities where they were distributed and continue to be used today to ensure adequate access to care.	Data was collected around the tablet usage including number of clients who used the tablets and recording of which services were accessed using the tablets.
3) Interagency Collaboration	ERC collaborates on at least a monthly basis with various system partners including: Directly-Operated and contracted clinics across the County,	Collaborations are ongoing and important to ensure that the licensed residential care facilities and	Meetings are scheduled on a monthly basis and as needed to address issues as they arise.

Enriched Residential Care (ERC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	Department of Health Services (DHS), Community Care Licensing Division (CCLD), Department of Public Health (DPH), Long Term Care Ombudsman, Brilliant Corners and others.	clients residing in them are well supported.	
4) Integration of physical health, mental health, and substance use services	ERC collaborated with Department of Public Health Substance Abuse Prevention and Control (DPH-SAPC) to pilot on site substance abuse services at a number of licensed residential facilities.	This program has been implemented in at least two (2) sites with six (6) more in various stages of implementation.	
5) Trainings/case consultation	ERC provides trainings to service providers on the ERC program, requirements, and guidelines including the level of acuity required to qualify. ERC staff provide consultation to providers around challenging client situations and collaborate to ensure clients are able to obtain needed services and level of care.	This happens on an almost daily basis and it is ongoing.	
6) Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	ERC solicits stakeholder feedback regarding strategies to continue operating despite ongoing funding struggles.	This process is ongoing	LACDMH has implemented two (2) of the recommendations, including developing a bed tracking system and seeding a licensed residential care association.

Enriched Residential Care (ERC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
7) COVID-19 responsiveness at clinical and administrative program level.	ERC has been at the forefront of response to COVID-19 in licensed residential facilities. This has included: distributing information on COVID-19 response and infection control, assistance with coordinating testing and vaccinations, facilitating access to personal protective equipment (PPE), providing telephonic technical assistance and guidance, and monitoring outbreaks.	These activities have significantly decreased as facilities have become more able to manage COVID-19 independently and has the community prevalence rates of COVID have decreased. However, supports are still available on an as needed basis in case of outbreaks.	Monitoring of COVID-19 was managed through the distribution of weekly surveys to operators to assess status of COVID infection at their facility and assess needs for support.

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CONSUMERS SERVED BY ERC
FY 20-21

Program/ Activity	Total Unique # Consumers	# Consumers Served by Race/Ethnicity							Gender					Language of Staff
		White	African American	Latino	API	American Indian/ Alaska Native	Other (Multiple Races)	Unknown	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Number of unique clients referred to ERC during FY 20-21	586	164	157	118	66	3	7	71	M (356)/ F (229)	1	0	0	0	
Number of unique clients moving in the licensed residential care using ERC funding during FY 20-21	560	160	145	116	64	5	7	63	M (341)/ F (218)	1	0	0	0	
Number of unique clients residing in the licensed residential care using ERC funding during FY 20-21	1,112	312	250	272	125	11	16	126	M (713)/ F (394)	1	0	0	4	

Faith-Based Advocacy Council (FBAC)

LACDMH recognizes that many persons living with mental illness find strength, purpose, and a sense of belonging through their spiritual beliefs and practices. LACDMH collaborates with diverse clergy, lay leaders, and congregants through FBAC. This council increases the integration of spirituality and mental health messages and resources; increases community awareness of mental health and access to care; and decreases stigma by convening diverse faith community leaders, sharing information, and participating in collaborative learning.

To plan FBAC meeting agendas and collaborative learning sessions, LACDMH staff review published mental and public health data and examine racial, socio-economic, geographic, and other disparities. Furthermore, staff conduct needs assessment and opinion surveys of FBAC participants; survey findings help the FBAC Executive Board

plan and prioritize activities. In June 2021, staff conducted a 5-item online survey assessing utility and feedback regarding the weekly FBAC emails (containing meeting information, community resources, and uplifting interfaith mental health information) sent to 1,496 individuals on the FBAC list-serv. Most respondents (54%) read the weekly message every time, and 39% read it sometimes. Over half (53%) forwarded the message to others. Most respondents (85%) rated the weekly message as very useful or useful, and over half (58%) stated that the information contained in these messages was different from other information they received.

The FBAC has been contributing to LACDMH's provision of culturally and linguistically competent services. For example, an average of 48 (ranging from 39 to 55) diverse community leaders, serving in congregations across LA County, participated each month in FBAC general meetings throughout the fiscal year. The FBAC Executive Board convened 17 members to plan and evaluate meetings. Meetings were held virtually in English, using Microsoft Teams, with simultaneous interpretation provided in Korean and Spanish. FBAC Executive Board members and staff prepared and disseminated an informative and uplifting weekly email to the 1,496 members of the FBAC list-serv every Friday during the fiscal year.

Also, the FBAC participants learned about, accessed, and referred to mental health services. They integrated mental health messages and connected people experiencing mental health needs to relevant resources through their clergy or faith leader roles and faith community activities.

Faith-Based Advocacy Council (FBAC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
Collaboration with Faith-Based and Other Trusted Community Groups	Monthly meetings and discussions	In progress	Participant numbers recorded
Expand knowledge of FBAC membership on challenges they are currently facing within their respective congregations	• October 1, 2020 "Christianity and Mental Health," Pastor Christian Ponciano, Chair, Faith-Based Advocacy Council Executive Board; 45 participants • November 5, "Best Practices for Conducting Street Outreach with People Experiencing Homelessness," Tylana Thomas-Anderson; 51 participants • December 3, "Islam and Mental Health," Mahomed Khan and		

Faith-Based Advocacy Council (FBAC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	Sameera Qureshi, PhD; 42 participants • January 7, 2021 "United Mental Health Promoters," Adriana Carrillo, LCSW; 51 participants • February 4, "Honoring Black History Month, Collective Wellness," Angela Mull, LMFT; 50 participants • March 4, "DPH Vaccine Update," Lonnie Resser, MPH; 41 participants • April 1, "LA Vs. Hate," Terri Villa-McDowell, JD; 51 participants • May 6, "Good Sleep for Emotional Wellbeing," Haydeh Fakhrabadi, PsyD; 43 participants • June 3, "Resilience," Reyna Leyva; 44 participants		

Full Service Partnership (FSP)

LACDMH Adult Full Service Partnership (FSP) programs provide comprehensive, intensive, community-based mental health services to adults with a severe mental illness (SMI). Adult FSP Services aim to help enrolled clients increase their ability to function at optimal levels, decrease homelessness and incarcerations, and reduce unnecessary medical and psychiatric urgent care, emergency room visits, and hospitalizations. For those clients who are homeless, Adult FSP Services will help them transition from street to home by providing immediate and on-going assistance with securing and maintaining housing. Adult FSP Services are based on clients' individual needs and goals, with a commitment to do "whatever it takes" to help them progress toward recovery, health, and well-being.

Adult FSP Services used disparities data to understand where the greatest need is. The FSP programs understand that Asian Pacific Islander (API) populations require additional capacity and services delivered in their primary languages. The Department has worked with API alliance and increased FSP capacity across the county and in those specific areas identified in the disparities data collected. The FSP services have contracted with

agencies and continue to collaborate with those community partners serving the API populations to ensure that their mental health service needs are met.

The FSP programs are directly addressing the disparities that were identified via outcomes data collected by ethnicity/race. The FSP services have increased capacity for API in several specific areas in the county as a result. The FSP quarterly meetings and ongoing trainings increase knowledge of not only the FSP program, but also in how to deliver appropriate and culturally competent services to the most vulnerable populations in LA County. The FSP's ongoing communication and collaborative efforts with other community partners and agencies assist the program in reducing these disparities.

Full Service Partnership (FSP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
Pertinent to the 30 Countywide strategies, the FSP endorses the following: • Collaboration with faith-based and other trusted community entities/groups	• FSP contracted with various API community providers to ensure services are being delivered to their populations in their primary languages.	• FSP continues to grow capacity for those identified underserved populations (Ongoing)	• FSP looks at the outcomes and other data collected through several tracking and monitoring systems such as Integrated Behavioral Information System (IBHIS), Service Request Tracking System (SRTS), RTS (Referral Tracking System), OMA (Outcome Measures Application), etc.
• Development and translation of public informing materials that address mental health education	• FSP has translated its brochures in Spanish and is in the process of translating them in other threshold languages, as they've been updated.	• FSP continues to work in translating FSP brochures and other documents in the County's threshold languages.	• Internal Monitoring/tracing of updated forms and translations
• Field-based services-Flexibility in FSP enrollment such as allowing "those living	• 65% of FSP services are field based and are tracked by the Outcomes Division via internal	• FSP continues to maintain 65% or higher field-based	• Ongoing monitoring and tracking via several

Full Service Partnership (FSP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
with family" to qualify as "at-risk of homelessness"	applications such as IBHIS. • FSP continues to be flexible by allowing high acuity clients who may not meet exact eligibility requirements to enroll in the program	requirements and monitors FSP providers who have struggled through the pandemic. FSP service area navigators and FSP admin staff review referrals for their appropriateness into the program.	LACDMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.
• Augmentation of mental health service accessibility to underserved populations • Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings. • Integrated Supportive Services • Interagency Collaboration	• After identifying underserved populations such as API. We've worked with API alliance and have increased FSP capacity for those community agencies working with those populations. • Agencies ensure they have staff who are bilingual/multilingual to provide FSP services or work with interpreters/translators to ensure services are being delivered in the clients' primary languages. • FSP works collaboratively with other agencies and programs to ensure that all clients' needs are being met such as housing, establishment of benefits, substance use, etc.	• All activities are ongoing and are being monitored internally should we need to make changes to our cultural competency plan.	• Ongoing monitoring and tracking via several DMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.

Full Service Partnership (FSP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
• Provider communication and support • Trainings/case consultation • Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	• FSP has provided ongoing FSP trainings for new staff and hold both Adult and Child FSP Provider meetings on a quarterly basis to update providers with changes to the program and listen to any concerns and issues that arise from delivering services to the community. • FSP works collaboratively with various agencies countywide to address and promote health and wellbeing by ensuring FSP services are delivered to the most vulnerable populations.	• All these activities are ongoing and are being monitored internally.	• Ongoing monitoring and tracking via several LACDMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.

CONSUMERS SERVED BY FSP
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Unreported)	Female	Transman/ Transmasculine	Male	Transwoman/ Transfeminine	Unknown	
Adult FSP-MHSA	1707	2173	1720	360	78	1287	3078	4	4525	9	2	Unknown
Child FSP-MHSA	328	784	1655	79	17	807	1755	4	2013	3	2	Unknown
Measure H FSP	81	169	104	3	4	68	196	0	246	1	0	Unknown
MHSA FSP MC	2	0	4	0	0	2	6	0	2	0	0	Unknown
Older-adults-FSP-MHSA	633	518	281	110	18	394	964	0	1028	1	0	Unknown

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Unreported)	Female	Transman/ Transmasculine	Male	Transwoman/ Transfeminine	Unknown	
TAY_FSP - MHSA	292	592	1179	99	9	621	1460	4	1449	1	1	Unknown

Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Program

The GENESIS Older Adult Program offers 100% field-based outpatient comprehensive mental health services for Older Adults who are living with a severe mental illness and are unable to access services due to impaired mobility, frailty, or other limitations. The program provides specialized services to meet the unique needs of people ages 60 years and above. Services provided include individual and family counseling, medication services, education and support, assistance in accessing appropriate level of care, in-home supportive services, housing retention, and linkage in applying for other resources such as Medi-Cal, Medicare, Social Security, and VA Benefits.

The Older Adult population in LA County is ethnically and racially diverse. It is estimated that by 2030 the Older Adult population, ages 60 and older, will increase to about 3 million (https://www.bscc.ca.gov/wp-content/uploads/Demographic-Reference-Data-Los-Angeles.pdf). To promote healthy aging communities, it is imperative to increase quality of life by addressing the physical health and mental health needs of Older Adults. The GENESIS Older Adult Program is culturally sensitive and linguistically appropriate and aims to provide mental health services primarily for homebound, frail Older Adults, age 60 and above, with mental health and comorbid physical health disorders. The field-based staff consist of a social worker and nurse team to provide a comprehensive and holistic approach for the treatment and wellbeing of Older Adults from diverse cultures. To address cultural competence, reduce linguistic barriers, and improve access to care for Older Adults residing in LA County, mental health services are delivered in various threshold languages (e.g., Spanish, Russian, Farsi, and Tagalog) to address the needs of these specific communities.

The GENESIS Older Adult Program regularly outreaches to the Older Adult community to provide information about its specialty field-based services designed to provide mental health bio-psycho-social treatment services in field-based settings. These services are provided in English, Spanish, Russian, Tagalog, and Farsi and tailored to meet the cultural and linguistical needs of the Older Adult population as well as assist with aging in place. Outreach activities to promote services for the Older Adult community include senior centers, senior housing locations, community medical primary care providers and other community-based agencies serving the Older Adult population. The presentations

were conducted virtually at various facilities targeting Older Adults. These presentations were delivered in a culturally sensitive and linguistically appropriate manner (English, Spanish, and Korean).

GENESIS OLDER ADULT PROGRAM			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)	Mental Health Clinician (e.g., MSW) is co-located, four hours per week, at the Antelope Valley APS office to provide consultation for APS staff working Older Adults due to elder abuse reporting. 6/9/2021 – Conducted in-person training for eight APS staff	Due to COVID-19 pandemic, co-location consultations pivoted from onsite/in-person to telephone.	Monthly log submitted with number of hours of consultation. For FY 20-21 total of 48 hours consultation and outreach for 63 individuals.
2) Field-based services	The program is designed to provide field-based mental health assessment and services in the community such as home, senior centers, parks, and community at large depending upon individual's need/request. Services include a bio-psycho-social assessment, nursing (head-to-toe) physical health assessment, and a myriad of mental health services including psychotherapy, family therapy, case management, medication management, linkage to resources, and benefits establishment.	Ongoing program implementation	LACDMH IBHIS electronic medical record documentation system: Approximately 29 assessments per month; and approximately 348 ongoing clients served for FY 20-21.
3) Integration of physical health, mental health, and	Field-based multi-disciplinary teams consist of a 1) social worker to provide	Ongoing program implementation	DMH IBHIS electronic medical record documentation

GENESIS OLDER ADULT PROGRAM			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
substance use services	psychosocial assessment, therapy, individual and family; 2) nurse to provide head-to-toe physical examine, consultation with medical providers, and individual rehabilitation; 3) case manager to ensure benefits establishment, housing retention, and resources such as in-home support and adequate food supply; 4) substance abuse counselor to address substance use disorders providing counseling and resources; and 5) psychiatrist and nurse practitioner to provide medication management/prescriptions and consultation.		system: Approximately 29 assessments per month; and approximately 348 ongoing clients served for FY 20-21.
4) Trainings/case consultation	Older Adult Consultation Team (OACT) is a geriatric-specialty multidisciplinary group to support to <u>all</u> clinicians working with Older Adults. Consultants include: UCLA expert consultant, neuropsychologists, geriatric psychiatrists, pharmacist, social workers, nurses, nurse practitioners, clinical pharmacists, medical case workers & community workers, Adult Protective Services, Office of Public Guardian, Full Service Partnership (FSP).	Ongoing Older Adult Consultation Team (OACT) bi-monthly consultation meetings	Approximately four to five case consultations per month for FY 20-21 for total of forty-four consultations including fifteen-thirty participants.

CONSUMERS SERVED BY GENESIS OLDER ADULT PROGRAM
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Your Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Older adults age 60 and above	80	42	112	14	0	98	M (104)/ F (242)					English, Farsi, Russian, Spanish, Tagalog

Health Neighborhoods (HN)

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

To meet the specific needs of a defined community, place-based Health Neighborhoods must remain organic in nature with a shared leadership and commitment by the three (3) Health Departments and community stakeholders. Each Health Neighborhood develops an annual Action Plan that outlines specific issues to be addressed along with an annual budget. As Health Neighborhoods identify needed resources or barriers to attain their goals, the Operations Committee leverages resources among the Health Departments.

Health Neighborhoods aim to provide culturally and linguistically competent services by creating and sustaining a network of coalitions comprised of diverse stakeholders including mental and public health providers, community and city-based agencies, educational institutions, housing services, social service providers, faith-based groups, and community members. The mission of Health Neighborhoods is to create and sustain a collaboration of community partners working to build thriving communities in underserved areas through prevention, improved coordination, and strong support networks.

Health Neighborhoods increase access to mental health services and eliminate disparities by making meetings open to diverse communities. Health Neighborhood attendees are encouraged to share meeting information with other community members to increase participation. Projects and activities focus on outreaching to the diverse

populations within each Health Neighborhood. Providers and networks collaborate on community projects that vary racially, ethnically, and culturally and bring their expertise to connect and reach those diverse groups. This type of collaboration greatly contributes to the Department's mission of culturally and linguistically appropriate services.

Through effective recruitment and diverse participation, the HN is able to gather observational and anecdotal data to understand disparities in cultural and linguistic accessibility to services.

HEALTH NEIGHBORHOODS (HN)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	• The HN conducts monthly meetings of the LACDMH service and community partners including Health, Public Health, faith-based, substance use, and other providers.	HN meets monthly	Attendance tracking
2) Trainings/case consultation	• Case consultation and linkage to service providers	Ongoing	Follow-up
3) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	• Outreach activities and community-based events	Limited to virtual events due to the pandemic	New participant tracking and outreach
4) COVID-19 responsiveness at clinical and administrative program level	• The Public Health staff are key participants who provide regular updates, community education, and resources	Ongoing	Individual follow-up by Public Health staff

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HEALTH NEIGHBORHOODS BY SERVICE AREA

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

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

HOME teams were developed to support the Department's mission to be both culturally and linguistically competent. HOME teams are comprised of staff who come from a multitude of backgrounds and experiences, so they can effectively engage individuals in the community. By providing in-person services where the client is at and making every attempt to meet the client's needs via a mechanism that makes the client the safest, the HOME program aligns with the Departments goal of providing the best client care. Also, the HOME program looks at demographic composition of community being served and composition of the team serving that community to ensure that culturally and linguistically appropriate and accessible services are available.

The fundamental mission of the HOME program is to provide services to clients who are unable to obtain traditional services. Services are rendered in the field where it is hard to reach in non-traditional manners. HOME teams collaborate with other LACDMH partners, DHS, Los Angeles Homeless Services Authority (LAHSA) and any community entity who

can support the mission. The teams are trained regularly on new techniques and best practices to serve the most disenfranchised individuals in the county. HOME teams are regularly thinking outside of the box to do whatever it takes to meet an individual's needs, many times outside of what one might consider mental health. The team approaches the whole person and engages in meaningful activities to support the client. The HOME staff are "concierge" teams to engage, link, support and follow clients through various stages of recovery.

Homeless Outreach and Mobile Engagement (HOME)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	HOME teams participate with faith-based organizations and community groups to engage the clients and locate and provide resources to the underserved	Completed and ongoing	Meetings and conversations
2) Community education to increase mental health awareness and decrease stigma	The team provides regular education in the community when engaging in outreach as well as participation in community meetings for participants to learn about services and trainings on how to engage those with mental illness	Completed and ongoing	Ongoing training and feedback
3) Field-based services	All services performed by this program are in the field	Completed and ongoing	Outcome data collection
4) Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	The team has been a part of creating new policies around medication delivery in the field to support clients who are unable to attend to this task independently	Completed	
5) Augmentation of mental health service accessibility to underserved population	The program's goal is to provide mental health services in the hardest to reach places and for those who are unable to access or unwilling to access services	Completed but always in progress to find new and innovative ways to serve.	

Homeless Outreach and Mobile Engagement (HOME)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
6) Interagency Collaboration	An essential function of the program is to work collaboratively with the other outreach teams in the homeless services arena including: LAHSA, HFH, street medicine teams and community partners	Completed but also always in progress. Collaboration is ongoing.	Regular meetings, feedback, surveys
7) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	The staff for the HOME team come from multiple cultural backgrounds and utilize numerous languages to engage the community when doing outreach. If there is a need that the team cannot meet, we enlist our community partners to support.	Completed and ongoing	Ensuring during hiring process and attempts at retention
8) Integration of physical health, mental health, and substance use services	The team is comprised of individuals who can provide all these services. When additional support is needed, the team links clients to these services within the community and with the lowest barriers possible.	Completed and ongoing	Ensuring during hiring process and attempts at retention
9) Trainings/case consultation	The team provides training to community partners, organizations, and stakeholders regularly. There is a regular case consultation that goes on in both the homeless services sector as well as with other LACDMH partners.	Completed and ongoing	

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CONSUMERS SERVED BY HOME
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Language of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
7933A SA1 HOME	15	28	7	0	1	3	M (28)/ F (26)	0	0	0	1	English, Spanish
7922A SA2 HOME	13	7	11	1	0	6	M (21)/ F (17)	0	0	0	0	English, Spanish
7921A SA3 HOME	13	8	21	2	0	17	M (32)/ F (29)	0	0	0	0	English, Spanish
7924A SA4 HOME	13	20	1	2	0	7	M (26)/ F (17)	0	0	0	0	English, Spanish
7701A SA4 HOME SKID ROW	20	28	7	1	0	10	M (41)/ F (25)	0	0	0	0	English, Spanish, Portuguese
7934A SA5 HOME	15	12	1	3	0	7	M (15)/ F (22)	0	0	0	1	English
7917A SA6 HOME	5	17	9	1	0	5	M (20)/ F (17)	0	0	0	0	English, Spanish, Mandarin
7929A SA7 HOME	15	3	17	0	0	6	M (16)/ F (25)	0	0	0	0	English, Spanish
7935A SA8 HOME	3	11	2	1	0	2	M (12)/ F (7)	0	0	0	0	English, Spanish

Housing and Supportive Services (HSSP) - Formerly known as the Housing FSP program

Housing and Supportive Services Program (HSSP) provides onsite mental health services to individuals experiencing homelessness and mental illness who are living in Permanent Supportive Housing (PSH) locations. Services include individual and group therapy, crisis intervention, and medication management. HSSP services are part of an integrated service team that includes the Intensive Case Management Services (ICMS) and the Client Engagement and Navigation Services (CENS).

LACDMH is a key partner in discussions about equity issues in the homeless service system. An example is utilizing the California Policy Lab report and recommendations to determine changes in the system to eliminate inequities. The report revealed that the Coordinated Entry System survey used to determine vulnerability and housing needs is not equitable for women or Black/African American individuals. As a result, the University of Southern California (USC) and University of California, Los Angeles (UCLA) are

working with system partners including individuals with lived experience of homelessness to develop a new tool using data to ensure the questions are not racially and gender biased. The Coordinated Entry System Triage Tool Research and Refinement Core Planning Workgroup includes the participation of LACDMH's Deputy Director and two (2) housing specialists.

Another example of how the HSSP works to ensure services are culturally and linguistically appropriate is that, per the contract, providers are expected to hire staff who represent the cultural and linguistic needs of the population they serve. For example, providers hire Korean or Spanish speaking staff to work at properties with large Korean or Spanish speaking populations. The HSSP program also provides services at PSH locations to reduce barriers caused by lack of transportation.

Housing and Supportive Services (HSSP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Community education to increase mental health awareness and decrease stigma	• HSSP administrative staff coordinate and provide trainings for staff working at Permanent Supportive Housing locations to promote increased understanding and competency around serving clients with serious mental illness. Training includes overview of mental health conditions, crisis intervention, case studies, etc.	Ongoing	
2) Provider communication and support	• HSSP staff have regularly scheduled meetings with providers to provide case consultation, technical assistance, and monitor adherence to program goals.	Ongoing	
3) Trainings/case consultation	• HSSP coordinates training for providers as needed. HSSP staff also provide case consultation to providers around challenging cases and collaborate to ensure goal of helping clients maintain their housing.	Ongoing	
4) Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding	• HSSP staff meet regularly with Department of Health Services - Housing for Health (HFH) staff to discuss the following: improving service coordination; ensuring	Ongoing	

Housing and Supportive Services (HSSP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
cultural competence, linguistic appropriateness, and equity	equitable service delivery; disparities faced by participants; and how to reduce these disparities		
5) Interagency Collaboration	• HSSP staff collaborate on at least a monthly basis with various system partners including Housing for Health (HFH), Department of Public Health – Substance Abuse Prevention & Control (SAPC), Brilliant Corners, and others through regularly scheduled bi-weekly and monthly meetings.	Ongoing	
6) Integration of physical health, mental health, and substance use services	• Services are an integrated care model that include ICMS, HSSP and CENS. Services are field based as they are on site at the housing development. • Training is provided to the service providers as needed on the integrated service model expectations which are also detailed in the Statement of Work LACDMH has with the HSSP providers	Ongoing	

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CONSUMERS SERVED BY HSSP
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify) Unknown or Multi-Racial	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
HSSP	299	620	306	20	19	21	M (643)/ F (624)	4	10	4		Spanish Korean

Linkage Programs

Linkage programs connect community members to essential services, including treatment, housing, and other mental health services throughout Los Angeles County. Linkage Services program addresses the needs of individuals in collaboration with the judicial system by providing identification, outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits, and other services as indicated by individual needs and situations. The goal is to successfully link individuals to community-based services, not the streets, thereby decreasing the risk of re-incarceration and unnecessary emergency/acute psychiatric inpatient services.

Men's Community Re-Entry Program (MCRP) – Formerly known as the Men's Community Reintegration Program

Men's Community Re-Entry Program (MCRP) is an evidence-based forensic mental health program that aims to increase prosocial methods of living and reduce maladaptive behaviors among justice-involved individuals. The population of MCRP consists of justice-involved men 18 to 65 years of age who present with high risk factors for recidivism and moderate acuity of mental illness. The clients commit to program participation for a minimum of one year and maximum of 18-24 months.

Persons with criminal histories have more difficulties securing housing, employment, education and even access to health care. MCRP staff have observed that justice-involved men are at high risk of discrimination and lack of access to needed services due to their background and mental health diagnoses. MCRP staff work with advocates such as Public Defenders, leaders of community organizations, and others

to address clients' need for housing, education, treatment, and employment. Program staff work collaboratively to serve clients with specific histories (such as sex offenses) and help them overcome barriers to rehabilitation and community reintegration.

The projects/activities of MCRP reflect LACDMH's goal to provide services aligned with the clients' cultural and linguistic needs. The program accesses language interpreters, including ASL interpreters, when needed.

Men's Community Re-Entry Program (MCRP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Designation and tracking ethnic targets for MCRP	MCRP has created an internal system to track the ethnic targets. This helps the program to know the clients' ethnic group and attempt to match them with staff who might be able to meet their cultural needs, and/or consider service array that meets these needs.	Internal System is updated daily and continues to be enhanced depending on the need of the program.	Different statistic graphs are added to the client roster to determine the composition of the treated population. Access to LACDMH Power BI reports also helps to track this.
2) Field-based services	Field-based services are provided focusing on wellbeing of MCRP participants.	MCRP staff are working collaboratively with staff members from Interim Shelters, Residential Programs and Sober Living Facilities to address any disparities when it comes to race, culture, or special needs.	Contact takes place on a weekly basis. Formal consultations take place at least once a month to make sure client's needs are addressed.
3) Interagency Collaboration	Collaborative discussion between forensic programs to address the cultural needs of the clients; have panel discussion with experts to better serve the target population.	Collaborative meetings continue to take place three (3) times a month or when needed; panel discussions were placed on hold due to the pandemic	During these collaborative meetings, program procedures and outcomes are discussed to determine the effectiveness of the program.

Men's Community Re-Entry Program (MCRP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
4) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	LACDMH provides trainings to Spanish speaking staff to help them learn and understand the specific clinical terminology when working with Spanish speaking clients.	Outreach and Engagement staff are better equipped when assessing clients at jail and/or courthouses.	Spanish-speaking supervisors will meet with staff on a regular basis to address any obstacles, training needs or determine their effectiveness in addressing multicultural/multilingual needs.
5) Provider communication and support	Case consultations are being held. They are an excellent way of providing feedback and support when addressing cultural disparities or obstacles to the Responsivity Principle of the Risk-Need-Responsivity (RNR) Model.	Case consultations take place on a weekly basis. Clinicians and case managers are assigned to present a case addressing clinical and cultural factors pertaining to a client.	Management team attends each case consultation meeting to assess the effectiveness of the meeting and to provide focus and structure on clinical/cultural needs.
6) Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity	Partnerships between DHS/DMH/DPH have initiated to address reentry needs for the justice involved population. Additionally, collaborative work between the Office of the Public Defender, LACDMH and Substance Abuse Treatment providers has initiated to address the lack of housing and treatment services provided for the most disadvantaged clients who are in need of intensive services.	Bi-weekly or monthly meetings are in development.	Goals/ Objectives are still being developed. Further discussions will take place before a final plan is implemented.
7) Partnerships for reentry program clients, to support educational and	Addictions Studies Counselor Training certificate program in partnership with East LA College	In Progress	Staff to follow-up with school(s) and client(s)

Men's Community Re-Entry Program (MCRP)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
vocational goals	Dream Project – access to private donors to nominate reentry clients for funding of vocational education		

CONSUMERS SERVED BY MCRP
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Total	Languages used by Staff in service provision
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	TOTAL	
Men's Community Re-Entry Program	24	72	59	3	2	28	M						English/ Spanish

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

The target population of WCRP includes women with forensic experience, incarceration, jail time, complex trauma, and/or homelessness. WCRP works to reduce recidivism and promote wellness by recognizing criminogenic risk factors and addressing mental illness. WCRP is a Community Health Worker-driven, field psychiatry program which is accessible throughout LA County.

WCRP uses Level of Service/Case inventory to address clients' criminogenic risk factors. WCRP tracks risk factors, needs, and correlations of needs (e.g., increase risk of re-incarceration). For example, if clients are unable to obtain adequate

employment, safe housing, and reunification with their minor children, they are more at risk of re-incarceration.

WCRP staff also recognize and address the cultural and linguistic needs of their clients. WCRP staff consists of bilingual and bicultural Community Health Workers from diverse backgrounds, including Latino, Korean, Armenian, and Nigerian cultures.

Women's Community and Re-Entry Program (WCRP)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
Pertinent to the 30 Countywide strategies, the WCRP endorses the following: • Interagency Collaboration: Public defenders/ and PD mental health team. Engaging Judges to be aware of MHS as a diversion to incarceration. • Cultural Competence Enhancement Across Health Departments: Burbank Police Chief special case request via Burbank City administrative collaborative meeting. Oriented Burbank City officials of who WCRP Serves including discussion on	Collaborative court pilot project meetings - for women with dual diagnosis substance abuse and providing shelter. Early release with LACDMH committing to MHS. Assembled team to work with Court linkage MH staff, facilitated transfer of special client to Hollywood, MH court for client. Temporary Housing was secured, substance use agency linked.	In process, clients are now in Prototypes in SA 3. Judge McLaughlin— Bennett invited SA1 & 2 WCRP team to present in July. Special case client was conditionally released to shared housing.	Clients being housed and treated for their dual diagnosis. Early release from incarceration as a result. LACDMH Court linkage staff following up if she is rearrested. LACDMH collaborating with Burbank city administrators to help joint clients as a result of this collaborative efforts.

Women's Community and Re-Entry Program (WCRP)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
LBGTQ+ population			
• DHS office of Diversion and Re-Entry, ODR.	Receiving high needs/utilizer forensic clients into WCRP; triage, assessment and ongoing consultation and teaming to best serve common client. Housing established - for all women and gender diverse individuals.	Ongoing, as referrals come into WCRP and need for the Office of Diversion and Reentry (ODR) to assist with certain matters/issues.	Ongoing collaboration working closely together with WCRP staff and ODR providers. Lifelong case management support for clients.
• Investments in Learning: Addictions Sturdies Program, East Los Angeles College (ELAC).	College courses for current WCRP consumers, who can eventually become certified substance abuse counselor and if desired continue college courses to earn a bachelors.	Five (5) WCRP clients have passed the first 8-week course, three (3) passed the three (3) weeks 2nd class. One (1) more class to obtain Prevention certificate. Four (4) more consumers for the next cohort to start in July.	WCRP O.T. collaborates with ELAC liaison and director of Addiction studies program. Ongoing communication and consulting to support consumers to succeed and register. Tutoring available.

CONSUMERS SERVED BY WCRP
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Total	Languages used by Staff in service provision
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	TOTAL	
WCRP	30	147	52	1	0	1 Persian			1		1		Spanish

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Total	Languages used by Staff in service provision
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	TOTAL	
(All MHS Mostly in the field: CHW case management, psychotherapy, groups, individual in field services, field psychiatry, In-reach services)													English Armenian Tagalog Korean Portuguese

Maternal Mental Health (MMH)

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

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

MMH is a community-based program which provides services and events in the community to decrease mental health stigma and encourage participants' willingness to engage in services. Services are provided in person and virtually to increase accessibility.

Social determinants of health data at the Service Area level was reviewed and evaluated to ensure that underserved communities, including Latino and Latinx, API, and Black/African American, were provided with mental health community support and education, linkage, and resources pertaining to maternal mental health. In addition, data related to mental health disparities in LA County was utilized to determine the geographic

areas, ethnic/cultural groups, and linguistic needs for the targeted population for the MMH program.

LACDMH is committed to providing culturally and linguistically appropriate services to its ethnically diverse communities. The mission of the Department is to create a system of care that is in alignment with the needs of the community. MMH program specifically provides mental health services to vulnerable and marginalized ethnic populations in LA County.

This program aims to provide community education, increase mental health awareness, provide resources, linkages, and direct mental health services to women and birthing people from underserved communities, who are currently pregnant or during the post-partum period, typically after a year of childbirth. By developing community partnerships, increasing mental health education, and providing direct mental health services, health disparities for pregnant women and birthing people will be significantly decreased in LA County.

Maternal Mental Health (MMH)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
1) Community education to increase mental health awareness and decrease stigma.	The Service Area Maternal Mental Health (MMH) Leads provide outreach and educational presentations and support groups to community agencies, community members, faith-based organizations, and participate in community resource fairs throughout the County informing them of MMH services and providing education on the mental health needs of pregnant women.	Ongoing	In SA 6, the following groups are offered to community members: 1. Life Skills Support Group for New Mothers; 2. After Glow Post-Partum Support Group; 3. Parenting Classes & Substance Use support group for Post-Partum Mothers; and 4. Financial Planning Group for Mothers.
2) Interagency Collaboration	The MMH Leads regularly interface with the Department of Health Services (DHS), Department of Public Health (DPH), Department of Children and Family Services (DCFS), and other governmental entities to address community needs and linkage services to mental health resources.	Ongoing	Working in collaboration with the agencies support MMH's mission to provide community education, reduce mental health disparities and stigma. In addition, LACDMH actively works with DHS to make referrals to Transitional Aged Youth (TAY) Full Service Partnership (FSP) Program, the Young Mothers and Babies FSP

Maternal Mental Health (MMH)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
			program, and the MMH Champions Program.
3) Collaboration with faith-based and other trusted community entities/groups	In SA 1, MMH is actively collaborating with DPH and the Antelope Valley African American Infant and Maternal Mortality outreach and engagement workgroup to increase awareness about African American mortality rates and promote mental health. In addition, the SA 1 MMH Lead tabled the Black Maternal Health Expo and presented on Maternal Health in the African American Community. Lastly, they partnered with Women's Pavilion and other agencies. The partnerships in SA 7 include: Mexican American Opportunity Foundation, Montebello YMCA, and Eastern Los Angeles Regional Center.	Ongoing	The purpose of the workgroup is to decrease maternal mortality and birth related death by addressing racial disparities. In addition, these collaborations increase awareness about maternal health for all populations as well as addressing unequal maternal care for disadvantaged populations.
4) Training/Case Consultation	We provide consultation and support to the following community entities/groups: Operation Motherhood Group; The Village African American Mental Health Support group; High Desert DHS OBGYN Clinic; MOMMA DHS program; the SA 7 Birth to Five DCFS Collaboration; and LA County Health Services' MAMA's Neighborhood Program.	Ongoing	MMH has continued requests for these consultations targeting different ethnically diverse communities in the County.
5) Service Area 7 Young Mothers and Babies Full Service Partnership (FSP) Program	The Young Mothers and Babies Full Services Partnership (FSP) Program provides comprehensive mental health services for pregnant and parenting young women and their infants or toddlers through a trauma informed, developmentally-	Ongoing	The program is allocated 25 children's slots and 25 adult shots, totaling 50 slots. Currently, the program's enrollment is at full capacity. For FY 20-21, 115 clients were served by

Maternal Mental Health (MMH)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
	biologically respectful and relationship-based approach.		the Young Mothers and Babies FSP Program.
6) Service Area 8 Maternal Mental Health Champions Program	This program provides psychotherapy and psychiatric services focused on perinatal mental health. Further, consultation and linkage services to LACDMH for DHS-wide MAMA's Program are coordinated. In addition, Perinatal Depression, Anxiety, and mental health education, supportive, and preventative mental health activities/skill-building groups (in English and Spanish) are conducted within the Service Area.	Ongoing	The purpose of the MMH Champions Program in SA 8 is to increase awareness about maternal health for all populations as well as addressing unequal maternal care for disadvantaged populations
7) Co-location with other county departments	In SA 1 and SA 8, MMH is actively collaborating with DPH and DHS to increase awareness about maternal mental health issues and how that impact pregnant women from underserved communities. MMH provides co-located services at different sites and areas within LA County as an effort to increase community reach and engagement.	Ongoing	The co-located efforts increase awareness about maternal health for all populations as well as addresses unequal maternal care for unserved and hard to reach communities.
8) Field-based Services	The Young Mothers and Babies Full Services Partnership Program is field-based, and it provides comprehensive mental health services for pregnant and parenting young women and their infants or toddlers through a trauma-informed, developmentally-biologically respectful, and a relationship-based approach.	Ongoing	The program provides field-based services in SA 7. MMH's clinical staff which is composed of mental health clinicians, a nurse, and case managers also provide in-home services to increase engagement with underserved/hard to reach populations.

My Health Los Angeles (MHLA) Behavioral Health Expansion Project

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

In 2015, LACDMH began planning partnerships with Federally Qualified Health Centers (FQHC) to provide early intervention/preventive mental health treatment to underserved, uninsured community members. Over time, and in response to the 2018 Board of Supervisors motion, the project shifted and LACDMH partnered with MHLA to add a new mental health prevention benefit for participants. MHLA, LACDMH, the Community Clinic Association of LA County, and CPs collaborated to create the MHLA Mental Health Behavioral Health Expansion Project. This project is designed to help build protective factors and reduce risk factors associated with the onset of serious mental illness. Under the program, 52 CPs are responsible for screening MHLA participants and providing them with prevention services.

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

LACDMH is utilizing MHSA funding to support mental health prevention services and/or activities focused on prolonged engagement to help build protective factors and reduce/manage risk factors associated with the onset of serious mental illness of low

income MHLA participants. The services are being provided at MHLA-contracted Community Partner Clinics; LACDMH is the project administrator.

MHLA Behavioral Health Expansion project contributes to LACDMH's goal of delivering culturally and linguistically competent services by making mental health prevention services and activities available in a less stigmatizing venue such as a community-based comprehensive health care clinic. The target population is traditionally underserved, mostly monolingual Spanish-speaking individuals who have low income and lack health insurance.

MHLA			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
Pertinent to the 30 Countywide strategies, the MHLA program endorses the following: • Collaboration with faith-based and other trusted community entities/groups • Community education to increase mental health awareness and decrease stigma • Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery • Augmentation of mental health service accessibility to underserved populations • Integration of physical health, mental health, and substance use services	For each of the six (6) strategies noted in this table, LACDMH utilizes a variety of activities (noted here) such as ongoing technical assistance calls individually with each clinic and in group meetings with various roundtables (CEOs, CMOs, BH Directors, and QI Managers) from the clinics and the Clinic Association. Examples of the content of such calls includes ways of messaging to the communities that these Mental Health Prevention services are available, also working with clinics' medical teams to increase their collaboration with their behavioral health teams on how to do warm handoffs. LACDMH works with DHS to make sure the dedicated DHS-MHLA website is having its web postings updated for public view and access. Another example of how this program enhances its collective cultural competence is by having made sure that 100% of the exercises in its three (3) LACDMH created Mental Health	Status and progress in each of these six (6) areas remains fluid as this is a pilot program, and so changes and improvements are constantly evolving as this project moves into its 3rd fiscal year of implementation. Challenges of implementation are met with and resolved through a scope of project adjustment as needed and agreed upon by all parties to the extent possible. For example, expanding the use of allowed outcome measures (added the PHQ-2) to be incorporated in a mental health services prevention screening process to help the clinics medical teams that are doing some of the initial mental	LACDMH through technical assistance calls is continually working with CPs on reviewing a clinic's business and clinical workflow, to see what improvements can be made that might then increase the access to these services. LACDMH routinely conducts QI virtual site reviews with each CP to go over claiming, data submission, as well as a review of documentation.

MHLA			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	Prevention curricula are available in Spanish to ensure the population served as access to key materials in their preferred language.	health prevention screenings.	

CONSUMERS SERVED BY MHLA
FY 20-21

Ethnicity	
Asian	513
Asian Indian	13
Black/African American	42
Cambodian	4
Chinese	19
Filipino	270
Hispanic	25,835
Japanese	3
Korean	65
Laotian	2
Other or Mixed Race	32
Pacific Islander/Native Hawaiian	2
Samoan	2
Vietnamese	1
White	220

Language	
Albanian	1
Amharic	1
Arabic	3
Armenian	84
Chinese (Multiple Dialects)	21
English	1,900
Hindi	5
Italian	1
Japanese	1
Khmer	4
Korean	104
Lao	2
Persian (Farsi)	3
Tagalog	34
Polish	1
Portuguese	3
Russian	8
Spanish	25,132
Thai	239
Vietnamese	1

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Older Adult (OA) Service Extenders (SE) Program

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

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

Service Extender Program utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to communities by reviewing data (penetration rate and client demographics) and implementing strategies to identify and recruit volunteers from diverse backgrounds. For example, the Service Extenders include volunteers from the API, Latino, Russian, and Black/African American communities.

The Outpatient Services Division administrative team continuously outreaches to Older Adult LACDMH programs and mental health providers, considering their cultural needs to identify appropriate placement for Older Adult Service Extenders. During FY 20-21, the Outpatient Services Division had twenty-four (24) Service Extenders representing multiple ethnic backgrounds, cultural groups, and language capabilities.

Service Extenders Program aims to increase access to mental health services by helping clients navigate the mental health system. This is accomplished through Service Extenders sharing their lived experience from a culturally and linguistically appropriate perspective.

Older Adult (OA) Service Extenders (SE) Program			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Quarterly Service Extender meetings: • 12/14/2020 “Holiday Blues” and “Promoters Presentation” • 4/21/2022 “Stress in America/Coping with COVID-19” • Service Extenders have been invited to attend numerous trainings, conferences, webinars, and presentations offered in English and Spanish.	Cultural competency is an important aspect of trainings and discussions during quarterly meetings. Service Extenders share their experiences of	Service Extender quarterly meetings are well-attended by Service Extenders. The meeting agenda is carefully designed to

Older Adult (OA) Service Extenders (SE) Program			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	• July 2020: "Caring, Compassion, and Connections: A Mental Health Series for Faith Community Leaders • July 2020: Digital heath literacy training by Painted Brain • Aug 2020: The 123's & ABC's of Department of Rehabilitation (DOR) • August 2020: Self-Care for Providers • August 2020: Human Trafficking • August 2020: Trauma and Resilience Informed Care Foundations • September 2020: 10th Annual Suicide Prevention Summit hosted by LA County Suicide Prevention Network • September 2020: COVID-19 prevention, testing and finding resources • October 2020: The History of the Peer Movement and Our Fight for Equity • October 2020: National Cybersecurity event • October -December 2020: Mindful Awareness Practice (MAPS) Courses • November 2020: Substance Use and Suicide: Identifying and Mitigating Risk • November 2020: Self-Advocacy in Action: Know your Rights and How to Advocate for Them • November 2020: LA County Native American Wellness Forum • December 2020: Service Area 2 Interfaith Leaders and Community • December 2020: The Benefits of Having a Mental Health Crisis Prevention and Intervention Plan • December 2020: Guidance for Relieving Stress • December 2020: Relapse Prevention and Healthy Coping • January 2021: Ak the Psychiatrist • January 2021: Leaders in the Fight Against Human Trafficking • February 2021: Voluntary Psychiatric Hospitalizations: What Patient's Rights Apply?	working with clients from diverse cultural backgrounds and receive feedback from facilitators and their peers. Service Extenders are regularly invited to attend relevant training opportunities to enhance their knowledge and capacity to promote health, well-being, and access to underserved populations.	support Service Extenders and also to enhance their skills of working with diverse Older Adults in LA County. The program manager and designated staff inform the Service Extenders upon receipt of these trainings, and as needed, assist and support the Service Extenders to participate.

Older Adult (OA) Service Extenders (SE) Program			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	• March 2021: COVID-19 Vaccine Meeting • April 2021: Armenian Genocide: Transgenerational Effects & Healing • May 2021: 3rd Annual Mental Health Symposium • June 2021: Substance Use and Suicide: Identifying and Mitigating Risks		

Olive View Community Mental Health Urgent Care Center (Olive View UCC)

Olive View Community Mental Health Urgent Care Center (Olive View UCC) was developed with the two (2) goals of decompressing the psychiatric emergency room at the Olive View Medical Center and providing a rapid alternative to accessing outpatient mental health care. The Olive View UCC partners with the network of County-operated and contracted mental health providers, and it is common for consumers to initiate their services at the UCC and continue with their home provider.

Services at the Olive View UCC include:

1. Screening and triage
2. Brief clinical assessment
3. Medication evaluation and medication services
4. Identification of immediate case management needs
5. Identification of acute psychological needs and provision of crisis intervention services as needed
6. Linkage to community providers for ongoing services

Consumers of the Olive View UCC typically need:

- A mental health screening to ensure safety
- Same-day access to medication services to prevent the need for hospitalization
- Crisis resolution services
- Close monitoring of symptoms in response to medications prescribed by UCC staff
- Linkage to ongoing community-based services

Consumers who fit into the model of services offered by the UCC include:

- Those who have recently run out of or are within a day of running out of needed psychiatric medications
- Those who are not in need of psychiatric emergency room services (i.e., not imminent threat to the health and safety of themselves or others)
- Those experiencing the onset of mental health issues which prevents them from participating in daily life functions (school, family, work, etc.)
- Those who are not already connected to a mental health service provider

Services are rendered based on level of acuity and immediate need. UCC staff screen consumers as they arrive to determine level of need. As a result, some consumers may be seen sooner than others, and some consumers may be referred out to community-based services. This allows the UCC to focus in on the needs of the most acute consumers primarily for safety purposes, and secondarily to prevent the need for hospital-based or emergency services.

Since the UCC is designed to address immediate needs, consumers can expect to walk away with (as needed):

1. Verification of whether they need higher levels of care
2. An appointment or referral to a community-based mental health provider
3. A prescription and instructions for psychiatric medication (if needed)
4. Referrals to related social service resources as needed

Consumers are typically followed at the UCC while they wait to access services at a partner outpatient mental health provider. The UCC can provide same day services because consumers are linked for ongoing care in the community.

The Olive View UCC also has a Crisis Stabilization Unit (CSU). This specialized unit partners with mental health providers and law enforcement agencies as a lower acuity alternative to psychiatric emergency room services. Consumers receiving CSU services are typically on an involuntary hold. A multidisciplinary staff operates the CSU with the goal of stabilizing a consumer in under 20 hours and linking that consumer to ongoing outpatient mental health services.

The program uses the LACDMH Clinical informatics Program Profile to monitor the cultural and linguistic needs of individuals seeking services at this facility. During the COVID-19 pandemic, LACDMH has been providing staff with masks with clear protective pieces over the mouth to assist UCC staff in communicating with visitors who were deaf and relied on lip reading.

The Olive View UCC is an urgent walk-in program that does not advance schedule appointments. As a result, the program does not know who the population served will be other than generating estimates based on demographic community data. For example, the high rate of suicide within the monolingual Spanish-speaking population was identified using the Department of Public Health's demographic data and health condition report. The Olive View UCC in partnership with the LACDMH Suicide Prevention Network reached out to Didi Hirsch Mental Health Center to build the capacity to address the needs of survivors after suicide attempts. The UCC is a responsive and reactive program attempting to meet the needs of the community once needs or gaps in service are identified.

Additionally, the model of walk-in services eliminates the possibility of no-show appointments and attends to the urgent needs of individuals on the day they present for services. Additionally, the urgent mental health care model creates a symbiotic

relationship between the program and community partners who cannot provide same-day access, but can provide ongoing, community-based long-term services.

OLIVE VIEW UCC			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	Active participation in SA 2 Clergy Roundtable	Ongoing	Multiple case consultations supporting both clinic activity and parishes in crisis situations
2) Co-location with the Department of Health Services (DHS)	Operation of the Crisis Stabilization Unit with DHS staff	Ongoing	Quality Assurance Division for Medi-Cal Certification, Lanterman-Petris-Short (LPS) Facility Designation Unit for LPS requirements, and use of Seclusion and Restraint Report
3) Community education to increase mental health awareness and decrease stigma	Active participation in the Speaker's Bureau as needed, partnerships with the National Alliance for Mental Illness (NAMI) NAMI San Fernando Valley (Sfv) and NAMI Spanish Sfv	Ongoing	Maintenance of open communication and sharing of resources
4) Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery	Active participation in Service Area Leadership Team (SALT 2), SA 2 Providers Meeting and Clergy Roundtable	Monthly	Regular reporting out of program activities and receipt of verbal community input
5) Implementation of new departmental policies and procedures that improve the quality and timeliness of	Radical modifications to UCC workflow to accommodate influx of visitors and clients, and to maintain the health and safety of all visitors and staff	Ongoing	No reported known transmission of COVID-19 within the facility among staff or visitors

OLIVE VIEW UCC			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
delivering mental health services			
6) Augmentation of mental health service accessibility to underserved populations	Initial development of Survivors After Suicide program in conjunction with Didi Hirsch Mental Health Center to specifically address the high rate of suicide among the Spanish-speaking communities in Pacoima, Arleta and surrounds	Initiation of training and identification of staff and volunteers with lived experience of losing a family member or someone close to suicide	Training and implementation delayed due to availability of trainers and need for further curriculum development
7) Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments	Regular use of the language lines available to LACDMH clinics	Ongoing	Confirmation that visitors can receive services in the preferred language of choice
8) Interagency Collaboration	Partnerships with SA 2 community-based agencies (and beyond) to assist clients with access to urgently needed mental health services	Ongoing	Direct service reports, direct service detail reports, linkage activities with partner agencies for ongoing mental health services
9) Integration of physical health, mental health, and substance use services	Staffing by board-certified addiction psychiatrists, partnership with DHS and the LACDMH Pharmacy in the Crisis Stabilization Unit to provide both mental health and physical healthcare medications as needed, close working collaboration with DHS programs on the campus of Olive View Medical Center	Ongoing	Regular communication with the LACDMH pharmacy, weekly management team meetings which include crisis stabilization unit supervisor, weekly meetings with CSU staff, coordination as needed between DMH

OLIVE VIEW UCC			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
			and DHS supervisors and managers
10) Programs that target specific ethnic and language groups	Initial development of Survivors After Suicide program in conjunction with Didi Hirsch Mental Health Center to specifically address the high rate of suicide among the Spanish-speaking communities in Pacoima, Arleta, and surrounds Ongoing partnership with Spanish NAMI Sfv for provision of NAMI resources to the Spanish-speaking community	Ongoing	Training and implementation delayed due to availability of trainers and need for further curriculum development Regular communication and collaboration with NAMI Sfv representatives
11) Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	Active participation in Service Area Leadership Team (SALT 2), SA 2 Providers Meeting and Clergy Roundtable	Ongoing	Regular reporting out of program activities and receipt of verbal community input
12) Utilization of the workforce's responses to cultural competence organizational assessments, surveys, and focus groups to address knowledge gaps and support advancements in cultural competence	Monitor program services utilization and profile information, which include gender, race/ethnicity, primary language, age, housing, substance use, psychiatric diagnosis, and caregiver language	Semi-annually	Data initially developed for Medi-Cal recertification, and is applicable to monitoring demographics of clients served, as well as to monitor compliance with collecting these indicators

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CONSUMERS SERVED BY OLIVE VIEW UCC
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify) " Other/ Multi"	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
7591A (14984 visits, est. 7500 unique clients)	25%	10%	44%	3%	.5%	7%	M(50%)/ F(49%)	0	.5%	0	0	English, Spanish, Armenian, Russian, Farsi, Hindi
7913S (510 admissions)	24%	8%	33%	3%	0	32%	M(57.7%)/ F(41.8%)	0	.5%	0	0	English, Spanish, Tagalog, Armenian, Russian

Prevent Homelessness and Promote Health (PH)^2

(PH)^2 is a collaboration between LA County Department of Health Services, Housing for Health (HFH), and Department of Mental Health (DMH). It is a Countywide program that conducts field-based outreach services to assist individuals and families experiencing untreated serious and persistent medical and mental illness. They often have severe functional life impairments and might be at imminent risk of homelessness due to lease violations in LA County.

(PH)^2 uses an interdisciplinary approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH), and other community housing agencies to address risk factors threatening the stability of Permanent Supportive Housing (PSH) of those experiencing mental illness. All initial outreach is provided in the community where the individual lives to promote access to care. The (PH)^2 team conducts triage, coordination of services, brief clinical interventions as well as incorporating Motivation Interviewing (MI), Harm Reduction, Trauma Informed therapy, Solution Oriented therapy, Cognitive Behavioral therapy, and Seeking Safety to improve housing stability and provide linkage to appropriate level of care to achieve long-term housing stability.

The (PH)^2 team utilizes disparities data in the implementation of strategies to make its services culturally and linguistically accessible to communities. Every individual/family referred to this program is met with culturally competent clinicians who regularly participate in state-of-the-art cultural competence trainings. (PH)^2 has, three (3) bilingual

staff, and all staff have access to and are proficient in utilizing interpretation services which include a list of approved contractors for language interpretation as well as American Sign Language (ASL) services.

PREVENT HOMELESSNESS PROMOTE HEALTH (PH)^2			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)	Bi-weekly meetings for case consultation and support with DHS Housing for Health. Collaborative outreaches and treatment plans	Current and in progress	IBHIS (PH)^2 Activity Logs and bi-weekly case consultation
2) Community education to increase mental health awareness and decrease stigma	Regular contact with Intensive Case Management providers providing mental health education and support	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs
3) Consultation to gatekeepers	Regular contact with Intensive Case Management and other collateral agencies to provide mental health education and support	Current and in progress	
4) Evidence-Based Practices (EBPs)/ Community-Defined Evidence Practices (CDEs) for ethnic populations	Staff complete mandatory Cultural Competency trainings as well as those that are offered to meet specific cultural and ethnic populations such as: • Racial Trauma in the Latinx Community • Mental Health Providers and Immigration • Evaluating Seniors for Cognitive Impairments	Current and in progress	Training certificates
5) Field-based services	Target population: Previously homeless individuals now at risk of returning to homelessness are	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request

PREVENT HOMELESSNESS PROMOTE HEALTH (PH)^2			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	met in the community where they live		Logs, and (PH)^2 Referral Logs
6) Augmentation of mental health service accessibility to underserved populations	Target population: Previously homeless individuals now at risk of returning to homelessness. Only one other program currently providing similar services: Housing Supportive Services.	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs
7) Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings	Staff have access to and are proficient in utilizing interpretation services which include a list of approved contractors for language interpretation as well as American Sign Language services.	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs
8) Interagency Collaboration	Daily collaborative calls with ICMS providers, coordination of care with MH providers of past services for re-linkage as well as to DO and contracted MH providers for current services.	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs
9) Multi-lingual/multi-cultural staff development and support O/E efforts	Completion of pertinent trainings such as: • Racial Trauma in the Latinx Community • Mental Health Providers and Immigration • Evaluating Seniors for Cognitive Impairments	Current and in progress	Training certification

PREVENT HOMELESSNESS PROMOTE HEALTH (PH)^2			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
10) Integration of physical, mental, and substance use services	Assessment of needs identify areas of support needed. Staff work collaboratively with Housing for Health nurses to provided evaluation and treatment. Conversely Housing for Health identifies individuals that need mental health services and both DHS and DMH utilize Substance Abuse Service Helpline (SASH) hotline and substance abuse treatment providers	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs as well as bi-weekly consultation notes
11) Training/case consultation	• Training provided to ICMS and HFH staff. • Each referral results in consultation with referring party • Bi-weekly case consultation with Housing for Health	Current and in progress	IBHIS (PH)^2 Activity Logs, Service Request Logs, and (PH)^2 Referral Logs as well as bi-weekly consultation notes

CONSUMERS SERVED BY (PH^2)
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Not reported	
Outreach and Engagement	2	5	2			1	10					Spanish

Prevention and Early Intervention (Older Adults)

Prevention & Early Intervention (Older Adults) includes the Anti-Stigma & Discrimination (ASD) team that presents the Mental Wellness Series for Older Adults. This series is a community education program providing psycho-educational presentations related to mental wellness and well-being in various languages. The program was designed to increase Older Adults' wellbeing throughout LA County, particularly in underserved communities.

To promote healthy aging communities, it is imperative to increase quality of life by addressing the physical and mental health needs of Older Adults. The Older Adult Mental Wellness Series is an outreach and engagement strategy that is culturally sensitive and linguistically appropriate and aims to provide prevention services primarily by increasing awareness of mental wellness for Older Adults throughout LA County, particularly among underserved and underrepresented communities. To address cultural competence, reduce linguistic barriers, and improve access to care for Older Adults residing in LA County, these presentations have been translated and delivered in various threshold languages (e.g., Spanish, Farsi).

The ASD team regularly outreaches and provides presentations to Senior Centers, Senior Housing locations, Faith Based Organizations, and other community-based settings where Older Adults gather, considering their cultural/language needs. During FY 20-21, the Outpatient Services Division Older Adult Anti-Stigma and Discrimination Team conducted 70 virtual community presentations outreaching to 1,119 LA County residents. These presentations were conducted virtually at various facilities targeting Older Adults. These presentations were delivered in a culturally sensitive and linguistically appropriate manner (English, Spanish, and Korean) to promote access to mental health services by conducting community presentations related to mental health and wellness for Older Adults. This includes providing information regarding how to access mental health services throughout LA County.

Prevention & Early Intervention (Older Adults)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
• Collaboration with faith-based and other trusted community entities/groups	Community Presentations: These presentations were conducted in English and Spanish at Clergy Roundtable meeting; Countywide faith-based meeting; Clergy Breakfast meeting; Church Program	Presented on various topics related to mental health: Good Sleep for Emotional Well-being; Late-life Transitions; Social Isolation; Holiday Blues; Depression and Anxiety; Health,	SA 1 SA 2 SA 8 Countywide Meeting

Prevention & Early Intervention (Older Adults)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
		Wellness, and Wholeness.	
• Community Education to increase mental health awareness and decrease stigma	Community Presentations: These community presentations were presented in the following languages: English, Spanish and Korean Various Settings (Virtual): Community Centers Senior Centers Senior Housing Other (Library, Church, City Hall)	Topics of Presentations: Depression and Anxiety; Good Sleep for Emotional Well-being; Health, Wellness and Wholeness; Hoarding; Holiday Blues; Isolation; Late-Life Transitions; Preserving your Memory; Resiliency; Elder Financial Exploitation: Impact on Mental Health; Stress Management; Emotional Intelligence	Countywide Presentations: SA1: 2 SA2: 18 SA3: 8 SA4: 13 SA6: 9 SA7: 6 SA8:14

Prevention - Family Community Partnership and Innovation (INN)2/ Community Ambassador Network (CAN)

This project aims to implement community partnerships within geographically defined communities. The CAN program supports distinct communities utilizing strategies to reduce the trauma experienced by community members at risk of serious mental illness or serious emotional disturbance.

One integral strategy under the Innovation (INN) 2 project involves hiring Community Ambassadors. Community Ambassadors are people with lived experience, who are trusted members of the community, trained to serve as lay mental health access agents, navigators, and mobilizers in their neighborhoods. Community Ambassador Networks (CANs) serve the most disadvantaged and marginalized communities in LA County. Since community members have more trusted relationships with their peers, they can help respond to community suffering resulting from systemic oppression, job loss and other stressors brought on by systemic inequities and the COVID-19 pandemic. This network of trained and empowered community ambassadors can help drive a collective self-help model, using the inherent strengths of the community to promote real healing, recovery, and community empowerment.

The Family and Community Partnerships (FCP) team strengthens systems and builds community capacity to address the mental health needs of children and their families through trainings, program and policy development, improve workforce development and promote strategic investments in prenatal, infant, early childhood, and school-based mental health. Using a public health approach, FCP provides outreach, engagement to the community and develops partnerships to build resilient communities for those impacted by trauma and mental illness by promoting protective factors using prevention and early intervention.

- Partners in Suicide Prevention
  The Partners in Suicide Prevention (PSP) Team funded by Proposition 63, Mental Health Services Act (MHSA), is an innovative program designed to increase public awareness on suicide and reduce stigma associated with seeking mental health and substance abuse services. PSP Team activities include but are not limited to increasing public awareness, reducing stigma and discrimination associated with mental illness, substance abuse and suicide, providing education and training, identifying underserved communities, promoting prevention and early intervention, creating linkages, providing referrals, assisting care providers, and participating in countywide committee and networks.

- Los Angeles Suicide Prevention Network (LASPN)
  As part of the Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) Plan, the LA County Partners in Suicide Prevention (PSP) Network created the Los Angeles Suicide Prevention Network (LASPN). The LASPN, under Prevention, Family and Community Partnerships, is a public-private partnership that is inclusive of mental health professionals, advocates, survivors, providers, researchers, and representatives from various agencies and organizations working together to decrease the numbers of suicides in LA County. The mission of the LASPN is to promote public and professional awareness, education, training, and engagement regarding suicide and suicide prevention, intervention, and postvention in LA County. Through the collaboration of the various members of the Network, the LASPN is working to leverage the talent and resources available locally to work towards comprehensive suicide prevention.

Key activities of the LASPN include creating a county-wide strategic plan on suicide prevention, planning an annual Suicide Prevention Summit, implementing and coordinating suicide prevention planning and activities across different sections, populations, and systems.

FCP does not provide direct mental health services; however, the team provides community support and increases capacity of the LA County and City workforces, communities, and organizations in areas of suicide prevention, anti-stigma, birth to five services, Cognitive Developmental Disabilities (CDD), and parent partners. Prevention Services within FCP supports the following programs and partnerships:

- Prenatal to Five
- School Mental Health

- Partners in Suicide Prevention
- Los Angeles Suicide Prevention Network
- Stigma and Discrimination Reduction
- PEI Evidence-Based Programs (EBPs) for Children
- Parent Partner Training Academy (PPTA)
- Health Neighborhoods

The INN2 program is grounded in community capacity building and utilizes a bottom-up approach to address trauma, which empowers community agencies to partner with the community to provide outreach, group activities, and support/resources which are guided by the community's needs and preferences. Lead agencies utilized disparities data in their initial proposals to highlight the need and benefit of a community capacity building approach within their geographic neighborhood. These agencies were selected for INN2 because of the higher proportion of underserved or underrepresented community members facing trauma or economic disparities within those areas. While the capacity-building strategies utilized by each partnership may target similar populations such as families with young children or transition-aged youth (TAY), the resources and engagement events are unique and tailored by geographic and cultural communities. Also, since partnerships are embedded within the communities they support and have hired individuals from the community as community ambassadors, these agencies have a true understanding of the cultural identities and the barriers which impact access and awareness. Community ambassadors have lived experience and are linguistically representative of the communities they serve.

The culturally competent services are provided in the preferred language of the participants who are involved in the INN 2 project Community Ambassador:

- Commitment to the integration of cultural competency/trauma informed in all aspects of INN 2-CAN program
- Shared definition of cultural humility and trauma informed and operationalization (creating safe and welcoming environment, language capacity, no dominant language, prevent secondary trauma, commitment to self-reflection and addressing power unbalances, etc.)
- Self-assessment of current level of integration of cultural competence (organizational, staff, practice, clients, and participants)
- Continuous efforts to increase integration via training, coaching, capacity building, hiring of trained INN 2-CAN workforce
- Communicating and advocating about the efforts and need for cultural competency transformation
- Capturing voices of stakeholders regularly and frequently and adjusting accordingly

The INN 2-CAN program understands that underserved communities within Los Angeles County (LAC) have historically experienced high levels of financial instability, violence, and trauma accompanied by unmet mental and physical health needs and significant challenges to service access and knowledge. Underserved populations are disproportionately impacted by the negative outcomes of the pandemic and the economic, health, social, and emotional challenges that accompany them. The program's long-term

impact is intended to strengthen physical and mental health, promote wellbeing of the most vulnerable individuals and families in LA County and support recovery from trauma secondary to the COVID-19 health emergency. The INN 2-CAN continues evaluating the effectiveness of the program's goals and objectives, including long term outcomes for cultural competence. The evaluation focuses on activities carried out in high-need communities impacted by trauma and the COVID-19 pandemic.

INN 2 – CAN			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
Collaboration with faith-based and other trusted community entities/groups.	• Hiring CA(s) who are culturally representative with lived experience and reside within the identified community • INN 2-CAN providers and their sub-contracts collaborate with staff and communities to enhance cultural and linguistic competence through trainings, meetings, workgroups community events • Training CA's and CA Interns in the following: ➢ Community Resiliency Model (CRM) ➢ Emotional CPR / Mental Health First Aid ➢ LACDMH's "Becoming Trauma-Informed" and other general Trauma-Informed Care trainings ➢ Trauma-Informed Education / Training Practices	• INN 2-CAN staff and community participant self-reported perception of experience, indicators of wellbeing/protective factors • CA's and CA interns report use of knowledge and skills upon follow up with supervisors • Cultural competency efforts, trauma trainings, CRM and events are tracked in a monitoring system: INN2 Health Outcomes Management System (iHOMS)	• Cultural training/education dissemination as evidenced by collective tracking data from iHOMS and submitted to INN 2-CAN Admin Staff monthly • INN 2-CAN Providers continue to cooperate with LACDMH in the regularly scheduled monitoring of the program, including review of agency and program records, site visits, telephonic conferences, correspondence, and attendance at provider meetings where the providers adherence to the performance-based criteria will be evaluated
Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery	• INN2-CAN providers and sub-contractors continue to provide on-going training and meet within their agency and communities to address the Culture Competency and humility	• INN 2-CAN staff and community participants self-report perception of experience, indicators of wellbeing/protective factors	• INN 2-CAN Providers continue to cooperate with the INN 2-CAN in regularly scheduled monitoring of the program, including review of agency and program records, site visits, telephonic conferences, correspondence, and

INN 2 – CAN			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
			attendance at provider meetings
Interagency Collaboration	• INN 2-CAN Providers participated in a Cultural Competency Workgroup. The primary purpose of the Cultural Competency Workgroup: ➢ Develop a cultural competency/humility framework. The development of this common framework was tailored to the goals of INN 2 ➢ Adopt a learning approach within the current evaluation activities and aim to measure the progress over time • The development of a cultural competency self-assessment, as well as developing learning goals for the workgroup	• During the discussion of the purpose, participants did elevate questions about the connection of this work to that of the overall evaluation ➢ Sharing the disconnection between the outcome measures and the application of cultural competence ➢ The Interagency collaboration workgroup went through an interactive activity influenced by design thinking methods that used different analogies. ➢ The diversity of the workgroup determined each INN 2-CAN provider is in different place on the journey toward cultural competence	• Self-Assessment Questionnaire was administered and captured samples of mainstream and extreme situations: ➢ Over 85% of INN 2 partners felt that their partnerships use positive communication techniques with community members, including the use of "people-first" and descriptive language to describe community members rather than labels or characterizing terms. ➢ The percentage of INN 2-CAN partners who agreed with the communication items increased for partners who completed both the current assessment
Investments in learning (e.g., Innovation Plan)	• All providers' communication is translated in the languages of the communities they serve • Interpretation is always provided during the program activities. These include the partnership meetings, NLG meetings and all innovations related learning activities • Two-hour cultural humility training during providers regularly scheduled monthly partnership meetings. The trainings focused on the	• Culturally responsive to the needs of community members including making learning resources and information available in the languages spoken by the communities	• Teacher-led committee discussion on school transformation that includes trauma informed practices and policies that promote safety, connection, and self-regulation

INN 2 – CAN			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	foundation concepts of diversity, privilege, intersectionality, and cultural humility		
Coordination of language interpreter and closed captioning in real-time services for consumer, family member, and community member participation in clinical appointments and stakeholder meetings	• Requested interpreter services through LACDMH for Learning Session, CAN Plan Meeting, and any other meeting that need the interpreter services. Spanish was requested monthly	• Strategy 7 Culturally Competent Non-Traditional Self-Help activities for Family with Multiple Generations experiencing Trauma. Activities are held in different LA County languages	• Outcomes have not been collected
Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	• The hiring of the CANS who are ethnically and linguistically diverse to serve communities. CAN educates the community about the trauma, physical/mental health, coping skills, and resilience to promote recovery and wellbeing. CAN conducts culturally appropriate outreach, education, and engagement and culturally appropriate intergenerational family wellness screening.	• Each Staff will receive ongoing training to address the culture that is served in their community	• Training that addresses the cultural awareness and the reassurance that each staff is getting the proper training
Programs that target specific ethnic and language groups	• INN 2 Strategy 7 Culturally Competent Non-Traditional Self-Help activities for Family with Multiple Generations experiencing Trauma. Strategy 7 targets all cultures including diverse racial, ethnic, and language groups	• Each program successfully establishes agency partnerships. The assessment was conducted in a partnership with the strength and impact on the community, methodology, and tools determined by LACDMH and with the community	• Monthly assessment with data that the worker and staff inputting into the iHOMS systems and monitored by University of California San Diego (UCSD)

INN 2 – CAN			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
		input regarding specific ethnic group	
Training/case consultation	• Weekly meetings and ongoing training within the providers that address the Culture	• Training plan was created by LACDMH to assure that each provider was getting the training that was required by LACDMH and the Statement of Work (SOW)	• Monitoring each month UCSD (iHOMS)
Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	• Community meetings in the Services Areas addressing the issues within the community and promoting wellness	• Each community's partnerships and CANS related to each strategy implemented will be assessed for effectiveness in identifying serving and supporting those at risk of or experiencing trauma	• 100% of survey participants reported that they received services that were culturally competent and relevant and provided in the preferred language of each participant.
Utilization of the workforce's responses to cultural competence organizational assessments, survey and focus group to address knowledge gaps and support advancements in cultural competence.	• Implementation of a cultural competency group specifically for providers	• INN 2 and CAN capacity and leadership assessment were implemented and were compared over the term of the project. Cultural competence measures were determined by LACDMH and were monitored by the Evaluation team with the input from the community and leaders ongoing	• Monthly monitoring by the evaluation team at UCSD

Promotores de Salud Mental and the United Mental Health Promoters (UMHP) Program

The Promotores de Salud Mental and the United Mental Health Promoters (UMHP)' program strives to reduce stigma associated with mental illness among underserved cultural and linguistic communities in Los Angeles County (LAC) by increasing awareness about mental health issues, removing barriers, and improving timely access to culturally and linguistically appropriate care and resources.

The Promotores de Salud Mental Program was a pilot program initiated in 2010-2011 within the Latino, Spanish-speaking community. The UMHP Program is the multi-cultural expansion of the original program. The UMHP expansion started in November 2020. The unified programs merge a community leadership/peer-to-peer approach with support, guidance and training from LACDMH licensed clinicians. In addition, Senior and Supervising Community Health Workers who once served as Promotores and/or peer advocates provide mentorship and share knowledge and lived experiences to further support Mental Health Promoters.

The Promoters possess a high degree of passion and commitment to helping others and have a profound desire to improve their communities. They have served as leaders in peer support networks, health centers and other community organizations. Many have lived experience or have cared for family members with mental health conditions; thus, they possess a unique understanding and skill set. This experience, combined with the training provided by licensed clinicians on signs and symptoms of mental health, makes them effective in preventing and mitigating mental health disorders. They are ideal in helping and supporting residents of their communities with mental health awareness.

Promoters are from the communities they serve, and prior to the 2020 pandemic closures, they delivered face-to-face mental health workshops and resources in safe and trusting spaces within their communities. Following the pandemic closures, Promoter activities shifted to virtual platforms, and in the FY 20-21 reporting period, most workshops and linkages continued to be delivered online. Within a notable exception, partnerships with Los Angeles County (LAC) Board of Supervisors (BOS) staff were initiated in April 2021 to conduct vaccine outreach activities in-person at vaccination sites and other community locations.

Communities of color bear a high and unequal burden in accessing and receiving health and mental health services. The impact of COVID-19 on already marginalized communities further exacerbates long-standing inequities that pervade the health care system and society at large. The communities served by the Promoters have been hardest hit by the pandemic, with residents getting sick and dying from COVID-19 at rates far exceeding white and primarily English-speaking communities. Each LAC community has its own unique set of challenges, and Promoters, being from the communities they serve, are acutely aware of these challenges. Demographic data used by the UMHP program further inform targeted outreach and service needs, including implementation of culturally relevant and geographically accessible referrals to areas in greatest need. Promoters' unique skills set allow them to provide culturally relevant services to address residents' most pressing mental health concerns while adeptly shifting their efforts when needed to focus on emerging and rapidly evolving situations.

The UMHP program's projects and activities have been contributing to LACDMH's provision of culturally and linguistically competent services as follows.

- *Reduce stigma* - Through shared life experience, Promoters normalize the experience of living with a mental health condition. Through self-reflection and appropriate self-disclosure, Promoters are better able to support community residents in examining their thoughts and feelings about mental health issues.

- *Educate communities* – Promoters inform their communities about the signs and symptoms of mental health conditions and the impact of COVID-19 on mental and emotional health. Presentations address the impact that social determinants of health (e.g., neighborhood and physical environment, socioeconomic status, and social support networks) may have on how individuals and families experience mental health conditions and how they are treated. Promoters are not only trained on specific modules, but also on core competencies, such as how to engage communities, active listening, and public speaking.
- *Assist community residents in accessing care* – Promoters map out the communities they serve to identify culturally appropriate and geographically accessible resources. They utilize the information to link community members to a wide range of social services. Based on the resident's needs and preferences, Promoters are the bridge between community members and formal and informal service settings, making referrals to settings such as support groups, women's centers, regional centers, Head Start, University of Southern California (USC) Wellness, community-based organizations, and mental health programs.

For residents facing cultural, linguistic, and economic barriers to mental health resources, providing the opportunity to receive services from knowledgeable members of their own communities means that significant mental health problems can begin to be addressed sooner and possibly be prevented from becoming worse with time. The program provides an effective, economically feasible approach to offer culturally responsive grass-roots mental health outreach, engagement and education to communities that may feel mistrust of government organizations or otherwise be unable to access mental health resources.

Promotores de Salud Mental & United Mental Health Promoters Program		
Strategy Description	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
1) Due to attrition, increase the number of Promoters in the Promotores de Salud Mental Program. Expand the program to incorporate the United Mental Health Promoter Program to include additional underserved cultural communities: • American Indian/Alaska Native (AI/AN) • Asian/Pacific Islander (API)	A significant recruitment effort was initiated in the Fall of 2020 to expand language capacity. Through recruitment, building trust with underserved communities and program promotion, community helped disseminate the job posting. Candidates with a second language were supported with the job application process by program staff.	By the end of FY 20-21, Language capacity included Amharic, Chinese, English, Khmer, Korean, Spanish

Promotores de Salud Mental & United Mental Health Promoters Program		
Strategy Description	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
• Black and African Heritage (BAH) • Eastern European/Middle Eastern (EE/ME) • People with Disabilities • LGBTQIA2-S		
2) LACDMH and the UMHP program staff collaborated with UCLA BASIC-T to update training content to address the mental health effects of COVID-19, and tailor workshops to priority populations' needs using a train the trainer model.	UMHP Promoters and program staff attended COVID-19-related trainings and collaborations to update workshops in response to the pandemic and priority populations being served.	UMHP program staff participated in culturally focused trainings on vaccines (*My Turn: COVID-19 Vaccines, ¡Tu Turno!: Las Vacunas de COVID-10);* COVID and the Brain; and COVID and Return to School. Program staff then provided Promoters with trainings and updated PowerPoint slides.
3) Promoters delivered mental health awareness workshops to communities across all eight service areas.	Workshops covered 15 different topics including: • COVID-19 and Emotional Wellbeing • COVID-19 and Impact on the Brain • COVID-19 and Impact on Returning to School • Mental Health and Stigma During COVID-19 • COVID-19 and Symptoms and Treatment of Depression • Impact of COVID-19 on Anxiety in Adults • COVID-19: Recognizing Grief and Loss • Drug and Alcohol Prevention During COVID-19 • Family Violence Prevention During COVID-19 • Child Abuse Prevention During COVID-19 • Suicide Prevention During COVID-19 • Childhood Disorders – Neurodevelopmental Disorders	In FY 20-21, 6,735 is the number of total workshops conducted by Promoters (July 2020-June 2021). 55,005 is the total number of attendees counted in the 6,735 workshops. The demographics are collected by the state's survey- SDR-Stigma and Discrimination Reduction Survey managed by the Training and Outcomes Division Team -Drs. Joshua Cornell and Sharon Chapman.

Promotores de Salud Mental & United Mental Health Promoters Program		
Strategy Description	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
	• Childhood Disorders – Anxiety, Depression • Childhood Disorders- Other- Bipolar, PTSD, ODD, Conduct Disorder • Estrés Emocional Traumático Debido al Clima de Inmigración [SPANISH ONLY] Promoters supporting API communities in SAs 2,3,4,7,8, and Promoters supporting AI/AN communities in SA 8 prepared to deliver workshops by participating in training and curriculum development.	
4) Promoters provided linguistically and culturally relevant referrals and linked residents.	Referrals and linkages were provided to resources including support groups, mental health clinics, legal aid, substance abuse treatment, food banks, rental assistance and COVID-19 testing.	In FY 20-21, A total of 3,837 referrals were documented.
5) Promoters provided outreach in SAs 3, 4, and 7 in collaboration with the Board of Supervisors staff at Vaccine sites, LA County Point of Dispensing (POD) sites, Community Centers, Schools, Food Distribution Events, Parks, Housing Sites, Swap Meets and other locations.	Promoters provided vaccine information and support as well as mental health resources at outreach events.	In April through June 2021 Promoters' outreach efforts reached an estimated 31,591 LAC residents.
6) The Program recruited Promoters through collaboration with community-based, faith-based organizations, LACDMH UsCCs, SALTs, community town hall meetings, word of mouth, using our existing Promoters who are leaders in their	The program successfully onboarded 135 Promoters. Recruitment included help with resumes, assistance with navigating the online LAC HR application process, collaborating with UsCC to ensure cultural and language expertise during the interviewing process, conducted interviews, tracked the HR process, onboarded.	The program will continue this effort until 300 Promoters are onboarded.

Promotores de Salud Mental & United Mental Health Promoters Program		
Strategy Description	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
local communities. The program staff helped applicants one-on-one and through group settings. Staff put forth workshops and trainings in navigating the county Human Resources system.		
7) The UMHP Program continued the process of adapting workshops to be responsive to COVID-related mental health and well-being issues; these workshops were also being tailored to priority populations	The program has curriculum workgroups which include individuals with cultural and language expertise. Members include Promoters, Clinicians, Senior Community Health Worker (CHW), and Supervising CHW.	The adapted curriculum is taken into the community to ensure cultural and linguistic competence and their feedback is incorporated.

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Service Area-Based Outreach and Engagement (O & E) Activities

LACDMH considers SA wide O&E Work group to be critical activities that embody cultural competence within the framework of the Department's vision of hope, wellbeing, and recovery. Education is the primary purpose of these activities – in particular, educating the community about mental health issues in a manner that meets the audience where they are. For example, going into an ethnic community to talk about suicide may not be successful given the stigma associated with this topic. Since O&E Work teams have developed effective working relationships with local community-based organizations and community groups over time, they present information in more accessible and less stigmatizing approaches, building stronger connections with residents.

LACDMH O&E activities exemplify the Department's commitment to form partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations, and other County Departments to achieve the promise of the MHSA especially for underserved, unserved, inappropriately served, and hard-to-reach populations.

Members of the SA O&E Workgroup engage in the following activities:

- Targeted outreach activities in each Service Area
- Conduct outreach at health fairs and conferences
- Network with agencies, schools, providers, and community groups to offer presentations to the community at large
- Collaborate with various community organizations
- Conduct presentations to community members regarding community mental health resources and mental health education
- Educate community members on how to access mental health resources
- Translation of presentation materials into the preferred language of the intended audience
- Conduct online research and compile resources for parents and community members

The following table shows the examples of O & E Workgroup activities across all eight (8) SAs for FY 20-21.

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O & E SAMPLE ACTIVITIES
ACROSS ALL EIGHT (8) SERVICE AREAS (FY 20-21)

SERVICE AREA (SA) 1		
Month-Year	**Event**	**Number of People Reached**
Jul-20	Self-Care during COVID Presentation Location: Online	20
Jul-20	Backpack & School Supply Giveaway event Location: Christ Church of the Valley	400
Aug-20	Backpack event - Desert Vineyard Church	800
Aug-20	Virtual Community Event: LIBERTY Dental Plan LA County	120
Sep-20	Suicide Prevention Network Suicide Prevention Summit - Sage Middle School	100
Sep-20	Red Cross Community Conversations Event - City of Hope/Lancaster	140
Sep-20	AV Youth Fest Anxiety and Depression Presentation - Virtual	15
Oct-20	Antelope Valley College Community Resource Fair - Antelope Valley Partners for Health	150
Oct-20	October AV Health Neighborhood Meeting - Case Management Seminar	75
Oct-20	Black Infant Health Virtual Resource Fair - Virtual/Online	100
Oct-20	Maternal Mental Health Presentation for AV AAIMM CAT - Virtual/Online	85
Sep-20	Candy Crawl Event - AV Lancaster Clinic	150
Nov-20	Wellness Symposium - Virtual/Online	100
Nov-20	Black Mental Health Resource Fair - Virtual/Online	42
Nov-20	Coping though the Holidays Presentation for Av AAIMM CAT - Virtual/online	50
Dec-20	Mental Health Training to SA 2 Partners - Online/virtual	55
Dec-20	Day of Giving Event - Christ Church of the Valley	500
Dec-20	Surviving Stress During the Pandemic Presentation - Online/Virtual	60
Dec-20	Virtual Fun House Scavenger Hunt - Online/Virtual	10
Jan-21	DMH Virtual Fun House - Online/Virtual	15
Jan-21	Virtual Scavenger Hunt - Online/Virtual	10
Feb-21	A Virtual Photovoice Gallery Event by the Smoke-Free AV Lancaster Coalition - Virtual/Online	98
Feb-21	Black mental Health Task Force Virtual Resource Fair - Online/Virtual	58

Feb-21	Virtual Fun House	10
Mar-21	Maternal Mental Health Training for Service Providers - Online/Virtual	50
Mar-21	Youth mental Health Presentation for Project Joy - Online/Virtual	15
Mar-21	AVC Student Services Happy Healthy You MG Presentation - Online/Virtual	50
Apr-21	HOPE Drive-Thru Event - Foundation Christian Ministries Church	500
May-21	Women's Forum - HN Online/Virtual Event	60
May-21	Youth Mental Health Presentation for Project Joy - Online/Virtual	17
May-21	C.R.E.A.T.E. Art Show - Online/Virtual	23
Jun-21	Father's Day Drive Thru - Admin Parking Lot	100
Jun-21	UR loved Event - Crosswind Church	100

SERVICE AREA 2		
Month-Year	**Name of Event**	**Number of People Reached**
Jun-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	18
Jun-20	Virtual SA 2 Clergy & Community Meeting	25
Jul-20	Virtual SA 2 Clergy Roundtable Monthly Meeting	10
Jul-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	38
Aug20	Virtual SA 2 Clergy Roundtable Monthly Meeting	9
Aug-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	41
Aug-20	SA 2 Virtual COVID-19 Youth Townhall	38
Sep-20	SA 2 Virtual Suicide Prevention Training for Faith-Based Leaders/Clergy	25
Sep-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	43
Oct-20	Virtual SA 2 Clergy Roundtable Monthly Meeting	10
Oct-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	42
Noc-20	Addressing Mental Health with Local SA 2 University Students	39
Dec-20	Virtual SA 2 Clergy & Community Meeting	30
Dec-20	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	41
Dec-20	San Fernando Valley Refugee Children's Center Holiday Food Giveaway Event	100

Jan-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	45
Jan-21	Virtual SA 2 Clergy Roundtable Monthly Meeting	7
Feb-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	32
Feb-21	Virtual SA 2 Clergy Roundtable Monthly Meeting	8
Mar-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	30
Mar-21	Virtual SA 2 Clergy & Community Meeting	10
Apr-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	38
Apr-21	Virtual SA 2 Clergy Roundtable Monthly Meeting	7
May-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	35
May-21	Virtual SA 2 Clergy Roundtable Monthly Meeting	7
Jun-21	LACDMH- SA 2 COVID-19 Vaccine Community Event in Partnership with SA 2 Clergy/Congregation	45
Jun-21	Virtual SA 2 Clergy Roundtable Monthly Meeting	6
Jun-21	Virtual SA 2 Health Neighborhoods Collaborative Monthly Meeting	38

SERVICE AREA 3		
Month-Year	**Name of Event**	**Number of People Reached**
Jul-20	A 3 Maternal Mental Health AdHoc Group (virtual meeting)	8
Jul-20	Meeting with Pasadena City College Staff (virtual meeting)	3
Jul-20	East San Gabriel Valley Health Neighborhood (virtual meeting)	5
Jul-20	SA3 Interfaith Clergy Roundtable Meeting (virtual meeting)	6
Jul-20	El Monte Health Neighborhood (virtual meeting)	4
Aug-20	African American Infant and Maternal Mortality (AAIMM) (virtual meeting)	3
Aug-20	BVS Crime Roundtable (virtual meeting)	3
Aug-20	BVS Crime Roundtable (virtual meeting)	3
Aug-20	Glendora RCA (virtual meeting)	6
Aug-20	Triage	1
Sep-20	African American Infant and Maternal Mortality (AAIMM) (virtual meeting)	3
Sep-20	East San Gabriel Valley Health Neighborhood	5

Sep-20	Glendora RCA (virtual meeting)	6
Sep-20	SA3 Interfaith Roundtable Meeting (virtual meeting)	7
Sep-20	SPIRTT Family Services PFF (virtual meeting)	2
Sep-20	African American Infant and Maternal Mortality (AAIMM) (virtual meeting)	8
Sep-20	El Monte Health Neighborhood (virtual meeting)	6
Oct-20	African American Infant and Maternal Mortality (AAIMM) (virtual meeting)	3
Oct-20	East San Gabriel Valley Health Neighborhood (virtual meeting)	5
Oct-20	Glendora RCA	8
Oct-20	SA3 Interfaith Roundtable Meeting (virtual meeting)	7
Oct-20	African American Infant and Maternal Mortality (AAIMM)	4
oct-20	SA 3 African American Maternal Mental Health Event (virtual meeting)	1
Nov-20	SA 3 Clergy Roundtable	5
Dec-20	San Gabriel Valley Maternal Mental Health (virtual meeting)	9
Dec-20	San Gabriel Valley Door to Door Deliveries holiday event (virtual meeting)	8
Dec-20	San Gabriel Valley Door to Door Deliveries Holiday Planning (virtual meeting)	6
Jan-21	San Gabriel Valley Maternal Mental Health Workgroup (virtual meeting)	9
Jan-21	SA 3 ESGV Health Neighborhood (virtual meeting)	3
Jan-21	SA 3 Clergy Roundtable (virtual meeting)	5
Jan-21	El Monte Health Neighborhood (virtual meeting)	6
Feb-21	SGV MMH Workgroup (virtual meeting)	5
Feb-21	San Gabriel Valley MMH Planning (virtual meeting)	8
Mar-21	Health Neighborhood Data Workgroup (virtual meeting)	9
Mar-21	SGV Planning Workgroup (virtual meeting)	7
Mar-21	SGV MMH Adhoc (virtual meeting)	6
Mar-21	SGV Dark Side of the Full Moon (virtual meeting)	3
Mar-21	Outreach and Engagement (phone call)	160
Mar-21	Outreach and Engagement (phone call)	131

Apr-21	Asian American Health Initiate COVID (virtual meeting)	8
Apr-21	RCA	7
Apr-21	Asian American Pacific Islander Workgroup (virtual meeting)	2
Apr-21	SGV AAIMMH	1
Apr-21	SGV African American Maternal Mental Health (virtual meeting)	6
Apr-21	Asian American Pacific Islander COVID Workgroup (virtual meeting)	11
May-21	Asian American Pacific Islander COVID Workgroup (virtual meeting)	8
May-21	SA 3 Faith Based (virtual meeting)	2
May-21	SGV African American Maternal Mental Health (virtual meeting)	6
May-21	Hilda Solis COVID 19 Resource Fair	300
Jun-21	2021 SPIRITT connect resources	1
Jun-21	ESGV Health Neighborhood (virtual meeting)	5
Jun-21	SA 3 Clergy Roundtable (virtual meeting)	4
Jun-21	SPIRITT (virtual meeting)	3
Jun-21	BVS (virtual meeting)	3
Jun-21	El Monte Health-Neighborhood (virtual meeting)	4

SERVICE AREA 4		
Month-Year	**Name of Event**	**Number of People Reached**
Jul-20	Hollywood Neighborhood Meeting	29
Jul-20	Boyle Heights Neighborhood Meeting	21
Aug-20	Boyle Heights Neighborhood Meeting	20
Aug-20	Hollywood Neighborhood Meeting	26
Sep-20	Hollywood Neighborhood Meeting	19
Sep-20	Boyle Heights Neighborhood Meeting	24
Sep-20	Louie Clinic Event	15
Oct-20	Catholic Archdiocese	43
Oct-20	Hollywood Neighborhood Meeting	32

Oct-20	Boyle Heights Neighborhood Meeting	21
Nov-20	Louie Clinic	22
Dec-20	Louie Clinic	20
Mar-21	Louie Clinic	25
Mar-21	Boyle Heights Neighborhood Meeting	18
Mar-21	Hollywood Neighborhood Meting	18
Mar-21	Louie Clinic	22
Apr-21	Collaborative Meeting with Boyle Heights & Hollywood Neighborhood	45
Apr-21	Louie Clinic	25
May-21	Collaborative Meeting with Boyle Heights & Hollywood Neighborhood	36
May-21	Louie Clinic	18
Jun-21	Juneteenth Resource Event	76
Jun-21	Boyle Heights Neighborhood Meeting	29
Jun-21	Hollywood Neighborhood Meeting	20
Mar-21	Skid Row Wellness Resource Fair	36

SERVICE AREA 5		
Month/Year	**Description/Name**	**Number of People Reached**
Jul-20	Faith-based Advocacy Committee (FBAC)-Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders and Reps from Agencies with tools they can use to create/encourage healthy emotional well-being to their community	27+
Jul-20	Clergy Roundtable-Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing.	6
Jul-20	COVID-19 Updates/Resources-Email Blast Email Blast of Resources and Support during COVID-19	1000+
Aug-20	FBAC-Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representatives.	25
Aug-20	Allies for Every Child Network Meeting-Promoting Mental Health with Community members, partners, providers, law enforcement.	20

Aug-20	All Faith Quarterly Virtual Meeting-Promoting Mental Health with Community members, partners, providers, law enforcement consumers and Faith community members.	22
Aug-20	Clergy Roundtable-Engage Faith Leaders and Therapist: Creating opportunity for faith community to embrace mental health services.	7
Aug-20	Westside Faith Coalition-Collaborate with Faith Community and Agencies to encourage healthy emotional wellbeing.	17
Aug-20	Email Blasts to the community-Provide many Resources for Safe and happy living during this COVID-19 time.	1000+
Sep-20	FBAC-Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representatives.	22
Sep-20	Allies for Every Child Network Meeting-Promoting Mental Health with Community members, partners, providers, law enforcement.	18
Sep-20	Clergy Roundtable-Engage Faith Leaders and Therapist: Creating opportunity for faith community to embrace mental health services.	6
Sep-20	Faith Meeting: Westside Coalition-Collaborate with Faith Community and Agencies to encourage healthy emotional wellbeing.	19
Sep-20	Email Blasts to the community-Provide many Resources for Safe and happy living during this COVID-19 time.	1000+
Sep-20	West LA Health Neighborhood + Handle with Care Community Event-Promoting Mental Health with Community members, partners, providers, law enforcement and consumers.	70
Oct-20	Faith Based Advocacy Council -Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	37
Oct-20	Clergy Roundtable- Promoting all faith with Faith Leaders.	3
Oct-20	Virtual Community Event Preparation: Allies for Child's Arts Festival Outreach Event Swag Promoting Mental Health to children, parents, patrons, and consumers.	49
Oct-20	Virtual Community Event Preparation: Allies for Child's Arts Festival Outreach Event Swag Promoting Mental Health to children, parents, patrons, and consumers. LACDMH Wellbeing PowerPoint presentation.	9
Oct-20	SA 5 Email Blast Resources Promoting Mental Health with Community members, partners, providers, law enforcement consumers by email disbursements.	1000+
Oct-20	BVS/Crime Survivors Zoom Roundtable Meeting-Attending LA County District Attorney's Office, Understanding crime survivors, abuse victims, domestic violence and victims of crime discussions	125

	with Crime Advocates, Law Enforcement, FBI, L.A. Co. Probation Department and L.A. Co. Districts Attorney' s Office.	
Nov-20	Faith Based Advocacy Council -Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	10
Nov-20	Clergy Roundtable- Promoting all faith with Faith Leaders.	5
Nov-20	Virtual Community Event Preparation: Allies for Child's Arts Festival Outreach Event Swag Promoting Mental Health to children, parents, patrons, and consumers.	4
Nov-20	SA 5 Email Blast Resources Promoting Mental Health with Community members, partners, providers, law enforcement consumers by email disbursements.	900+
Nov-20	BVS/Crime Survivors Zoom Roundtable Meeting-Attending LA County District Attorney's Office, Understanding crime survivors, abuse victims, domestic violence and victims of crime discussions with Crime Advocates, Law Enforcement, FBI, L.A. Co. Probation Department and L.A. Co. Districts Attorney' s Office.	117
Nov-20	Faith Meeting: Westside Coalition-Collaborate with Faith Community and Agencies to encourage healthy emotional wellbeing.	25
Dec-20	Partner with Allies for Every Child & Health Neighborhoods Purpose: Plan Community Outreach Event to encourage emotional wellbeing & Food Security	3
Dec-20	FBAC- to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	
Dec-20	Clergy Roundtable- Promoting all faith with Faith Leaders.	5
Jan-21	Westside Mental Health Network-Collaboration amongst various Mental Health agency (Networking)	17
Jan-21	FBAC- to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	45
Jan-21	Westside Faith Coalition Celebrating Martin Luther King-Collaboration: Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation/people they serve.	112
Jan-21	Mar Vista Neighborhood Planning Meeting Purpose: Engage Community Members/Stakeholders- Opportunity to Community Capacity Build Mental Health Awareness. To do presentations for the community.	35
Jan-21	COVID-19 Updates/Resources-Email Blast- Email Blast of Resources and Support during COVID-19	1200+

Feb-21	Meeting With Nisa Kove-LA City-Goals to Help the Homeless in Culver City	13
Feb-21	SA 5 Clergy Roundtable & All Faith Quarterly Faith Gathering-Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation.	21
Feb-21	Religion and Domestic Violence Issues: Committee Collaboration: Promoting Healthy Emotional Wellbeing.	15
Feb-21	Health Neighborhood Summit Collaboration: Promoting Healthy Emotional Wellbeing. Networking	65
Feb-21	FBAC- to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	42
Feb-21	Westside Faith Coalition: Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation/people they serve.	63
Feb-21	COVID-19 Updates/Resources-Email Blast- Email Blast of Resources and Support during COVID-19	2100+
Feb-21	Westside Mental Health Network Collaboration among various Mental Health agency (Networking)	17
Mar-21	Westside Mental Health Network-Collaboration among various Mental Health agency (Networking)	6
Mar-21	FBAC- to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	39
Mar-21	COVID-19 Updates/Resources-Email Blast- Email Blast of Resources and Support during COVID-19	2100+
Mar-21	Clergy Roundtable Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation.	6
Apr-21	Faith Based Advocacy Council-Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	44
	Interfaith Clergy and Mental Health Roundtable- Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation.	6
Apr-21	Westside Mental Health Network- Collaboration amongst various Mental Health agency (Networking)	6
Apr-21	AFSP Campus Walk “Team Riley” Collaboration amongst various Mental Health agency (Networking) and Community members. -	37
Apr-21	COViD-19 Updates/Resources-Email Email Blast of Resources and Support during COVID-19Blasts-	2100+

May-21	Allies Virtual Community Network Meeting-Collaboration amongst various Mental Health agency (Networking)	19
May-21	Religion and Domestic Violence Issues: Committee Collaboration: Promoting Healthy Emotional Wellbeing.	13
May-21	COViD-19 Updates/Resources-Email Blasts Email Blast of Resources and Support during COVID-19	2100+
May-21	Interfaith Clergy and Mental Health Roundtable All Faith Virtual Gathering Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation.	12
May-21	Westside Mental Health Network-Collaboration amongst various Mental Health agency (Networking)	8
May-21	Faith Based Advocacy Council Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	41
May-21	Health Neighborhood Summit Collaboration: Promoting Healthy Emotional Wellbeing (Networking)	65+
Jun-21	Crime Survivors zoom roundtable. DV Anti-Violence Issues. Collaboration: Promoting Healthy Emotional Wellbeing.	102
Jun-21	Westside Anti-Violence Issues: Authority Committee-collaboration promoting healthy emotional wellbeing and open dialogue	12
Jun-21	COViD-19 Updates/Resources- -email blasts of resources and support during COVID- 19	2100+
Jun-21	Faith Based Advocacy Council Monthly Microsoft Teams Virtual Meeting to promote Mental Wellbeing by having All Faith Leaders and Community members all together in one meeting sharing information. Collaboration with county-wide Faith based Council, Faith Leaders, Consumers, Community members, and various agencies representative	43
Jun-21	Westside Mental Health Network-Collaboration amongst various Mental Health agency (Networking) Interfaith Clergy and Mental Health Roundtable Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation	7
Jun-21	Interfaith Clergy and Mental Health Roundtable Promoting Healthy Emotional Wellbeing. Supporting Spiritual Leaders to encourage emotional healthy wellbeing in their congregation	6

SERVICE AREA 6		
Month-Year	**Name of Event**	**Number of People Reached**
Jun-21	Watts Vaccine Outreach Call (via Zoom)	11
Jun-21	COVID-19 Virtual Support Group	3

Jun-21	Watts Vaccine Outreach Call (via Zoom)	10
Jun-21	SA6 Virtual Clergy Breakfast	18
Jun-21	COVID-19 Virtual Support Group	2
Jun-21	Watts Vaccine Outreach Call (via Zoom)	8
Jun-21	Community Response System of South Los Angeles (Virtual)	22
Jun-21	South Los Angeles Health Neighborhood (Virtual)	33
Jun-21	COVID-19 Support Group	3
Jun-21	Watts Vaccine Outreach Call (via Zoom)	9
Jun-21	SLAHN Park Therapy Meeting	12
Jun-21	Westmont/West Athens Community Action for Peace Meeting (via Zoom)	18
Jun-21	COVID-19 Support Group	3
Jun-21	Animo Mae Jemison Middle School Back to School	9
Jun-21	SLASB AAIMM COE VirtualiTEA – A Community Conversation: Birthing & Parenting in the LGBTQIA2S+	50
May-21	EOPS/CARE Advisory Committee Meeting (via Zoom)	23
May-21	Best Start Compton/East Compton (via Zoom)	49
May-21	COVID-19 Support Group (via Zoom)	4
May-21	Watts Vaccine Outreach Call	10
May-21	SPA6 TAY Coordination Meeting (via Google Meets)	39
May-21	SLA Health Neighborhood Virtual Fair (via Zoom)	42
May-21	COVID-19 Support Group (via Zoom)	3
May-21	Watts Vaccine Outreach Call (via Zoom)	11
May-21	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	42
May-21	COVID-19 Support Group (via Zoom)	2
May-21	COVID-19 Support Group (via Zoom)	3
May-21	Westmont/West Athens Community Action for Peace Meeting (via Zoom)	21
May-21	SLASB AAIMM COE VirtualiTEA – Mental Health: A Focus on Families (via Zoom)	55
Apr-21	Best Start Westmont/West Athens (via Zoom)	57

Apr-21	TPI Street Outreach: Community Town Hall (via Webex)	49
Apr-21	Crime Survivors Zoom Roundtables	101
Apr-21	Casa Bella/SLA/SB AAIMM COE: Baby Bundle Toy Drive Thru Giveaway to culminate Black Maternal Health Week	143
Apr-21	SA6 Clergy Breakfast (via Microsoft Teams)	19
Apr-21	SA6 Homeless Collaborative Meeting (via Zoom)	43
Apr-21	The Return of Children to School During COVID-19 (via Microsoft Teams)	26
Apr-21	South Los Angeles Health Neighborhood (via Microsoft Teams)	33
Mar-21	Best Start Compton/East Compton (via Zoom)	50
Mar-21	LAPD Southeast Community Station Conference Call (via conference call)	25
Mar-21	SA6 Clergy Breakfast Presents: Women of Faith VirtualiTea Conference (via Microsoft Teams)	71
Mar-21	South Los Angeles Health Neighborhood (via Microsoft Teams)	38
Mar-21	SPA6 TAY Coordination Meeting (via Google Meets)	47
Mar-21	Westmont/West Athens Community Action for Peace Meeting (via Zoom)	19
Feb-21	Best Start Compton/East Compton (via Zoom)	52
Feb-21	Best Start Westmont/West Athens (via Zoom)	71
Feb-21	Best Start Broadway/Manchester (via Zoom)	66
Feb-21	Service Area 6 Clergy Breakfast (via Microsoft Teams)	21
Feb-21	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	42
Feb-21	SLASB AAIMM COE Virtual TEA – Preconception, Pregnancy & Beyond: Heart Health and Nutrition (via Zoom & Facebook Live via Black Infants & Families Page)	222
Jan-21	Best Start Westmont/West Athens (via Zoom)	55
Jan-21	LAPD Southeast Community Station Conference Call (via conference call)	22
Jan-21	Best Start Compton/East Compton (via Zoom)	69
Jan-21	South Los Angeles Health Neighborhood (via Microsoft Teams)	29
Jan-21	Westmont/West Athens Community Action for Peace (via Zoom)	17
Jan-21	SLASB AAIMM COE VirtualiTEA – Well Baby Visits (via Zoom)	30

Dec-21	Service Area 6 Clergy Breakfast (via Microsoft Teams)	21
Nov-20	SLASB AAIMM CAT VirtualiTEA Takeover (via Zoom & Facebook Live via Black Infants & Families Page)	102-273
Nov-20	Best Start West Athens/Westmont (via Zoom)	40
Nov-20	DPH: Youth Community Forum (via Webex)	42
Nov-20	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	36
Nov-20	SLASB AAIMM COE VirtualiTEA – Prematurity Awareness Month (via Zoom & Facebook Live via Black Infants & Families Page)	211
Oct-20	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	42
Oct-20	SD2/SNN Back2School Event At Earvin “Magic” Johnson Park (905 E El Segundo Blvd, Los Angeles, CA 90059).	750
Oct-20	SLASB AAIMM COE VirtualiTEA – Black Birthing Bill of Rights (via Zoom & Facebook Live via Black Infants & Families Page)	140
Sep-20	Manchester/Broadway Best Start (via Zoom)	29
Sep-20	SA6 Clergy Breakfast (via Microsoft Teams)	21
Sep-20	SLA/SB AAIMM CAT Bi-monthly Meeting (via Zoom & Facebook Live via Black Infant & Families Page)	48
Sep-20	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	35
Sep-20	SLASB AAIMM COE VirtualiTEA – Belly of the Beast & Forced Sterilization (via Zoom)	70
Aug-20	SLASB AAIMM COE VirtualiTEA – Black Breastfeeding Week (via Zoom & Facebook Live via Black Infants & Families Page)	731
Aug-20	Special Needs Network Speakers Night (via Zoom)	40
Aug-20	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	37
Aug-20	SLASB AAIMM COE VirtualiTEA – Revive, Reclaim & Restore Breastfeeding! A Multigenerational Panel (via Zoom & Facebook Live via Black Infants & Families Page)	619
Jul-20	SA6 Clergy Breakfast (via Microsoft Teams)	15
Jul-20	Community Forum: Violence, Racism, Violence (via Webex)	51
Jul-20	South Los Angeles Health Neighborhood Meeting (via Microsoft Teams)	41
Jul-20	SLASB AAIMM Communitywide Action Team (CAT) Bi-Monthly Meeting (via Zoom & Facebook Live via Black Infants & Families Page)	290

Jul-20	Empowerment Congress: Mental Health Committee Meeting (via Zoom)	20
Jul-20	South Los Angeles/South Bay (SLASB) African American Infant & Maternal Mortality (AAIMM) Community Outreach & Engagement (COE) VirtualiTEA – Black Maternal Health & Doula Chat (via Zoom & Facebook Live via Black Infants & Families Page)	526

SERVICE AREA 7		
Month-Year	**Name of Event**	**Number of People Reached**
Jul-20	Health Neighborhood	44
Jul-20	Clergy Roundtable	16
Jul-20	Clergy Breakfast	54
Jul-20	Holy Family Church Homeless Services Day	22
Aug-20	Health Neighborhood	33
Aug-20	Clergy Roundtable	5
Aug-20	Holy Family Church Homeless Services Day	32
Sep-20	Health Neighborhood	27
Sep-20	Clergy Roundtable	4
Sep-20	Holy Family Church Homeless Service Day	38
Oct- 20	Health Neighborhood	84
Oct- 20	Clergy Roundtable	9
Oct- 20	Clergy Breakfast	34
Oct- 20	Spiritt Family Services-Children's Halloween Drive Thru	50
Oct- 20	Holy Family Church Homeless Services Day (2 events)	70
Nov-20	Health Neighborhood	27
Nov-20	Holy Family Church Homeless Services Day	34
Dec-20	Health Neighborhood	21
Dec-20	Clergy Roundtable	4
Dec-20	Holy Family Church Homeless Services Day (2 events)	66
Dec-20	Salazar Park Xmas Senior Drive Thru	50
Dec-20	Salazar Park-Children's Holiday Celebration	50

Dec-20	Hilda Solis's ELA Civic Center Holiday Event	75
Dec-20	Veteran's Memorial Park Holiday Drive Thru	50
Dec-20	Commerce Senior Center Holiday Celebration	50
Jan-21	Health Neighborhood	24
Jan-21	Clergy Roundtable	5
Jan-21	Clergy Breakfast	24
Jan-21	Holy Family Church Homeless Services Day	36
Feb-21	Health Neighborhood	24
Feb-21	Clergy Roundtable	5
Mar-21	Health Neighborhood	28
Mar-21	Clergy Roundtable	6
Mar-21	Holy Family Church Homeless Services Day	48
Apr-21	Health Neighborhood	28
Apr-21	Clergy Roundtable	6
Apr-21	Clergy Breakfast	34
Apr-21	Holy Family church Homeless Services Day (2 events)	100
May-21	Health Neighborhood	24
May-21	Clergy Roundtable	4
May-21	Holy Family Church Homeless Services Day (3 events)	200
Jun-21	Health Neighborhood	24
Jun-21	Clergy Roundtable	4
Jun-21	Holy Family Church Homeless Services Day (6 events)	418

SERVICE AREA 8		
Month-Year	**Name of Event**	**Number of People Reached**
Jul-20	Community Services Coordinators / Housing / 4th Friday of the Month	15
Jul-20	Clergy RoundTable / 1st Tuesday of the Month	40
Jul-20	Clergy Breakfast / 3rd Tuesday of the Month	15

Jul-20	Health Neighborhood LB / 2nd Tuesday of the Month	10
Jul-20	Health Neighborhood Hawthorne / 3rd Thursday of the Month	5
Jul-20	Facebook Live presentation for Cambodian Buddhist Monk Society USA, on Mental Illness and Khmer History, along with Professor Hansen	20,000
Aug-20	Community Services Coordinators / Housing / 4th Friday of the Month	15
Aug-20	Clergy RoundTable / 1st Tuesday of the Month	30
Aug-20	Clergy Breakfast / 3rd Tuesday of the Month	25
Aug-20	Health Neighborhood LB / 2nd Tuesday of the Month	20
Aug-20	Health Neighborhood Hawthorne / 3rd Thursday of the Month	20
Sep-20	Community Services Coordinators / Housing / 4th Friday of the Month	10
Sep-20	Clergy RoundTable / 1st Tuesday of the Month	40
Sep-20	Clergy Breakfast / 3rd Tuesday of the Month	25
Sep-20	Health Neighborhood LB / 2nd Tuesday of the Month	15
Sep-20	Health Neighborhood Hawthorne / 3rd Thursday of the Month	10
Oct-20	Community Services Coordinators / Housing / 4th Friday of the Month	25
Oct-20	Clergy RoundTable / 1st Tuesday of the Month	30
Oct-20	Clergy Breakfast / 3rd Tuesday of the Month	30
Oct-20	Health Neighborhood LB / 2nd Tuesday of the Month	15
Oct-20	Health Neighborhood Hawthorne / 3rd Thursday of the Month	5
Nov-20	Community Services Coordinators / Housing / 4th Friday of the Month	30
Nov-20	Clergy RoundTable / 1st Tuesday of the Month	40
Nov-20	Clergy Breakfast / 3rd Tuesday of the Month	20
Nov-20	Health Neighborhood LB / 2nd Tuesday of the Month	25
Nov-20	Health Neighborhood Hawthorne / 3rd Thursday of the Month	6
Nov-20	Holiday meals for clients & families	10 families
Dec-20	Clergy RoundTable / 1st Tuesday of the Month	40
Dec-20	Health Neighborhood LB / 2nd Tuesday of the Month	20
Dec-20	Community vaccination day	50+

Dec-20	Toy drive to benefit Harbor UCLA Medical Center pediatric ward	100+
Dec-20	Holiday meals for clients & families	10 families
Jan-21	Community Services Coordinators / Housing	10
Jan-21	Clergy RoundTable / 1st Tuesday of the Month	30
Jan-21	Clergy Breakfast	10
Jan-21	Health Neighborhood Long Beach	15
Jan-21	Health Neighborhood Hawthorne	5
Feb-21	Community Services Coordinators / Housing	15
Feb-21	Clergy RoundTable / 1st Tuesday of the Month	40
Feb-21	Clergy Breakfast	15
Feb-21	Health Neighborhood LB	25
Feb-21	Health Neighborhood Hawthorne	10
Feb-21	Cerritos College APIDA Awareness Week Zoom presentation on Suicide in Asian Americans	25
Mar-21	Community Services Coordinators / Housing	20
Mar-21	Clergy RoundTable / 1st Tuesday of the Month	25
Mar-21	Clergy Breakfast	25
Mar-21	Health Neighborhood LB	20
Mar-21	Health Neighborhood Hawthorne	3
Mar-21	AAPI Listening Session for Mental health providers in U.S. through Southwest MH Technology Transfer Center	100
Mar-21	API Pilot Project presentation for DMH Program Head meeting	80
Mar-21	Grief & Loss for Palmdale City Council	26
Apr-21	Community Services Coordinators / Housing	15
Apr-21	Clergy RoundTable / 1st Tuesday of the Month	30
Apr-21	Clergy Breakfast	15
Apr-21	Health Neighborhood LB	10
Apr-21	Health Neighborhood Hawthorne	5
Apr-21	DMH CCC Panel Discussion on AAPI Hate Crimes	50
Apr-21	Mandarin TV interview on ETTV America on mental health issues and challenges during COVID-19 Pandemic	2500

Apr-21	Microsoft Teams presentation for APCTC on Asian Hate Crime, impact on providers and self-care	11
May-21	Community Services Coordinators / Housing	10
May-21	Clergy RoundTable / 1st Tuesday of the Month	40
May-21	Clergy Breakfast	10
May-21	Health Neighborhood LB	15
May-21	Health Neighborhood Hawthorne	10
Jun-21	Community Services Coordinators / Housing	20
Jun-21	Clergy RoundTable / 1st Tuesday of the Month	40
Jun-21	Clergy Breakfast	25
Jun-21	Health Neighborhood LB	20
Jun-21	Health Neighborhood Hawthorne	5
Jun-21	Cerritos Residents Against Asian Hate Crimes at Don Kanabe Regional Park	300

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

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

- Consumers and family members who are advanced in their own process are trained in leadership skills to facilitate support groups and then are mentored to implement and run support groups in Spanish
- Offering psychoeducational materials in Spanish, inspired by the needs and strengths of consumers and the community
- Running twenty (20) Spanish support groups with culturally relevant activities
- Offering activities facilitated by Peers within mental health clinics. Peers or "Compañeros de camino" (in Spanish) are incorporated into leadership teams and provide valuable assistance to others. As mental health consumers, peers maintain an active connection to their clinic or mental health center. Consequently, they are excellent liaisons for group members who require encouragement to get to the clinic,

as well as for consumers who are advanced in their recovery and need to take new steps to reintegrate into everyday life

- The support groups offer a place to process concerns, empower participants in managing their emotions, and advancing toward recovery
- Having Support Groups strategically located within organizations trusted by the Latino/Latinx community such as churches, libraries, community centers and hospitals. These groups attract high-risk participants who are not accessing mental health services due to stigma or lack of information
- From the support groups and with the experience accumulated over the years, the empowered members are serving their community in actions of prevention and promotion of mental health. Also, several group members have become LACDMH workers
- Support groups facilitate the expression of the cultural protective factors such as music, theater, arts and crafts, gastronomy, family ties and the celebration of cultural events. Engaging in these activities provides participants a unique opportunity to display and develop their skills while bonding with other consumers over shared experiences of wellness and recovery. LACDMH staff has designed curriculums and an implementation process for four (4) trainings related to art and mental health:
  - Theater training: learning theater techniques can help participants express and regulate their emotions, develop skills, improve communication skills, and body expressions, and increase awareness to combat stigma
  - Painting training: painting has a healing power and allows for a creative outlet for repressed emotions and helps individuals appreciate their self-worth
  - Arts and Crafts training: the act of building artistic objects or decorations helps participants feel empowered and creative, develop new skills, and feel useful
  - Music training: music and songs influence the emotion and can refresh moods. It also stimulates the creative sensibilities, the mind, and helps liberate from suffering or isolation

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

Support Groups in Spanish and Latinx Community Outreach		
Projects/Activities/Strategies	**Status / Progress**	**Monitoring / Outcomes / Findings**
2) Community Empowerment and Mental Health Training	Twelve (12)-week classes were provided for members of the Support Group leadership teams to participate in community outreach and empowerment actions.	Graduates participated in community outreach tasks and established collaboration with other local agencies.
3) Latino/Latinx Community Outreach through the Arts Project	Weekly classes facilitated by art teachers were offered including arts & crafts, painting, music, and theater.	Participants displayed their final products during cultural events throughout the year.
4) Leadership and Support Groups Facilitator's Training	This twelve (12)-week training was offered to individuals interested in becoming support group facilitators.	Graduates from this training reinforced leadership teams and facilitated the opening of new support groups in the community.
5) End of Year Celebration	The main purpose of this event was to celebrate the graduation of those who completed the trainings and to thank and highlight the achievements of the existing support group facilitators throughout the year.	Approximately 100 individuals participated in this community event and to celebrate their individual and collective achievements.
6) "Salud Mental y Bienestar" News87ocfletter	The newsletter reflects the activities of the support groups members and highlights the achievements on their road to recovery and empowerment.	Two (2) are published per year
7) Support Networks during Times of Crisis Bulletins	Two (2) volumes of the bulletins were distributed to group participants at the beginning of the COVID-19 pandemic.	Provided information about available resources and messages of encouragement, hope, and motivation Promoted resiliency and mental health through

Support Groups in Spanish and Latinx Community Outreach		
Projects/Activities/Strategies	**Status / Progress**	**Monitoring / Outcomes / Findings**
	Reading materials were also developed to help get out of social isolation.	motivational stories identified by participants Shared art projects that participants completed during the pandemic

This program increases access to mental health services and contributes to reducing disparities by engaging and training mental health consumers who are linguistically and culturally diverse. When necessary, peers accompany members to the clinics or help them get connected to the services that they need. Spanish speaking Peers bring significant help to new members and to consumers who have been in the system for many years. They motivate others to take steps, starting with the idea that "if he/she can succeed then I could do it too."

To achieve the program's objectives, the current staff makes an enormous effort to assure that twenty (20) support groups are running effectively. The leadership team for each group is made-up of volunteers, in some cases with more than 12 years of experience in that role.

SPANISH SUPPORT GROUPS COUNTY LEVEL DISTRIBUTION
FY 20-21

	Support Group name	Days/Time	Location	SA
1 *	Placita Olvera SG	Wednesdays 9-11 am	Queen Los Angeles Church 535 N Main St Los Angeles, CA 90012	SA 4
2 *	El Sereno SG	Tuesdays 6-8 pm	El Sereno Library 5226 Huntington Dr S. Los Angeles, CA 90032	SA 4
3 *	El Monte SG	Fridays 4-6 pm	Pacific Clinic 9864 Baldwin Pl El Monte CA 91731	SA 3
4 *	West Central SG	Thursdays 4-6 pm	West Central MHC 3741 Stocker St Los Angeles CA 90063	SA 6
5	East LA SG	Thursdays 10-12 pm	Anthony Quinn Library 3965 Cesar E Chavez Ave Los Angeles CA 90063	SA 7
6 *	Whittier SG	Thursdays 6-8 pm	Presbyterian Hospital 12401 Washington Blvd Whittier CA 90602	SA 7
7 *	Huntington Park SG	Fridays 10-12 pm	Rio Hondo W Center 2677 Zoe Ave H Park CA 90255	SA 7

	Support Group name	Days/Time	Location	SA
8 *	Torrance SG	Tuesdays 4-6 pm	Harbor UCLA MC 1000 W Carson St Torrance CA 90509	SA 8
9 *	San Pedro SG	Wednesdays 4-6 pm	San Pedro Church 575 W O'Farrell St. San Pedro CA 90731	SA 8
10 *	Hawthorne SG	Tuesdays 9-11 am	San José Church 11901 W 119 St Hawthorne CA 90250	SA 8
11	Lennox SG	Wednesdays 9-11 am	Lennox C. Serv. Center 4343 Lennox Blvd Lennox CA 90304	SA 8
12 *	Wilmington SG	Mondays 4-6 pm	Sagrada Familia Church 1122 E Rubidoux St Wilmington CA 90744	SA 8
13 *	Highland Park SG	Mondays 9-11 am	Arroyo Seco Library 6145 N Figueroa St Los Angeles CA 90042	SA 4
14 *	Cerritos SG	Fridays 1-3 pm	Rio Hondo MHC 17707 Studebaker Road Cerritos CA 90280	SA 7
15	North Hollywood SG	Fridays 10-12 pm	Valley Plaza Library 12311 Vanowen St. North Hollywood CA 91605	SA 2
16 *	Compton SG	Wednesdays 10-12 pm	Compton Library 240 W Compton Blvd Compton CA 90220	SA 6
17 *	Pico Union SG	Thursdays 10-12 pm	SSG-BACUP 515 Columbia Ave Los Angeles CA 90017	SA 4
18 *	Baldwin Park SG	Wednesdays 4-6 pm	Tery G Muse Family Center 14305 Morgan St. Baldwin Park CA 91706	SA 3
19	Lawndale SG	Wednesdays 10-12 pm	Lawndale Library 14615 Burin Ave Lawndale CA 90260	SA 8
20	Shout Gate SG	Fridays 9-11 am	Fe y Esperanza Lutheran Church 13431 Paramount Blvd South Gate CA 90280	SA 7

(*) For reasons of the COVID-19 pandemic and social distancing health measures, since March 2020, 15 support groups have been working via teleconference. According to the directives, they progressively return to witness. For the same reason, five (5) support groups were suspended.

Transitional Age Youth (TAY) Drop-In Centers

Outpatient Care Services (OCS) TAY Drop-In Centers are an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are living on the streets or in unstable living situations. They offer basic supports (showers, meals, clothing, vouchers, etc.) as well as linkage and referrals to help the youth work towards stability and recovery. Seeking Safety (SS)

groups are offered to address risk factors including trauma, alcohol/drug use, rejection from peers/family, and interpersonal conflict/stress.

Drop-In Centers have a strong emphasis on outreaching TAY, who are difficult to engage and would otherwise remain unserved, by linking TAY to a range of resources that promote stability and self-sufficiency. Drop-In Centers operate daily including evenings and some weekends. They provide "low demand, high tolerance" environments in which youth can find temporary safety and begin to build trusting relationships with staff members who can connect them to the services and supports they need. They also help to meet the youths' basic needs such as meals, hygiene facilities, clothing, a mailing address, and a safe place to rest indoors. Generally, these centers are operated during regular business hours.

TAY Drop-In Centers aim to provide culturally and linguistically competent services to TAY by addressing the cultural and linguistic needs of the youth from their respective community. The annual youth events held by the TAY Drop-In Centers allow them to educate and partner with local community agencies to offer the youth a holistic approach with respect to services. Contract providers ensure that staff providing services have similar cultural and linguistic backgrounds to those clients being served.

In addition, their activities increase access to mental health services through outreach and engagement services to those youth who may be homeless or in unstable living situations. These youth and young adults are often experiencing complex trauma as victims of abuse in their homes, in the streets, and in their communities. The complex trauma may manifest in their inability to maintain relationships, keep jobs, or stay in school, and often put them at risk of unemployment, school dropouts, incarceration, and victimization.

TAY DROP-IN CENTERS			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	• The Transition Age Youth (TAY) Drop-In Centers host annual youth events inviting local community groups and agencies that promote mental, physical, and spiritual health to the youth.	• Efforts made by the Transition Age Youth Drop-In Centers to continue to host the annual youth events while adhering to the safety protocols has slowed the progress. New Transition Age Youth Drop-In Center contractors have yet to host the annual event	• Contract Management and Monitoring Division (CMMD) staff attends the event and provides technical assistance as needed.

TAY DROP-IN CENTERS			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
		due to the current state of the pandemic.	
2) Community education to increase mental health awareness and decrease stigma	• TAY Drop-In Centers provide an array of different activities and groups that are inviting to all youth from the community while at the same time educating the participants on the importance of mental health and reducing stigma.	• Currently all TAY Drop-In Centers provide activities and groups that educate youth on mental health and reduce stigma.	• TAY Drop-In Centers submit monthly activity logs promoting the activities and groups. Contract Management and Monitoring Division staff review the calendar for appropriateness.
3) Field-based services	• During the height of the COVID-19 pandemic, the TAY Drop-In Centers changed the way services were rendered. The TAY Drop-In Center staff went out to meet the youth in the community to continue to provide critical basic services such as food and clothing.	• TAY Drop-In Centers continue to provide field-based services to ensure that those youth that are in need continue to receive basic services such as food and clothing.	• TAY Navigation teams met with TAY Drop-In Center staff and participants via telehealth.
4) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	• TAY Drop-In Centers hire staff who have similar cultural and linguistic backgrounds to the youths. The staff receives annual cultural competence training.	• TAY Drop-In Centers continue to provide culturally and linguistically appropriate outreach and engagement services.	• Contract Management and Monitoring Division and TAY Navigation teams meet with TAY Drop-In Center staff to address any language or

TAY DROP-IN CENTERS			
Strategies	**Activities**	**Status/Progress**	**Monitoring Procedures and Outcomes**
			cultural capacity issues.
5) Integration of physical health, mental health, and substance use services	• TAY Drop-In Centers are an entry way to receiving physical health, mental health and substance use referrals and resources. They also offer Seeking Safety groups facilitated by a licensed clinical professional/licensed waivered clinician that address mental health trauma and substance use.	• TAY Navigation staff provide youth with referrals to receive the necessary assistance including physical health, mental health, and substance use services. They also offer a group that uses Evidence-Based Practice (EBP) model to the youth.	• TAY Drop-In Center staff submit log of linkages monthly.
6) Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	• TAY Drop-In Centers hire staff who have similar cultural and linguistic backgrounds to the youths. They also host annual youth events and partner with local agencies to provide resources and linkage to the youth promoting health and wellbeing.	• TAY Drop-In Centers continue to provide culturally and linguistically appropriate services that meet the needs of the youth using local agencies.	• Contract Management and Monitoring Division staff attends the annual youth events to provide support and technical assistance.

CONSUMERS SERVED BY TAY DROP-IN CENTERS
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender				Staff's Language
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify) Multi-Race	Male/Female	Transman/ Transmasculine Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
TAY Drop-In Centers	132	431	435	22	17	163	1,338	45	Unknown	40	English, Spanish, Korean, Armenian, Tagalog, Vietnameese, American Sign Language

LOCATION OF DROP-IN CENTERS BY SERVICE AREA
FY 20-21

SA	Agency Name	Administrative Offices	TAY Drop in Center Address
1	The Children's Center of Antelope Valley	45111 Fern Ave. Lancaster, CA 93534	45111 Fern Avenue Lancaster, CA 93534
1	Penny Lane	43520 Division St Lancaster, CA 93535	43520 Division St Lancaster, CA 93535
2	The Village Family Services	6736 Laurel Canyon Blvd., Ste 200 North Hollywood, CA 91606	6801 Coldwater Canyon Blvd. North Hollywood, CA 91606
3	Pacific Clinics	800 S. Santa Anita Blvd. Arcadia, CA 91000	13001 Ramona Blvd Irwindale, CA 91706
4	Los Angeles LGBT Youth Center on Highland	1625 N. Schrader Blvd. Los Angeles, CA 90078	1220 N. Highland Ave. Los Angeles, CA 90038
6	Volunteers of America of Los Angeles	3600 Wilshire Blvd. Los Angeles, CA 90010	5344 Crenshaw Blvd. Los Angeles, CA 90043
7	Penny Lane	43520 Division St Lancaster, CA 93535	5628 E. Slauson Ave. Commerce, CA 90040
8	Good Seed	6568 5th Ave. Los Angeles, CA 90043	6568 5th Ave. Los Angeles, CA 90043

Transitional Age Youth (TAY) Navigation Team

TAY Navigation Team operates in the field and is comprised of clinicians, medical case workers who serve in the role of Housing Specialists, a Substance Use Counselor, and a Community Health Worker who work with TAY ages 16-25 countywide. The primary

mission of the TAY Navigation Team is to work with homeless TAY and link them to housing, mental health resources, and other essential social services in order to enhance TAY overall functioning in the community. Each Service Area has one (1) clinician and one (1) housing specialist assigned. The staff also provide clinical consultations to County Departments and organizations while outreaching and engaging TAY who are referred.

A key role for the TAY staff is in the Enhanced Emergency Shelter Program (EESP) for TAY. The EESPs are located in SAs 4 & 6 and provide 60-day shelter for TAY. The EESP offers a warm, clean, and safe place to sleep, hygiene facilities, hot meals, and case management services. The staff provides youth with needed mental health support, employment resources and permanent housing plan.

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

TAY Navigators serve a high percentage of the LGBTQ+ community members. One of EESPs is the LGBT Youth Center, which shelters a good percentage of youth. In FY 20-21, the Youth Center had a capacity of 20 beds available for youth. These beds were consistently full or near to full, depending upon COVID-19 restrictions. This knowledge has informed the training planning to ensure the staff are better trained on the needs of this population, including examining their biases, their use of language, and making workspaces more inclusive.

Occasionally, Gatekeeper gets a call from a youth or family member/interested party who is monolingual Spanish-speaking, and Spanish-speaking staff follow up on those calls and refer appropriately. Additionally, the team makes every effort to match a monolingual Spanish-speaking TAY in EESPs to one of the TAY Navigation's staff who is Spanish-speaking. These staff also assist in any needed advocacy.

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

TAY Navigation Team			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	TAY Navigation Team interacts with faith-based and other community-based agencies including responding to calls, providing consultation, and assisting with referrals or resources. This includes its daily 'Officer of the Day' who provides mental health support as well as housing support.	Ongoing	Any calls or referrals are tracked via our Call Log.
2) Development and translation of public informing materials that address mental health education	In collaboration with the Public Information Office (PIO), the informational flyers on TAY Navigation services were developed in both English and Spanish.	Ongoing	TAY Navigation team reviews and updates as needed, including updates to the LACDMH website when there are any program changes.
3) Community education to increase mental health awareness and decrease stigma	TAY Navigation team provides outreach and educational presentations to community agencies throughout the County informing of services and educating on TAY needs.	Ongoing	TAY Navigation team has continual requests for these presentations. During FY 20-21, the team provided ten (10) presentations in total.
4) Consultation to gatekeepers	The team is daily responding to calls, providing consultation, and assisting with referrals or resources. This includes the daily 'Officer of the Day' who provides mental health support as well as housing support.	Ongoing	Any calls or referrals are tracked via the Call Log.
5) Field-based services	The TAY Navigation team is a field-based team working in the EESPs as well as the Drop-In Centers.	Ongoing	Supervisors track the field work and location of each staff daily
6) Interagency Collaboration	The TAY Navigation team regularly interfaces with DCFS as well as DPSS to address	Ongoing	Working in collaboration with these agencies supports clients obtaining

TAY Navigation Team			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	clients' needs and link to resources.		needed services such as housing and benefits.
7) Trainings/case consultation	The team provides outreach and educational presentations to community agencies throughout the County informing of the services and educating on TAY needs. The team also consults on TAY cases as needed.	Ongoing	TAY Navigation team has continual requests for these presentations. During FY 20-21, ten (10) presentations were delivered. Consultations are tracked via the call log.

CONSUMERS SERVED BY TAY NAVIGATION TEAM
FY 20-21

Program/Activity	# Consumers Served by Race/Ethnicity						Gender				Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other	Male/Female	Transman/ Transmasculine Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
TAY Navigation Team - Enhanced Emergency Shelter Program	45	149	116	4	3	19	M (262) F (82)	31		2	Spanish Korean

Telemental Health

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

program is to use technology in order to improve care, access to care, treatment adherence and outcomes, and consumer satisfaction.

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

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

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

The Telemental Health and Consultation Team (TMHCT) provides medication review, medication counseling/education and prescriptions as permitted by their licensure with documentation in the medical record of each client. Prescriptions are sent through the EMR. There will be no dispensing or storing of medication at the unit site.

The TMH program assigns psychiatrists to provide remote telepsychiatry coverage of clinics throughout LA County based upon data. The data that is used to determine need is the caseload for psychiatrists located in each clinic. Because there are geographic

disparities in psychiatrists' physical locations that lead to disparities in caseload per psychiatrist (i.e., clinics that are underserved by psychiatrists have larger caseloads), the TMH program helps to improve access to psychiatric treatment in underserved regions of LA County.

The TMH program increases access to mental health services and works on reducing disparities. The goal is to increase access to psychiatric medication services throughout the County, especially targeting geographically underserved areas. By using telepsychiatry, LACDMH is able to overcome the geographic barrier to care in certain areas of LA County experiencing a shortage of psychiatrists such as the Antelope Valley. TMH aims to utilize disparities data to make services culturally and linguistically accessible to communities by basing physician work placement (remote services) based upon caseload data from clinics in each service area.

Telemental Health Program (TMH)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	Assigning remote physician placement using caseload data	Implemented	Monthly meetings to monitor caseload and evaluate ongoing physician placement.
2) Implementation of new technologies to enhance the Department's service delivery	Implemented telehealth platform	Implemented	Ongoing evaluation of use of the platform (i.e., Number of clients seen)
3) Augmentation of mental health service accessibility to underserved populations	Using telehealth to increase access to patient care	Implemented	Ongoing evaluation of patient access, provider/clinic caseloads, frequency of visits
4) COVID-19 responsiveness at clinical and administrative program level.	Using telehealth to maintain client care/services provided	Ongoing	Monitoring clients served and services provided

Training Unit

Training Unit is a component of the Quality, Outcomes and Training Division. This unit coordinates most of the Departmentwide training offerings both to Directly Operated and Contracted programs. A substantial number of training offerings are led and directly coordinated by programs such as 0 to 5, Specialized Foster Care, Juvenile Justice, Adult Forensic, Veterans, and Outpatient (Children, Transitional Age Youth (TAY), Adult and Older Adult). Training Unit utilizes disparities data in the planning and implementation of strategies and trainings to ensure they address culturally and linguistically appropriate service delivery.

Training Unit is also tasked with management and implementation of the Mental Health Services Act – Workforce Education and Training (WET) Plan in the County of Los Angeles. The MHSA WET Plan funds programs that prepare the workforce to provide effective and culturally competent services to the unserved and underserved communities in LA County. The funded programs focus on at least one of the following premises:

- Integration of consumers, family members, and parent advocates/parent partners into the public mental health workforce
- Retention of current skilled workforce and recruitment of future workforce, with priority afforded to individuals that represent an unserved or underserved population and/or speak a needed language
- Outreach to community partners, such as community colleges and faith-based leaders/organizations, to build collaborations and address stigma often associated with mental illness, while creating partnerships with community-based organizations that may create an additional way for consumers to enter the public mental health system
- Train the mental health workforce about the consumer culture and the promotion of hope, wellbeing, and recovery
- Culturally responsive and linguistic enhancement of interpreters and the clinicians that utilize them

The MHSA WET Plan programs include:

- Interpreter Training – Provides training to bilingual staff performing interpreter services and is intended to enhance the service by addressing the complex roles of interpreter services, reviewing interpreting models, identifying standards of practice, and problem-solving challenges that present when interpreting
- Charles Drew Affiliation Agreement – Pathways to Health Academy- Year long academic and internship program for high school students in South Central Los Angeles (African American/Latino community specific) with a behavioral health concentration including mental health
- UCLA Affiliation Agreement – Public Mental Health Partnership (PMHP) UCLA Public Partnership for Wellbeing Agreement. This agreement provided specialized training relevant to mental health direct services as well as outreach and engagement staff (Promotoras and/or other field-based direct service staff) serving historically un- or under- served communities

- Psychiatric Residency Program – Funds a two (2) year psychiatric resident training program based in South Central Los Angeles with rotations in the community that include inpatient, emergency psychiatric room and outpatient experiences
- Mental Health Psychiatrist Loan Repayment/Mental Health Psychiatrist Recruitment Incentive/ Mental Health Relocation Expense Reimbursement Programs – Recruits and retains psychiatrists specific to service provision to outpatient, homeless, street mental health including other important service initiatives

The trainings offered by the Training Unit provide opportunities for acquiring and enhancing knowledge and a skill set important to the delivery of direct mental health services. Trainings inform participants of underserved communities' present and historical experiences within a foundational context relevant to the provision of essential mental health services. For detailed information regarding workforce capacity building efforts, see the Criterion 6.

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<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr>
<td><u>Public Mental Health Partnership (PMHP)</u> (UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)

The mission of the UCLA-DMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County (LAC); and to do so in the context of a transparent, trusting partnership with the Los Angeles County Department of Mental Health (LACDMH) that generates benefits for both the University and public health communities. The PMHP is comprised of two (2) sections focused on serious mental illness -- the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program.</td>
<td>Ongoing</td>
<td>During the reporting period, the PMHP delivered 110 trainings over 315.5 hours, with an attendance of 4,683 participants. The training team provided trainings on a wide variety of topics including person centeredness, cultural humility, and psychiatric disorders and symptoms (Table 10). The training topics delivered to the most participants include “Crisis & Safety Intervention” (1,321 participants) and “Continuous Quality Improvement” (776 participants)

<table>
<tr><th>Topic Name</th><th>Number of Trainings</th><th>Training Hours</th><th>Number of Participants</th></tr>
<tr><td>Crisis & Safety Intervention</td><td>18</td><td>59</td><td>1321</td></tr>
<tr><td>Continuous Quality Improvement</td><td>33</td><td>44.5</td><td>776</td></tr>
<tr><td>Manualized Evidence-Based Practices</td><td>10</td><td>43.5</td><td>473</td></tr>
<tr><td>Provider Wellbeing</td><td>8</td><td>15.5</td><td>379</td></tr>
<tr><td>Trauma</td><td>10</td><td>37.5</td><td>376</td></tr>
<tr><td>Psychiatric Disorders & Symptoms</td><td>6</td><td>19.5</td><td>355</td></tr>
<tr><td>Cultural Humility</td><td>7</td><td>27</td><td>247</td></tr>
<tr><td>Person Centeredness</td><td>5</td><td>21</td><td>203</td></tr>
<tr><td>Persistent & Committed Engagement</td><td>3</td><td>5</td><td>202</td></tr>
<tr><td>Co-Occurring Disorders</td><td>3</td><td>15</td><td>131</td></tr>
<tr><td>Team-Based Clinical Services</td><td>3</td><td>15</td><td>129</td></tr>
<tr><td>Whole Person Care</td><td>2</td><td>10</td><td>60</td></tr>
<tr><td>Everyday Functioning</td><td>1</td><td>1</td><td>31</td></tr>
<tr><td>Ethical Issues</td><td>0</td><td>0</td><td>0</td></tr>
<tr><td>Service Delivery Skills</td><td>1</td><td>2</td><td>0</td></tr>
<tr><td>TOTAL:</td><td>110</td><td>315.5</td><td>4,683</td></tr>
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Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T) *(UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)*

BASIC T: Professional trainees within the Hispanic Neuroscience Center of Excellence (HNCE) consist of three (3) early entry neuropsychologists, three (3) postdoctoral fellows, and three (3) clinical social workers who work in multidisciplinary teams. The neuropsychologists are receiving training in the completion of comprehensive neuropsychological assessments across the life span, while the clinical social workers are being trained to provide allied linkage services following comprehensive assessment and psychosocial support that addresses multiple social determinants of health including: economic stability, education access and quality, healthcare access and quality, neighborhood and build environment, social and community context. During the reporting period, HNCE trainees have collectively cared for 258 patients, with a total of 504 since program inception.

Ongoing

During the reporting period, the HNCE delivered 88 trainings over 151 hours, with an attendance of 1,060 participants. This was on par with maintaining the initial rapid COVID-19 Pivot made prior to the current reporting (i.e., April to June 2020), during which HNCE delivered 48 trainings over 122 hours, with an attendance of 1,274 participants. The training team provided bilingual trainings in English and Spanish on a wide variety of topics, including mental health stigma among communities of color during COVID-19 and support groups for isolated older adults and parents of children with developmental disabilities during COVID-19. Some of the training topics delivered to the most participants include “Culturally Competent COVID-19 Psychological First Aid for Faith based Organizations and Churches” (260 participants), “Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations” (140 participants), and “Culturally Competent Recovery & Resilience Intervention during COVID-19” (138 participants). Participants in the HNCE trainings represented all five (5) LA County Supervisorial Districts. In addition to direct participants reached through HNCE trainings, it is important to highlight that the training provided through the HNCE on COVID-19 topics for Health Promoters has already resulted in the Latina/o/x Promotoras reaching an additional 15,705 community members via their own 2,171 trainings over 3,505 hours.

Topic Name	Number of Trainings	Training Hours	Number of Participants
Culturally Competent COVID-19 Psychological First Aid for Faith Based Organizations and Churches	11	22	260
Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations	6	11	140
Culturally Competent Recovery & Resilience Intervention during COVID-19	3	4	138
COVID-19 & the Brain (Promotoras)	8	16	113
Virtual Support Groups for Isolated Older Adults during COVID-19 (Genesis)	25	50	94
Support Groups for Latino and Spanish-speaking Parents with Children Diagnosed with Neurodevelopment Disabilities during COVID-19	20	20	61

COVID-19: Psychiatric & Cognitive Sequelae	3	5	57
Psychological First Aid Related to COVID-19 & Related Trauma (Promotoras)	3	6	54
Use of Telehealth & Digital Platforms for Psychological Intervention during COVID-19 (Promotoras)	2	4	54
The Community Mental Health Promoters Model: The roles of mental health promoters and popular education during COVID-19	1	2	20
Social Determinants of Health & COVID-19	1	2	20
Mental Health & Stigma Among Communities of Color during COVID-19	1	2	20
Resilience & the Role of Self-Care in the time of COVID19	1	2	20
Culturally Competent Support Groups for Caregivers of Older Adults with Dementia during COVID-19 (Genesis & Others)	3	5	9
TOTAL:	**88**	**151**	**1,060**

Consultations For the reporting period, HNCE spent 324 hours on consultation providing support to LACDMH clinicians with respect to ongoing needs for psychometric assessment, resilience/ coping/ bereavement, and continued COVID-19 related program development. Additionally, BASIC-T conducted a number of mass media appearances via COVID-19 related PSAs and interviews that reach a large TV, radio, and online viewership within Los Angeles, as well as nationally and internationally in Spanish (e.g., 1.0 to 3.5 million media consumers locally).

Psychiatric Residency Program: Charles Drew University Agreement The County Board of Supervisors formed the LA County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County. The first class started in Academic Year 2018-2019 with trainees ranging from Post Graduate Year Is to IVs. The first class will graduate in June 2022. **CDU Clinical Rotations:** <u>PGY-1: 6 Psychiatric Residents</u> 1 month of university onboarding is done at CDU VA Long Beach (Inpatient Psychiatry): 4 months Rancho Los Amigos (Inpatient Medicine): 2 months Rancho Los Amigos (Neurology): 2 months Kedren (Outpatient Medicine): 2 months Harbor-UCLA (Emergency Psychiatry): 1 month <u>PGY-2: 6 Psychiatric Residents</u> VA Long Beach (Inpatient Psychiatry): 1 month VA Long Beach (Consultation and Liaison): 2 months VA Long Beach (Emergency Psychiatry): 1 month VA Long Beach (Substance Abuse): 2 months VA Long Beach (Geriatric Psychiatry): 1 month Kedren (Inpatient Psychiatry): 3 months Resnick Neuropsych Hospital UCLA (Child and Adolescent Psychiatry): 2 months The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus. <u>PGY-3: 6 Psychiatric Residents</u> Rotations in DMH Directly Operated Clinics and Programs: Augustus F. Hawkins MHC West Central MHC Compton MHC Child & Adolescent Psychiatry Women's Community & Reintegration Center Harbor UCLA Medical Center HIV Clinic Street Psychiatry/HOME Team and Disaster Service Collaborative Care/Telepsychiatry	Ongoing	**Outcomes 2020-2021** PGY-1: 6 psychiatric residents PGY-2: 6 psychiatric residents PGY-3: 6 psychiatric residents Total: 18 psychiatric residents

DMH + UCLA General Medical Education (GME) – *(UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)* Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry.	Ongoing	During the reporting period, the trainees provided a total of 574 patient visits during their public psychiatry rotations **Outcomes 2020-2021** PGY-4: 4 psychiatric residents Child Psychiatry Fellows: 3 Fellows Geriatric Psychiatry Fellow: 1 Fellow Forensic Psychiatry Fellows: 3 Fellows **Total: 11 trainees**
LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees – *(UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)* Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits. NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with LACDMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country. LACDMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include: • Participating in coursework, the equivalent of a master's program or auditing as an option. • Conducting up to 20% clinical work with LACDMH and participate in leadership activities. • Conducting 1-4 projects, at least 1 of which is in partnership with DMH. • Participating in a policy elective their second year when possible. • Attending annual NCSP meetings and other local and national meetings. • Access to research funds and a mentorship team	Ongoing	Provided 114 patient visits

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<td>Navigator Skill Development Program
Health Navigation Certification Training
This program trains individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. Training was limited during the COVID-19 pandemic, and training was delivered to one (1) cohort.</td>
<td>Ongoing</td>
<td>In this group, 18 individuals completed this model, with 44% spoke a threshold language, and 83% represented an un- or under- served community</td>
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<td>Interpreter Training Program
The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English-speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. Due to COVID-19, this program had limited offerings.</td>
<td>Ongoing</td>
<td>FY 20-21 Outcomes:

<table>
<tr><th>TRAINING</th><th># OF ATTENDEES</th></tr>
<tr><td>Increasing Spanish Mental Health Clinical Terminology</td><td>43</td></tr>
<tr><td>Introduction To Interpreting in Mental Health Settings</td><td>11</td></tr>
<tr><td>TOTAL</td><td>54</td></tr>
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<td>Learning Net System
The Department has developed an online registration system called EventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. EventsHub is fully operational with most if not all clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes. Enhancement and maintenance of EventsHub continues through FY 21-22.</td>
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<td>This system allows non-staff (Peers, general public) to register and attend appropriate training resources.</td>
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<td>Intensive Mental Health Recovery Specialist Training Program
Intensive Mental Health Recovery Specialist Training Program prepares individual, mental health consumers and family members, with a minimum of two (2) years of college credit, to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor and local community college. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Due to COVID-19, only one (1) cohort was able to complete this training.</td>
<td>Ongoing</td>
<td>27 individuals began this training, 18 completed the training with 76% representing an un- or under- served community and 73% speaking a second language. Of those that completed the training, 50% have secured employment, with all but one working in the mental health field.</td>
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Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System **Honest, Open, Proud Program –** During FY 20-21, one training (4 online sessions) was delivered on 6/8, 6/9, 6/15 and 6/16/2021. The training demonstrated the necessity and importance of effective self-disclosure in self-empowerment and providing peer support services. It provided strategies on how to effectively disclose their lived-experience for the provision of peer support services as the LACDMH Peer Workforce. Additional components of this training are planned for subsequent Fiscal Years. **Intentional Peer Support (IPS) Advanced Training -** During FY 20-21, one (1) Advanced Intentional Peer Support training (6 online sessions) was provided: 04/27,05/04,05/11,05/18,05/25, and 06/01/2021. Advanced level IPS practices were covered and included a review of core principles, application of strategies to real-life scenarios, affirmation of self-reflection understanding and promotion of enhanced mutual connections all relevant to sustaining the practice. Staff regularly met to review and discuss issues and concerns associated with implementation of peer services and application of the IPS practice. Topics included peer to peer relationship challenges, unhelpful assumptions, and fidelity of IPS principles to peer service practices. **Parent Partners Training Program** This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.	Ongoing	A total of 17 LACDMH Peer staff have successfully completed the training. The training was provided to help the LACDMH Peer Workforce to identify and overcome the negative impact of the internalized shame and stigma of mental illness. Sixteen (16) LACDMH Peer Staff, former graduates of the Core Training, completed this Advanced IPS Training. During FY 20-21, one cohort of IPS Co-reflection training was delivered (6 online sessions were provided) with 7 Peer Staffs from DMH and DMH contracted agencies participating. During FY 20-21, available training opportunities moved to an online platform, resulting in 1,568 individuals receiving this training through 39 online sessions.

Continuum of Care Reform (CCR) Assembly Bill (AB) 403, also known as Continuum of Care Reform (CCR) provides comprehensive transformation of the foster care system with the intent of achieving permanency planning for foster youth and their families. In particular, this legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, the following table outlines LACDMH-offered trainings and include topics subjects such as introduction to mental health, diagnosis/assessment and self-care.	Ongoing	A total of 1,459 individuals were trained. Breakdown as follows:
Child and Family Team Process Overview This training will provide an overview of how the Child and Family Team process is utilized in the Continuum of Care Reform (CCR). In CCR, the Child and Family Teaming process is the decision-making vehicle for case planning and service delivery. This training will review the elements involved in the Child and Family process, team members, and their roles. This training identifies the Integrated Core Practice Model elements embedded in the Child and Family Teaming process, and its role in providing collaborative services. Participants will learn engagement strategies and the importance of keeping the child and family's voice and choice at the center. Participants will learn strategies for effective teaming with children and families, and formal and informal supports. This training will review how teaming can promote positive permanency outcomes and assist with meeting the underlying needs of children. This training utilizes both didactic and experiential learning strategies to support the transfer of learning.		113 Individuals were trained.
Integrated Core Practice Model Overview This training provides an overview of the Continuum of Care Reform, Integrated Core Practice Model practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice behaviors. Participants will learn to utilize interagency teaming strategies while providing services to children and families involved in the Child Welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and well-being promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge.		143 individuals were trained.
LGBTQ+ Youth In Placement This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens will be utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers will highlight appropriate		35 individuals were trained.

LGBTQ+ terminology as well as explore the impact of stigma, particularly as it relates to LGBTQ+ youth of color. Lastly, participants will learn about Eli Coleman's Identity Model as a way to conceptualize the coming out process and the value of acceptance. Group activities will be facilitated to enhance application of learning and increase one's self-awareness as it relates to this population.		
LGBTQ+ Youth In Care: Guidelines for Clinical Practice This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens will be utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers will highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma, particularly as it relates to LGBTQ+ youth of color. Lastly, participants will learn about Eli Coleman's Identity Model as a way to conceptualize the coming out process and the value of acceptance. Group activities will be facilitated to enhance application of learning and increase one's self-awareness as it relates to this population		29 individuals were trained.
Crafting Underlying Needs Statements and Services This training provides information on Underlying Needs and its application in the Continuum of Care Reform (CCR) process. It prepares providers to identify the relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants will learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs-based statement and support development of individualized services for youth and families in the Child Welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills and implementation of training strategies.		177 individuals were trained.
Engaging Runaway Youth In Placement: Overview and Strategies for Response Most runaway youths struggle with substance abuse and mental health issues, are at high risk for being a victim of sex trafficking and have higher rates of involvement with the juvenile justice system. This training shall increase participants' understanding of the characteristics of youth who run and the impact of traumatic experiences and development on running behavior. It will provide strategies to reduce the risk of running, including recommended policy, practice, training, and direct engagement with youth. The curriculum will take a case-based approach to designing implementable strategies to reduce risk to run. Following the introduction of core content,		177 individuals were trained.

attendees will review case information using a multidisciplinary and collaborative lens to assist them in identifying effective strategies for engaging youth and reducing run risk. Teams will learn to develop safety plans that encompass run behavior prevention and intervention.		
Creative Interventions for System Involved Youth This training prepares Continuum of Care Reform (CCR) providers to explore the transformative and restorative power of creativity for youth. Discover how providers can utilize creative interventions when working with youth who are involved in systems of care including child welfare, mental health and probation. Discussions will include the key components of trauma-informed expressive art therapy, creative art therapy modalities, and adaptable interventions. Participants will build awareness of the benefits of utilizing creative trauma-informed interventions and identify tools to support the implementation of art, dance/movement, music, play, drama, and other expressive modalities in their work with youth. Lastly, this training incorporates both didactic and experiential learning to support transfer of understanding, knowledge and integration of training objectives.		28 individuals were trained.
Prevent the Eruption: Trauma Informed De-Escalation Strategies (3-hours) This training seeks to provide LACDMH, DCFS, Probation, and Contract Provider staff with the knowledge in recognizing and better understanding trauma when observed in children and youth, the impact of trauma on the brain and provide learning on trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training will review and describe the ascent of escalation phases, de-escalation phase clues, and offer trauma informed interventions for each phase including specifics regarding the debriefing process and strategies for prevention of self-injurious behavior. Additionally, this training will assist the participants with the understanding and application of trauma informed consequences. Finally, the importance of self-care is discussed and the participants will learn how to develop self-care strategies for themselves.		513 individuals were trained.
Prevent the Eruption: Interventions Booster (2 hours) This booster training seeks to provide DMH, DCFS, Probation and Contract Provider staff with information and practice in the following areas: engagement, phases of escalation, strategies to de-escalate youth, and ways to manage trauma triggers and unsafe behaviors. This training builds upon strategies learned in the Prevent the Eruption: Trauma- Informed De-escalation Strategies to further equip providers with developmentally and culturally relevant tools to support the de-escalation process. Participants will be placed in breakout rooms to facilitate the learning process through group work and discussions.		45 individuals were trained.

Engaging Youth in Placement: From Admission Through Aftercare This training provides an overview and practical applications for engaging youth in placement throughout the course of treatment from admission to aftercare. Topics covered include trauma, challenges and barriers to engagement, specific strategies to initiate and maintain engagement with youth, interagency collaboration, and aftercare planning. Utilizing a trauma-informed lens, trainers discuss the impact of trauma on youth's overall development, attachment, and relationships. Participants learn a variety of approaches to aftercare planning which they may integrate into their own agencies. Interagency collaboration efforts as well as connecting youth to community resources are considered. The warm hand-off and facilitation of a "good goodbye" with youth and families are highlighted. Group activities enhance learning and provide opportunities to apply a variety of useful strategies to promote engagement.		24 individuals were trained.
Youth with Developmental Disabilities and Mental Illness: Overview and Interventions This training focuses on youth with developmental disabilities and mental illness. It addresses how to identify common mental health symptoms for youth with developmental disabilities placed in a STRTP. Differences abide in presentation of mental illness symptoms in this population and such conditions warrant adapting interventions to meet their unique needs. Lastly, additional discussion includes the CFT process, which is a collaboration strategy which can provide practical tools and techniques to support providers who work directly with this population.		105 individuals were trained.
Engaging Probation Youth This training will provide the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. The impact of trauma and its effects on the brain, attachment, physiology, and social relationships will be examined. There will be an overview of a trauma informed approach, cultural sensitivity, and underlying needs. Tools for engagement as well as staff's awareness of their countertransference will be explored. Group activities will be facilitated to enhance application of learning and address challenging behaviors. Lastly, self-care will be discussed, and the participants will identify self-care strategies.		70 individuals were trained.

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Underserved Cultural Communities (UsCC) Subcommittees

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

UsCC Subcommittees include:

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

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

Intended Outcomes:

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

Observance of COVID-19 physical distancing measures directly impacted the implementation of UsCC capacity building projects, which had to utilize different virtual platforms.

An overview of each UsCC subcommittee's projects for FY 20-21 is provided in the following table.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Access For All Access For All Mental Health Needs Assessment for the Physically Disabled Community	Completion Date: June 30, 2022.	The objective of the Physically Disabled Community Mental Health Needs Assessment Project is to outreach and engage people within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project targets physically disabled community members from the eight (8) Service Areas across LA County. The Consultant outreached to people within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LA County Department of Mental Health (LACDMH). Outcomes for FY 20-21 • Developed flyers and other promotional materials and utilized social media platforms to recruit participants with physical disabilities across eight Service Areas. • Developed Resource Guide with Countywide resources for physically disabled community and posted at the Department of Mental Health (DMH) website. • Of the 40 individuals with physical disabilities initially recruited for the focus groups, 35 attended. • Facilitated nine virtual focus groups, which ended on May 30, 2022. • Awaiting final summary report due on June 30, 2022, which will include mental assessment outcomes, feedback, and recommendations.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Access For All Mental Health Needs Assessment for the Blind, Partially Sighted, and Visually Impaired Community	Completion Date: June 30, 2022.	The objective of the Blind, Partially Sighted, and Visually Impaired Community Mental Health Needs Assessment Project is to outreach and engage people within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project targets blind, partially sighted, and visually impaired community members from the eight Service Areas across LA County. The Consultant outreached to people within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LACDMH. Outcomes for FY 20-21 • Developed flyers and other promotional materials, and utilized social media platforms to recruit blind, partially sighted and visually impaired individuals across eight Service Areas. • Developed Resource Guide with Countywide resources for the blind, partially sighted, and visually impaired individuals and posted at LACDMH website. • Recruited 41 blind, partially sighted, and visually impaired individuals to participate in the focus groups. • Facilitated nine virtual focus groups, which ended on May 30, 2022. • Awaiting final summary report due on June 30, 2022, which will include mental assessments' outcomes, feedback, and recommendations.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Access For All Mental Health Needs Assessment for the Deaf and Hard of Hearing Community	Completion Date: June 30, 2022	The objective of the Deaf and Hard of Hearing Community Mental Health Needs Assessment Project is to outreach and engage people within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project targets deaf and hard of hearing community members from the eight Service Areas across LA County. The Consultant outreached to people within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LACDMH. Outcomes for FY 20-21 • Developed flyers and other promotional materials and utilized social media platforms to recruit deaf and hard of hearing individuals across eight Service Areas. • Developed Resource Guide with Countywide resources for the deaf and hard of hearing community and posted at the Department of Mental Health (DMH) website. • Recruited 45 deaf and hard of hearing individuals to participate in the focus groups. • Facilitated nine virtual focus groups, which ended on May 30, 2022. • Awaiting final summary report due on June 30, 2022, which will include mental assessments' outcomes, feedback, and recommendations.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
American Indian/Alaska Native (AI/AN) AI/AN Outreach and Engagement Toolkit Project	Completion Date: December 21, 2021	The purpose of the AI/AN Outreach and Engagement Toolkit project was to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in LA County, as well as increase community member engagement in the LACDMH stakeholder process. The first phase of this project included the recruitment of AI/AN community members, peers, and family members into a Cohort. The second phase of this project included the development of an Outreach and Engagement Toolkit including a training video. The final phase of this project included a Community Wellness Forum on 12/11/2021 where a panel of Cohort members shared their experiences participating in the Cohort and presented the Toolkit and training video. Outcomes for FY 20-21 • In total, 25 community members throughout all eight Service Areas of LA County participated in the Cohort and identified as either AI/AN, Native American, or Indigenous, and represented over 20 different tribal nations and Indigenous communities. • Eight (8) two-hour Cohort meetings were held throughout September-November 2021. • Cohort members completed a pre-test and a post-test, which reflected the following outcomes: o Question, “How aware are you of services available in LA County for AI/Ans and/or Indigenous people?” Pre-test reflected 38.7% of Cohort members responded “a lot” as compared to 47.6% in the post-test. o Question, “To what extent do you think it would be helpful for AI/ANs and/or Indigenous people to engage in cultural practices to help with mental health challenges (i.e., traditional medicines, traditional ceremony, drumming, etc.)?” Pre-test reflected 90.3% of Cohort members responded “very helpful” as compared to 100% in the post-test. • In total, 26 community members attended the Community Wellness Forum.

AI/AN Community Mental Health Needs Assessment Project	Completion Date: April 25, 2022	The purpose of the AI/AN Community Mental Health Needs Assessment Project was to outreach and engage the AI/AN population into a discussion regarding the needs of their community, as well as reduce stigma associated with mental health services. Additionally, this project aimed to increase awareness of the mental health needs of AI/AN individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. This project had a goal of increasing community member involvement in the LACDMH stakeholder process. The first phase of this project included outreach to AI/AN community members, especially to persons with lived experience (i.e., consumers, family members of consumers, etc.), into a series of focus groups to assess the mental health needs of AI/AN individuals, identify gaps in access to mental health services, and identify how to engage community members into mental health services. The second phase included hosting an AI/AN Community Mental Health Forum made up of leaders and providers who were brought together into a learning collaborative to discuss the needs of the community. Outcomes for FY 20-21 • In total, five focus groups were held throughout August 2021 focused on the following communities: Indigenous youth, two-spirit community members, Indigenous elders, parents/caregivers of children with special needs, and one for the general Indigenous community. • 65 unique/unduplicated community members participated in the focus groups including 12 Indigenous youth, five two-spirit community members, six Indigenous elders, six parents/caregivers, and eight from the general community. • In total, 21 community members attended the Indigenous Community Mental Health Forum. • Needs most consistently identified by community included: more Native/Indigenous and people of color providers, more cultural competency training, increased understanding of historical trauma, visibility and resources, increased access to services, aging mastery programs, navigating systems, transportation, knowledge of cultural contributions, medication management, inclusive spaces, support groups and parenting classes, and advocacy for children.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
AI/AN Wellness Forums Project	Projected Completion Date: July 31, 2022	The purpose of the Wellness Forums project is to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing. Attendees of the Wellness Forums are given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by AI/AN community members. • In total, seven Forums will be held, six (6) of which have already been held on the following dates: 12/4/2021, 1/22/2022, 2/12/2022, 3/19/2022, 4/9/2022, and 5/14/2022. • The final Forum will be held on 6/25/2022. Forum topics included: Grief, Loss, and Resilience; Awareness, Treatment, and Recovery from Depression; Emotional Wellbeing and the Brain; and Mental Health and Stigma. Outcomes for FY 20-21 • As of June 1st, 2022, six (6) of the seven (7) Wellness Forums have been conducted. • Final outcomes will be shared once the project is completed by July 31st, 2022.

Asian Pacific Islander (API) UsCC Asian Pacific Islander – Sharing Tea, Sharing Hope	Completion Date: June 30, 2021	This project focused on outreaching to the API community using a mobile Tea Cart service, or virtual tea salons via Zoom with the goal of creating space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma, and gaps in mental health service delivery through sharing of tea. Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various Outreach events with the goal of engaging discussions about mental health and providing information on mental health issues and services focusing on the Cambodian (Khmer), Chinese (Mandarin or Cantonese), Filipino (Tagalog), Vietnamese, and Korean communities. Outreach events focused on areas across LA County where there are large concentrations of API community members. Outcomes for FY 20-21 • 192 Sharing Tea Sharing Hope surveys were collected from four different events. • Community members from nine API cultural communities/nationalities participated: Chinese (49), Japanese (4), Korean (3), Vietnamese (9), Filipino (53), Indian (1), Malaysian (3), Indonesian (2), Thai (1), and Multi-ethnic (31). • Project reported success reaching sub-populations that are normally very difficult to reach: monolingual API, over 50 years old, immigrant or mixed status community members. • 59% of the participants agreed or strongly agreed **before the STSH session** of being familiar about the topic of mental health. • 88% of the participants agreed or strongly agreed **after the STSH session** of being more familiar with the topic of mental health. • 50% agreed or strongly agreed **before the STSH session** of knowing mental health signs & symptoms of common mental health issues impacting the API community. • 77% agreed or strongly agreed **after the STSH session** of having learned more about mental health signs & symptoms of common mental health issues.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
		• 49% agreed or strongly agreed **before the STSH session** of being aware of the stigma surrounding mental health in the API community. • 76% agreed or strongly agreed **after the STSH session** of being more aware of the stigma surrounding mental health in the API community. • 23% agreed or strongly agreed **before the STSH session** of being more aware of mental health resources in the community. • 76% agreed or strongly agreed **after the STSH session** of being more aware of mental health resources in the community.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Asian Pacific Islander Families – Our Stories and Our Journey on Mental Health Recovery and Resilience (currently in progress)	Projected Completion Date: July 31, 2022	This project is designed to address an identified need to reach various API communities in their own spoken language with audio-visual presentations that promote mental wellness and recovery, and to reduce stigma about mental health issues and recovery. Since some of the most vulnerable sectors of the API community may not be literate in their own languages, printed materials may not be very helpful for them. Hence, the project looks to compile and adapt existing mental health information and recovery stories into an audio-visual format to reach more community members. This project intends to collaborate with members of API communities to create culturally and linguistically relevant resources in the members' own voices. This project proposes to compile helpful mental health wellness information, resources, and personal stories of recovery and resilience in audio-visual format to share with various API communities (e.g., Cambodian, Chinese, Filipino, Korean, South Asian, Vietnamese). The audio-visual format, such as narrated Power Point presentations (with audio and video segments), could be shared via social media (such as: YouTube; WeChat) and in waiting rooms of clinics to de- mystify mental health issues. Outcomes for FY 20-21 • This project is still in process and outcomes will be shared once completed.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Black and African Heritage (BAH) UsCC Empowering the Black and African-American Family, A Wellness Conversation Series in Service Area 3 Project	Completion Date: May 31, 2022	A facilitator was hired to develop a Wellness Conversation Series that included outreach to Black and African American community members and addressed important topics that influence community wellness in Service Area 3. This project aimed to increase awareness about mental health in order to decrease mental health related stigma and encourage early access of services. The objective of this project was to increase awareness and dialogue surrounding mental health issues, signs, and symptoms; provide multidisciplinary psychoeducation on mental health challenges experienced by Black and African American adults and youth; and destigmatize the topic of mental health in these communities. The goal was to have a monthly Wellness Conversation to decrease stigma about mental health issues and increase awareness of healthy coping strategies, and to connect community members to supportive resources and services needed to improve opportunities for healing and wholeness in their lives. Outcomes for FY 20-21 • In total, three (3) Wellness Conversations were held in Service Area 3. • Topics included: Supporting Black Parents, Cannabis in the Black Community, and Supporting Black LGBTQIA+. • For the Wellness Conversation on Supporting Black Parents, 66% of attendees identified as Black/African American, 14% identified as Latino or Latinx, 7% identified as White, and 13% as Other. • For the Wellness Conversation on Cannabis in the Black Community, 45% of attendees identified as Black/African American, 30% as Latino or Latinx, 19% as White, and 6% as Other. • For the Wellness Conversation on Supporting Black LGBTQIA+, 70% of attendees identified as Black/African American, 15% as Latino or Latinx, 8% as White, and 7% as Other. • 250 individuals completed the pre-test and 150 completed the post-test. • Post-test results indicated that the Wellness Conversation Series were effective (80% of attendees stated that they felt empowered and confident as a result).

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Black and African-American Village Elders Mental Health Project	Completion Date: June 30, 2022	The purpose of the Black and African American Village Elders Mental Health Project is to build a cadre of Community Service Leaders (CSLs) that have the knowledge and capacity to recognize and respond to signs of social isolation and disconnection from community amongst Black and African American elders and their caregivers. CSLs will present community seminars specifically to these populations. This project involves two components: 1) The first component will include recruitment of CSLs, followed by the facilitation of a forum for the CSLs that focuses on how to work with and assist the Black and African American elder population, as well as their caregivers, with regards to mental health awareness and signs and symptoms of isolation and depression. 2) The second component involves CSLs conducting community mental health seminars to outreach and engage elders and their caregivers. Outcomes for FY 20-21 • This project is still in process and outcomes will be shared once completed.

Eastern European/Middle Eastern (EE/ME) UsCC Armenian Mental Health Symposiums	Completion Date: May 9, 2022	A trainer was hired who specializes in providing mental health services to the Armenian population. This Trainer was responsible for implementing the Virtual Armenian Community Symposiums project. The purpose of the Virtual Community Symposiums project was to engage, empower, and enlist the Armenian community into conversations about mental health and traditional forms of healing. Attendees of the Virtual Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the Armenian community and the traditional forms of healing that are practiced by Armenian community. Three major virtual symposiums were completed and included various Armenian Mental Health Professionals and professionals from other fields. Symposium topics included Depression, Anxiety, PTSD from the 44-Day War in Nagorno Karabagh, and healing issues within Armenian Youth, domestic violence, substance abuse issues within the Armenian Community, etc. Outcomes for FY 20-21 • A total of 113 participants attended the Community Symposiums. • The first symposium was held on December 5, 2021, from 2-6pm, and was attended by 38 participants. The first part of the presentation was on education about depression. This was followed by a presentation on Substance Abuse and information on intimate partner violence. Important information was provided on core substance use issues, chemical changes, and treatment levels. • The second symposium was held on January 27, 2022, from 2-6 pm, and attended by 43 people. The general topic was youth issues and mental health, especially concerns brought up by community members that Armenian youth do not feel included in the Armenian community for a variety of reasons. • The third symposium was held on March 6, 2022, from 1-5pm, and joined by 32 people. Two different Armenian mental health professionals presented on treatment of family members of soldiers effected from PTSD due to the 44-day War in Nagorno Karabagh and how family members can support a soldier who is

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
		experiencing PTSD. The non-traditional component of this symposium was a discussion and meditation exercise. • A total of 113 pre/posts tests were given. However, the pre/post tests were challenging to complete for many reasons including technical difficulties as well as concerns around providing feedback and ideas through a manual testing system; participants usually just share their thoughts and opinions among each other after a given event/presentation/lecture/symposium. • Overall, the feedback from the participants was extremely positive and appreciative. People sent emails expressing that these were topics that were important and relevant in the Armenian community and more of these educational programs need to be conducted. • There are a few important facts about the Armenian community which must be taken in consideration: o Virtual Community Symposiums are not very accepted in the Armenian community since they prefer to attend in person events where there is also an opportunity to interact and socialize. o To increase community members' participation within the EE/ME subcommittee, it is crucial that community members realize the benefits of this subcommittee and what it can do for the community.

Russian Mental Health Media Outreach Campaign (currently in progress)	Projected Completion Date: September 30,2022	A consultant was contracted to develop a mental health media and social media outreach campaign for the Russian community that resides in LA County. This project aims to broadcast 12, 90-second Public Service Announcements (PSAs). The 12 PSAs were developed in the Russian language and three in the English language. The media campaign involves the following components. Component number one is a TV media campaign. Component number two is a social media campaign. The Russian Mental Health PSAs have been airing on various Russian television stations in LA County on daily basis. Specifically, the PSAs have been airing on the Russian-Armenian TV station, ARTN, four times a day and Russian TV Station, RTN, two times a day. The PSAs were shortened by the TV Stations from 90 to 30 seconds as needed, to fit the guidelines of the TV stations. The PSAs are advertised and boosted via Facebook, Instagram, Twitter, and other social networking platforms for a period of 12 months. The PSAs include Russian celebrities, health, and mental health professionals, including psychologists or social workers, known professionals from different fields, influencers, and community leaders to promote mental health awareness and at the same time encourage the Russian population in LA County to access services provided by LACDMH. Outcomes for FY 20-21 • A total of 12 PSAs were aired on TV and posted on social media. • The consultant communicated with Russian Mental Health providers and community members to determine the subject matter of the PSAs. • There has been a great deal of positive feedback about the PSAs from the Russian speaking community members. Community members have been contacting the TV station and Vendor expressing gratitude, stating that the airing of the PSAs has been done at an appropriate time, given the current war between Russia and Ukraine. • The airing started on August 1, 2021 and is scheduled to be completed on July 31, 2022. • Some of the topics which PSAs covered have been the following topics: Depression, Anxiety, Post Traumatic Stress Disorder, PTSD, parenting, LGBTQ Issues, intergenerational conflict, acculturation issues, etc. • Final Project Summary with outcomes will be provided when the projected is completed at the end of September 2022.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
The Farsi Poetry Night Mental Health Virtual Outreach Project (currently in progress)	Projected Completion Date: August 31,2022	A consultant was contracted to develop and implement the virtual Poetry Night Mental Health Outreach Project. This project targets Farsi speaking adults and older adults residing in LA County. This project consists of virtual Poetry Night events two times a month, for 10 consecutive months. Poetry is an important part of the Iranian culture and is traditionally used as a tool to help individuals heal from their mental and emotional problems. The Poetry Night Mental Health Outreach Project or "Shabeh Sher" will provide a place for Farsi speaking adults to get together and interact with one another. It will also provide a safe space for them to share their emotional and mental health issues in a culturally appropriate and acceptable manner. Poetry night events are facilitated by a poetry expert, who will bring in poems to share with the participants and have interactive group discussion. Outcomes for FY 20-21 • Vendor reported that the Virtual Poetry Night Classes have been going well. There has been great deal of positive feedback from the community over the Virtual Poetry Night MH classes. • During the poetry events, community members learn more about themselves through the teachings of Persian master poets and philosophers. Participants have also had opportunities to write their own poetry, share original poetry, and present their favorite poems. Poems often resemble the plight of the Persian people, Persian history, love, different human emotions, and other topics. • The poetry workshops have been advertised on a local Farsi speaking Radio station, KIRN 670AM. • Flyers and all outreach materials continue to be utilized by the vendor for advertisement purposes to increase participant attendance. • Project began on July 1, 2021 and will be completed on August 31, 2022. Project summary report will be provided when the project is complete.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Focus Groups	Completion Date: June 30,2022	The objective of the Arabic focus groups is to engage the Arabic speaking population into a virtual discussion regarding the needs of the community, as well as reduce stigma associated with mental health services. This project aims to increase awareness of the mental health needs of Arabic speaking individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. This project targets both leaders and providers within the Arabic speaking community, as well as community members. Individual interviews are conducted as well as a community meeting. The project has been completed in two phases. The first phase includes the consultant outreaching to the Arabic speaking community members to assess the needs of the community, identify gaps in access to mental health services, and identify how to engage community members into mental health services provided by LACDMH. The second phase involved the Consultant conducting a community meeting with Arabic speaking professionals and community leaders, who were brought together virtually (i.e., Zoom, Skype) into a learning collaborative to discuss the needs of the community. Outcomes for FY 20-21 • The hired consultant shared findings from the individual needs assessment interviews which were conducted confidentially. For this reason, interviews took a long-time to complete and the project ended later than the projected date. • The Final Project Summary with outcomes will be provided when the projected is completed at the end of June 2022.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Latino Latino Older Adults Outreach and Engagement	Projected Completion Date: July 31,2022	This project will target the Latino older adult community at large by promoting mental health literacy, increasing mental health service utilization and education, and reducing mental health stigma. A Focus group was created for Latino older adults to help identify resources most useful to their specific population group and provide feedback (User-Centered Design) throughout the creation of health resource booklet that is being distributed to Latino older adults throughout LA County. Through a series of workshops, this project will provide support to Latino older adults, their family members, and caregivers via culturally appropriate workshops focused on enhancing the overall wellbeing using a holistic perspective. Additionally, the workshops aim to increase awareness and knowledge related to mental health illness, combat stigma and discrimination towards Latino older adults, as well as educate and provide them, their families, and caregivers with mental health resources. By providing these workshops in Spanish, the project seeks to build and strengthen resilience in Latino older adults so that they can be better equipped to face the challenges and barriers associated with potentially experiencing mental health difficulties as they age. Outcomes for FY 20-21 • This project is still in process and outcomes will be shared once completed.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Latino Garment Workers Outreach Project	Projected Completion Date: July 31,2022	The goal of the Latino Garment Worker Project is to outreach, educate, and increase knowledge pertaining to mental health services and resources. To accomplish this, the project sought to provide support to Latino garment workers via culturally respectful workshops (either in-person or virtual) focused on enhancing emotional wellbeing from a holistic perspective and increase awareness and knowledge related to mental health illness and combat stigma and discrimination towards the immigrant Latino community. The workshops and materials were translated and made available in English, Spanish, and in indigenous languages (K'iche, Mixtec, Zapoteca, or Q'anjob'al) appropriate to the target community. In addition, this project also had the objective of educating the Latino garment worker community on how to access mental health services (virtually and in-person) and understand some of the cultural biases associated with experiencing a mental health condition in the Latino community as well as provide the garment worker community with resources and information regarding available in-person and remote services in LA County geared towards the Latino community. Outcomes for FY 20-21 • This project is still in process and outcomes will be shared once completed.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
LGBTQIA2-S UsCC Non-Binary and Intersex Mental Health Survey Project	Completion Date: September 29, 2021	The purpose of the Non-Binary and Intersex Mental Health Survey Project was to remove barriers to mental health services for the non-binary and intersex communities in LA County by conducting research to identify barriers, opportunities, and best practices for servicing this community. This project included a community survey, including focus groups, of the non-binary and intersex communities to promote mental health services, reduce stigma and barriers to mental health services, and increase the capacity of the public mental health system in LA County. As non-binary and intersex identities are becoming more visible and understood by the public, there remains very little data and research around mental health and related issues/challenges regarding non-binary and intersex people. Outcomes for FY 20-21 • In total, 20 community members participated in the focus groups. Of those participants, 17 identified as non-binary and three as intersex. • Two different surveys were conducted: Survey one yielded 296 usable entries and survey two yielded 300 usable entries. • 58% of survey respondents stated that they are currently receiving or have received mental health care services in the past. • 80% of survey respondents reported that they had virtually accessed LA County services (of any kind). • 65% of survey respondents reported that they had encountered barriers to care while trying to access mental health services. • 23% of survey respondents stated that they had stopped utilizing LA County mental health services due to discrimination based off gender identity. • 30% of survey respondents reported having an affirming experience around gender identity while utilizing LA County mental health services. • 93% of survey respondents felt that telehealth is a beneficial tool to assist in affirming gender identity during medical appointments.

LGBTQIA2-S Youth Innovation Lab & Fellowship Project	Completion Date: March 17, 2022	LGBTQIA2-S Youth Innovation Lab and Fellowship Project: The purpose of the LGBTQIA2-S Youth Innovation Lab and Fellowship Project was to reduce mental health access barriers for LGBTQIA2-S youth by recruiting Youth Fellows throughout Los Angeles County to meet and develop user-centered, innovative strategies for outreach and engagement of this marginalized population. This project included outreach and engagement of 15 LGBTQIA2-S Youth Fellows into a Youth Innovation Lab, which took place during one week in August 2021. During the Lab, the Fellows divided into groups of three or four based on interests and developed innovative strategies for reducing mental health access barriers for their community, worked on building stronger social connections, and developed tools and resources to be shared with other LGBTQIA2-S youth, as well as clinicians and providers. Following the Lab, Youth Fellows prototyped their strategies in their communities.
		
		Outcomes:
		• In total, 15 Youth Fellows participated in and completed the Lab.
		• Youth Fellows completed a pre-test and a post-test utilizing a Likert scale from 1 to 5 with 1 being Strongly Disagree and 5 being Strongly Agree. The following outcomes were reported:
		  ○ Question, “If I have a concern or a problem, I know what to do and who to talk to.” The average post-lab answer increased from 3.87 to 4.64.
		  ○ Question, “I am comfortable seeking mental health assistance when needed, regardless of my sexual orientation or gender identity.” The average post-lab answer increased from 3.33 to 4.21.
		  ○ Question, “I feel safe when accessing mental health services.” The average post-lab answer increased from 3.07 to 3.64.
		  ○ Question, “When I am in distress, I practice healthy coping mechanisms.” The average post-lab answer increased from 3.4 to 4.14.
		• The Lab and Fellowship survey results show an overall positive impact on participants both quantitatively and qualitatively.
		• The strategies the Youth Fellows developed were found to be innovative in their approaches to violence prevention and LGBTQIA2S+ mental health advocacy.
		• Following the completion of the Lab, several challenges arose that impacted the success of the prototyping phase as follows:

		○ Youth Fellows' availability had significant changes due to work schedules, school being back in session, mental health factors, and personal tragedies. ○ More than one Fellow shared that they lost someone close to them in the Months of September or October, and several were overwhelmed by the pandemic and other compounding stressors. ○ Multiple Fellows were unable to be contacted after the Lab, and after weeks of no communication or response they were let go from the prototyping phase. ○ Of the four groups, one was able to successfully complete the prototyping phase. This group managed to successfully conduct a prototype and gain insight about their strategy: Compassion For Them, with the idea of a Trans & Nonbinary Youth Resources Fair. The group conducted an online survey and a developed a flyer to promote it. They received a total of 32 responses. As an incentive, they raffled off ten $20 Starbucks gift cards for participants. Some findings included the following: ▪ Prospective participants in a resource fair were slightly more interested in live programming, but many open to a hybrid in-person/virtual set up ▪ The ideal time to host an event like this would be weekend afternoons or mornings ▪ Beyond job opportunities and medical services, prospective participants are interested in know-your-rights workshops, trans and nonbinary art showcase or gallery, and panels featuring various trans and nonbinary speakers ▪ Participants recognized that a resource fair like this would directly or indirectly support their mental health. ○ Suggestions were gathered on how to increase participation in future projects utilizing this model such as ▪ Restructuring how incentives are provided during the entire Lab and Prototyping process (i.e., provide half of the stipend at the end of the Lab and the other half after the prototype is completed). ▪ Consider how the funding for the Group Prototypes could be increased ▪ State exact dates for Prototyping when recruiting applicants for the Lab, instead of utilizing vague statements dates, i.e., "within a month after the Lab."

LGBTQIA2-S Youth Mental Health Community Engagement Campaign	Completion Date: May 16, 2022	The purpose of the LGBTQIA2-S Youth Mental Health Community Engagement Campaign was to reduce mental health access barriers for LGBTQIA2-S youth by creating content that would reach and inspire youth to promote mental health services, reduce stigma related to mental health services for LGBTQIA2-S youth, and increase the capacity of the public mental health system in LA County. The campaign included production and distribution of five 15-60 second videos via social media platforms including TikTok and Instagram. These five videos served as the centerpiece of the engagement efforts and were focused on highlighting local LA County LGBTQIA2-S history. The campaign ran for 12 weeks during October-December 2021. Outcomes for FY 20-21 • In total, 5 Youth content creators participated in the campaign. • Analytics from the initial campaign via TikTok and Instagram showed a reach of 36,316 accounts and 5,007 likes. • The videos were also shared via three larger accounts (@Pride, @LGBT, and @LGBTQ) and analytics showed this led to an additional reach of 2,164,936 as well as 2,300,113 views and 64,449 likes. • Combined with the reposts, the campaign had an overall reach of 2,201,252 accounts across TikTok and Instagram. • Youth content creators completed a pre-test and a post-test utilizing a Likert scale from 1 to 5 with 1 being Strongly Disagree and 5 being Strongly Agree. The following outcomes were reported: o Question, “If I have a concern or a problem, I know what to do and who to talk to.” The average post-lab answer increased from 4.2 to 4.8. o Question, “I am comfortable seeking mental health assistance when needed, regardless of my sexual orientation or gender identity.” The average post-lab answer increased from 3.8 to 4.8. o Question, “I feel safe when accessing mental health services.” The average post-lab answer increased from 3.6 to 4.4. o Question, “When I am in distress, I practice healthy coping mechanisms.” The average post-lab answer increased from 3.8 to 4.6.

UsCC		
Strategies and Activities	**Status and Progress**	**Monitoring/ Outcomes/Findings**
Black LGBTQIA2-S Family Unity Project	Completion Date: June 30, 2022	The purpose of the Black LGBTQIA2-S Family Unity project was to develop tools, resources, and educational videos to help Black and African American caregivers in working with their LGBTQIA2-S identified youth as well as help providers and clinicians in engaging and working with the Black LGBTQIA2-S community. This project involved two components. The first included outreach and engagement of 20 Black and African American parents and caregivers of LGBTQIA2-S identified youth, as well as the youth themselves into a Collaborative. Collaborative members participated in two-hour weekly meetings over a period of eight weeks during October-December 2021 to develop a Toolkit, including two training videos, designed to assist Black parents and caregivers in working with their LGBTQIA2-S identified youth. The second component involved Collaborative members hosting a Community Wellness Forum on 2/26/2021 with the purpose of further building community connections and sharing personal testimonials regarding their experiences during the Collaborative meetings and providing attendees with a copy of the Toolkit. Outcomes for FY 20-21 • As of June 1st, 2022, outcomes from the pre-test and post-test are being aggregated by the Facilitator. • Final outcomes will be shared once the project is completed by June 30th, 2022. • In total, 24 community members attended the Community Wellness Forum.

Veterans Peer Access Network (VPAN)
The mission of VPAN is to provide a high quality, coordinated, enduring, and world-class network of care that is easily accessible for LA County service members, veterans, and their families. VPAN deploys trained Veteran and Military Family Peers throughout LA County to connect veterans and their families to critical resources including housing, mental health care, substance use treatment, job placement and legal services. VPAN started in early 2020 and engaged many veterans.

VPAN is led by veterans for veterans and helps veterans and their families navigate often complicated systems so that they can receive the services they deserve. The first-ever community-driven support network serving veterans and their families in the U.S., VPAN connects County Departments, non-profits, the Veterans Administration and Los Angeles City programs. The network embodies the #YouMatter ideal that veterans deserve hope, wellbeing, and a greater quality of life as valued members of the community.

VPAN will put trained Veteran Peers on the ground in LA County communities to assist in connecting veterans to the services they need as they transition out of the military and into LA County.

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

VPAN utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to communities. Some examples include the following:

- The VA is drastically under-utilized and VPAN strives to ensure that veterans and military families to have timely access to the VA
- Most community providers are not aware of veteran-specific resources or what veterans may qualify for services at the VA
- High numbers of veterans experience homelessness; VPAN provides intensive street outreach and engagement to these veterans in order to get them permanently housed
- Through a study with the Coroner's office, VA, and LACDMH, they found that veterans are 4x more likely to die by suicide than non-veterans in LA County; the creation of a Suicide Prevention Coordinator addresses this disparity and assists with monitoring high risk veterans in hopes of reducing this number

VPAN identifies disparities and provides culturally and linguistically competent services to veterans residing within LA County. Many veterans do not feel comfortable engaging with non-veteran providers. The program recruits veterans and family members of veterans who can share their lived experience and apply it to effectively engage with the LA County Veteran community.

The VPAN Veteran Support Line provides coverage from 9 am – 9 pm. They immediately create referrals for mental health services as needed and respond to referrals within 2-3 days. Agents on the support line can directly transfer calls to ACCESS when callers require more immediate assessment and crisis management. The VPAN Veteran Support Line utilizes a low barrier approach with minimal eligibility criteria. In the coming years, the program's goal is to move VPAN operation to 7 days a week and being able to respond to the field immediately as needed.

Veterans Peer Access Network (VPAN)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
1) Co-location with other county departments	VPAN HQ is at Bob Hope Patriotic Hall which belongs to Department of Military and Veterans Affairs (DMVA). Staff are stationed in the lobby and work closely with DMVA staff on cases to ensure veterans are linked appropriately not falling through the cracks. VPAN staff are also collocated at various Rally Points such as Job Vision Success (JVS), Volunteers of America (VOA), Battleship Iowa, Goodwill to enhance partnership with Community Based Organizations (CBOs) servicing veterans and family.	On-going	
2) Community education to increase mental health awareness and decrease stigma	VPAN Veteran Support Line • Agents on the line provide resources to callers about mental health services and normalize the process of seeking mental health services VPAN Field based team participates in many community events to reduce stigma for veterans seeking mental health services. Due to COVID-19, the team participated in many virtual events.	On-going	Numbers of calls from veterans looking for emotional support and resources are tracked and reported to program managers.

Veterans Peer Access Network (VPAN)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
3) Consultation to gatekeepers	VPAN staff and VPAN Suicide Prevention Coordinator act as consultants for community providers who may not be versed in veteran services and resources. Gatekeepers/providers contact the staff to consult on cases.	On-going	
4) Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery	Los Angeles Veterans Collaborative (LAVC) meets monthly to discuss topics that impact the veteran community in LA County.	On-going	
5) Field-based services	VPAN services are performed in the field. VPAN team conducts homeless outreach, home visit, and collaborates with Psychiatric Mobile Response Team (PMRT) /Mental Evaluation Team (MET) on high risk cases	On-going	
6) Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	VPAN Support line helps with prevention and increase access to care for veterans experiencing stress. If callers on the line need additional mental health support, they are referred to VPAN peer support to assist with linkage to care in a timely manner. VPAN referral response time is up to 2-3 business days but sometime on the same day.	On-going	
7) Implementation of new technologies to enhance the Department's service delivery	VPAN Support Line uses the Virtual Contact Center (VCC). VCC application assists with ability to track calls, monitors calls, and transfers back to ACCESS as needed if a caller needs urgent help.		

Veterans Peer Access Network (VPAN)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
8) Augmentation of mental health service accessibility to underserved populations	Suicide Prevention Coordinator (SPC) is a new position created to address the high rate of suicide among veterans. SPC will review high risk cases and flag for 90 protocols if needed. Clients are contacted more frequently to ensure they are accessing needed services. SPC also identifies any gaps that might exist in the client care and coordinates appropriate response to ensure veteran stay safe.		Through a study with the Coroner's office, VA and LACDMH, they found that veterans are 4x more likely to die by suicide than non-veterans in LA County.
9) Integrated Supportive Services	VPAN aims to assist veterans and their families holistically. VPAN works closely with DMVA for benefits establishment, VA for healthcare, LACDMH DOs and community partners for housing, substance abuse treatment and more.		Cases are open for at least 90 days to ensure proper linkage. Monthly housing survey to track number of Veterans were matched & placed in permanent housing.
10) Interagency Collaboration	VPAN aims to assist veterans and their families holistically. VPAN works closely with CBOs such as Job Vision Success (JVS), VOA, Battleship Iowa, Goodwill, DMVA for benefits establishment, VA for healthcare, LACDMH DOs and community partners for housing, substance abuse treatment and more.	On-going	
11) Investments in learning (e.g., Innovation Plan)	VPAN collaborates with UCLA, SCG, and internal LACDMH training division to create trainings specific to veteran population.	On-going monthly meeting	Monthly meeting to review training needs for VPAN, track attendance, and develop future training topics.
12) Multi-lingual/multi-cultural staff development and	VPAN hires staff who are bilingual (Spanish, Arabic,	On-going	

Veterans Peer Access Network (VPAN)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
support Outreach and Engagement (O&E) efforts	Vietnamese, etc.) to outreach to military families who are monolingual speakers residing in LA County.		
13) Integration of physical health, mental health, and substance use services	VPAN aims to assist veterans and their families holistically. VPAN work closely with VA for healthcare, LACDMH DOs and community partners for mental health, substance abuse treatment and serves veteran such as Banyan Treatment Center.	On-going	Supervisors meet weekly with staff for case consultation.
14) Provider communication and support	VPAN leadership team meets with SCG/CBOs (contracted providers) on a weekly basis to assist with program development and monitoring.	Weekly meeting and ongoing	
15) Trainings/case consultation	VPAN supervisors and managers provide ad hoc trainings and case consultation to CBO peers. VPAN staff attend various community events to present on topics relevant to veteran needs to the public.	On-going/ as needed	
16) Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	VPAN leaderships are active in the Los Angeles Veterans Collaborative (LAVC) activities. LAVC is a structured network of public, private, and government agencies working together to reduce suffering and improve the lives of veterans, service members, and military families in LA County. This is achieved through strategically improving and coordinating their access to services, reducing barriers to care, and influencing policy.	On-going monthly meeting	

Veterans Peer Access Network (VPAN)			
Strategies	**Activities**	**Status/ Progress**	**Monitoring procedures and outcomes**
17) COVID-19 responsiveness at clinical and administrative program level.	VPAN Support Line was created at the onset of the pandemic to support unique emotional needs of veterans in LA County.	On-going	

CONSUMERS SERVED BY VPAN
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages used by Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
VPAN Veteran Support Line*						5,630*						26 callers requested language assistance. English, Spanish, Mandarin
Permanent Housing	4	12	5	0	1	8	M (26)/ F (4)					English, Spanish
Suicide Prevention Coordinator	12	9	6	4	1	7 (no response)	M (34)/ F (4)		1			English

**VPAN Support Line does not collect race/ethnicity and gender data.*

Wellness Outreach Workers (WOW) Program

WOW staff are highly valued volunteers with lived experience who provide peer support in Directly Operated programs. They work with the treatment teams to assist clients on their path to wellbeing and recovery. The purpose of this program is to provide ongoing wellness and recovery-promoting peer support to vulnerable adult clients to facilitate community reintegration and educate consumers, family, and community members about mental health care through culturally sensitive treatment options.

The WOW program aims to provide culturally and linguistically competent services. The 40 WOW volunteers served at various Directly Operated programs providing peer support in Spanish, Chinese, Khmer, Korean, French, Greek and Russian. Collectively, they generated a total number of 5,063 days of peer enrichment from July 2020 to June 2021.

Their activities included providing information on resources to the community, promoting a welcoming environment in clinic settings, and helping visitors navigate services. They also provide peer-to-peer support by facilitating virtual groups and warmline calls, sending appointment reminders, providing linkage to community-based services and COVID-19 resources. WOW volunteers bring the peer perspective to clinical treatment teams and sensitize staff to consumer culture.

The WOW volunteers are consumers advanced in their own recovery and able to share their lived experience to promote recovery among their peers. They also provide assistances in navigating the mental health system by facilitating virtual support groups and providing linkage to community services and resources. WOW volunteers are a culturally and linguistically diverse group which includes volunteers with special skills from the following diverse communities: Latino, Black and African American, Russian, Korean, Cambodian, Chinese, Greek, and LGBTQIA2-S.

Wellness Outreach Workers (WOW) Program			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and Outcomes**
1) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Bimonthly WOW meetings (7/2/2020, 9/23/2020, 11/18/2020, 2/23/2021, 5/12/2021)	• During FY 20-21, WOW team continued to support current WOW volunteers placed in LACDMH Directly Operated Wellness centers to improve access to mental health services and provide peer to peer support.	• 20-30 WOW volunteers attended the bi-monthly meetings. The meeting agenda addresses areas of diversity as well as strengthens supportive service skills in working with adult consumers.

Whole Person Care (WPC) - Intensive Service Recipient (ISR) and Kin through Peer (KTP) Program

Whole Person Care (WPC)-Intensive Service Recipient Program (ISR) and Kin Through Peer (KTP) are field-based programs. They focus on serving adults aged 18 and older with severe and persistent mental illness (SPMI), including co-occurring substance use disorders. Clients eligible for the program must be Medi-Cal eligible, reside in LA County, and have had at least two (2) psychiatric inpatient hospitalizations within the last 12 months.

The program provides a wide range of supportive services by providing emotional support and referral to community agencies that prevent unnecessary psychiatric inpatient hospitalization. Supportive services include crisis support services; service navigation; benefits establishment; linkage to mental health, health care, and substance use disorder providers; assistance with emergency food, clothing, purchase of personal hygiene items, and household goods; linkage to housing resources, social services, educational and employment services, and legal assistance; and transportation.

KTP program provides ongoing support from a peer substituting as a family member to provide a surrogate "kin" function for clients that need longer-term social help from Community Health Workers (CHW). The CHW's focus on intense relationship-building and long-term sustainable community reintegration to preserve healthy well-being.

WPC's projects and activities aim to provide culturally and linguistically competent services. LACDMH WPC works collaboratively with county community partners including inpatient psychiatric hospitals. In addition, some WPC services are co-located at other County Departments such as Workforce Development Aging & Community Services (WDACS), DHS, and DPH. This practice fosters collaboration and the ability to address the cultural and linguistic needs of the consumers served. WPC staff members come from of various cultural backgrounds, religious affiliations, gender identities, and many of them are bilingual. In general, WPC provides comprehensive services in collaboration with consumers' collateral contacts to deliver these services in a cultural and linguistic manner, offering accessibility, and equity. WPC understands the importance of collaboration with providers and community partners as they have witnessed improved outcomes and success with the consumers. WPC staff reduce barriers and assist consumers to better acclimate and reintegrate into their community. Due to WPC staff awareness of the role that cultural competence plays in the consumers' lives, they can sensitively identify and meet their needs. Cultural competence involves honoring the cultural and linguistic preferences of consumers to support their process of healing, recovery, resiliency, and well-being. Staff assist clients with language barriers on how to utilize the County's Language Line. In addition, staff incorporate the knowledge, perspectives, and skills learned during cultural competence trainings provided for WPC.

Strategic outreach and engagement activities focus on eliminating mental health disparities and addressing service gaps experienced by unserved and underserved populations. It requires listening, learning, and connecting LACDMH with its constituents, their family members, and communities. Provision of WPC field-based services has

increased accessibility and flexibility for clients to effectively participate in treatment from the comfort of their homes or a preferred community venue. The implementation of new technologies has enhanced and augmented the department's delivery of mental health services through the use of telehealth services via county iPhone, text messaging, laptops, virtual clinical appointments, and the virtual platforms for provider communications. Furthermore, the program assists clients in need of transportation to doctor and benefits establishment of appointments. Clients receive assistances in completing applications for cell phones, social security benefits, and housing.

Whole Person Care (WPC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
1) Collaboration with faith-based and other trusted community entities/groups	WPC sought to build working relationships with community food banks, shelters, transitional living residences to maximize consumers' success in achieving greater independent functioning. Staff participated in monthly Service Area Leadership Team (SALT) meeting further fostering community relationships with faith-based organizations and community groups, such as NAMI.	Ongoing	Successfully linked consumers to community resources as a result of collaboration with faith based/community entities/groups.
2) Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)	WPC programs can be co-located with other County departments. For example, WPC in SA 7 is co-located with Department of Health Services (DHS), Department of Public Health (DPH), and Workforce Development Aging & Community Services (WDACS).	Ongoing	Increase in communication, collaboration, and consumer access to needed services.
3) Community education to increase mental	WPC employs Peer Specialists to work with consumers. The Peer	Ongoing	Increase in consumer linkage to providers, increase in knowledge

Whole Person Care (WPC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
health awareness and decrease stigma	Specialists find opportunities to share their journey of recovery. In addition, staff promote help seeking and emotional well-being practices, and education geared toward reducing the stigma of mental health.		about mental health for consumers, consumer's family, and community
4) Field-based services	WPC staff conducts field-based services for the majority of their day. That includes visiting prospective clients and/or current clients at inpatient facilities (hospitals, substance abuse programs). Staff also accompany consumers to medical appointments, grocery stores, etc.	Ongoing	Progress note review, significant decrease in target population's high utilization of ER services
5) Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health.	Some WPC service areas are co-located with other County departments which foster cultural and linguistic competence. In addition, many of the trainings that are offered by DHS (SAPC), UCLA Partnership, and LAHSA further promote cultural and linguistic competence	Ongoing	Staff participation in cultural and linguistic competence trainings and collaboration
6) Implementation of new technologies to enhance the Department's service delivery	Telehealth, Virtual trainings	Ongoing	Consumer attendance to telehealth visits
7) Augmentation of mental health service accessibility to underserved populations.	WPC has established relationship with inpatient psychiatric hospitals and facilities in order to establish relationships with unserved consumers. The goal is to assist them with receiving	Ongoing	WPC staff were able to establish relationships and enroll consumers in services in order to assist them with aftercare services

Whole Person Care (WPC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	ongoing mental health treatment through outpatient services or FSP		
8) Integrated Supportive Services	WPC staff meet the consumers where they are. With the support of WPC staff, consumers have been able to integrate back into school, utilizing public transportation, libraries, and local community centers, etc.	Ongoing	Consumers have shown active and positive participation in the respective integrated services.
9) Interagency Collaboration	WPC staff encourages consumers to have interdependent connections with others rather than isolating. Frequent communication of needs and hopes with family, FSP, and other members of their team.	Ongoing	Consumers have shown active and positive collaboration with members their treatment team.
10) Investments in learning (e.g., Innovation Plan)	CHW staff members are provided with training certification opportunities such as Wellness Recovery Action Plan (WRAP) and Peer Specialist Certification. All staff members are encouraged to participate in trainings that are going to enhance or refine skills related to their job duties.	Ongoing	Staff receives certificates of completion, continuing education units, or certifications.
11) Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	WPC staff members are comprised of various genders, cultural backgrounds, and they speak the language needed to meet the consumers where they are at.	Ongoing	Staff are too continuously monitor the cultural and linguistic needs of their consumers.
12) Integration of physical health, mental health, and substance use services	WPC staff work in collaboration with mental health, medical provider, and substance use providers to	Ongoing	Staff will be encouraged to accompany consumers to appointments as support is needed.

Whole Person Care (WPC)			
Strategies	**Activities**	**Status/Progress**	**Monitoring procedures and outcomes**
	address the consumer needs and appropriate services.		
13) Provider communication and support	WPC serves as advocates for the consumers they serve. Through weekly face to face visits consumers communicate concerns from running low on medication to conflicts with their family. WPC staff assists the consumer with developing the skills to advocate for themselves and/or offer to serve as their voice.	Ongoing	The consumer is empowered to participate in their recovery. The consumer participates in their treatment planning and goals.
14) Trainings/case consultation	WPC staff are offered mandatory trainings and selective trainings to participate in throughout the year. Case consultation occurs throughout the consumers participation in WPC.	Ongoing	WPC staff works collaboratively with the mental health providers consulting about the consumers progress and participation in treatment. Staff continue to comply with Departments training requirements and programs training expectation.

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CONSUMERS SERVED BY WPC
FY 20-21

Program/ Activity	# Consumers Served by Race/Ethnicity						Gender					Languages of Staff
	White	African American	Latino	API	American Indian/ Alaska Native	Other (Specify)	Male/Female	Transman/ Transmasculine	Transwoman/ Transfeminine	Non-Binary/Gender Fluid	Unknown	
Whole Person Care ISR/KTP	428	307	442	17	20	207	F (380)/ M (681)	12			31	Spanish

The MHSA Annual Update FY 22-23 report details the outcomes of the MHSA funded programs and services. This report is considered to be an important complement to the information presented in this criterion ***(See the Criterion 3 Attachment 2).***

The table below highlights MHSA-funded programs that exemplify additional LACDMH efforts to deliver culturally and linguistically competent services. It also includes page numbers to access to the specified programs in the MHSA Annual Update report.

MHSA Funded Programs Selected From MHSA Annual Update FY 22-23	PAGE #
Alternative Crisis Services	p.36
Crisis Residential Treatment Programs (CRTP)	p.41
Early Intervention - Evidence Based Practices (EBP)	pp. 59-64
Enriched Residential Services (ERS)	pp.40-41
Home Visitation Program (HVP)	pp.67-68
Jail Transition and Linkage Services	p.50
Latina Youth Program (LYP)	p.90
Law Enforcement Teams (LET)	p.43
Library Child, Family and Community Prevention Programs	pp.68-70
Psychiatric Urgent Care Centers (UCC)	pp.37-40
School Threat Assessment and Response Team (START)	p.156
Stigma and Discrimination Reduction (SDR)	pp.84-89
Suicide Prevention	pp.90-95
TAY Probation Camps	p.33
Veterans Service Navigators	p.76
Youth Diversion and Development (YDD)	pp.77-78

Source. Mental Health Services Act (MHSA) Annual Update FY 22-23
http://file.lacounty.gov/SDSInter/dmh/1120630_MHSAAnnualUpdateFY2022-23.pdf

Criterion 3 APPENDIX

Attachment 1: 2022 Cultural Competence Plan CR 3 Acronyms

Attachment 1_Acronyms CR 3_Upc

Attachment 2: Mental Health Services Act (MHSA) Annual Update FY 22-23

MHSAAnnualUpdateFY2022-23.pdf

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criterion 4

Cultural Competency Committee

August 2022

Criterion 4: Cultural Competency Committee: Client/Family, Member/Community Committee, and Its Integration of the Committee within the County Mental Health System

I. LACDMH Cultural Competency Committee

A. Description, Organizational Chart, and Committee Membership

The Cultural Competency Committee (CCC) serves as an advisory group for the infusion of cultural competence in all Los Angeles County Department of Mental Health (LACDMH) operations. Organizationally, the CCC is housed within the Anti-Racism, Diversity and Inclusion (ARDI) Division - Cultural Competency Unit (CCU). The CCC membership includes the cultural and linguistic perspectives of consumers, family members, advocates, Directly Operated (DO) programs, Contracted providers, and community-based organizations. Additionally, the CCC considers the expertise from the Service Areas' (SA) clinical and administrative programs, front-line staff, and management essential for sustaining the mission and goals of the Committee.

CCC Mission Statement and Motto

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

CCC Leadership

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

- Facilitate all monthly meetings
- Engagement of members in Committee discussions
- Collaboration with the ARDI Division-CCU in the development of meeting agendas, planning of committee activities, vetting of Unit's projects and fulfillment of Cultural Competence Plan Requirements
- Appointing of ad-hoc subcommittees as needed

- Communicating the focus of the CCC's goals, activities, and recommendations at various Departmental venues
- Representing the voice of the CCC membership at the Department's "YourDMH" and Stakeholder Groups Leadership meetings, and the community at large

The Department's Ethnic Services Manager (ESM) monitors all activities pertaining to the CCC and provides technical support to the Co-Chairs and the committee at large. The ESM is also the program manager for the ARDI Division - CCU and is an active member of the Departmental Quality Improvement Council (QIC). This structure facilitates communication and collaboration for attaining the goals as set forth in the Department's QI Work Plan and the Cultural Competence Plan (CCP) to reduce disparities, increase capacity, and improve the quality and availability of services. Relevant CCC decisions and activities are regularly reported to the membership at the monthly Departmental QIC meeting.

For Calendar Year (CY) 2021, the CCC leadership was composed of:
- Two Co-Chairs who are community representatives
- LACDMH ESM

In accordance with its bylaws, the committee operates under the following principles:
- The CCC actively engages with and amplifies the collective voice of consumers; family members; community members; cultural groups and brokers; peers; staff from LACDMH Directly Operated, Legal entities/Contracted and administrative programs; and Community-Based Organizations
- CCC meetings are held on a monthly basis and are open to everyone
- The CCC embraces all elements of culture and advocates for equity and inclusion of all cultural groups inclusive of, but not limited to:
    - Age
    - Country of origin, degree of acculturation, generation
    - Educational level obtained
    - Family and household composition
    - Gender identity and sexual orientation
    - Health practices, including use of traditional healers
    - Language
    - Perceptions of health and well being
    - Physical abilities or disabilities; cognitive ability or disabilities
    - Political beliefs
    - Racial and ethnic groups
    - Religious and spiritual characteristics
    - Socio-economic status

Source: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A blueprint for Advancing and Sustaining CLAS policy and Practice, April 2013

(See Attachment 3: CCC Bylaws for additional details)

B. Policies, procedures and practices that assure members of the CCC reflect the community

CCC Membership

During CY 2021, the CCC had a total of ninety-two (92) active members. The CCC membership consisted of representatives from different cultural and linguistic groups, different roles, and walks of life including consumers, family members, caregivers, community members, advocates, peers, and LACDMH stakeholder groups. Among them are the Underserved Cultural Communities subcommittees (UsCC), Service Area Leadership Teams (SALT), consumer-run organizations, community-based organizations, State and local advocacy agencies, mental health providers, and Los Angeles County sister Health Departments. The functions of the LACDMH-affiliated members include volunteers, peers, management, and staff from administrative and clinical programs.

The richness of the CCC's diversity can be easily appreciated across multiple elements of culture including race and ethnicity, linguistic capability, gender identity, gender pronouns, sexual orientation, physical and cognitive abilities and disabilities, and a wide variety of agency affiliations.

<u>Race and Ethnicity</u>

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

- African American
- American
- Armenian
- Asian
- Black, Black American
- Caucasian
- Guatemalan
- Indígena (indigenous) Latina
- Korean
- Latino(a)
- Mexican American
- Native Indian
- Spaniard/Latino/American Indian
- Spanish
- White

<u>Language</u>

The linguistic diversity of the CCC for CY 2021 consisted of the following eleven (11) languages:

- American Sign Language (ASL)
- Armenian
- English
- German

- Igbo
- Japanese
- Korean
- Portuguese
- Spanish
- Swahili
- Tagalog

Gender and Gender Pronouns

Out of 92 members, twenty-one (21) self-identified as male and seventy-one (71) as female. All CCC members reported being cisgender[RG1]. The gender pronouns endorsed by the membership include:

- He/him
- She/her
- They/them
- We/us
- Ze/hir

Sexual Orientation

The committee's diversity in terms of self-reported sexual orientations included heterosexual, lesbian, and gay.

LACDMH Stakeholder Group Affiliations

- Access for All Underserved Cultural Communities Subcommittee (UsCC)
- American Indian/Alaska Native (AI/AN) UsCC
- Asian Pacific Islander (API) UsCC
- Black & African Heritage (BAH) UsCC
- Eastern European/Middle Eastern (EE/ME) UsCC
- Latino UsCC
- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Two-Spirit (LGBTQIA2-S) UsCC
- Service Area Leadership Team (SALT 1)

LACDMH Program Representation

1. *Directly Operated Programs*
    - Downtown Mental Health Services
    - Edelman Mental Health Clinic
    - East San Gabriel Valley Mental Health Center
    - Martin Luther King Jr. Community Hospital – Augustus F. Hawkins Mental Health Center
    - Rio Hondo Community Mental Health Center
    - West Central Mental Health Service

2. *Contracted/Legal Entity Providers*
    - Alafia Mental Health

- Alma Family Services
- Amanecer Community Counseling Services
- Asian Pacific Counseling and Treatment Centers (APCTC)
- Children's Institute Inc.
- El Centro Del Pueblo
- Five Acres
- Gateways Hospital
- Hillsides
- Koreatown Youth and Community Center
- Mount St. Mary's University
- Northeast Mental Health Clinic
- San Fernando Valley Community Mental Health Clinic (SFVCMHC)
- Shields for Families
- Southern California Health and Rehabilitation Program (SCHARP) & Barbour Medical Associates
- Star View Behavioral Health
- Star View Community Services
- Stars Inc.
- Tarzana Treatment Center
- The Children's Center of the Antelope Valley
- The Village Family Services
- Trinity Youth Services
- Victor Treatment Center

3. LACDMH Administrative Programs

- ARDI Division-CCU
- Compliance, Privacy, and Audit Services
- Help Line-ACCESS Center
- LGBTQ+ Services
- Quality and Outcomes Training Division
- Office of Discipline Chiefs
- Peer Resource Center
- Quality Improvement Council
- Service Area Leadership Teams (SALT) 1 - 8
- SA 2 Administration and Quality Improvement Committee
- SA 3 Administration and Quality Improvement Committee
- SA 4 Administration and Quality Improvement Committee
- SA 5 Administration and Quality Improvement Committee
- SA 6 Administration and Quality Improvement Committee

<u>CCC Members' Agency Affiliation in the Community at Large</u>

CCC members contribute a rich combination of organizations representing different aspects of community life. The list below specifies the community organizations represented by the CCC membership.

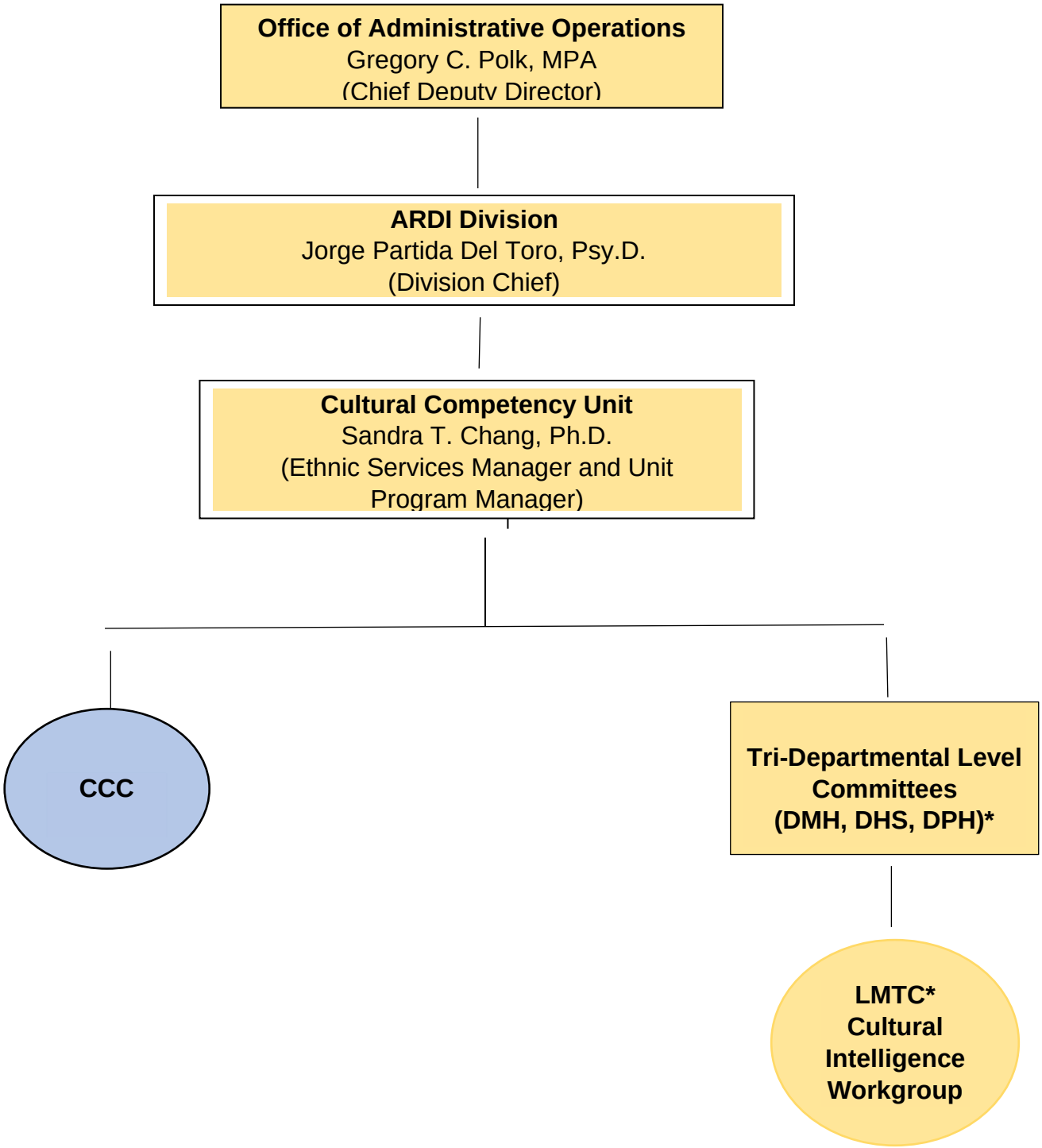
1. Consumer-Based Organizations
    - Asian Coalition
    - Aurrera Health
    - Latino Coalition
    - Los Angeles County Client Coalition

2. Community-Based Organizations
    - Academy of East Los Angeles (AELA)
    - ACCESS Los Angeles County
    - Alzheimer's Association
    - Amanecer Semillas Charter Schools
    - Cal Voices
    - Child & Family Center
    - City of Pasadena
    - Disability Rights California (DRC)
    - Greater Los Angeles Agency on Deafness (GLAD)
    - Olive Support Services
    - Rancho San Antonio
    - State ACCESS
    - Wellnest Los Angeles

3. Los Angeles County Departments
    - Department of Children and Family Services (DCFS)
    - Department of Public Health (DPH)
    - Department of Workforce Development, Aging and Community Services
    - Department of Health Care Services (DHCS)
    - Los Angeles County Commission on Human Relations

4. Additional Government Entities not listed above
    - Pasadena Public Health
    - National Disability Rights (NDR)
    - California Health & Human Services Agency (CHHS)
    - Office of Statewide Health Planning & Development (OSHPD)

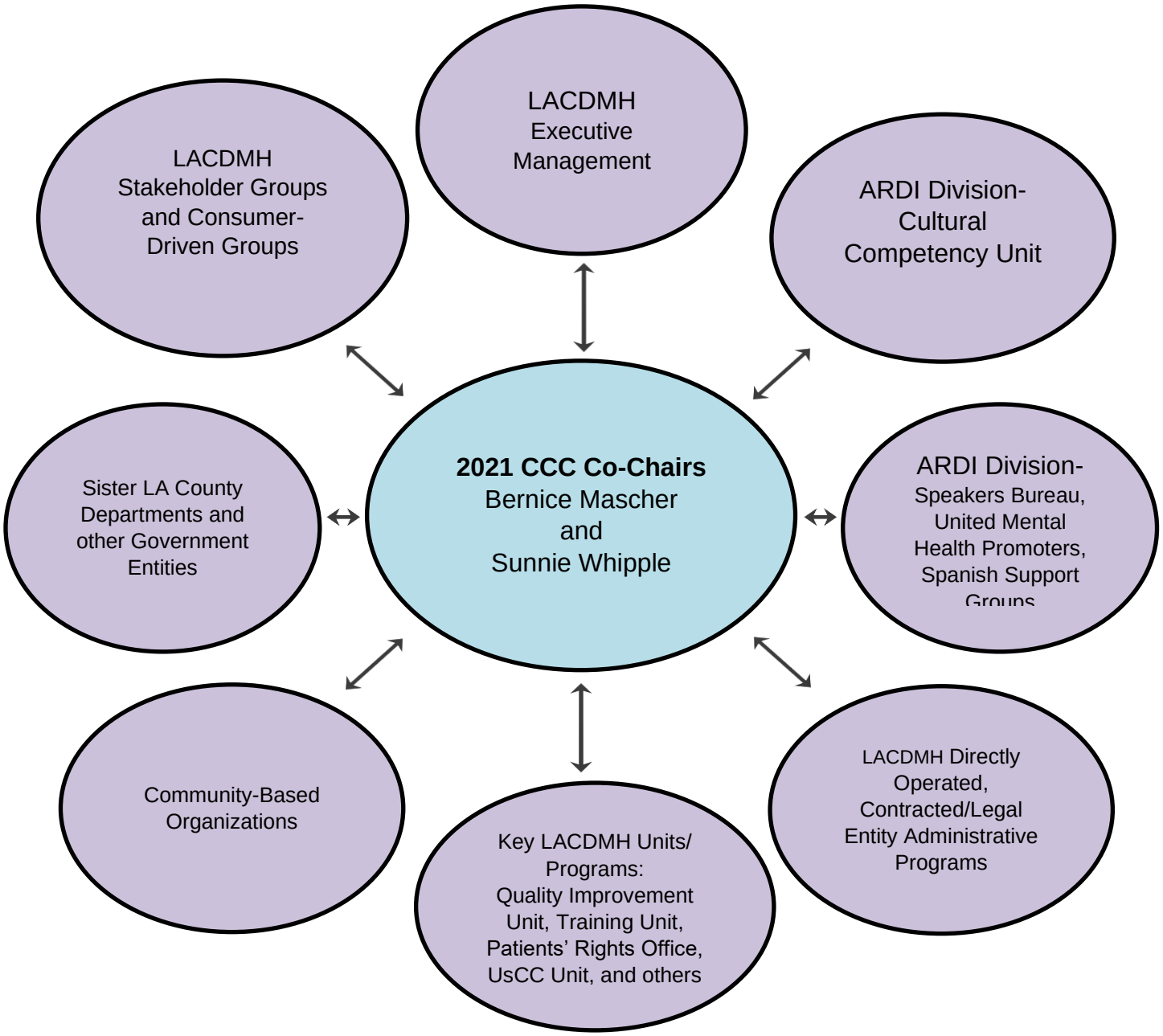
C. Organizational Chart of the CCC, CY 2021



* LMTC = Labor Management Transformational Council
DHS = Department of Health Services
DPH = Department of Public Health

II. CCC integration within the Mental Health System

CCC Departmental Partnerships and Collaborations, CY 2021



A. Evidence of policies, procedures, and practices that demonstrate the CCC's activities

The CCC embodies and carries out the Cultural Competence Plan Requirements pertinent to Criterion 4 as mandated by the Department of Health Care Services. LACDMH P&P 200.09 "Culturally and Linguistically Inclusive Services" defines the CCC as follows: The[RG2] ***Cultural Competency Committee*** serves as an advisory group for the infusion of cultural competency in all LACDMH operations. Administratively, the CCC is housed within the ARDI Division-CCU. Per DHCS Cultural Competence Plan Requirements, all Counties are mandated to have an established committee to address cultural issues and concerns with representation from different cultural groups. The CCC membership includes the cultural perspectives of consumers, family members, advocates, peers, staff from Directly Operated (DO) providers and legal entities/contracted providers, and community-based organizations. The CCC advocates for the needs of all cultural and linguistic groups. Additionally, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining the mission of the Committee.

P&P 200.09 also specifies LACDMH's recognition of the role of the CCC as an advisory body for cultural competence and states that "LACDMH clinical and administrative programs support the activities of the CCC by participating in monthly meetings and contributing toward the fulfillment of committee goals and activities (i.e., delivering presentations, providing information regarding program outcomes, and implementing the committee recommendations in projects and initiatives)."

CCC Activities and Workflow

At the end of each CY, the CCC holds an annual retreat to review its goals, activities, and accomplishments; vote on cultural competency objectives to be undertaken for the next year; and reinforce the collaborative team atmosphere among Committee members. Once the CCC identifies areas of organizational cultural competence to be addressed, it proceeds to operationalize its goals and objectives. For CY 2021, the CCC membership decided on a model based on monthly presentations scheduled by strategically selected LACDMH programs and initiatives related to cultural competence. This model ensures the engagement of the CCC as an advisory body to provide recommendations for the planning, implementation, and evaluation of cultural diversity and cultural competence-related efforts.

Throughout the year, CCC members actively identified initiatives of interest to be presented during monthly committee meetings. At the end of each presentation, the committee provided feedback and recommendations to ensure the inclusion of cultural competence in all LACDMH services. Presenter programs and units are invited back to provide updates and follow-ups on CCC recommendations. The table below summarizes the presentations and discussions of the CCC during CY 2021.

TABLE 1: SUMMARY OF PRESENTATIONS PROVIDED TO AND TOPICS OF DISCUSSIONS HELD BY THE CCC, CY 2021

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
January	Collaborative CCC and ARDI Division-CCU Project: Cultural Traditions and Connections Newsletter
February	Special Panel Presentation: Black History Month LACDMH Bilingual Capacity of the System of Care Los Angeles County Threshold Languages and Consumer Utilization
March	LACDMH Community Ambassador Network (CAN) Program
April	Special Panel Presentation: Raising Awareness on Violence Toward Asian Americans
May	LACDMH Consumer Satisfaction Perception Survey
June	Special Presentation: Dialogues and Action Towards Recovery from Systemic Racism and Oppression
July	LACDMH Senate Bill 803: Mental Health Services Peer Support Specialist Certification
August	LACDMH Help Line Call Center Modernization LACDMH Tribal Affiliation Data in IBHIS Update
September	LACDMH United Mental Health Promoters Program Update LACDMH Current Client Demographics Dashboard Project CCC Virtual Code of Conduct
October	LACDMH Cultural Competence Organizational Assessment Project Findings

November	Special Panel Presentation: Honoring Our Veterans LACDMH Veteran Access Network (VPAN) Program
December	Annual Retreat Reflections on CY 2021: Honoring Late Mr. Sunnie Whipple, CCC Co-Chair

* Due to the ongoing COVID-19 pandemic, CCC meetings continued to be held via a virtual platform.

III. A. 1. Review of County Programs and Services

The CCC serves as an advisory group to the Department as mandated by the DHCS Cultural Competence Plan Requirements (CCPR). The CCC invites, collects, analyzes, and provides feedback and recommendations to departmental programs and initiatives to strengthen LACDMH's cultural and linguistic competence. The collective voice of the CCC is also represented at the Service Area Leadership Team (SALT) meetings. This practice ensures that the voice and recommendations of the committee are heard at these system wide decision-making meetings. The voice of the CCC is also amplified by the Co-Chairs' participation in the UsCC Leadership Team. Working together, the CCC and UsCC subcommittees advocate for the needs of underserved cultural groups and the elimination of mental health disparities.

The CCC also has an impact on the system of care by inviting and scheduling presentations from various LACDMH programs. These presentations take place during the monthly meetings. Feedback is either provided via the committee at large or via ad-hoc workgroups, when the Committee deems that an in-depth project review is necessary. The primary goal of the CCC is to ensure that cultural competence and linguistic appropriateness are included in new LACDMH projects and initiatives. [RG3] When deemed necessary, the Committee will request presenters to return with updated information or work products to ensure the feedback has been incorporated. Below is a summary of presentations delivered at CCC monthly meetings during CY 2021. It is important to point out that the summary does not capture the richness of CCC discussions and interactions with the presenters. Rather, the summary is comprised of selected excerpts that illustrate the depth of CCC discussions and member recommendations.

1. **Cultural Traditions and Connections Newsletter Project**
   In January 2021, the CCC membership welcomed this presentation on the Cultural Traditions and Connections Newsletter project with great excitement. The project has its roots in the CCC's "Share your Culture" meeting segment. As a result of the COVID-19 pandemic and the shift to virtual meetings, the ESM proposed the development of the newsletter to unite members in a collaborative effort with the ARDI Division CCU that would reduce COVID-19 imposed social isolation, increase a sense of positive energy and hope, and foster cross-cultural learning, understanding, sensitivity, and appreciation. The goal of the newsletter is to promote the sharing of

cross-cultural knowledge, appreciation for diverse cultural traditions and walks of life. The opportunity to submit content is open to everyone, to embody the newsletter motto, "for the community by the community." The newsletter will be released quarterly and will allow members, consumers, family members, and the community at large to participate by providing articles and other types of content. An initial draft produced by the ARDI Division-CCU was shared with the CCC to demonstrate what the newsletter could look like and what it could accomplish. CCC members were invited to share their talents. The project was well received and approved by the CCC. As a next step, the ARDI Division-CCU plans on presenting this project to all the UsCC and other stakeholders with a cordial invitation to join the cultural traditions and connections movement.

CCC Feedback[RG4]

Members provided ideas for the newsletter content; for example, one member would like to contribute an article on Black History Month. Another member spoke about the "Walking in Someone's Shoes," program at Stanford University, in which participants experience what someone with a mental health condition may experience. Members demonstrated enthusiasm and a desire to get involved in creating content for the newsletter, since it will help uplift readers and keep the community informed, using channels other than social media. The CCC agreed to form a workgroup specifically designed to implement the quarterly newsletter. Several members signed up for the workgroup during the meeting.

2. Black History Month and Black African Heritage UsCC Subcommittee

In February 2021, CCC membership welcomed presentations on Black History Month and the Black and African Heritage UsCC. The featured speakers were Mr. James Coomes, LACDMH Speakers Bureau; Ms. Senait Admassu, Executive Director of the nonprofit African Communities Public Health Coalition and an active member of the Black & African Heritage (BAH) UsCC; and Ms. Wendy Cabil, BAH UsCC Co-Chair; and Ms. Nakeya Fields, BAH UsCC Co-Chair. These dynamic presentations centered on African American history and resilience in the United States. On a national level, programs such as the 1619 Project and Filling the Gaps aim to teach the history of slavery, Jim Crow, and Civil Rights movements. On a local level, the Black Mental Health Task Force focuses on self-care and celebration, building positive relationships with African American clients and community members.

CCC Feedback

This presentation was described by the membership as timely and relevant. A member commented that he agreed with the presenters that progress is made from the bottom-up and not from the top down. The issue of intergenerational trauma was discussed. Recommendations included: continuing discussions with the BAH and American Indian/Alaska Native UsCC subcommittees regarding trauma in these communities with the goal of inspiring capacity building projects for FY 21-22. Other members pointed out that intergenerational trauma is experienced not only in the African American community but also with other communities of color[RG5], and that in that

sense, we all are traumatized. The CCC decided to continue coordinating special presentations and inviting all stakeholder groups to join as a way of fostering unity, collaborations, and collective advocacy. As one member summarized it, “advocacy is good, but without action, it is just a dream.”

3. Cultural Traditions and Connections Newsletter Project Update

LACDMH’s ESM, Dr. Sandra Chang, gave an update on the Cultural Traditions and Connections newsletter. This new project was approved by executive management. The ARDI Division-CCU has been presenting the project at all the stakeholder groups, including all UsCC, Service Area Leadership Teams, Faith-Based Advocacy Council, among others, to invite them to be a part of this project. All Stakeholder groups will have a section in the newsletter to introduce the community to their respective committees and activities. The first edition of the newsletter is being developed with a target date for release by March 31, 2021. To date, several community members and LACDMH staff have submitted poems, pictures, quotes, and articles about their own experiences in celebration of cultural traditions. The newsletter will also include a mental health education section, written by members of LACDMH’s Speakers Bureau, community resources, and information on participation in stakeholder meetings.

(See Attachment 3: Cultural Traditions and Connections Newsletter.)

CCC Feedback

Members shared additional content suggestions, which were highly praised by the ESM. For example, a member recommended having content regarding the American Disabilities Act (ADA). A discussion was held regarding ADA-related considerations for the publication of the newsletter such as font size, the use of graphics for persons who may be blind or have sight conditions. Dr. Chang welcomed this input and elaborated that the newsletter will be posted online, which will allow viewers to select their specific settings. Additionally, based on these insightful recommendations, the newsletter will be made available in Word format, not pdf, and contain no graphics, to ensure that the content can be viewed clearly and not be distorted for persons who have visual disabilities. The newsletter will also be made available in hard copy based on requests from the Cultural Competency Committee and the Underserved Cultural Communities subcommittees plans for distribution will be one of the areas of focus in future newsletter workgroup meetings. Members were invited to participate in the workgroup, which welcomes new members to ensure inclusion of different stakeholder groups, consumers, family members, peers, advocates, and community members. Everyone is welcome.

4. Community Ambassador Network (CAN)

In March 2021, CCC membership welcomed a presentation on the Community Ambassador Network Program. Members learned that this program hires and trains trusted community members to promote mental health in the community. The goal of the program is for ambassadors to screen the needs of families and neighborhoods, engage the community with available resources, provide accurate educational mental health messages, and facilitate collaboration between leaders and organizations to

form coalitions that empower communities. This CAN program prioritizes the Asian Pacific Islander communities and Black, Indigenous, and other People of Color. The program was expanded by leveraging existing Mental Health Services Act (MHSA) dollars and the network of established community-based providers, including organizations that have implemented MHSA-Innovation (INN) 2 projects. By repurposing unspent MHSA-INN 2 funds, providers can hire and/or promote qualified community members and staff to become Community Ambassadors.

CCC Feedback

The membership asked many inquisitive questions about this new project. A member inquired about the difference between the role of the Community Ambassador and that of the Promotores de Salud Program. One particular concern expressed by the CCC was to ensure that the Department has cultural and linguistic relevance in the staffing of this program as well as appropriate planning to inform culturally diverse communities of CAN services. The presenter explained that Promoters have historically served as vendors and that LACDMH is recruiting 300 additional Promoters to work with the Department. Many of them prefer to work part-time, whereas Community Ambassadors will be fulltime positions with benefits. On the other hand, Community Ambassadors directly link people to services, whereas Mental Health Promoters provide community-based training sessions. The presenter stated that the estimated 200 CAN positions will be funded by INN 2 unspent funds.

5. Raising Awareness on Violence Towards Asian Americans

In April 2021, the CCC membership welcomed a panel presentation on the critical topic of Raising Awareness on Violence Toward Asian Communities. Moderated by CCC Co-Chairs, Sunnie Whipple and Bernice Mascher, featured speakers were Ms. Nagamatsu, of the Greater Los Angeles Agency on Deafness (GLAD Inc.); Mariko Kahn, Director of Pacific Asian Counseling Services and Co-Chair of the Mental Health Committee; Dr. Derek Hsieh, LACDMH Speakers Bureau member; Josephine Dhungana, LACDMH Speakers Bureau member; Roque Alas Bucton, Access for All Co-Chair; Pamela Inaba, CCC and Asian Coalition Member; Kathy Moon, an-LACDMH Speakers Bureau member; and Richer San, API UsCC Co-Chair. Presenters offered personal experiences and social analyses on how past and current violence against the Asians and Pacific Islanders affect the community; what the API community should do in the event they experience or witness a violent act; guidance to understand the signs or red flags leading to aggression and how to recognize need for assistance with mental wellbeing; and identify community support resources.

CCC Feedback

The committee expressed appreciation for the rich panel presentation and resources provided by the speakers. The members engaged in a reflective discussion: A member commented that this is good timing for everyone to look and notice how one moves through life and treats other people. It was pointed out that there is a lack of cultural competency between us all and that lack of awareness is unknowingly

transmitted day-to-day. A call was made for members and meeting participants to look back at themselves and what they are transmitting to the world. These instances have been happening for years and unfortunately, hate crimes have historically happened against particular racial and ethnic groups. Members shared comments about the need for all people to learn how to live together, side-by-side, embrace each other, in mutual struggles and come closer together. The CCC Co-Chairs and members, expressed deep appreciation to each panelist for their time and wealth of information provided. A guest in attendance commented that there were only two consumers who were on the panel, and it is important to hear the voice of mental health services consumers.

6. Consumer Satisfaction Perception Survey

In May 2021, CCC membership welcomed a presentation from LACDMH Quality Improvement Team regarding the Consumer Satisfaction Perception Survey, which is administered twice a year at randomly selected provider sites. The purpose of the 2020 CPS redesign to the CCC was to gather input on 1) data identified as meaningful for various audiences, 2) how to adapt data to existing surveys, 3) how to reduce redundant or unnecessary information, and 4) how to make CPS information accessible to the public. A one-page overview of data was developed, and in-depth provider-level reports include detailed data. The presenter reported on the feedback received for this presentation from the Service Area Leadership Teams (SALT). These presentations are pinpointing opportunities to make the surveys more user-friendly and ensure that consumers are receiving the surveys. Most respondents wanted to know how consumers in the community are coping. Specifically, are the services that LACDMH provides helping them improve? Are some communities not benefiting from LACDMH services? Which clinics are struggling the most? Do consumers have access to services? Are service providers punctual? Is the service provided what the consumer requests? Are services provided in the appropriate languages?

CCC Feedback

The CCC members analyzed the CPS data presented and critically questioned the QI Team's rationale for working with a significantly small number of survey responses. These questions turned into recommendations for the QI Team to consider. For instance, a member pointed out that such small samples are not useful for drawing any accurate conclusions. Another member stated that if LACDDMH uses this information, it will cause more inequities for stakeholders, especially Black, Indigenous, and other People of Color (BIPOC) since there are no concrete efforts to gather CPS outcomes form these racial/ethnic groups. Another member added that the CPS sample does not include sufficient participation from parents of consumer children and youth. A recommendation was made for the hours of the surveys go beyond 9 am-5 pm, so that working parents can participate. A member asked about CPS accommodations for literacy levels and expressed concerns about the accuracy of survey questions being written at a third-grade level. Other comments and recommendations revolved around the CPS being mailed to consumers' residences with insufficient consumer engagement in general, which puts into question the process to distribute this important survey communication for a wide range of responses from the community.

Another member commented that the CPS surveys that LACDMH is utilizing have many inequities such as there being only one respondent for some of the Service Areas, thereby highlighting racial inequalities in access by immigrant communities: African American, Native American, Latino, API, LGBTQIA2-S communities. A recommendation was made for LACDMH to take these surveys to the streets, on the buses, and metro. Another recommendation was to add more options in terms of sexual orientation and gender identity, given that the current gender options only include male, female and other. Furthermore, the surveys lack questions about sexual orientation. A member advised the QI Team about using highly technical terms for sexual orientation stating that children and Transition Age Youth (TAY) can answer these questions, however, parents may not be able to understand such technical terms. A member also asked whether training is being provided for staff who are administering these surveys. A member commented that he is impressed by the inclusivity of these recommendations and looks forward to seeing these included in future Consumer Perception Surveys (CPS).

7. **Dialogues and Action Towards Recovery from Systemic Racism and Oppression**

In June 2021, CCC members welcomed a presentation by Dr. Jorge Partida, ARDI Division Chief titled **"**Dialogues and Action Towards Recovery from Systemic Racism and Oppression." He stated that this is a very difficult topic, but it is especially important for LACDMH during this time with the most recent civil unrest. He reported that LACDMH is starting an ARDI Division in alignment with County efforts to create a greater focus on antiracism, diversity, and inclusion. This rich presentation highlighted that this is a very critical time in that these conversations are again trending. Main points of the presentation included the following: 1) We must be mindful and insightful enough to plan beyond what is popular and really think of what it means for us, collectively as a people, to begin to recover from the trauma of mutigenerational and systemic racism and oppression that we have dealt with for generations. 2) Our work starts with becoming aware of how we participate in systems of oppression, how we have been impacted by oppression ourselves, and considering how our humanity has been robbed and how we participated in the robbing of other people's humanity. If we are not able to recover from trauma, we tend to perpetuate hurt and pain on others that we see as less able to defend themselves. If we do not heal our hurts when we get into power and authority, we can perpetuate the same hurt done upon us. 3) It is critical that we have enough of a safe space for us to begin to analyze our own experiences of oppression and marginalization so that we can begin to recognize that we have healing to do within ourselves. For those of us who have lived through collective oppression, racism, and marginalization, we need to be aware and accept the fact that oppression has had an impact on our lives and relationships. While critical dialogue is important, it also is not sufficient. We must have the courage to move beyond dialogue to actionable items. 4) Once we become aware of the issue itself and give ourselves space to have analytical open dialogues, we will begin to recognize that we ourselves must be a part of that shift and be in a better position to

address issues systemically. This presentation facilitated CCC learning about LACDMH's ARDI Staff Advisory Council, the Action Learning Community and the 125 recommendations to create a systemwide anti-racism impact.

CCC Feedback

The CCC listened to this presentation attentively and asked several questions mainly targeting the Department's decision to engage in racial justice work including the implementation the ARDI Staff Advisory Council without community engagement. Feedback also pointed out the importance of LACDMH Peers participating in these efforts. CCC Co-Chairs emphasized the repeated disconnect between the department's bureaucratic and academic powers, and the community at large. Recommendations included: 1) for ARDI efforts to engage the community from the early stages of planning and recommendations, 2) for the Division to facilitate opportunities for diverse voices from the community to be the main force for input pertinent to planning, progress evaluation, and outcomes of service delivery for the community.

8. LACDMH Initiative regarding Senate Bill 803: Mental Health Services Peer Support Specialist Certification

In July 2021, CCC membership welcomed a presentation on Senate Bill 803: Mental Health Services Peer Support Specialist Certification, which included and an overview of SB 803, which passed into law by Governor Newsom in 2020. Accordingly, Counties will have an option to participate in expanding the training and certification of people with lived experience Peer Support Specialists, which Los Angeles County has agreed to. The State of California is calling it the Medi-Cal Peer Support Specialist Program because those who are certified can technically bill Medi-Cal without involving a licensed professional within a program setting for individual and group peer support services. The presenter shared a comprehensive information on the standards for Initial Certification, competencies, and eligibility requirements. The presenter informed the Committee that the participating counties would submit their curriculum through CALMHSA by November 19, 2021, and about opportunities to provide feedback to the State.

CCC Feedback

The presentation received a combination of observations and recommendations. For example: a member commented that the Department focuses more on severe mental health challenges and not on individuals who may have moderate or mild mental health issues. He asked whether peer specialists would be trained on how to work with consumers who have moderate mental health conditions. Another member recommended not adding more Peer Support Specialists, rather focus on training existing peers. Another recommendation was to expand the language capacity in the pool of peers, specifically indigenous languages. Another important question raised by the members was what would happen to persons who are already working as Peer Support Specialists considering SB 803 and there was a concern about them being

remove from this role if they did not meet the new competencies. A member was concerned about departmental paperwork and documentation being only in English, with no option to include progress notes taken in another language. Finally, it was recommended that input be gathered from all stakeholder groups, including UsCC and SALTs so that the Peer Specialist items will reflect the needs of the consumers to be served and the community at large.

9. LACDMH Help Line

In August 2021, CCC membership welcomed a presentation from the LACDMH Quality Assurance Unit regarding efforts to modernize and improve services provided by the Help Line Call Center. The Call Center serves as the primary entry point for mental health services within Los Angeles County and offers services through three distinct lines: the ACCESS Center, Emotional Support Line, and the Warm Line. The traditional line, ACCESS Center, remains in place. Additions include an Emotional Support Line to assist community members address stressors due to COVID-19, and the Veterans & Military Family member support line, designed for veterans and their families who need emotional support or assistance connecting to resources. The CCC learned about State minimum requirements for the Help Line such as 1) language capacity in all languages spoken by beneficiaries in the county, 2) ability to provide beneficiaries with information on how to access mental health and other social services, 3) assessment regarding medical necessity criteria being met, 4) dissemination of information urgent care services and how to use the beneficiary problem resolution and fair hearing process.

The Department recognized that improvements were needed to the Call Center in order to facilitate equitable access and enhance the experience of community callers by having different connectivity options like telephone line, chats, or video interactions; minimize wait times; and seamless call transfers when indicated. Attention is also given to the pursuit of culturally and linguistically relevant desirable outcomes. In an effort to modernize the technology, chat, email, and text notifications are being utilized, as well as reducing time to care and coordination of services inclusive of:

- Information and referrals
- Centralized appointment scheduling
- The Emotional Support Line services
- The Crisis Response dispatch (PMRT), and the potential to bring in the Suicide Prevention Line to talk to a crisis counselor

Additionally, the presenter reported that LACDMH is working on several pilot projects in SA 3 for the hospitals to schedule appointments with directly operated or legal entity providers by contacting the Help Line. Other pilot projects involve law enforcement and Didi Hirsch coordinate of call transfers from the Suicide Prevention Line to the Help Line if PMRT dispatch is needed instead of relying on 911. Finally, the Department is also redesigning the Provider Directory and online tools for community members to - navigate and access mental health services.

CCC Feedback

The CCC was appreciative of this presentation. The committee inquired about several new features of the Help Line modernization. Among them, a member asked regarding the use of PMRT services, which their limited deployment may lead to calls being channeled to 911. Another member brought up safety mechanisms in place to prevent or limit the number of calls directed to law enforcement. Members discussed the critical issue of excessive force by law enforcement and the likelihood of incidents escalating to violent outcomes for callers or their families. Members communicated concerns of frequent violence particularly in underserved communities. The group inquired about mechanisms in place to minimize these incidents, specifically having these crises diverted to law enforcement. A member inquired about "linguistically competent services: how does the Department determine need and linguistic competence." A suggestion from the CCC membership was to have a menu of languages that gets announced to the callers in those specific languages, rather than only in English.

10. LACDMH Inclusion of Consumers' American Indian/Alaska Native Tribal Affiliation in the Integrated Behavioral Information Systems (IBHIS)

This presentation was brought to the CCC per the ESM's request to engage the committee in providing input and recommendations made by the Committee to LACDMH's Human Resources to hire clinicians specialized in the American Indian/Alaska Native (AI/AN) population. The presenter informed the CCC of current efforts to include tribal affiliation data in IBHIS by the American Indian Counseling Center, the ARDI Division-CCU, and Clinical Informatics dashboard workgroup and the Quality Assurance Division. The presenter emphasized the importance for LACDMH to pursue this consumer demographic information. She has met with several of the UsCCs where she shared a list from the Bureau of Indian Affairs with the goal of gathering feedback, and she is pursuing the CCC input today. The list shared with the group contains federally recognized tribes. She also shared a document on California-recognized tribes, explaining that some tribes may be state recognized but not always federally recognized. This is an ongoing effort to accurately collect tribal data to clearly identify where Native Americans live and where they are accessing services. She added that this data could be interesting. For example, the data showed 200,000 Native Americans living in Los Angeles County. Once feedback is gathered from the UsCC and the CCC, the finalized list will be submitted to the Quality Assurance Division to add a data field for tribal affiliation. Clinic staff who work directly with American Indian consumers would then enter this information. The ARDI Division-CCU and the data dashboard workgroups are discussing the need to gather this information to better understand service needs and improve accessibility and cultural relevance for AI/AN consumers.

CCC Feedback

The CCC approved this project. CCC members of AI/AN ancestry asked about the various Native American lineages that could be reported. For example, having a father who is Cherokee Indian, Spanish, and African American. Another member asked whether the Department could share tribal affiliation with consumers' health clinics and Indian Health Service (IHS). A member stated that she has Indian blood on both sides of her family and asked whether American Indian Counseling Center could assist consumers find the lineage or help them in their journey of discovery.

11. LACDMH United Mental Health Promoters Update[RG6]

In September 2021, CCC membership welcomed a presentation regarding the United Mental Health Promoters Program expansion to the following high-priority populations identified by the LA County Board of Supervisors: Black and African American, API, and AI/ANLACDMH has surpassed the expansion parameters to include the LGBTQIA2-S, persons with physical disabilities, and the Eastern European/Middle Eastern communities. Another important distinction to be made is that the program is not intended to be a translation or an adaptation from the Spanish curriculum to other cultures. The Department does not just want to translate the documents into different languages but rather engaging critical stakeholders in helping LACDMH identify whether the curriculum is culturally sound and supportive for the communities that they are intended to serve. LACDMH relies heavily on input from the CCC and UsCCs. The presentation also provided an update on the status of the hiring process and shared that LACDMH will be conducting a hiring recruitment fair that will focus on getting the word out and having qualified candidates apply. Dr. Partida informed the CCC that Promoters will be hired for all threshold language and cultures. To be considered for employment, a candidate must demonstrate community knowledge and at least six months of full-time equivalent work in the community that the candidate is intended to serve.

CCC Feedback

The committee members demonstrated great interest in this presentation and how the UMHP is addressing the cultural and linguistic needs of the community as they recruit new promoters. Several members asked the presenter to highlight the challenges faced by community members in seeking employment at LACDMH. Others asked about the application process and the extremely detailed information it requires. A member asked how HR measures lived experience and community involvement that would qualify. The CCC expressed interest in getting updates on this program to determine progress made with recruitment and culture-specific curriculum adaptations.

12. LACDMH Client Demographics Dashboard Project

The second presentation brought to the September 2021 CCC meeting focused on the Consumer Demographic Dashboard by LACDMH Clinical Informatics Team. The presenters explained and demonstrated the current consumer data contained

in the dashboard based on cultural elements such as race/ethnicity, language, sexual orientation, diagnostics, age group, type of service(s) being rendered by the Department, etc. The goal of this dashboard is to make this information easily accessible and understandable to the public. It is very important for the Department to receive feedback and observations about the dashboard from the CCC membership. The presenters shared that there was extensive thought and discussions held with the ESM, Quality Improvement Team, and Quality Assurance Unit to build the content of the dashboard. What is most important is to gather feedback from the CCC regarding the usefulness of the information included and how it is displayed. LACDMH is hoping that this will be helpful and interesting for consumers, families, and the public. The dashboard exists for an internal audience at this time and there is no Public Health Information (PHI) included in it. Once it is finalized, it will be posted on the Department's website and accessible to the public.

CCC Feedback

A member commented that he is very excited about the cultural competence dashboard. He liked all the categories, specifically the ethnicities section. He recommended inclusion of Service Area-specific information and data on the physical disabilities. This is an important demographic that needs to be expanded. Another member pointed out that the Department needs be more diligent about collecting demographics data pointing out that LACDMH may not be collecting all the demographics from consumers.

A question was raised regarding how LACDMH derives the categories for the specific racial ethnic groups. He stated that, for example, "non-Latino White" is the only white race ethnicity category represented within the US Census. Dr. Benson replied that these labels are the ones LACDMH has included in the electronic health record, since it was adopted seven years ago. Dr. Benson added that LACDMH collects the data differently from the US Census, allowing consumers to check off any categories they self-identify with, and then LACDMH rolled it up to the higher-level category. For example, a consumer may choose White and another race or ethnicity. In this case, this person would be under the multi-category in this roll-up because LACDMH did not have the ability to distinguish.

Dr. Chang, LACDMH ESM invited the Committee to provide additional feedback. A member inquired about the data on the Indigenous population from Latin America. This is one of the largest populations in the country, and he hopes that LACDMH does not forget to include this group. Dr. Chang reported that the ARDI Division-CCU has been working with the American Indian Counseling Center and Clinical Informatics Unit to add American Indian/Alaska Native tribal affiliations. The next quest will be to incorporate indigenous communities from Latin American countries in IBHIS. The ARDI Division-CCU has done preliminary research and needs feedback from experts to develop a listing of tribal affiliations from Latin Americans who are residing in LA County. An invitation/request has been made to the Office of Immigrant Affairs to join LACDMH in this quest, since expertise from CCC and

other stakeholders who have this knowledge is greatly needed and appreciated. The ARDI Division-CCU has also pursued the inclusion of IBHIS consumer demographic fields for physical disabilities beyond deaf and hard of hearing.

Dr. Chang invited Dr. Rebecca Gitlin, LACDMH LGBTQ Services Specialist, to present the efforts to expand sexual orientation and gender identity (SOGI) data collection and analysis to have more accurate and affirming data. Dr. Gitlin stated that she would only cover a few of the terms and definitions. Three distinct categories that LACDMH will be collecting information about are:

- Sexual orientation
- Gender identity
- Designated or listed sex at birth

In terms of designated or listed sex, these are the terms and definitions that LACDMH has; male, female, intersex, and X, which is a designation that can go on a person's birth certificate or Driver's License in California. For gender identity, categories include cisgender, cisgender or non-transgender man, cisgender or non-transgender woman, non-binary, transgender man, transmasculine, transgender, transfeminine, and Two-Spirit. For sexual orientation, the categories are heterosexual/straight, bisexual, gay/lesbian, pansexual, queer, and asexual. Work is also being done to prepare how LACDMH staff ask questions about gender identity; this is a two-step approach. The first is to introduce the topic by asking, "I want to ask you about your gender identity and your sex designated or listed at birth. Gender identity refers to how you identify yourself, which may or may not be the same as the sex you were designated or listed at birth. We ask these questions because consumers are diverse and LACDMH wants to make sure that everyone is being treated equally and that we are meeting everyone's individual needs. If you prefer not to answer these questions, you can state you prefer not to answer."
Dr. Chang shared that groups of programs that meet every other week with clinical informatics, such as the ARDI Division-CCU and Quality Improvement Unit, to gather input from the CCC, to gather feedback as to what is clear, what is not, and most importantly, what is missing. There have been ongoing conversations to look specifically at including tribal affiliations, SOGI data, and race and ethnicity category expansion.

CCC Feedback
A member asked where on the dashboard consumers could find this information**.** Dr. Benson stated that there will be a section for public dashboards for consumers to access, and that they are working with the Public Information Office. Another member asked if this data would map to existing categories in other data sets like the US Census. Dr. Gitlin responded that it is something that LACDMH took into consideration on a broader scale, in helping County departments communicate better with each other about Los Angeles County residents' needs, service utilization, and disparities. LACDMH looked at how other LA County departments

can map existing data (in this case, the limited data that is already housed within IBHIS) to the new SOGI categories and how can LACDMH map department-specific data alongside one another.

A member asked for clarification in terms of placing an "X" on one's birth certificate. Is this done at birth or when someone is an adult, and how is this process completed? Dr. Gitlin replied that adults can go back to change their birth certificate to reflect their authentic gender more accurately by reporting their designated sex as "X." This is something that someone can do on their driver's license as well.

13. CCC Virtual Code of Conduct Unveiling

The CCC embarked in the process of developing a virtual code of conduct to complement the existing code designed for in-person meetings. CCC Co-Chair Ms. Mascher introduced the new virtual code and explained its purpose is to establish expectations for all committee members, staff, and guests as well as all presenters in attendance to on-line meetings. The new code applies to sidebar chats, which are considered a very important component for member participation during virtual meetings. The emphasis of the virtual code of conduct is for participants to feel safe to discuss their individual thoughts and points of view. It was pointed out that the code of conduct for in-person meetings still applies and will be included as part of the meeting agenda and virtual code. Additionally, the virtual code of conduct was released on September 8, 2021, for CCC members to review and comment.

Virtual code highlights:

- Some of the points are the same from the original code of conduct for in-person meetings.
- A fourth point was added under purpose: "To ensure everyone is given an opportunity to participate. We will make active efforts for persons with access challenges; we will create accommodations for persons with disabilities."
- One of the most important points to this virtual code of conduct is that participants find a quiet place where there is no extra outside noise, which will help participants clearly hear the virtual meeting.
- The CCC will not tolerate any disruptive side conversations and condescending chat box comments will be captured in the recordings. Please alert the CCC co-chairs and LACDMH staff if there are any questionable situations that arise.
- If there are discussions that become troubling, please feel free to exit the meeting briefly or let LACDMH staff or co-chairs know you are feeling uncomfortable with the topic or direction of the conversation.
- A queue will be established at all virtual meetings to ensure that everyone has an opportunity to speak. Raise your hand to be added to the queue and when called upon, state your name for purposes of the CART transcript.
- If time runs out and there are additional thoughts and questions, these can either be added to the chat box or they can be emailed to the co-chairs, as well as LACDMH liaisons so that those thoughts/questions can be added to the recorded information.
- Be attentive to the person speaking and respectful to fellow participants.

- Practice your patience, be a good listener, try to understand the perspective of others.
- Embody a team spirit by avoiding discriminatory language or harassment in any form.

(See Attachment 3: Virtual Code of Conduct for additional details)

14. LACDMH Cultural Competence (CC) Organizational Assessment

In October 2021, CCC membership welcomed a presentation on the Cultural Capacity of LACDMH. The Cultural Competence Organizational Assessment was completed with LACDMH staff. An independent consultant/researcher was hired to develop the tool that was utilized to collect this information from staff. The overall goal of the organizational assessment is to determine the degree of knowledge that the staff has regarding different aspects of cultural and linguistic competence pertinent to service delivery, policies and procedures, trainings, and community stakeholder committees, among others. Data was collected in December 2018 and January of 2019. The ARDI Division-CCU delivered presentations on the project findings throughout the system of care to inform LACDMH clinical and administrative programs about staff knowledge gaps and where to obtain information needed.

CCC Feedback

The members expressed appreciation for LACDMH's transparency in sharing the results of the cultural competence organizational assessment. Specific recommendations included: surveying youth consumers, members from the SALT, and the UsCCs to compare the results and to establish "outside/inside" baselines.

15. Honoring Our Veterans and LACDMH VPAN Presentation

In November, CCC membership welcomed a panel presentation in honor of Veterans' Day. This panel presentation had three objectives:

- Enhance CCC participants' knowledge and sensitivity about Veteran culture, and the experience of communities of color in military service
- Feature LACDMH's Veteran Peer Access Network (VPAN) Program
- Hold a space of gratitude and admiration for veterans and their families

Speaker 1 began his presentation recognizing the 246th birthday of the United States Marine Corps. He reminded participants that Veterans Day is a day to honor veterans who are still living. He sang a chant he learned when he was serving in the military. He stated that Native American service members were not given an opportunity then and are still not given an opportunity to practice their faith. Instead, then and now, they were escorted to many services, usually Christian services, non-denominational, Protestant, Latter Day Saints, etc. He, along with other Native American service men began to gather on their own, going behind the barracks, to find a place to share their stories and talk about their families. The men that he learned the chant and music from were Seminal, Choc Ta, Oklahoma Black Feet, Crow, Navajo, and even Innuit. Together they would gather on the Sabbath Day, that the Marine Corps would not

give them, which is still a day that is not given to the Native people who serve. Today, many active-duty men and women who have converted to Islam are allowed to practice their faith, but not the Native America men and women who serve. If these practices are taken away, as is the case with the United States military, now a Native person who is serving feels alone, feels pain, anguish, guilt and all these feelings begin to multiply, to weigh on their spirit and their heart becomes heavy. This needs to be brought up to the attention of the Department of Defense (DOD) and the Veterans Administration (VA) to begin to understand that Native veterans are in crisis. They do not want psychotherapy; they do not want pharmaceutical drugs. Native veterans want attention given to their need, that they can gather, be among themselves, make offerings, and pray.

Speaker 2, a manager from LACDMH's Veterans Peer Access Network (VPAN), began her comments by stating that it is an honor to have been invited to speak on Veterans Day. She shared with the membership that the veteran community is a subculture, with a different language and different way of thinking and living. Native Americans serving in the military have their own subculture. The presenter commented that although she is not a veteran, she has family members who have served. Serving in the military can be very complex, as it causes both physical and mental trauma. Her role is about helping veterans who have put their lives on the line and have sacrificed so much to protect our freedoms.

Speaker 3, a Psychiatric Social Worker with VPAN and the Suicide Prevention Coordinator for the program, is a veteran and active in the Reserves for the United States Marine Corps. He served four years of active duty in the Marine Corps Infantry, stationed in Hawaii. He completed two tours in Iraq. He knows firsthand some of the struggles that some veterans and military family members experience, specifically some of the stressors and some of the challenges as veterans transition back from combat. The presenter provided a brief history of Veterans Day. He commented that often nonveterans thank veterans for their service. He encouraged nonveterans to take some time to get to know the veteran by asking them what branch they served in and what was their experience while serving.

The VPAN program is a network of providers and collaborates with Volunteers of America Los Angeles (VOALA), Goodwill, and Battleship USS Iowa, one of their partners in the network. VPAN's mission is to serve veterans and their families. There are no criteria; anyone who has served can contact VPAN for assistance. If a veteran needs assistance, VPAN will help link the veteran to the services they need. Importantly, VPAN is fully staffed by veterans and family members of veterans. VPAN staff have a unique connection and understanding of the military culture. Helping others allows veteran peers to feel a sense of purpose that they once had in the military. Some veterans lost that sense of purpose when they transitioned back to civilian life. Becoming a certified peer helps bring back that sense of purpose to

veterans because they are now helping their brothers and sisters. Veteran peers can relate with their veteran clients, letting them know they have also been there.

Speaker 4 is a member of three affiliated tribes in North Dakota: Mandan, Si Datasa and Rickoraugh. He was born in Long Beach and raised in Southern California and identified himself as an Urban Indian. He is a Gulf War veteran who served in the military seventeen years, including seven years of active duty in the Navy and ten years in the U.S. Army. He was discharged in 2013. He taught post-secondary vocational adult education for twenty-two years. He is now the director of career placement in community development for Veterans Stand Together in Torrance, California. The speaker continues to serve even though he is not in the military. As a Native American in the military, he had a unique experience. Many Native Americans serving in the military are often overlooked in terms of their demographic. When Native Americans leave the military and transition back to civilian life, they continue to face many of the same disparities they experienced while serving in the military.

Speaker 5 is a Marine Corps veteran and a Peer Support Specialist, having worked for LACDMH for a little over seven years, working on homeless outreach and engagement. He was responsible for working with the homeless population and assisting them with permanent housing, linking them to case management, mental health services and substance abuse treatment. Prior to that, he was recovering from his own nineteen-year battle with IV substance abuse, self-medicating, untreated mental health problems, and six years of homelessness. LACDMH helped him work through his issues. His clinician inspired him to assist one person in the same way he was helped and gave him the opportunity to volunteer and go out into the community and be of service by doing outreach. Today, seven years later, he serves as lead Peer Navigator for the Scan Health Plan, building the Street Medicine Team from the ground up. He trains these Peer Navigators on connecting the homeless population into County programs like LACDMH. He is getting ready to launch this program in January 2022.

CCC Feedback

A member asked they could speak on the topic of participation of Native women in the military. Not enough recognition is given to Native women who serve**.** Another member commented that her son is in the Air Force and as he is moving up in rank, she has noticed things changing about him. To her, it is a fight with himself of who he was when he went in, who he is becoming and who he is now. She is hoping he can hold onto who~~m~~ he is. It is this assimilation within the military that is turning him and changing him. How does she support her son for serving but at the same time not cause conflict for him? The speaker pointed out that her son is not that person anymore. He now belongs to the United States Military, and he serves there, he is no longer a civilian. He is now part of the military community. He is not the person she knew. Many veterans make this mistake when they return home because they

wish to recover that part of their life that they left behind. They can never go back to the person they once were. This is a conflict within families. A member asked how much money the VPAN receives from the VA as a way of emphasizing the need for shared responsibility from the Federal government in addressing veterans' needs.

16. LACDMH Bilingual Capacity of the System of Care

The CCC welcomes this presentation every year. The purpose of this annual presentation is to update the membership with an annual report regarding the Department's language capacity. The presenter shared information regarding bilingual bonus compensation, number of employees receiving a bilingual bonus, the languages represented by bilingual certified staff, recruitment protocols employed by Human Resources (HR), and the exam process.

CCC Feedback

The Committee focused their initial feedback on the Department's lack of adequate American Sign Language (ASL) representation, stating that services in this language are both a cultural resource and an accessibility issue. The group also raised concerns that ASL interpreters may know ASL but are not proficient enough when it comes to mental health. The presenter responded that ASL falls under the Americans with Disabilities Act (ADA), in which the examiner must be a certified examiner. Another member asked whether the Department has established a need for interpreters who speak traditional or Native languages. At this time, LACDMH has no Native American tribal languages represented in the certification process. A member inquired whether staff from contracted programs are eligible for this compensation. The presenter explained that contracted employees may not qualify to receive the bilingual bonus. The Committee also expressed a recommendation for the Department to coordinate certification in Native American and indigenous languages from Latin America. The Committee voiced concerns about language assistance services not being sufficiently available for consumers. Members expressed that they want to pursue language justice and would consider advocating before the Los Angeles County Board of Supervisors and at a national level.

17. ARDI Division-CCU Presentation on LA County Threshold Languages and Consumer Utilization Data

Dr. Chang followed HR's presentation to display consumer utilization data by threshold language. She introduced data tables and explained the definition of threshold languages as those declared by the California Department of Health Care Services. She presented data on threshold language profiles by Service Area. [RG7]

18. Honoring Co-Chair Sunnie Whipple's Legacy

The CCC engaged in a tribute to Mr. Sunnie Whipple, former Co-Chair of the CCC, who passed away unexpectedly. This sharing of special memories and words of solace for Ms. Bernice Mascher and the CCC membership included the following:

Ms. Aguilar shared her poem "Sunnie[RG8]", which she wrote when she received the email regarding his passing. "He was like the sun-he was warmth, he had this energy that

when you were in a room with him, you instantly felt at ease. Sunnie like the sun was radiant. There was something about him that made you feel as though you had known him for years. His name was Sunnie-a name that was so fitting for someone who was like the sun of our days warm, kind and selfless. Sunnie as I write these words, I am still hoping to hear your voice-that you will still call me to ask a question or just to chat. However, I know that your body has transitioned, and you are now with the spirits of your ancestors. Sunnie, you had a way of lighting up a room. You were bright, you shined, and you shared your light with everyone. You leave a void that will be difficult to fill. Your presence, your energy, your dedication to be the voice for so many are all the things you did with such grace. Sunnie-such a fitting name for someone who was warm, who was light, who radiated kindness. Mr. Sunnie, it was an honor to have met you. Like the sun that rises, your energy has been released into the universe to guide us all to continue the work of helping others."

CCC feedback:

Members collectively expressed their sense of loss and how much they were going to miss Sunnie and the way Sunnie asked questions, how he was curious about various topics and cultural traditions. One member commented that his inquisitive nature, the way he interacted with the group, and his passion for the Native American community and for all underserved communities. Additional comments from the members included:

- "I will miss Sunnie. He truly embodied cultural competency in the way he respected and honored all cultures and people. I will consider Sunnie our forever CCC co-chair."
- "Sunnie was a graceful warrior and advocate."
- "May Sunnie rest in greatness with his Ancestors and may he intercede on our behalf."
- "At night, let us go outside to look at the heavenly sky filled with twinkling stars and the darkness that surrounds their halo. Perhaps they are not the stars, but rather openings in heaven where the love of our lost ones pours through and shines upon us to let us know they are happy. Know that Sunnie smiles upon us, he is happy for he is amongst the dancing star girls. As we bid his physical presence goodbye, let us welcome his spirit into our hearts forever."
- A member from the Latino UsCC shared a quote from Sunnie:
  "I want to be more involved in bringing positive change to the Indian community, to be an agent of change and empower my people and set an example for the younger generation and get them integrated as change agents. I am particularly interested in closing the gaps of disadvantage and negative stats that reveal how underserved and unserved our community is in L.A. County and in the nation as a whole. I have been building inter-relationships with the Native community and 'outside' world for now well over 20 years and seek to partner with other like-minded individuals to return dignity and health to our community. I bring to the table the value of my own diverse lived experience, as well as a unique worldview. I hold fast to extended family and many friendships, as well as my own traditions

and seek to collaborate with others to find effective solutions to problems rather than just talking about them. I want to see spirituality and identity strengthened and want to get other Natives involved to ensure their voice gets heard. My broad connections with many organizations including the family community can potentially be a great asset, to build a strong AI/AN Commission and stronger working relationship with the County and the many priorities that the Supervisors have set forth to engage in. Increasing cultural competency is one example."

III. CCC's Reports to the Quality Improvement Council

The Ethnic Services Manager represents the CCC at the monthly Quality Improvement Council (QIC) meetings. Additionally, the ESM oversees the administrative support and technical assistance provided to the CCC Co-Chairs and membership. As a standing member of the Departmental QIC, the ESM provides updates and presentations on the CCC activities as well as the ARDI Division-CCU's projects. This structure accomplishes several goals: 1) fosters communication, 2) facilitates the advancement of cultural and linguistic competence in the system of care, and 3) promotes a sense of responsibility toward the attainment of Cultural Competence Plan goals to reduce disparities and improve the quality and availability of services.

Another level of connection and collaboration with the Departmental QIC involves working directly with the Service Area-based Quality Improvement Committees (SA-QIC). The ESM and ARDI Division-CCU provide presentations on cultural and linguistic competence-related projects and new initiatives to the SA-QIC. Furthermore, the CCC invites the SA-QIC memberships to the CCC's monthly meetings and special presentations. This practice increases cross-committee knowledge and understanding, promotes collaborative efforts that focus on cultural and linguistic competence, and facilitates access to the collective wisdom and expertise of these committees**. (*See attachment 2: CCC special presentation flyers)***.

IV. Review of the Year and CCC Co-Chair reflections

The current CCC Co-Chairs were engaged in a reflection exercise on the achievements of the CCC over the past year. The first co-chair interviewed was Ms. Johana Lozano, an active CCC member for years who just began a leadership role in the committee. She shared that the CCC Co-Chairs and the ARDI Division-CCU have created an atmosphere of belonging and harmony for the membership. The new Co-Chair described the experience of CCC members as possessing a "palpable sense of solidarity and cohesion which in turns has created a positive, inclusive, cooperative culture of healing:

- The CCC is the place to come and feel welcome and feel heard."
- The Co-Chairs don't just present and study a topic…they live it!
- The Co-Chairs helped the members feel safe to be vulnerable with each other, exchange stories and ideas, and heal.

- Members are equal participants: “You don’t know which participant is a service provider and which is a consumer…you’re all in the same boat.”

The second Co-Chair, Ms. Bernice Mascher co-lead the Committee along with late Co-Chair Sunnie Whipple from January to November 2021. She shared the following reflections about the CCC as follows:

- “The loss of Sunnie Whipple as a friend and Co-Chair has deeply saddened us, but the Department and community support that rallied around has drawn us together…this is probably why the CCC participants chose the words ‘faith’ and ‘hope’ to continue on in 2022…we have helped build these attributes in one another.”
- “We really came to see everyone like a big extended family.”
- “We have come to recognize our need for each other as we understand everyone is going through very difficult times and facing major challenges…we have come to recognize the ‘power of small things’ to get us through another day…a small word of encouragement, a smile, a shared moment around the telling of a story, a joke, a poem, or an experience. Meeting regularly, ends up building us up and intertwining us and knitting us closer together…contributing to a very diverse, rich, and unifying force between us all.”

Criterion 4 APPENDIX

1. CCC Meeting Agendas and Special Presentation Flyers, CY 2021


CCC flyer for 2-10-2021 FINAL.pdf


CCC flyer for 3-10-2021 FINAL.pdf


CCC flyer for 4-14-2021 FINAL.pdf


CCC flyer for 5-12-2021 FINAL.pdf


CCC flyer for 6-9-2021 FINAL.pdf


CCC flyer for 7-14-2021 FINAL.pdf


CCC flyer for 8-11-2021 FINAL.pdf


CCC flyer for 9-8-2021 FINAL.pdf


CCC flyer for 11-10-2021 FINAL.pc


CCC flyer for 12-8-2021 FINAL (1).


CCC 3-10-2021 Agenda FINAL.pdf


CCC 4-14-2021 Agenda FINAL.pdf


CCC 5-12-2021 FINAL Agenda.pdf


CCC 6-9-2021 Agenda FINAL.pdf


CCC 7-14-2021 Agenda FINAL.pdf


CCC 8-11-2021 AGENDA FINAL.pdf


CCC 9-8-2021 Agenda FINAL.pdf


CCC 11-10-2021 Agenda FINAL.pdf

2. CCC Bylaws and CCC Virtual Meeting Code of Conduct


CCC Bylaws Updated 12-8-2021.


CCC Code of Conduct for Meetin

3. Cultural Traditions and Connections Newsletter


CTC Magazine_Spring20

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criterion 5

Culturally Competent Training Activities

August 2022

Criterion 5: Culturally Competent Training Activities

I. LACDMH Cultural Competence Training Plan

The LACDMH Cultural Competence Training Plan aims to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge and cross-cultural competencies, all of which are essential to effectively serve our culturally and linguistically diverse communities. This plan is based on the Cultural Competence Plan Requirements, which affirm that 100% of employees must receive annual cultural competence training, inclusive of clerical/support, financial, clinical/direct service, and administration/management at Directly Operated, Legal Entities/Contracted, and Administrative programs whether directly employed, contracted, subcontracted, or affiliated.

This three-year training plan presents employees with options to fulfill their annual cultural competence training requirement. The plan also avails staff the opportunity to engage in a personal evaluation of their training needs and customize their training profile. The goals of providing a customizable training plan are to:

- Engage the workforce in individualized cross-cultural skill set development
- Promote exploration of new professional areas of interest
- Equip staff with multiple opportunities to enhance their professional service delivery
- Expand staff's insights regarding the vital role of cultural competence in decreasing disparities and promoting health equity
- Deepen employees' cross-cultural compassion, humility, and empathy in working with consumers and co-workers from different cultural backgrounds

Additionally, the training plan includes blended learning opportunities that offer a combination of online and instructor-led trainings. By strategic design, the plan includes a broad spectrum of trainings that focus on specific elements of culture and cultural groups.

In accordance with DMH Policy No 614.02, In-Service Training, LACDMH is committed to provide training activities with the purpose of preparing staff to perform specific functions, tasks, and procedures necessary for the operation of their programs or units. All Department employees are eligible for in-service training according to the needs of their specific assignments.

- This policy enhances staff capabilities to carry out mandated requirements associated with their positions.
- Supervisors are expected to 1) work with employees in identifying training needs and 2) to notify the Office of Administrative Operations (OAO)-Training Unit of training needed for their programs. Supervisors may authorize or require an employee's attendance at any approved in-service training conducted within LACDMH. The in-service training must be job related and should directly add value to employees' work performance.

Table 1: LACDMH Three-Year Training Plan, FY 18-19 through FY 20-21

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 18-19		
<u>Innovative training feature 1</u> • IB/CC (Los Angeles County Board of Supervisors-mandated training)	• LACDMH – Human Resources Bureau (HRB) and Cornerstone Learning	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
<u>Innovative training feature 2</u> • Gender Bias Training Series (See Section F. below)	• LACDMH Cornerstone Learning	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 3 • LACDMH Multicultural Mental Health Conference: Health Integration through a "WHO-LISTIC" Approach	• LACDMH app for Network Adequacy: Provider and Practitioner Administration (NAPPA) • ARDI Division-Cultural Competency Unit's (CCU) Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 4 • Los Angeles County Equity Summit	• LACDMH app for NAPPA	• Available to Administrative/Management
Training alternative 1 • Cultural competence related SMHS offered by the OAO-Training Unit. Training bulletins available via the intranet	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Foundational Cultural Competence Training (See Section F. below)	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS ○ Practitioners providing direct services
Training alternative 3 • Cultural competence related SMHS offered by the OAO-Training Unit. Training bulletins available via the intranet	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS ○ Practitioners providing direct services
Training alternative 4 • Language Interpreter Series ○ Introduction to Interpreting in Mental Health Settings ○ Advanced Mental Health Interpreter Training ○ Use of Interpreter Services in Mental Health Settings	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Language Interpreter Series trainings are available to bilingual certified staff • Use of Interpreter Services Training is available to all monolingual-English staff

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 19-20		
<u>Innovative training feature 1</u> • Positive Psychology and Wellbeing for Clinicians and Consumers Addressing Burnout, Compassion Fatigue and Secondary Trauma in the COVID-19 Era	• LACDMH Cornerstone Learning Link • LACDMH app for NAPPA • ARDI Division -CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
<u>Innovative training feature 2</u> • Suicide Prevention and COVID-19: A Training for Disaster Services Workers and Warm Line Workers	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 3 • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Community-Based Organizations	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 4 • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Faith-Based Organizations	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 5 • Suicide Prevention and COVID-19: A Training for DSW-Shelter Workers	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 6 • Pediatric Psychology COVID-19 Response: Considerations for using Telehealth with Latino/Bilingual Children and other Diverse Youth	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 7 • Building and Maintaining Recovery and Resiliency through the Pandemic: A Culturally-Competent Approach	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 1 • Cultural competence related SMHS offered by the OAO-Training Unit. Training bulletins available via the intranet Examples of new training offerings: ○ DMH Clinicians: Culturally Competent COVID-19 Mental Health Intervention with Faith-Based Organizations and Churches ○ Resilience Check-ins with DMH Clinicians involved in the Speakers Bureau	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS ○ Practitioners providing direct services
Training alternative 2 • Foundational Cultural Competence Training	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: ○ Directly Operated ○ Legal Entities/Contracted ○ Administrative ○ Management ○ Clerical/support ○ Staff providing SMHS ○ Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF

Training alternative 3
• Language Interpreter Series
  ○ Introduction to Interpreting in Mental Health Settings
  ○ Use of Interpreter Services in Mental Health Settings
  ○ Therapeutic Cross-Cultural Communication
	• LACDMH app for NAPPA
	• ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs
		• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS
		  ○ Practitioners providing direct services

FY 20-21		

Innovative training feature 1
Racial Trauma in the Cambodian Population and Implications for Clinical Work
	• LACDMH app for NAPPA
	• ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs
		• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS
		  ○ Practitioners providing direct services

Innovative training feature 2
A Different Look into the African American Community and Mental Health Treatment
	• LACDMH app for NAPPA
	• ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs
		• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS
		  ○ Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 3 Armenian Genocide-Experience of Collective Trauma: Integrating Loss and Trauma: When More is Too Much	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 4 Engaging the Muslim American community	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 5 Racial Equity: Racism and Mental Health	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training Alternative 1 • Integration of Cultural Competence in the Mental Health System of Care [designed for newly hired staff and offered during New Employee Orientation	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training Alternative 2 • Cultural Competence related – SMHS offered by the OAO-Training Unit. Training bulletins available via the Intranet	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training Alternative 3 • Annual cultural competence related conferences	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF

Training Alternative 4
• Language Interpreters Series
  ○ Introduction to Interpreting in Mental Health Settings
  ○ Advanced Mental Health Interpreter Training
  ○ Use of Interpreter Services in Mental Health Settings
	• LACDMH app for NAPPA
	
	• ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs
		• Available to all staff including:
		  ○ Directly Operated
		  ○ Legal Entities/Contracted
		  ○ Administrative
		  ○ Management
		  ○ Clerical/support
		  ○ Staff providing SMHS
		  ○ Practitioners providing direct services

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Training Plan Specifications

LACDMH can choose a training option described as an "Innovative training feature" or other training alternatives.

A. Innovative Training Features

Refers to any trainings, including conferences that have been provided through the Office of Administrative Operations - Training Unit.

B. Foundational Cultural Competence Trainings

- "Cultural Competency (CC) 101"

The ARDI Division-CCU developed a basic cultural competency training in response to the External Quality Review Organization (EQRO) recommendation that system-wide training in cultural humility and cultural sensitivity be provided. The training, "Cultural Competency 101," was originally designed as a train-the-trainer model for the Service Area Quality Improvement Committee (SA QIC) members. This on-line learning has been made available to the entire LACDMH workforce, including Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs.

Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data [Duration: 37 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6638

Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources [Duration: 30 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6640

Part 3: Cultural competency scenarios and group discussion [Duration: 18.5 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6639

- "Implicit Bias and Cultural Humility"

  This virtual training was developed by the ARDI Division-CCU as a training that applies to all employee functions. The objectives of this training include engaging participants in a personal understanding of implicit bias, identifying ways to address personal and professional biases, and answering a personal call to practice cultural humility. This training facilitates the participants' awareness of how implicit bias impacts the quality of services provided and LACDMH's internal work environment.

- "Diversity Skills for the 21st Century Workforce"

  This four-hour class is geared toward assisting all employees in broadening and deepening their understanding, experience, and critical thinking skills regarding cultural and personal differences, and effective interpersonal communication in the workplace. The course content is highly interactive and emphasizes introspection about one's own identity and how that identity either facilitates

and/or hinders workplace interactions. Through group discussions and guided experiential activities, participants are encouraged to cultivate various tools to help them appreciate the similarities and differences of diverse groups and individuals within the workplace. This course includes a brief review of the County Policy of Equity (CPOE) and related policies and laws that aim to ensure an environment in which all individuals' contributions are valued, and their rights protected.

- "Integration of Cultural Competence in the Mental Health System of Care"

  This training is provided by the ARDI Division-CCU to all LACDMH new employees during the New Employee Orientation. This training provides information on the CLAS definition of culture, County of Los Angeles demographics, federal, state, and county regulations governing cultural competency, the Cultural Competence Plan Requirements, mental health disparities, and Departmental strategies to reduce disparities in care.

C. Specialty Mental Health Services

The cultural competence-related trainings offered by the OAO–Training Unit incorporate a multiplicity of cultural elements:

- Age group diversity (Children, Transition Age Youth, Adults and Older Adults)
- Persons who are deaf and hard of hearing
- Persons with justice system involvement
- Persons experiencing homelessness
- Persons with intellectual and physical disabilities
- Language interpreter services
- Race and ethnicity
- Racism
- Gender identity
- Sexual orientation
- Substance use and co-morbidity
- Spirituality
- Trauma-informed services
- Veterans

Some of the trainings are offered in a language other than English, such as Spanish, Farsi, Chinese and Khmer. Cultural competence is also a specific topic for clinical supervision trainings. Culture-specific conferences also provide an opportunity for the workforce and consumers to benefit from topics relevant to mental health disparities and culturally appropriate services for underserved/unserved communities, such as Latinos and Asian Pacific Islanders. ***(See section II below for specific details)***

D. Language Interpreters Series

The language interpreter training series is available to all LACDMH workforce, including administrative/management, clinical, and support/clerical staff.

The Department recognizes that even though administrative/management staff do not routinely perform language interpreter services, their positions may involve significant public contact, which requires use of their bilingual skills. Additionally, the trainings are strategically planned and include a series of threshold language specific Mental Health Terminology trainings along with offerings specific for who utilize interpreters. The following language interpreter trainings are available for bilingual-certified staff:

- *Introduction to Interpreting in Mental Health Settings*

  This three-day language interpreter training series is designed for bilingual staff that who are proficient in English and another language. The main purpose of the training is to ensure that the bilingual workforce accurately interprets and meets the requirements of Federal and State laws pertaining to language interpreter services. The introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter. The course provides the interpreters with knowledge and skills related to models of interpreting, mental health terms, standards of practice, cultural interpreting, and skills to address common challenges when interpreting. Development and maintenance of specialized mental health glossaries based on the interpreter's level of proficiency in both languages is included in the training. Role-playing, memory exercises, videos, and interactive exercises offer an opportunity to practice the newly acquired skills.

- *Advanced Interpreting in Mental Health*

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

- *Cross-Cultural Communication and the Therapeutic Use of Interpreters*

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

effective communication, techniques are modeled and practiced throughout the training session.

- *Increasing Spanish Mental Health Clinical Terminology*

  This training aims to increase cross-cultural knowledge and skills with Spanish-speaking populations, specifically to improve clinicians' and bilingual staff's vocabulary and the use of terms related to the provision of mental health services, including assessment, diagnosis, treatment, and crisis intervention. Additionally, topics cover common challenges in interpreting and providing services in Spanish. For example, the use of incorrect or misleading terminology, misunderstanding of information, misdiagnosis, inappropriate, diagnosis, and other unintended consequences. This training is designed for participants of varying levels of Spanish language proficiency.

- *Increasing Mandarin Mental Health Clinical Terminology*

  This training aims to increase cross-cultural knowledge and skills with Chinese-speaking populations, specifically to increase clinicians' and bilingual staff's vocabulary and use of terms related to the provision of mental health services inclusive of assessment, diagnosis, treatment, and crisis intervention. Training content covers the challenges in interpreting and providing services in Chinese. For example: the use of incorrect or misleading terminology, misunderstanding of information, misdiagnosis, inappropriate diagnosis, and other unintended consequences. Exercises are conducted in Mandarin.

LACDMH conducts bilingual proficiency examinations and certifications for its bilingual employees. In accordance with LACDMH Policy No. 602.01, Bilingual Bonus, a certified bilingual employee possesses "a valid Language Proficiency Certificate issued as a result of the County's Bilingual Proficiency Examination, which tests for proficiency to speak, read, and/or write the language.

- Candidates tested for bilingual proficiency as part of the examination process, if successful, are issued a Language Proficiency Certificate.
- Successful candidate names are placed on the eligible lists. Hiring managers select candidates from the eligible lists when the foreign language skills are needed, including translation of materials and/or interpreter services by diverse LACDMH Programs/Units.
- Candidates who are selected from the eligible lists are employed on the condition that they use their bilingual skills while holding the position and may participate in translation of materials or interpreter services upon solicitation by various LACDMH Programs/Units."

  (See Criterion 5 Appendix, Attachment 1: Interpreter Trainings, FY 20-21)

E. Training Alternatives for Managers and Supervisors

In addition to the Cultural Competence-related trainings for staff providing Specialty Mental Health Services, learning opportunities are available specifically to managers and supervisors through OAO–Training Unit. Examples of FY 20-21 offerings include:

- Clinical Supervision in Juvenile Justice Settings: A Competency-Based Approach
- Multicultural Clinical Supervision

- Los Angeles County Health Agency Just Culture Program for Managers and Supervisors
- Supervision of Clinicians Providing Trauma-Informed Care to Child Welfare Involved Children, Youth, and Families

F. Gender Bias Training Series
Developed by the County of Los Angeles Department of Human Resources (DHR) in partnership with the Women's and Girls Initiative

- Understanding and Tackling Gender Bias in the Workplace
- Diversity Makes Simple Series for Line Staff and Supervisors
- Employee Essentials

Information regarding the LACDMH training plan has made available via the following process

- **Memo regarding cultural competence training requirement (March 2018)**
- Departmental Quality Improvement Council meetings
- Service Area-based Quality Improvement Committees
- Departmental Cultural Competency Unit webpage
- Frequently Asked Questions handout
- New Employee Orientation PowerPoint

(See Criterion 5 Appendix, Attachment 2: Examples of materials used to inform programs of the annual cultural competence training requirement)

G. Tracking and Reporting Mechanisms
Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs are regularly reminded that 100% of their employees must complete annual training in cultural competence The following guidelines are provided for the tracking and reporting of this requirement:

- Completion of the cultural competence training shall be monitored and tracked at all staff levels (e.g., clerical/support, administrative/management, clinical, subcontractors, and independent contractors)
- Program managers/directors shall monitor, track, document (e.g., training bulletins/flyers, sign-in sheets specifying name and function of staff, and/or individual certificates of completion, etc.)
- Program managers/directors make available upon request by the Federal, State and/or County the annual cultural competence training provided to staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors
- Program Directors/Managers of Directly Operated Programs may attest to the completion of annual cultural competence training by 100% of their staff in the Fourth Quarterly Monitoring Report for every Calendar Year (CY)
- Program Directors/Managers of Legal Entity/Contracted Providers may attest to the completion of annual cultural competence training by 100% of their staff in the Annual Quality Assurance Monitoring Report for every CY

- The implementation of the NAPPA app has facilitated the tracking of completed annual cultural competence training by provider site and practitioner. The ARDI Division-CCU is in the process of developing a similar online process in collaboration with the Chief Information Office Bureau (CIOB) for administrative programs. Meanwhile, and Annual Cultural Competence Training Attestation form is required from Program Managers as evidence of annual completion of cultural competence training. The completed and signed attestation form is submitted to the Cultural Competency Unit's mailbox at dmhcc@dmh.lacounty.gov. When Program Managers/Directors reported less than 100% of staff completion of annual cultural competence training, a revised form is required to be resubmitted once the goal of 100% completion is reached. ***(See Criterion 5 Appendix, Attachment 3: ARDI Division-CCU Annual Cultural Competence Training Attestation form***

  COVID-19 significantly impacted the Department's training operations. The OAO-Training Unit faced unprecedented challenges and continued to evolve in order to maintain high standards in training coordination and delivery. As of March 2019, all training offerings shifted from in-person/live to a virtual platform. Training coordinators became subject matter experts in delivering trainings virtually utilizing Microsoft Teams, which markedly increased the technological knowledge and competence of the Unit. Furthermore, the OAO-Training Unit offered services to record and edit trainings for virtual distribution throughout the system of care.

  Additionally, the OAO-Training Unit continued to develop its online training registration system, EventsHub, funded by the MHSA Workforce Education and Training Plan. Most clinical trainings are now managed through EventsHub. These trainings are available to LACDMH staff, contractors and community partners who are eligible to participate in Department-sponsored training. Once training participants establish their EventsHub account, they can easily register, receive confirmation of registration, complete training evaluations, and access attendance or continuing education certificates.

II. Annual Cultural Competence Trainings

LACDMH provides a plethora of training offerings during each fiscal year (FY), with topics covering a wide spectrum of culturally relevant issues: race/ethnicity, age group, underserved cultural populations, lived experience, language interpreter trainings, and culture-specific conferences. While these trainings target clinical skill acquisition, licensed administrative and management staff also attend these trainings to learn about clinical service delivery updates and their application to clinical supervision. Additionally, at the beginning of each FY, the OAO-Training Unit contacts the administrators for the Cultural Competency Committee (CCC) and Underserved Cultural Communities (UsCC) subcommittees to solicit stakeholder input into new cultural competence-related trainings that could be implemented.

The OAO-Training Unit enforces guidelines for the inclusion of cultural responsiveness in all trainings. These guidelines specify the following:

- Trainers are expected to incorporate cultural references in trainings and are monitored by training coordinators
- Training bulletin notices include learning objectives referencing cultural issues/ concerns relevant to the topic. A checkbox was added to the bulletins to inform the participants when a training meets the cultural competence training requirements
- Training evaluations collected from participants are reviewed to ensure the training met the cultural inclusion objectives. When participant evaluations indicate that the cultural inclusion objectives were not followed or important cultural issues were not covered, training coordinators follow up by reviewing the evaluation results with the trainer to ensure similar issues are considered in future training offerings

  (See Criterion 5 Appendix, Attachment 5: Inclusion of Cultural Responsiveness in Trainings)

Furthermore, the OAO-Training Unit tracks training attendance by staff function via a training evaluation form at the request of the ARDI Division-CCU. Training participants self-report their staff function by choosing among the following options:

- Direct Service, County
- Direct Service, Contractor
- Support Services
- Administration/Management
- Religious/Spiritual Population
- Community Organization
- Community Member
- Mental Health Board
- Interpreter
- Other staff function not specified above

(***See Attachment 6: LACDMH Training Evaluation Form)***

Trainings offered by the OAO-Training Unit align with areas of cultural competence specified in the Cultural Competence Plan Requirements. Each year, the ARDI Division-CCU collaborates with the OAO-Training Unit in analyzing the cultural competence-related themes covered in each training. This practice allows LACDMH to ensure that cultural competence trainings expose staff to various levels of skill acquisition. Examples of training content themes include:

- Cultural formulation
- Multicultural knowledge
- Cultural sensitivity
- Cultural awareness
- Client culture/family inclusion

- Social/cultural diversity
- Service integration and outcomes
- Co-occurring disorders
- Language interpreter services
- Underserved populations (i.e., persons involved with the justice system, persons experiencing homelessness, gender, sexual orientation, and age group specific) ***(See Criterion 5 Appendix, Attachment 7: Cultural Competence Trainings by Content Category.***

Table 2: Examples of Cultural Competence-Related Specialty Mental Health Trainings Offered by the OAO-Training Unit, FY 20-21

Title of Trainings
African American
A Deeper Look into the African American Community and Mental Health Treatment
Addressing Racial Trauma in the African American Community
How to Treat Race Based Stress/Trauma: Clinicians Serving Communities of Color
Asian
A Sociodemographic and Clinical Profile of Asian Americans Served in Community Mental Health Centers for a Diagnosis of Schizophrenia Spectrum Disorder
Children
Bringing Science into Practice Series, Adapting Evidence-Based Practices for Diverse Children and Families: Integrating Lessons from Clinical Research and Community Practice
Brain Development, Trauma, and Attachment
Child and Family Team Facilitator Training
Fetal Alcohol Spectrum Disorder for the Mental Health Professional
Fostering Crucial Conversations about Race with Children and Families
Integrated Core Practice Model and Child and Family Team Training
Integrated Core Practice Model Foundational Training
Promoting Placement Stability Utilizing the Child and Family Team Process
Role of the Clinician: Participating in the Child and Family Teaming Process
The Commercial Sexual Exploitation of Children (CSEC) 101
Co-Occurring Disorder
Co-Occurring Disorder Mini-Conference
Threating Disordered Eating with Cognitive Behavioral Therapies (CBT-E)
COVID – 19
COVID-19 Online Mental Health Workshop Series (Korean)
Building and Maintaining Recovery and Resiliency through the Pandemic: A Culturally Competent Approach

Title of Trainings
Forensic
A Strength-Based Approach for Treatment of Forensic Consumers
Assessment and Treatment of Impulse-Control Disorders in Forensic Settings
Problem-Solving Therapy (PST) in Forensic Settings
Risk Assessment for Violence - Forensic Focus
Safety and Crisis Prevention/Interventions When Working with Forensic/Justice Involved Consumers
The Invisible Wound: Promoting Healing Via Trauma Informed Care Consciousness-Forensic Focus
Working with the Forensically Involved, Mandated Consumer
General Cultural Competency
Armenian Genocide - Experience of Collective Trauma: Integrating Loss, Grief, and Trauma
Cultural Humility Training
Cultural Humility: Crucial Reflections
Engaging the Muslim American Community
Racial Trauma in Cambodian Population and Implications for Clinical Work
Increasing Spanish Mental Health Clinical Terminology
Homelessness
Use of Atypical Antipsychotics Among Persons Experiencing Homelessness
Implicit Bias
Implicit Bias: A Self-Reflective Process to Identify Biases and Their Impact on the Communities We Serve
Language Interpreter
Increasing Spanish Mental Health Clinical Terminology
Introduction to Interpreting in Mental Health Settings
Justice System
Dialectical Behavior Therapy (DBT) For Justice Involved Consumers
Law and Ethics 101 for Juvenile Justice Mental Health Professionals
The Edge of Compassion: Staying Well While Working in High-Stress, Trauma-Exposed Juvenile Justice Settings
Trauma-Informed Treatment of Juvenile Justice Youth Part I: Assessment & Diagnosis
The Commercial Sexual Exploitation Identification Tool (CSE-IT) User Training for Juvenile Justice Mental Health Program Staff
Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, Two Spirit (LGBTQIA2S)
Building Allies: Turning Privilege into Change (Clinical
Building Allies: Turning Privilege into Change (Non-Clinical)
LGBTQ+ Youth in Placement
LGBTQ+ Youth in Care: Guidelines for Clinical Practice
Effective Treatment and Intervention, Including Families of LGTBQIA2S Youth in Juvenile Justice Settings

Title of Trainings
Fundamentals in Effective Work with LGBTQIA2S Youth in Juvenile Justice Settings
Case Studies in Loneliness, Anger and Risk: Danger in the Age of the Incel
Older Adults
Facilitating English and Spanish Support Groups for Caregivers and Providers of Older Adults
Peers
Intentional Peer Support Advanced Training
Physical and Developmental Disabilities
Mental Health Strategies for Individuals with Co-Occurring Developmental Disabilities (CDD)
Racial Equity
An Introduction to Racial Equity in Behavioral Healthcare
Fostering Crucial Conversations
Navigating Racial Trauma to Advance Racial Equity in Client Care
Racial Equity: Racism and Mental Health
Substance Use & Co-Morbidity
Co-Occurring Substance Use and Mental Health Disorders: Assessment & Differential Diagnosis with Juvenile Justice Involved Youth
Infants of Substance Abusing Mothers
Mindfulness-Based Practices for Mental Health Professionals Working with Addiction Populations
Substance Use in Old Age
SUD/COD & Harm Reduction and Crisis Intervention Training
Suicide Prevention
Question, Persuade, Refer: Gatekeeper Training for Suicide Prevention (AM)
Suicide Risk Reduction, Assessment, and Treatment in Juvenile Justice Settings - Part 1
Suicide Risk Reduction, Assessment, and Treatment in Juvenile Justice Settings - Part 2
Supervisors/Management
Clinical Supervision Training for Mental Health Professionals: A Competency-Based Approach
Cultural Humility in Clinical Supervision
Violence
Intimate Partner Violence 101(Non-Clinical)
Intimate Partner Violence: Treatment with an Emphasis on Motivational Interviewing
Youth
Creative Interventions for System Involved Youth
Dialectical Behavior Therapy (DBT) for Juvenile Justice Involved Youth: from Problems to Goals and Successful Reunification
Engaging Runaway Youth in Placement: Overview and Strategies for Response
Youth with Developmental Disabilities and Mental Illness: Overview and Interventions
Engaging Youth in Placement: From Admission through Aftercare

Title of Trainings
Engaging Probation Youth

Total number of unique trainings = 68

In addition to OAO-Training Unit learning opportunities, cultural competence-related trainings may be recommended and coordinated by program managers based on the collective training needs of their staff.

Table 3: Examples of trainings offered at the program level for FY 20-21*

Program Name	Title of Trainings
DMH/DHS Collaboration Program	• Therapeutic Fee Adjustment (TFA) -This training answers the questions: How to Do a TFA, Who is a TFA for, and How do we approach patients respectfully, humbly, professionally in order to gather information, reassure, and gain trust? What cultural and personal factors must be kept in mind during this process? • Gender Affirming Treatment Advocates and the Women's Health Form - An overview of the topic and a primer on clinical and support staff approaches to clients seeking gender affirming treatment. • Veteran Peer Access Network (VPAN) - An overview of veteran culture and mental health issues, along with services provided by VPAN and how to collaborate with their program.
GENESIS	• The Use of Cognitive Screening Measures: The Mini Mental State Exam (MMSE)-This training provides an overview of the MMSE, a screening tool to measure cognitive impairment. The training addresses the purpose of the MMSE as a screening tool, outlines the cognitive domains and provides an opportunity to practice administering and scoring it. Social/cultural considerations relevant to tests use and interpretation of scores to the Los Angeles County mental health consumers are addressed. Other topics explore the interpretation of screening results such as cut-off scores, when to refer for additional testing, and relevance of strengths and weaknesses; video-taped sessions of MMSE administration are reviewed to promote knowledge and skill enhancement. Finally, testing considerations for differential diagnoses and treatment options are included in the discussion. • Effective Techniques in Working with Older Adults with Mild to Moderate Cognitive Impairment - This training outlines different types of cognitive impairment often observed among older adults, including normal aging, mild cognitive impairment, dementia, and impairments resulting from COVID-19 and/or pandemic conditions. It also reviews Medi-Cal regulations associated with providing mental health services for persons with co-occurring mental illness and cognitive impairment. Additional training topics address common emotional and other internal experiences

Program Name	Title of Trainings
	of persons with cognitive impairment, along with psychotherapeutic and various mental health intervention. • The Use of Telehealth Cognitive Screening Measure the Montreal Cognitive Assessment (MoCA)- The purpose of this training is to provide an overview of The Montreal Cognitive Assessment (MoCA) a cognitive screening tool and its effective implementation via telehealth intervention and assessment. This training includes information on the purpose of the screening tool, cognitive domains covered by this screening tool, and how to administer and score the MoCA when assessing clients via telehealth. This training introduces participants to key principals of conducting telehealth when using cognitive screening tools.
Men's Community Re-Entry Program (MCRP)	• Cultural Humility: Crucial Reflections- This training increases participants' knowledge of privilege, bias, and microaggressions, and how these impact the work of mental health service providers and their interactions between children, families, and systems of care. • Implicit Bias and Cultural Competency: An Introduction: This course introduces the fundamental concepts of implicit bias and cultural competency. It also provides practical techniques that each learner can use to develop an individualized development plan to mitigate implicit biases and improve their cultural competence[EW9]. • Legal And Ethical Considerations: Working with Forensically Involved Individuals: This training focuses on legal and ethical considerations relevant to working with forensic/justice-involved consumers. Topics include confidentiality, privilege, reporting requirements, PHI, HIPAA, informed consent, agency policy/procedures and appropriate documentation. The training identified the various sources of current legal policies define patient-provider privilege, and reviews how to recognize signs of compromised boundaries (i.e., accepting gifts and inappropriate physical/personal boundaries). Ethical decision-making approaches relevant to individual and team accountability are addressed, as well as self- awareness and its applicability to forensic justice- involved program delivery services. • Suicide Prevention Service Provider Training- This training explores general risk factors, risk assessment, prevention (strength-based) and interventions. Clinical staff learn to identify techniques to ask specifically about suicide and intervene in the most appropriate and effective manner. Skills for effective clinical assessment, safety planning, record documentation, interventions, and management of individuals at risk for suicide are reviewed. Suicide statistics, risk and protective factors, cultural disparities and impact of COVID-19 are also discussed. • County Policy Equity-This 45-minute course is designed to help supervisors and managers understand the rights of employees to be free from discrimination, unlawful harassment, retaliation, and other inappropriate conduct. The course covers key points of the County Policy of Equity.

Program Name	Title of Trainings
Continued Men's Community Re-Entry Program (MCRP)	• Race and Trauma within Communities of Color – This training aims to destigmatize mental illness in communities of color; addresses trauma and the impact in the psychosocial functioning of the individual in relation to race; and describes the impact of mental health in the culture and family system. • Just Culture- This module provides workforce members with the basic knowledge on Just Culture and its concepts and principles. It covers how to create a kinder and fairer workplace that provides safer services to the community. • Applying the Risk-Need-Responsivity Principles (RNR) and Level of Service/Case Management Inventory (LS/CMI) in Your Practice - The RNR model is an evidence-based practice for working with justice-involved individuals to reduce recidivism. This training covers the theory and research behind RNR, as well as integration of RNR and the mental health recovery model at the clinic and organizational level. Clinic-level considerations include risk assessment, the concept of responsivity, and appropriate interventions based on individual risk factors. Considerations when effecting change at an organizational level are addressed. • Problem-Solving Therapy (PST) in Forensic Settings - Problem-Solving Therapy (PST) is a cognitive–behavioral approach centered on improving a person's ability to cope with stressful life experiences. Two major goals of problem-solving therapy are: 1) adaptive worldview toward problems of daily living, and 2) effective implementation of problem-solving behaviors. Forensic/justice-involved consumers are at increased risk for recidivism if they have difficulty identifying and solving everyday problems. This training provides participants with a foundation for competencies in assessing and developing problem-solving interventions. Assessment of problem-solving ability and style is measured through proctoring the Problem-Solving Inventory – Revised (SPSI-R). Participants will learn how to administer, score, and interpret the five SPSI-R scales: Positive Problem Orientation, Negative Problem Orientation, Rational Problem Solving, Impulsivity/Carelessness Style, and Avoidance Style. The results are utilized to develop interventions and measure progress in overcoming problem-solving difficulties. • Assessment and Treatment of Impulse-Control Disorders in Forensic Settings: The goal of this training is to develop knowledge and competence to assess and treat impulse-control disorders as well as disorders characterized by hyperactivity-impulsivity. This training provides participants with a foundation for competencies in assessment, treatment, and prevention of Impulse-Control Disorders/Behaviors. Assessment of impulsivity involves a combination of self-report questionnaires, neuropsychological tests, interview strategies, and diagnostic impressions.
Prevent Homelessness Promote Health (HP)	• Improving Access to Gender Affirming Care • Trauma Informed Care for Spanish Speaking Clients[EW10] • Racial Trauma in the Latinx Community.

Program Name	Title of Trainings
Promotores de Salud and United Mental Health Promoters	• DHR Dialogue Event: Race and Health- This training describes the myths and truths about disparities in health. • Complex Trauma: The Connection between COVID-19 and Social Unrest- Addresses the unprecedented stress impacting individuals, families and communities across cultures, generations, gender identities and racial groups. Systemic racism laid bare by the COVID-19 racial disparities and the murder of George Floyd sparking outrage and bringing to light the additional traumas experienced by Black, Indigenous and People of Color. • WEBINAR: Systemic Racism, Disparities and Health: The Impact of COVID-19 on Latino Health- The COVID-19 pandemic has highlighted the synergistic effects of systemic racism, combined with other factors, on the health. of Latinos in the United States. Long-standing and ongoing social and economic inequities–including health literacy barriers, disproportionate employment as essential workers and limited access to employment and insurance benefits–leave Latinos at increased risk of contracting COVID-19 and having more severe cases of the disease. • Emotional Health and the Effects of COVID-19 on the Brain. For Promotores -Topics include, cognitive impairment, especially in the Latino community. • Return of Children to School during COVID-19 - This training focuses on challenges and strategies to support children. • The Impact of Intimate Partner Violence on Children and their Development - This training aims to help participants understand how exposure to trauma can impact children's developing brains which can result in higher risks for learning disorders, ADHD, emotional, behavioral, and physiological problems. • COVID-19 and Return to School and Impact of COVID-19 addresses topics including challenges and factors affecting transmission and mortality of Hispanic children. • UCLA vaccine training incorporating culture *My Turn: COVID-19 Vaccines, ¡Tu Turno! Las Vacunas de COVID-19* - This offering *e*ngages participants in a discussion regarding cultural perspectives, value systems, suspicion and mistrust about vaccination, and issues related to access. • Diversity: Skills for the 21st Century Workforce - This webinar is designed to broaden and deepen participants' understanding of diversity and diversity-related issues in the workplace. Participants gain critical thinking skills and learn to work more collaboratively, respectfully, and inclusively with diverse groups to maximize individual and team strengths and increase cultural competence. • Combatting Systemic Barriers to Employment and Underemployment: This training addresses challenges to meaningful employment and strategies to overcome them.

Program Name	Title of Trainings
Continued United Mental Health Promoters	• Continuing the Focus on Social Inequities: this event highlights the various dynamics of employment, systemic barriers that perpetuate higher unemployment rates and lower paying jobs for communities disproportionately affected by systemic racism and discrimination. • Coronavirus Disease 2019 (COVID-19): Psychiatric and Cognitive Sequelae – The training addresses how unequal distribution of risk factors can impact the frequency, severity, and other outcomes of COVID-19 infection in African American and Latino patients. • Popular Education (Parts 1 and 2) • Introduces a theoretical framework and impact of Popular Education, especially among oppressed cultural groups and ethnicities. • Harbor UCLA Grand Rounds Black Mental Health Matters: Addresses issues related to allostatic load and other topics relevant to communities of color. • Explorando Auto-Compasión en Programas de Salud Mental para Mujeres Latinas Inmigrantes - The training looks at program of self-compassion for Latina Immigrant Women. • Mental Health American Conference - workshops highlighted the impact of the COVID-19 pandemic on mental health and wellbeing. • Suicide Prevention Conference - workshop participants gained a better understanding about how to support persons contemplating suicide and how to prevent it. • Life is Precious™: A Community Defined Practice Suicide Prevention Program for Latina Adolescent: This training addresses the factors that have led to an increase in Latina adolescent suicide attempts and possible interventions. • Hispanic Stress and Resilience During the Holidays - This training presents information on protective and risk factors in the Latino community during the holidays. • Exploring Cultural Awareness - This training cover show cultural communities heal from stressors. • UCLA training on Stigma - The training offers diverse cultural perspectives on how stigma impacts communities. • The State of TGI and LGBQ Mental Health in LA County: This training focuses on defining LGBT terminology, ways to support LGBTQ-identifying individuals and how to expand awareness about their experience. • Cultural Humility-Crucial Reflections - Self-reflection about one's culture, privilege, bias, and microaggressions. Participants learn how cultural humility can be used to improve engagement with children and families.

Program Name	Title of Trainings
Continued United Mental Health Promoters	• *Suicide Prevention Training - Participants enhance their skills for effective clinical assessment, safety planning, record documentation, intervention, and management of individuals at high risk of suicide.* • *A Sociodemographic and Clinical Profile of Asian Americans Served in Community Mental Health Centers for a Diagnosis of Schizophrenia Spectrum Disorder - This training offers a broad outline of the service needs of Asian Americans treated for schizophrenia.* • Spanish training for New Promoters - This training focuses on social determinants of health and addresses issues such as immigration status, economic burden, geographic region, and social connection/isolation.
TAY Navigation Team	• Intersectional and Trauma-Informed Practice with LGBTQIA2-S Communities - This training addresses LGBTQ+ TAY mental health needs, reviews societal biases, and describes best practices for services.
Wellness Outreach Workers (WOW)	• Homeless Outreach - The training demonstrates how to implement effective outreach strategies in working with individuals experiencing homelessness. • Mental Health Promoters Program -This training addresses full time and part time job opportunities for peer volunteers in the Department where they can utilize their linguistic and lived experience to promote recovery and reduce stigma. • Anti-Stigma Program - Participants enhance their understanding of stigma and how it can be a barrier for community members seeking mental health services. • Social Isolation - This offering provides techniques for effective psychoeducation to reduce social isolation • Re-entry and stress from COVID-19 - This training provides information on how the pandemic affected our population in different aspects of life.
Whole Care Person	• Understanding and Tackling Gender Bias in the Workplace - This training focuses on overcoming flawed beliefs regarding fundamental and universal differences between the sexes, gender inequality and discrimination. • Implicit Bias and Cultural Competency - This training explores implicit bias and cultural diversity in the workplace. • Diversity Skills for 21st Century -The training addresses inclusion in the workplace e. • DMH/DHS Homeless Outreach: Substance Use in Your Community - This training highlights substance use within communities experiencing homelessness. • DHR Dialogue Event: Race and Health - The training covers the myths and truths about racial disparities in health. • Cultural Humility: Crucial Reflections - This training defines the terms privilege, bias, and microaggression. • Racism in the Structure: Systemic Racism's Impact on Health Disparities

Program Name	Title of Trainings
Women's Community and Re-Entry Program	• Psychological Theories and Diagnostic Formulations for the African American Population - This training incorporates African American history to serve the African American population more accurately. • Implicit Bias and Cultural Competency - Participants gain awareness of how their implicit bias affects the provision of culturally sensitive services and measures the potential impact of discrimination. • Best Practices in Multicultural Clinical Supervision - This training increases the awareness and effectiveness for supervisors supervising multicultural staff. • Trauma Informed Practice for Forensically Involved Women - This training enhances the participants' understanding of complex trauma with women who have a history of incarceration, abuse, and neglect in their childhood. • Intersectional and Trauma Informed Practice with LGBTQIA-S Communities - Participants learn to 1. Watch their language. 2. Affirm a person's authentic identities as healing 3. Practice using intersectional and trauma-informed methods • Maternal Mental Health - This training addresses how hormones and pregnancy impact the mental health of women.

III. Monitoring of staff's skills/post skills learned in trainings

The OAO-Training Unit collects targeted outcomes for selected trainings scheduled throughout the year. Staff and managers collaborate to select which trainings will be assessed for to evaluate participant skill acquisition. Program needs determine which trainings are assessed on the following outcomes:

- Training cost
- Additional training needs
- Adequacy of content
- Clinical impact
- Knowledge/skill transfer

The OAO-Training Unit analyzes outcomes, to refine ongoing trainings, justify renewing training contracts, and plan for future trainings.

(See Criterion 5 Appendix, Attachment 8: Examples of trainings with one-month follow-up conducted by OAO-Training Unit)

Criterion 5 Appendix

Attachment 1: Interpreter Trainings, FY 20-21

ATTACHMENT 1 - CR 5 -INTERPRETER TRA

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

CC Plan 2017 PPT final 11.17.17.pdf

Annual Cultural Competence Training.

Attachment 3: ARDI DIVISION-CCU Annual Cultural Competence Training Attestation form

CC training attestation 9-12-18.p

Attachment 4: LACDMH Legal Entity Contract, FYs 21-22, 22-23 and 23-24

LE Contract 2021-22, 2022-23, 2023-24.pdf (Command Line)

Attachment 5: Inclusion of Cultural Responsiveness in Trainings

Inclusion of Cultural Responsiveness Trair

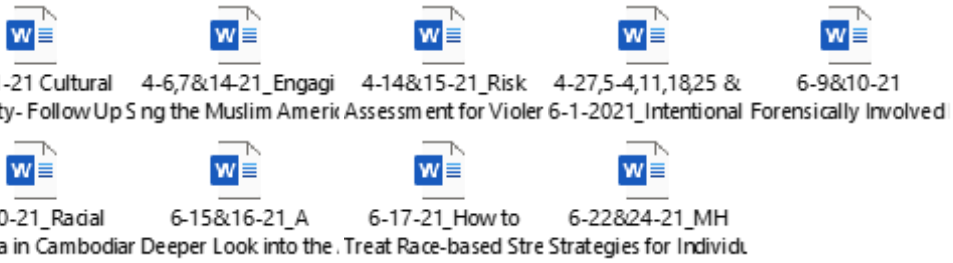
Attachment 6: LACDMH Training Evaluation Form

DMH_Training_Evalua tion_Form_2018.pdf

Attachment 7: Cultural Competence Trainings by State content category and sample training bulletins, FY 20-21

Trainings by Area of Cultural Competence

Attachment 8: Examples of trainings with one-month follow-up conducted by OAO-Training Unit, FY 20-21



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criterion 6

County's Commitment to Growing a Multicultural Workforce

August 2022

Criterion 6: County's Commitment to Growing a Multicultural Workforce

I. Recruitment, Hiring, and Retention

LACDMH is committed to growing a multicultural and language proficient workforce to serve our communities with quality services provided by those that increasingly reflect population served. Despite the myriad of challenges resulting from the large size and the cultural diversity of the County, the Department continues its efforts to recruit, hire, train, and retain culturally and linguistically competent staff through these strategies:

- Equip English-monolingual clinical staff with culturally responsive and linguistically competent language interpreters
- Integrate eligible consumers, family members, and parent advocates/parent partners into the public mental health workforce in peer, para-professional, and professional staff functions
- Retain workforce members representing cultural and linguistic underserved communities via tuition reimbursement and loan forgiveness programs
- Build collaborations with higher education institutions to promote mental health careers. This effort includes creation of pike lines for students to consider LACDMH employment upon completion of their academic degrees
- Provide the mental health workforce with a myriad of quality cultural competence trainings to enhance the service delivery at all points of contact
- Build the linguistic capability of the system of care by paying bilingual bonus to staff from Directly Operated programs
- Offer interpreter training to bilingual certified employees who are interested in providing language interpretation services
- Provide training for monolingual English-speaking staff on how to use language interpreters effectively

Below are examples of LACDMH's targets for workforce development efforts, FY 19-20:

1. **Public Mental Health Partnership (PMHP)** via the UCLA Public Partnership for Wellbeing Agreement
   The mission of the PMHP is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County. The PMHP is comprised of two sections focused on serious mental illness -- the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program.

2. **Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T)** via the UCLA Public Partnership for Wellbeing Agreement
   This program prepares trainees from the Hispanic Neuroscience Center of Excellence to work in multidisciplinary teams comprised of three (3) early entry neuropsychologists, three (3) postdoctoral fellows, and three (3) clinical social workers. The neuropsychologists are trained in the conduction of comprehensive neuropsychological assessments across the life span, while the clinical social

workers are being trained to provide allied linkage services and psychosocial support that addresses multiple social determinants of health including economic stability, education access, healthcare access and quality, neighborhood and build environment, social and community context. During the reporting period, HNCE trainees have collectively cared for 258 patients.

3. **Navigator Skill Development Program - Health Navigation Certification Training**
   This program trains individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers to navigate and advocate in both the public health and mental health systems. Training was limited during the COVID-19 pandemic, and training was delivered to one cohort.

4. **The Interpreter Training Program**
   The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English-speaking mental health providers. The use of linguistically and culturally competent interpreters is important factor in-bridging the language and cultural gap encountered in the delivery of services in public mental health. Due to COVID-19, this program had limited offerings.

5. **Learning Net System**
   The Department has developed an online registration system called eventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. EventsHub is fully operational and allows for most, if not all, clinical training to be administratively processed inclusive of posting, registration, and other training logistics important for tracking purposes. Enhancement and maintenance of eventsHub continues through FYs 20-22.

6. **DMH + UCLA General Medical Education (GME)** via the UCLA Public Partnership for Wellbeing Agreement
   This program targets adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry. Participants include Psychiatry Residency and Fellowships Professional Trainees and Public Psychiatry Professional trainees from the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior.

7. **LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees** via the UCLA Public Partnership for Wellbeing Agreement
   NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with DMH as their sponsor. The National Clinician Scholars Program is a multi-site program

for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country. Collectively, Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits.

8. **Psychiatric Residency Program: Charles Drew University Agreement**
   The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County

9. **Intensive Mental Health Recovery Specialist Training Program** prepares individuals, mental health consumers and family members, with a minimum of two (2) years of college credit to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor and local community college. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system. Due to COVID-19, only one cohort was able to complete this training**.**

10. **Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System (Honest, Open, Proud Program**
    The training demonstrates the necessity and importance of effective self-disclosure in empowerment and provision of peer support services. It provided strategies on how to effectively disclose personal lived experience in peer support services as well as within the LACDMH Peer Workforce. Additional components of this training are planned for subsequent Fiscal Years. During FY 20-21, one training (comprised of four online sessions) was delivered in June 2021.

11. **Intentional Peer Support (IPS) Advanced Training**
    The training focuses on advanced IPS practices, core principles, application of strategies to real-life scenarios, affirmation of self-reflection and understanding, and promotion of enhanced mutual connections all relevant to sustaining the practice. During FY 20-21, one Advanced Intentional Peer Support training (comprised of six online sessions) was provided from April to June 2021.

12. Parent Partners Training Program

This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports employment of parents and caregivers of children and youth consumers.

13. Continuum of Care Reform (CCR)

This training program provides an overview of the comprehensive transformation of the foster care system and its intent to achieve permanency planning for foster youth and their families. It introduces how pertinent legislation brings forth significant changes for group homes and respective providers that necessitate training for legislative compliance and provider readiness. To that end, the following table outlines DMH-offered trainings and include topics subjects such as introduction to mental health, diagnosis, assessment and self-care.

14. Child and Family Team Process Overview

This training addresses how the Child and Family Team process is utilized in the Continuum of Care Reform (CCR). In CCR, the Child and Family Teaming process is the decision-making vehicle for case planning and service delivery. The training covers the elements involved in the Child and Family process, team members, and their roles. It identifies the Integrated Core Practice Model elements embedded in the Child and Family Teaming process, and its role in providing collaborative services. Participants learn engagement strategies and the importance of keeping the child and family's voice and choice at the center. Participants also learn strategies for effective teaming with children and families, and formal and informal supports. This training offers didactic and experiential learning strategies to support the transfer of learning.

15. Integrated Core Practice Model Overview

This training provides an overview of the Continuum of Care Reform, Integrated Core Practice Model practice standards. It highlights expansion of the California's Core Practice Model, including the core values, principles, and elements; additional discussion incorporates the model's practice wheel components and practice behaviors. Participants learn to utilize interagency teaming strategies while providing services to children and families involved in the Child Welfare system. The child and family's voice and choice are of primary importance and supported utilizing a strength-based and trauma-informed approach. A review of safety, permanency, and Wellbeing promote the tenets of the model throughout the training. Lastly, both didactic and experiential learning strategies serve to enhance application of understanding and knowledge.

16. Crafting Underlying Needs Statements and Services

This training provides information on Underlying Needs and its application in the Continuum of Care Reform (CCR) process. It prepares providers to identify the

relationship between underlying needs and youth's behavior as well as highlight the importance of engaging youth and families and empowering their voice and choice. Participants will learn approaches for effective teaming and collaboration with children and families and their formal and informal supports. Incorporation of the family's culture and functional strengths inform the needs assessment and support development of individualized services for youth and families in the Child Welfare system. Both didactic and experiential learning activities serve to enhance understanding, knowledge, skills, and implementation of training strategies.

17. LGBTQ+ Youth In Placement

This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens will be utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma, particularly as it relates to LGBTQ+ youth of color. Lastly, participants learn about Eli Coleman's Identity Model to conceptualize the coming out process and the value of acceptance. Group activities are facilitated to enhance application of learning and increase one's self-awareness as it relates to this population.

18. LGBTQ+ Youth in Care: Guidelines for Clinical Practice

This training seeks to provide the audience with a better understanding of trauma and barriers specific to LGBTQ+ youth in the Child Welfare and Probation systems. A trauma informed lens will be utilized to increase participants' awareness of specific challenges that affect this vulnerable population. Using a culturally sensitive approach, trainers will highlight appropriate LGBTQ+ terminology as well as explore the impact of stigma, particularly as it relates to LGBTQ+ youth of color. Lastly, participants will learn about Eli Coleman's Identity Model to conceptualize the coming out process and the value of acceptance. Group activities will be facilitated to enhance application of learning and increase one's self-awareness as it relates to this population.

19. Prevent the Eruption: Trauma Informed De-Escalation Strategies (3-hours)

This training seeks to provide DMH, DCFS, Probation, and Contract Provider staff with the knowledge in recognizing and better understanding trauma when observed in children and youth, the impact of trauma on the brain and provide learning on trauma informed care strategies using a developmentally appropriate and culturally relevant approach. This training reviews the ascent of escalation phases, de-escalation phase clues, and offer trauma informed interventions for each including the debriefing process and strategies for prevention of self-injurious behavior. Additionally, this training assists participants with the understanding and application of trauma-informed consequences and self-care strategies.

20. Prevent the Eruption: Interventions Booster (2 hours)

This booster training seeks to provide DMH, DCFS, Probation and Contract Provider staff with information and practice in the following areas: engagement, phases of

escalation, strategies to de-escalate youth, and ways to manage trauma triggers and unsafe behaviors. This training builds upon strategies learned in the Prevent the Eruption: Trauma- Informed De-escalation Strategies to further equip providers with developmentally and culturally relevant tools to support the de-escalation process. Participants will be placed in breakout rooms to facilitate the learning process through group work and discussions.

21. Engaging Runaway Youth in Placement: Overview and Strategies for Response (Runaway)

Most runaway youths struggle with substance abuse and mental health issues, are at high risk for being a victim of sex trafficking and have higher rates of involvement with the juvenile justice system. This training increases the participants' understanding of the characteristics of youth who run and the impact of traumatic experiences and development on running behavior. It provides strategies to reduce the risk of running, including recommended policy, practice, training, and direct engagement with youth. The curriculum follows a case-based approach to designing implementable strategies to reduce risk to run. Following the introduction of core content, attendees review case information using a multidisciplinary and collaborative lens to assist them in identifying effective strategies for engaging youth and reducing run risk. Teams learn to develop safety plans that encompass run behavior prevention and intervention.

22. Creative Interventions for System Involved Youth

This training prepares Continuum of Care Reform (CCR) providers to explore the transformative and restorative power of creativity for youth. Participants learn how they can utilize creative interventions when working with youth who are involved in systems of care including child welfare, mental health, and probation. Discussions include the key components of trauma-informed expressive art therapy, creative art therapy modalities, and adaptable interventions. Participants build awareness of the benefits of utilizing creative trauma-informed interventions and identify tools to support the implementation of art, dance/movement, music, play, drama, and other expressive modalities in their work with youth. Lastly, this training incorporates both didactic and experiential learning to support transfer of knowledge, understanding, ~~knowledge~~ and integration of training objectives.

23. Engaging Youth in Placement: From Admission Through Aftercare

This training delivers an overview and practical applications for engaging youth in placement throughout the course of treatment from admission to aftercare. Topics covered include trauma, challenges and barriers to engagement, specific strategies to initiate and maintain engagement with youth, interagency collaboration, and aftercare planning. Utilizing a trauma-informed lens, trainers discuss the impact of trauma on youth's overall development, attachment, and relationships. Participants learn a variety of approaches to aftercare planning which they may integrate into their own agencies. Interagency collaboration efforts as well as connecting youth to community resources are considered. The warm hand-off and facilitation of a "good goodbye" with youth and families are highlighted. Group activities enhance learning

and provide opportunities to apply a variety of useful strategies to promote engagement.

24. Engaging Probation Youth

This training provides the audience with knowledge to recognize and understand trauma when observed in youth on probation through a trauma informed lens. It addresses the impact of trauma and its effects on the brain, attachment, physiology, and social relationships will be examined. It also provides an overview of a trauma informed approach, cultural sensitivity, and underlying needs. Tools for engagement as well as staff's awareness of their countertransference is explored with participants via group activities to enhance application of learning and training objectives. Lastly, identification and integration of self- care strategies into daily practice are addressed.

25. Youth with Developmental Disabilities and Mental Illness: Overview and Interventions

This training focuses on youth with developmental disabilities and mental illness. It addresses how to identify common mental health symptoms for youth with developmental disabilities placed in a STRTP. Differences abide in presentation of mental illness symptoms in this population and such conditions warrant adapting interventions to meet their unique needs. Lastly, group discussions on the CFT process provide participants with practical tools and techniques to work directly with this population.

26. Financial Incentive Programs

Mental Health Psychiatrist Student Loan Repayment Incentive

LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service in the Department and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the MH Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000.

27. Mental Health Psychiatrist Recruitment Incentive Program

This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. It is designed for eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in LACDMH and who have not participated in or received funds from the Student Loan Repayment Incentive program. It grants a one-time award of $50,000 consisting of $25,000 upon completion of the first year of continuous service at LACDMH, and an additional payment of $25,000 upon completion of the second year of continuous service.

28. Post-doctoral Fellowship

This program offers two (2) and three (3) year fellowship opportunities to individuals interested in the field of mental health.

Collectively, these 28 activities increase the cultural and linguistic competency of the LACDMH workforce via the following strategies:

- Provision of culturally responsive and linguistic enhancement of interpreters and the clinicians that utilize them
- Integration of consumers, family members, and parent advocates/parent partners into the public mental health workforce at peer, paraprofessional, and professional levels
- Retention of current skilled workforce and recruitment of future workforce, with priority afforded to individuals that represent an unserved or underserved population and/or speak a needed language
- Outreach to community partners, such as community colleges and faith-based leaders/organizations, to build collaborations and address stigma often associated with mental illness, while creating partnerships with community-based organizations that may create an additional way for consumers to enter the public mental health system
- Training the mental health workforce regarding the culture of lived experience and the promotion of hope, wellness, and recovery.

In addition to the 28 workforce development programs mentioned above and consistent with the CLAS standards, LACDMH builds its culturally and linguistically competent workforce by creating culture-specific job vacancies across a variety of positions. Examples include:

1. Community Worker

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

<u>ESSENTIAL JOB DUTIES</u>

- Provide Targeted Case Management services that include assisting consumers with obtaining and maintaining housing, benefits establishment, vocational rehabilitation, and linkage of consumers to community resources
- Complete all required documentation associated with on-going treatment services, such as progress notes, Community Functioning Evaluation form, Mental Health Triage and Client Treatment Plans
- Provide individual rehabilitation and group services to help clients develop appropriate coping skills and engagement in meaningful activities that promote wellness

- Provide field-based outreach services to consumers to assist with housing and interface with community resources and provide treatment as needed

2. Psychiatric Social Worker II (Spanish Speaking)

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

ESSENTIAL JOB DUTIES

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

3. Bilingual Spanish Speaking Licensed or License eligible Psychiatric Social Worker Mental Health Clinician

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

DESIRABLE QUALIFICATIONS

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

4. Intermediate Typist Clerk

The Specialized Foster Care Program (SFC) is seeking a motivated, positive, and experienced individual to fill the position of Intermediate Typist Clerk. Candidates with excellent administrative, organizational, verbal, and written communication skills are

encouraged to apply. The new hire is expected to work with the IBHIS System, DCFS referral portal and the electronic referral tracking system. The position is located at the Zev Yaroslavsky Family Support Center, 7555 Van Nuys Blvd, Van Nuys, CA 91405.

DESIRABLE QUALIFICATIONS

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

5. Psychiatric Social Worker I/II

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

ESSENTIAL JOB DUTIES

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

6. Psychiatric Social Worker II or Mental Health Clinician II

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

ESSENTIAL JOB DUTIES

- Complete adult assessments, screenings, and triages
- Provide individual and group rehabilitation/psychotherapy, case management, consultation, and crisis intervention
- Conduct weekly chart reviews
- Provide field-based services including outreach and engagement
- Actively participate in multi-disciplinary team meetings
- Assist in coverage as the officer of the day

7. Psychiatric Social Worker II/Mental Health Clinician II

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

ESSENTIAL JOB DUTIES

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

8. Clinical Psychologist I/II

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

ESSENTIAL JOB DUTIES

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

Workforce Enhancement Strategies

1. United Mental Health Promoters (UMHP) Program Recruitment

The UMHP was implemented in November 2020 as an expansion of the Promotores de Salud Program to the African and African American; Asian Pacific Islander (API); American Indian/Alaska Native (AI/AN); Eastern European/Middle Eastern (EE/ME); Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, Asexual and Two Spirit (LGBTQIA2S); and persons with disabilities. The expansion was based on the premises and accomplishments of the Promotores de Salud Program, namely that natural leaders once trained as mental health promoters are successful in bridging gaps between LACDMH and the communities they serve. The ARDI Division actively sought out recruitment from focal communities.

Using Demographic Data to Tailor Workforce Development

The formation of the ARDI Division in June 2021 prioritized LACDMH's commitment to combat racism by employing a workforce that serves and reflects the rich diversity of LA County. The recruitment and retention of peer, professional, and clinical staff from the diverse communities served, represents the Department's strategy to enhance its workforce by incorporating the knowledge and talents of natural leaders from underserved communities and persons with lived experience.

The Promotores de Salud Mental/United Mental Health Promoters (UMHP) Program exemplifies the implementation of this strategy. Through an LA County Board of Supervisors motion, the Promotores de Salud Mental program was expanded and adapted to serve priority underserved communities countywide. In expanding and diversifying the program's workforce, the ARDI Division used population demographics to allocate and recruit staff to optimize representation of the cultural and language diversity among underserved communities.

UMHP Hiring Implementation

Having been allocated 300 part-time (F) positions for expansion and diversification, the first step the ARDI Division took was to use population demographic data to allocate the limited number of positions across the diverse groups and across the eight Service Areas. A total of 290 positions were allocated using the data. The remaining 10 out of the 300 positions were assigned to the Eastern European/Middle Eastern cultural groups based on needs identified through threshold language.

Demographic Analysis for Position Distribution

Promoter F-Items by Priority Population and Service Area Based on LAC at or Below 138% FPL
December 2, 2020

SA	LAC Population[1]				Black and African Heritage			Asian/Pacific Islander			American Indian/AN			Latino/Hispanic			20-30 Promoter
	African American	Asian/Pacific Islander	Latino	Native American	Percent of LAC	% of 46 Promoters	Rounding	Percent of LAC	% of 46 Promoters	Rounding	Percent of LAC	% of 18 Promoter	Rounding	Percent of LAC	% of 180 Promoter	Rounding	Per SA
SA 1	18,141	2,830	56,357	443	8%	3.62	**4**	1.0%	0.47	**0**	9.6%	1.72	**2**	3.6%	6.55	7	**20**
SA 2	15,231	40,099	251,339	674	7%	3.04	**3**	14.6%	6.73	**7**	14.5%	2.62	**3**	16.2%	29.2	29	**20**
SA 3	11,353	89,638	193,954	528	5%	2.27	**2**	32.7%	15.04	**15**	11.4%	2.05	**2**	12.5%	22.54	23	**20**
SA 4	14,537	56,873	219,483	743	6%	2.90	**3**	20.7%	9.54	**10**	16.0%	2.88	**3**	14.2%	25.51	25	**20**
SA 5	5,130	15,470	17,328	122	2%	1.02	**1**	5.6%	2.60	**3**	2.6%	0.47	**0**	1.1%	2.01	2	**20**
SA 6	95,821	8,784	325,720	719	42%	19.12	**20**	3.2%	1.47	**1**	15.5%	2.79	**3**	21.0%	37.85	38	**20**
SA 7	7,326	16,209	274,318	567	3%	1.46	**1**	5.9%	2.72	**3**	12.2%	2.20	**2**	17.7%	31.88	32	**30**
SA 8	63,013	44,312	210,444	840	27%	12.57	**12**	16.2%	7.43	**7**	18.1%	3.26	**3**	13.6%	24.46	24	**30**
Totals	230,552	274,213	1,548,943	4,637	100%	46	**46**	100%	46	**46**	100%	18	**18**	100%	180	**180**	**180**

[1] From DMH Annual Quality Improvement Report and Work Plan, 2019, Table 4, Page 54 [Totals do not equal due to rounding].

UMHP Position Distribution by Cultural Groups

African American	Asian/ Pacific Islander	American Indian/ Alaska Native	Eastern European/ Middle Eastern	Latino	Total F-Items
Projected	Projected	Projected	Projected	Projected	Projected
2	0	2	0	20	24
3	7	3	3	20	36
2	15	2	0	20	39
4	10	3	3	20	40
4	3	0	2	20	29
19	1	3	0	20	43
1	3	2	1	30	37
11	7	3	1	30	52
46	46	18	10	180	300

The ARDI Division actively sought out recruitment from focal communities. Job announcements were intentionally customized for culture-specific recruitment purposes. The announcements included the following information:

- "Ideally, Mental Health Promoters: a) reside and volunteer in their communities; b) are committed to helping others and improving their community; c) have lived experience in the field of mental health and through this are able to help and support others; and d) have experience as "promoters" in other areas, including but not limited to, health, domestic violence, or HIV."
- "Able to complete Foundational Training, which includes paid training hours, and successfully pass final exams."

- “Have knowledge of their communities and willingness/ability to conduct outreach to find and develop venues for mental health presentations, e.g., community groups, churches, schools, community centers, neighborhoods, libraries, and parks.”
- “Able to attend monthly mandatory trainings and group supervision meetings.”
- “Able to present a minimum of four (4) presentations per month, and provide information and referrals, if needed, to the appropriate community resource.”
- “Able to consult with a multidisciplinary team if assistance is needed with the information, referral, and linkage of a community member to a needed resource.”
- “Be flexible and adaptable and be prepared to be called upon for special assignments in the field.”
- “Have ability to utilize computer for communication and presentation task, including effective communication and use of working electronic mail (E-Mail).”
- “Have a valid social security number at time of application.”
- “Interested applicants should submit their resume via email to: UnitedMHPromoters@dmh.lacounty.gov”

The customized job announcements were disseminated to various cultural and language communities at key community venues. Listed below are the focal communities with a culture-specific introduction:

A. Access 4 All (Persons with Physical Disabilities)
“LA County Department of Mental Health is seeking to include members of the Access 4 All community as United Mental Health Promoters. United Mental Health Promoters are members of the community who are recruited to give presentations on mental health topics to groups in various settings within their community.”

B. American Indian/Alaska Native
“LA County Department of Mental Health is seeking to include members of the American Indian/Alaska Native community as United Mental Health Promoters. United Mental Health Promoters are members of the community who are recruited to give presentations on mental health topics to groups in various settings within their community.”

C. Asian Pacific Islander
“LA County Department of Mental Health is seeking to include members of the Asian Pacific Islander community as United Mental Health Promoters. United Mental Health Promoters are members of the community who are recruited to give presentations on mental health topics to groups in various settings within their community.”

D. Black and African American
“LA County Department of Mental Health is seeking to identify members of the Black and African American community who are interested in becoming United Mental Health Promoters. United Mental Health Promoters are members of the community who provide education on mental health topics to groups in various settings within their community.”

E. Eastern European/Middle Eastern

"LA County Department of Mental Health is seeking to include members of the Eastern European/Middle Eastern community as United Mental Health Promoters. United Mental Health Promoters are members of the community who are recruited to give presentations on mental health topics to groups in various settings within their community."

F. LBTQIA2-S

"LA County Department of Mental Health is seeking to include members of the LGBTQIA2-S community as United Mental Health Promoters. United Mental Health Promoters are members of the community who are recruited to give presentations on mental health topics to groups in various settings within their community."

G. Promotores de Salud Mental

"El Departamento de Salud Mental del Condado de Los Angeles, está reclutando residentes de la comunidad de habla hispana para dar alcance y presentaciones en temas de salud mental a grupos en diferentes locaciones en las comunidades del condado de Los Angeles."

By the end of FY 20-21, the Promotores de Salud Mental/UMHP Program had 135 Promoters. Breakdown by Service Area, language and cultural community is shown in the following tables respectively.

PROMOTERS BY LANGUAGE
FY 20-21

Service Area		Language					
	Amharic	Chinese	English	Khmer	Korean	Spanish	Grand Total
1						10	10
2					2	11	12
3		1			5	19	25
4	1		1		3	12	17
5			1			3	4
6			8			15	23
7					1	18	19
8			6	1		18	25
Grand Total	**1**	**1**	**16**	**1**	**11**	**106**	**135**

PROMOTERS BY CULTURAL COMMUNITY
FY 20-21

Service Area	Cultural Community								
	AI/AN	API Cambodian	API Chinese	API Filipino	API Korean	African American	Latino	Latino and API Filipino	Grand Total
1							10		10
2					2		11		12
3			1		5		19		25
4					3	2	11	1	17
5						1	3		4
6						8	15		23
7					1		18		19
8	2	1		1		3	18		25
Grand Total	**2**	**1**	**1**	**1**	**10**	**14**	**105**	**1**	**135**

Data Source: ARDI Division, August 2022

2. ARDI Advisory Counsel

The ARDI Staff Advisory Council was created by Director Dr. Jonathan Sherin in the spring of 2021 following the completion of the Initial Action Learning Community, or ALC process. On July 21 of 2020 the Los Angeles County Board of Supervisors unanimously passed a motion to establish an Anti-Racist Los Angeles County Policy Agenda to address “general inequality and systemic anti-Black racism.” The Board had directed the County Chief Executive Officer to establish the Anti-Racism, Diversity & Inclusion (ARDI) Initiative, which is now led by Dr. D’Artagnan Scorza as Executive Director of Racial Equity.

Department of Mental Health Director Dr. Jonathan Sherin coordinated a Departmental response to identified experiences and observations of systemic racism, and specifically anti-Black racism within the public mental health system and secured consultants to initiate an Action Learning Community (ALC) process and an Intergroup Dialogue (IDG) process for staff to participate in.

The ALC process identified five domains. Co-chairs for each domain group, with the support of Dr. Rigoberto Rodriguez, helped to discern 102 specific goals by January of 2021. One of those goals was the establishment of the ARDI Staff Advisory Council tasked with overseeing the implementation of an anti-racism action plan with all ALC goals identified, and a second goal was for the establishment of an ARDI Division within DMH tasked with, among other responsibilities, implementation of said goals.

Dr. Sherin requested that the 10 co-facilitators serve as the inaugural Staff Advisory Council, and appointed Dr. Jorge Partida Del Toro as the Director of the ARDI Division.

- Mission statement
  To build an intra-departmental community of DMH employees who are connected through a shared commitment to advancing racial equity and shaping DMH as an organization grounded in principles of anti-racism, diversity, and inclusion.

- Membership demographics
  The current Council consists of 14 members. In the Fall of 2021, the Council developed an application process to expand membership as it had identified a significant lack of a few cultural experiences and identities. While it is important for each Council member to assert and express their own identities, the current Council is comprised of members who are Black, Latino/a and Latinx, API, AI/AN, White, CIS gendered female and male, LGBTQ+, peers and family members of mental health clients, Community Health Workers, clerical and administrative, licensed and license-eligible clinicians and supervisors, program managers and medical practitioners. Programs include staff from LACDMH Headquarters (countywide), the Olive View Community Mental Health Urgent Care Center and the San Fernando Child and Family Center (from SA2), The American Indian Counseling Center (from SA7, serves Countywide), Augustus Hawkins Mental Health Center (SA6), and the Countywide Psychiatric Mobile Response Team (PMRT) Program. The Council is aware that, despite attempts to be as inclusive as possible, LACDMH is ever evolving and continue to seek to identify, reflect and represent all the needs and identities within the workforce.

- Goals and activities
  1) Increase staff awareness and acknowledgement of anti-Black racism through education to promote intra-personal growth.
     a. Develop and deliver high-quality, accessible trainings addressing anti-Black racism
  2) Enhance staff well-being and empowerment
     a. Establish an Anti-Racism, Diversity, and Inclusion Staff Advisory Council.
     b. Create a safe work environment to discuss racial issues and concerns.
     c. Strengthen the department's Human Resources system.
  3) Increase hiring, supervision, and professional advancement. a. Recruit Black clinicians and staff in LACDMH and support their advancement.
     b. Support the equitable advancement of People of Color staff.
  4) Expand the service delivery system's capacity to provide anti-racist, culturally congruent, and responsive services.
     a. Establish a BIPOC Treatment Task Force.
     b. Develop outreach and education campaigns and expand the health promoters program targeting Black consumers and communities.
     c. Expand outreach and education campaigns and culturally congruent and responsive practitioners and practices
  5) Leverage partnerships and collaborations across Los Angeles County, City Departments, and Community Stakeholders.

a. Improve the County Policy on Equity (CPOE) system
b. Strengthen multi-stakeholder community collaboration.
c. Improve the crisis response system.
d. Improve collaborative practices with the Department of Children and Family Services.
e. Increase the number of facilities to co-locate physical health and mental health services.
f. Use digital technology to expand access to mental health services.
g. Partner with school districts to improve student mental health outcomes

6) Build strong commitment, accountability, and responsiveness of Executive Management and everyone in leadership roles. a. Executive Management commitment to anti-racism.

- Accomplishments
  The Council has presented at a DMH Town Hall Meeting, has meet with CEO ARDI Director Dr. D'Artanian Scorza, has held two meetings with DMH executive leadership, has expanded to 13 members, presented at the inaugural DMH Speaker's Bureau conference, provided Department-wide statements in response to community incidents and has developed a 3-year ARDI Action Plan to implement the original goals of the ALC process.

3. LGBTQ+ Services Specialist Position

Dr. Rebecca Gitlin, Ph.D. (she/her) is LACDMH's first LGBTQ+ Services Specialist. Her position was established on March 2, 2020. This part-time position serves to establish a centralized resource for the provision of culturally responsive services for the LGBTQIA2-S community in L.A. County. The LGBTQ+ Services Specialist serves as a SME for Countywide LGBTQIA2-S behavioral health consultation and program development.

The overall goals of the LGBTQ+ Services Specialist position and strategies to achieve these goals include:

1. Evaluate facilitators and barriers to LGBTQIA2-S responsive service provision within LACDMH's Directly Operated programs
   - Create and administer survey for LACDMH staff to assess current knowledge, skills, self-efficacy, perception of the professional environment, and training needs focused on serving LGBTQIA2-S community members
2. Oversee culturally responsive service provision for LGBTQIA2-S community members
   - Review LACDMH policies and advocate for necessary updates to expand protections for LGBTQIA2-S community members
   - Develop LGBTQ+ Champion Network within LACDMH
     - Establish a department-wide training plan to ensure that all LACDMH employees have the knowledge and skills to provide culturally responsive services

- Provide training and consultation for LACDMH Directly Operated and contract programs to increase capacity to provide LGBTQIA2-S responsive services
- Establish and oversee new clinical role within LACDMH's Directly Operated programs to ensure improved access to gender affirming treatment for transgender community members

3. Provide guidance on changes within LACDMH's EHR systems to use up-to-date and affirming language and identifier displays
    - Collaborate with Clinical Informatics office to generate affirming language and identify avenues for sustainable implementation

From March 2, 2020 through June 30, 2020, the LGBTQ+ Services Specialist accomplished the following:

- Updated written resources for L.A. County shelters and other facilities on culturally responsive disaster response services for LGBTQIA2-S community members
- Trained LACDMH pharmacists on trauma-informed practice and contraceptive counseling with gender diverse patients
- Initiated creation of survey for LACDMH staff to assess current knowledge, self-efficacy, professional environment, and trainings needs in order to provide effective and high-quality services to LGBTQIA2-S community members
- Integrated feedback from LACDMH and community stakeholders
- Founded the LGBTQIA2-S Specialty Care Workgroup within LACDMH's discipline of psychology in order to form a collaborative body of clinicians who are motivated to establish and improve standard practice in working with LGBTQIA2-S consumers
- Established the Gender Affirming Treatment Advocates clinical role, which includes clinicians with specialized training on writing support letters for transgender community members to facilitate access to gender affirming treatment
- Joined LACDMH Speakers Bureau to provide education and consultation to Countywide and community stakeholders on culturally responsive services for LGBTQIA2-S community members in response to the COVID-19 pandemic.

4. LACDMH LGBTQIA2-S Workgroup

The LACDMH LGBTQIA2-S Workgroup was initially established in July 2020 as the LGBTQIA2-S Specialty Care Clinical Workgroup under the leadership of the Chief of Psychology. The Specialty Care Clinical Workgroup consisted of 8 LACDMH psychologists, including the recently appointed LGBTQ+ Services Specialist for the Department. The LGBTQ+ Services Specialist served as the chair and facilitator for the LGBTQIA2-S Specialty Care Clinical Workgroup. The Specialty Care Clinical Workgroup met biweekly from July to December 2020 and focused on establishing broader Department-wide goals to establish best practices for affirming mental health

services for LGBTQIA2-S community members. Specialty Care Clinical Workgroup members identified the following key priorities:

- Supporting the LGBTQ+ Services Specialist in creation and dissemination of all-staff survey to establish baseline of LGBTQ+ clinical knowledge and utilization of affirming practice;
- Reviewing and updating LACDMH policies to be inclusive of diverse genders and sexualities;
- Beginning exploration of LACDMH LGBTQIA2-S Champion Network;
- Expanding language within IBHIS to reflect and affirm diverse genders and sexualities among LACDMH service recipients;
- Identifying opportunities to expand training opportunities for LACDMH staff to improve clinical practice with LGBTQIA2-S service recipients.

In January 2021, the Specialty Care Clinical Workgroup expanded its membership to include any LACDMH employees who were interested and motivated to improve our system of care for LGBTQIA2-S communities. The multidisciplinary LACDMH LGBTQIA2-S Workgroup met monthly during the 2021 calendar year and quarterly since the start of 2022, with the LGBTQ+ Services Specialist continuing to serve as chair and facilitator.

Membership

The LGBTQIA2-S Workgroup includes LACDMH employees from all levels of the organization, including our Chief Medical Officer, Service Area Chiefs, several Program Managers and supervisors, and clinicians and allied professionals. The number of attendees at each of the Workgroup meetings varies by month, ranging from approximately 8 to 23 employees.

There were 13 LACDMH employees, including the LGBTQ+ Services Specialist, who self-reported attending the meetings on a regular basis (at least 3 Workgroup meetings during CY 2021). Among these employees:

- Professional Identities

  Position within LACDMH
  - Five (5) serve as supervisors or managers for LACDMH (one Program Manager II, one Program Manager I, two [2] Supervising Psychologists, one Mental Health Clinical Supervisor)
  - Six (6) serve as clinical staff (two [2] Psychiatric Social Workers, four [4] Clinical Psychologists)
  - Two (2) serve as administrative staff (one Health Program Analyst I, one Intermediate Typist Clerk)

  Program or Division within LACDMH
  - Seven (7) work in administrative programs (one in Outpatient Services, two [2] in the Anti-Racism, Diversity, and Inclusion [ARDI] Division, two [2] in Quality, Outcomes, and Training Division [QOTD], one in Administrative Operations, one in Contract Management and Monitoring Division [CMMD])

- Three (3) work in direct clinical service (one at Hollywood Mental Health Center, one at Arcadia Mental Health Center, one at Olive View Urgent Care Center)
- Three (3) work in the Child Welfare Division (two [2] in Specialized Foster Care, one in Continuum of Care Reform)

- Social Identities

  Racial/Ethnic Identity
  - One (1) self-identified as Asian
  - Three (3) self-identified as Black/African American/African Heritage
  - Three (3) self-identified as Latino and Latinx
  - Six (6) self-identified as White/Caucasian

  Language(s) Spoken at Home
  - Twelve (12) reported speaking English at home
  - Two (2) reported speaking Spanish at home
  - One (1) reported speaking Korean at home

  Language(s) Spoken at Work
  - Thirteen (13) reported speaking English at work
  - Two (2) reported speaking Spanish at work

  Gender Identity
  - Eleven (11) self-identified as woman/female
  - Two (2) self-identified as man/male

  Sexual Orientation
  - Nine (9) self-identified as straight/heterosexual
  - One (1) self-identified as lesbian
  - One (1) self-identified as gay
  - Two (2) self-identified as queer

  Pronouns
  - Ten (10) reported using the pronouns she/her/hers
  - One (1) reported using the pronouns she/her/ella
  - Two (2) reported using the pronouns he/him/his

  LGBTQIA2-S Community Membership
  - Four (4) self-identified as members of the LGBTQIA2-S community
  - Nine (9) did not self-identify as members of the LGBTQIA2-S community

Workgroup Mission and Meeting Descriptions

The Workgroup aims to use our collective capacity as LACDMH employees to improve our professional and clinical environments and ensure an equitable and responsive system of care for LGBTQIA2-S service recipients, staff, and other community members. Workgroup meetings have focused on identifying Department-wide training priorities, discussing strategies for improving our collection of sexual orientation and gender identity

(SOGI) data from service recipients, and other systems-focused initiatives. The workgroup also invited guest speakers from other County departments and community agencies, and together, the workgroup engaged in mutual learning and discussion through film screenings and similar events.

Table 1: summary of LGBTQ+ Workgroup Meeting Presentations and Discussions

Month	Topics of Discussion
January	1. Introductions and foundation-setting 2. Review of LGBTQIA2-S initiatives within LACDMH 3. Breakout discussions
February	4. Departmental updates and announcements 5. Review of current SOGI terminology 6. Consumer Perception Survey (CPS) update/expansion
March	7. Update on BOS motion on SOGI data collection 8. Presentation and discussion about Transgender Day of Visibility
April	9. Check-in/feedback from #Out4MentalHealth Informational Presentations 10. Discussion on intra-Departmental advocacy regarding all-gender restrooms 11. Discussion on LGBTQIA2-S clinical consultation groups
May	12. Discussion on LACDMH funding for LGBTQIA2-S TAY services 13. Check-in regarding Workgroup structure and process 14. Pride commemoration discussion/planning
June	15. Film screening: *State of Pride*
July	16. Update on all-gender restroom access and advocacy 17. Update on SOGI data collection/expansion; discussion on next steps for implementation
August	18. Departmental updates and announcements 19. Guest speaker: Nicole Kristal, #Out4MentalHealth and Still Bisexual 20. Guest speaker: Dr. Katherine Gardner, Los Angeles County Department of Health Services
September	*No meeting*
October	21. Departmental updates 22. Guest speakers: Rashida Aziz and Camila Camaleón, Gender Justice LA 23. Discussion on LGBTQIA2-S “Hubs” and Champions within LACDMH
November	24. LGBTQIA2-S observances in October and November 25. Film screening and discussion: *Cured*
December	26. Departmental updates and announcements 27. Clinical Parameter on Sexual and Gender Diversity

	28. LGBTQIA2-S Champion Network and Signature Programs: continued discussion

Source: ARDI Division, LGBTQ+ Specialist at LACDMH

The section below provides the LGBTQ+ Workgroup Annual Report for CY 2021

1) January

The inaugural multidisciplinary LGBTQIA2-S Workgroup meeting primarily focused on community-building, foundation-setting, and reviewing LGBTQIA2-S initiatives for LACDMH. Previous and ongoing initiatives included:

- LACDMH staff survey on LGBTQIA2-S services
  - Survey data collected from LACDMH staff August-October 2020
  - Staff were asked about utilization of LGBTQIA2-S affirming clinical practices, LGBTQIA2-S-related training experiences and needs, and basic knowledge about LGBTQIA2-S concepts
- Gender Affirming Treatment Advocates
  - Establishment of a new clinical role within LACDMH
  - Gender Affirming Treatment Advocates are LACDMH clinicians with specialized training in conducting psychosocial assessments and writing referral letters for transgender, non-binary, and gender diverse clients seeking gender affirming medical services, in accordance with the World Professional Association for Transgender Health (WPATH) Standards of Care
- LGBTQIA2-S trainings for LACDMH staff and community partners
  - Collaborating with LGBTQIA2-S UsCC subcommittee and UCLA to identify Department-wide training priorities and explore avenues for implementation
- Updating LACDMH nondiscrimination policies
- LGBTQIA2-S Specialty Care Workgroup (predecessor to current Workgroup)
- Expanding language within IBHIS
  - Adding comprehensive sexual orientation and gender identity (SOGI) data fields
  - Expanding language in form titles (e.g., *Reproductive Health History Form* vs. *Women's Health History Form*) and psychosocial data collection (e.g., inclusive family structures in Child/Adolescent Initial Assessment form)
- Expanding affirming language and data fields within the Department's electronic system
- Integration of Just Culture
- LGBTQIA2-S training for LACDMH staff
  - Ensuring that trainings are mandatory
  - Standardized training approach for trainees within LACDMH
  - Accurately identifying individuals' training needs
  - Beyond LGBTQIA2-S 101
  - Considering specific subpopulations and areas for clinical specialization
- Integration of sexual and gender diversity within staff performance evaluations and cultural competence-related evaluations

- Advocacy and trainings for family members of LGBTQIA2-S community members
- Creating more community (e.g., LGBTQ+ support groups within LACDMH clinical programs)
- Building an affirming environment for anyone who walks through the door at LACDMH

2) February

The Workgroup was informed of a BOS motion that was passed in late January 2022, *Expansion and Standardization of Sexual Orientation and Gender Identity (SOGI) Data Collection in Los Angeles County*. Workgroup members learned about the content and focus of the motion, and the LGBTQ+ Services Specialist planned to provide updates as next steps were identified. Workgroup members were also informed about upcoming trainings and informational presentations related to LGBTQIA2-S mental health, and they were encouraged to disseminate this information to their colleagues within their respective programs. The LGBTQ+ Services Specialist provided an overview of SOGI concepts and terminology to ensure that Workgroup members shared the same foundation for affirming language and understanding the distinctions between gender identity, gender expression, assigned/designated sex, and sexual/romantic orientation. A Supervising Psychologist from LACDMH's Quality Improvement (QI) division presented proposed changes to the Consumer Perception Survey (CPS). The QI team was planning to update and expand the client demographics section of the CPS to include gender identity, sexual orientation, and consumer/client experiences related to LGBTQIA2-S affirming services. Workgroup members provided feedback on the proposed changes.

3) March

Workgroup members were informed that Subject Matter Experts, including the LGBTQ+ Services Specialist, had been identified from various County Departments to participate in a cross-Departmental SOGI Workgroup. The SOGI Workgroup would collaboratively draft the response to the BOS motion calling for the expansion and standardization of SOGI data collection. The LGBTQ+ Services Specialist announced an upcoming training for a new cohort of Gender Affirming Treatment Advocates. The Workgroup discussed strategies for recruiting clinicians to participate in the training cohort in accordance with current gaps within LACDMH (e.g., more providers working with children and adolescents). The Workgroup participated in a discussion about Transgender Day of Visibility (TDOV; March 31). Workgroup members were shown a video about TDOV and engaged in a dialogue about how LACDMH can practice greater awareness, inclusion, and celebration of transgender and non-binary community members within the workplace environment, within our families and social community, within the context of clinical service provision, and within LACDMH more broadly.

4) April

Workgroup members provided reflections and feedback following two #Out4MentalHealth Informational Presentations that were held for LACDMH leadership and staff (State of TGI Mental Health [March 18], State of LGBTQ Mental Health [April 8]). The LGBTQ+ Services Specialist updated the Workgroup that LACDMH's Training Advisory Committee reached out to her following the Informational Presentations to elicit LGBTQIA2-S training priorities for the Department. Workgroup members discussed potential avenues for intra-Departmental advocacy efforts to promote the importance of all-gender restroom access throughout new and existing LACDMH facilities. Workgroup members brainstormed effective strategies for implementing LGBTQIA2-S Clinical Consultation groups to supplement formal trainings. The Workgroup noted that many LACDMH clinical staff may have pertinent questions related to LGBTQIA2-S affirming healthcare but may not register for relevant trainings. Regularly scheduled LGBTQIA2-S Clinical Consultation meetings would allow for ongoing opportunities for collective capacity-building as relevant issues arose in the context of service delivery.

5) May

The Workgroup discussed potential steps to advocate for ongoing funding for LGBTQ+ TAY services, which had previously been contracted through LACDMH. The contract was scheduled to be discontinued the following month. Members provided feedback on the overall structure and process of the LGBTQIA2-S Workgroup meetings. Workgroup members expressed their appreciation for the time and space to discuss systems/culture change within LACDMH to promote a more affirming environment for LGBTQIA2-S communities. The Workgroup also discussed the possibility of formally collaborating with other County Departments in a cross-Departmental LGBTQIA2-S workgroup. The LGBTQ+ Services Specialist informed the Workgroup of plans to commemorate Pride Month (which takes place every June) through an existing, but soon to be discontinued, cross-Departmental LGBTQ+ Workgroup.

6) June

In commemoration of Pride month, Workgroup members watched a documentary titled *State of Pride*. Following the screening, members discussed their reactions to the film and explored the various meanings that Pride month has for LGBTQIA2-S community members.

7) July

Workgroup members were informed that, in response to their planned advocacy efforts, all-gender restrooms would be installed on certain floors of LACDMH's new Headquarters building. Members were allowed time and space to share their reactions. The LGBTQ+ Services Specialist provided an update on the final report submitted to the Board of Supervisors by the SOGI Workgroup in response to the motion calling for the expansion and standardization of SOGI data collection. She presented the key definitions, recommended questions, and response options for Gender Identity, Sex

Designated/Listed at Birth, and Sexual Orientation as unique data fields within each Department's respective client record system. Workgroup members discussed next steps for implementation within LACDMH, including cross-walking existing Gender/Sex data within IBHIS and training all LACDMH providers on new data collection approaches.

8) August

Workgroup members were provided updated information on expanding SOGI data collection within LACDMH after the LGBTQ+ Services Specialist presented the SOGI Workgroup's report to the IBHIS Clinical Council and the Training Advisory Committee. The LGBTQ+ Services Specialist also announced the official initiation of monthly LGBTQIA2-S Clinical Consultation Team meetings. Workgroup members were provided information on the overall structure and purpose of these meetings, and they were encouraged to disseminate this information to their clinics/programs. Guest speaker Nicole Kristal, co-chair of the LGBTQIA2-S UsCC subcommittee, spoke about her work with #Out4MentalHealth and Still Bisexual. She shared information about #Out4MentalHealth's statewide advocacy efforts, in addition to biphobia within healthcare institutions and the efforts of Still Bisexual to elevate the visibility of bisexual people's lived experiences to destigmatize and normalize bi+ identities. Guest speaker Dr. Katherine Gardner, family medicine physician with Los Angeles County Department of Health Services (DHS), spoke about the recently issued BOS motion *Care with Pride*. This motion called upon DHS, in collaboration with LACDMH and other County departments, to improve and expand interdisciplinary healthcare services for LGBTQIA2-S patients, with an emphasis on transgender and gender affirming healthcare. Dr. Gardner elicited Workgroup members' feedback on how these interdisciplinary care teams can be established between our respective Departments.

9) September: no meeting

10) October

Workgroup members were updated on a recently issued BOS motion, *Implementing Best Practices for SOGIE Competency Training and Data Collection*. This motion called upon the Department of Human Resources to respond with a comprehensive plan for ensuring that all County Departments trained their employees on best practices in collecting SOGI data and providing affirming services for LGBTQIA2-S community members. Workgroup members were informed that a new Pronouns field was being added to IBHIS, which would allow for clients' accurate gender pronouns to be identified within their charts. Members were provided information about where this information could be found within a client's chart and best practices for asking clients about their accurate gender pronouns. Guest speakers Rashida Aziz and Camila Camaleón spoke about their work with Gender Justice LA. They gave a presentation on transgender lived experiences and gender diversity, including best practices for affirming service delivery. They also presented Gender Justice LA's findings from their *TransMasculine Health Justice: Los Angeles* initiative. Workgroup

members engaged in a dialogue about the formation of LGBTQIA2-S "Hubs" within each Service Area and/or establishing the LGBTQIA2-S Champion Network. The Workgroup collectively identified facilitators and barriers to each. LGBTQIA2-S Hubs were noted to be helpful for visibility, but they may overly burden specific programs within each Service Area. Overall, the workgroup members preferred the design of a Champion Network, where individual staff and providers throughout LACDMH could participate according to their interest and expertise in order to promote affirming and culturally responsive services within their respective programs.

11) November

Workgroup members discussed October and November LGBTQIA2-S observances:

- October: LGBTQ+ History Month
  - National Coming Out Day (October 11)
  - International Pronouns Day (October 20)
  - Intersex Awareness Day (October 26)
- November: Transgender Awareness Month
  - Transgender Day of Remembrance (November 20)

In recognition of LGBTQ+ History Month, Workgroup members watched the documentary film, *Cured*, which chronicles the activism that ultimately resulted in the declassification of homosexuality as a mental disorder within the DSM. Following the screening, Workgroup members discussed their reactions. Members engaged in dialogue around stigma and pathologization of LGBTQIA2-S lived experiences – historically and currently – in addition to promoting affirming healthcare practices.

12) December

Workgroup members were provided with Departmental updates related to LGBTQIA2-S services, including recruitment for an upcoming Gender Affirming Treatment Advocates training and participation in a cross-Departmental video project to be released in June 2022. The Workgroup discussed priorities for a new LACDMH Clinical Parameter on Sexual and Gender Diversity. The LGBTQ+ Services Specialist explained the importance and overall context for LACDMH clinical parameters as an official policy on best practices within the Department's overall provision of culturally responsive services. Workgroup members who were interested in collaborating on a Clinical Parameter on Sexual and Gender Diversity were encouraged to reach out to the LGBTQ+ Services Specialist. Workgroup members continued discussing the structure and implementation of the LACDMH LGBTQIA2-S Champion Network, including the possibility of identifying "Signature Programs" within the Department. The Workgroup had previously identified the LGBTQIA2-S Champion Network as a preferred avenue for building a community of affirming service providers. However, questions remained regarding inclusion criteria, vetting, and ongoing accountability for LGBTQIA2-S Champions. LGBTQIA2-S Signature Programs could be established within at least one program per Service Area. Each Signature Program would be expected to include Gender Affirming Treatment Advocates, individual psychotherapy offerings, and LGBTQIA2-S support groups. As

with the previous discussion, Workgroup members expressed their preference for the Champion Network over establishing more consolidated Signature Programs throughout the Department.

LOS ANGELES COUNTY
DEPARTMENT OF
MENTAL HEALTH
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ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

CRITERION 7

Language Capacity

August 2022

Criterion 7: Language Capacity

The Los Angeles County Department of Mental Health (LACDMH) strives to meet the linguistic needs of its diverse communities by recruiting and employing ~~growing~~ a multicultural and multilingual workforce, providing training opportunities for bilingual certified staff to become language interpreters, operating, and contracting with Legal Entities for the provision of culturally and linguistically competent programs. The County of Los Angeles has thirteen threshold languages, which include:

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Korean
- Mandarin
- Russian
- Spanish
- Tagalog
- Vietnamese

Due to the size and diversity of Los Angeles County, LACDMH has determined threshold language profiles for each of our eight Service Areas (SAs), as detailed in Table 1 (below):

TABLE 1: SERVICE AREA BASED THRESHOLD LANGUAGES
FY 20-21

Service Area	Threshold Languages
1	English and Spanish
2	Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese
3	Cantonese, English, Korean, Mandarin, Spanish, and Vietnamese
4	Armenian, Cantonese, English, Korean, Russian, and Spanish
5	English, Farsi, and Spanish
6	English and Spanish
7	English, Korean, and Spanish
8	Cambodian, English, Korean, Spanish, and Vietnamese

Data reported only for LACDMH threshold languages. “Threshold language” means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Arabic is considered a Countywide threshold language[RG11]. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2020.

I. Increase bilingual workforce capacity

Bilingual Certified Employees

LACDMH's workforce is ~~composed~~ comprised of over 6,000 employees from Directly Operated (DO) and Contracted programs, with bilingual capacity in 60 languages. The majority bilingual certified employees are proficient in Spanish (over 4,500) and other languages well represented, with over 100 employees in the workforce which include Korean, Mandarin, Armenian, Tagalog, Farsi, and Cantonese.

According to information provided by the LACDMH Human Resources Bureau (HRB) regarding DO Programs, the Department pays a bilingual bonus for the following 39 languages, inclusive of threshold and non-threshold languages: American Sign Language (ASL), Arabic, Armenian, Bulgarian, Cambodian, Cantonese, Catalan, Chinese, Flemish, French, German, Greek, Hakka, Hebrew, Hindi, Ilocano, Italian, Japanese, Korean, Laotian, Mandarin, Nahuatl, Pangasinan, Portuguese, Russian, Samoan, Spanish, Swedish, Tagalog, Taiwanese, Thai, Toi Shan, Turkish, Urdu, Vietnamese, Visuyan, and Yiddish. The departmental practice of hiring employees with various bilingual capabilities and providing bilingual bonus compensation demonstrates the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards Nos. 3, 5, 7, and 8.

Per LACDMH Policy No. 602.01, Bilingual Bonus, LACDMH bilingual certified employees possess a valid Language Proficiency Certificate issued through the County's Bilingual Proficiency Examination, which tests for proficiency to either speak, read, and/or write the language. Bilingual compensation is paid to certified bilingual employees whose assignments require dual fluency in English and at least one foreign language, as well as knowledge of, and sensitivity toward, the culture and needs of the linguistic communities served by the Department. American Sign Language (ASL) is included within the category of foreign languages for purposes of this bonus. All LACDMH bilingual certified employees are placed on the eligible lists and are contacted when their foreign language skills are needed for translation of materials and/or language interpretation services by diverse LACDMH Programs/Units.
(See Criterion 7 Appendix, Attachment 1: LACDMH Policy on Bilingual Bonus).

The LACDMH Human Resources Bureau (HRB) is responsible for maintaining a current list of employees receiving a bilingual bonus. The list is categorized by employee name, payroll title, pay location, language, and language proficiency level (e.g., speaking, reading, and writing.) They can be requested by LACDMH managers directly from the HRB ***(See Criterion 7 Appendix, Attachment 2: List of LACDMH Bilingual Certified Staff).***

Linguistic Competence Trainings

The Department allocates funds for staff trainings and conferences each Fiscal Year (FY). A major portion of these expenditures is allocated for the provision of cultural competence trainings. Below is a brief list of sample expenditures for FY 20-21:

- $66,000 for Specialized Foster Care trainings

- $11,600 for Juvenile Justice trainings
- $28,317.50 for culturally specific trainings focusing on underserved populations
- $17,245 for interpreter trainings

Examples of trainings offered to increase the linguistic competence of staff:

Introduction to Interpreting in Mental Health Settings
This three-day language interpreter training series is designed for bilingual staff who are proficient in English and in a second language. This introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter. The purpose is to assist the Mental Health and Wellness programs by training the bilingual workforce to accurately interpret and meet the requirements of Federal and State law. This course provides the participants with the knowledge and skills pertaining to the role of interpreters, models of interpreting, mental health terminology, standards of practice, cultural interpreting, and skills to face challenges arising in the mental health field. This training also includes an introduction to glossary development and maintenance of specialized mental health glossaries based on the interpreters' level of proficiency in both languages.

Increasing Mental Health Clinical Terminology in Mandarin and Spanish
These trainings are intended to increase cross-cultural knowledge and skills in serving communities that speak the threshold language targeted by the training. Training content aims to increase clinicians' and bilingual staff's vocabulary and use of terms related to the provision of mental health services such as assessment, diagnosis, treatment and crisis intervention. Additionally, the training addresses challenges that may arise when performing services in the targeted threshold language (e.g., using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis, inappropriate diagnosis, and other unintended consequences). Participants also become familiarized with the challenges that may interfere with establishing rapport and treatment adherence.

Culturally and Linguistically Competent Programs
LACDMH also builds the linguistic capacity of the system of care by dedicating funding for culture-specific programs that increase service accessibility for underrepresented populations. For example, LACDMH allocates Community Services and Supports (CSS) Planning Outreach and Engagement (POE) funding for the seven UsCC subcommittees' capacity building projects. Each UsCC subcommittee receives $200,000 per FY to implement culturally and linguistically competent projects, totaling $1,400,000. The membership from each subcommittee generates conceptual ideas for capacity building projects, which are turned into proposals by the UsCC Unit, and presented for approval. The UsCC projects are voted on via a participatory and consensus-based approach within each subcommittee. Please refer to Criterion (CR) 1 and CR 3 for additional details.

Another example of a culturally and linguistically competent program at LACDMH is the Promotores de Salud Mental and United Health Promoters (UMHP) Program which operates in all eight Service Areas. During FY 20-21, LACDMH had 106 Promotores de Salud Mental and 29 UMHP collectively engaging the Ethiopian, Cambodian, Chinese, Korean, and Latino communities in their preferred languages and within a culturally grounded perspective.

Language Assistance Services

LACDMH is committed to funding various types of language assistance services to enable consumers, family members, and the community at large to have meaningful participation in departmental stakeholder meetings and events in their preferred language. During FY 20-21, language assistance services included the following:

- $102,235 for language interpreter services, which allowed consumers to participate in various departmental meetings and conferences
- $65,708 for language documents translation services
- $8,222 for ASL and Closed Captioning/Communication Access Realtime Translation (CART), coordinated by the Anti-Racism, Diversity and Inclusion (ARDI) Division-Cultural Competency Unit (CCU), for consumers, family members, and the community at large to participate in various departmental meetings and conferences
- $76,523 for closed captioning services
- $100,074 for ASL services offered to consumers from both DO and contracted clinics
- Approximately 500 bilingual employees receive a monthly compensation ranging between $85 and $100; LACDMH pays bilingual bonus for 39 different languages, inclusive of threshold and non-threshold languages

II. Services to persons who have Limited English Proficiency (LEP)

Table 2 below summarizes language assistance services coordinated by the CCU inclusive of the following:

- American Sign Language (ASL)
- Cambodian
- Korean
- Spanish
- Closed Captioning/CART Services

During FY 20-21, the ARDI Division-CCU facilitated and processed language assistance services for 23 different stakeholder meetings. Often, these meetings were held monthly and required more than one type of language or communication accommodation.

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TABLE 2: LANGUAGE ASSISTANCE FOR STAKEHOLDER AND COMMUNITY MEETINGS AND EVENTS, FY 20-21

MEETING AND EVENT	LANGUAGE ASSISTANCE PROVIDED	FREQUENCY
Cultural Competency Committee	Spanish, ASL, and Closed Captioning/CART	Monthly
Faith-Based Advocacy Council Executive Board	Korean	Monthly
Faith-Based Advocacy Council	Spanish	Monthly
Mental Health Commission Executive Committee	Spanish	Monthly
Mental Health Commission	Spanish	Monthly
Service Area Leadership Team (SALT) 1	Spanish	Monthly
SALT 2	Spanish	Monthly
SALT 3	Spanish	Monthly
SALT 4	Spanish and Korean	Monthly
SALT 5	Spanish	Monthly
SALT 6	Spanish	Monthly
SALT 7	Spanish	Monthly
SALT 8	Spanish	Monthly
Access for All UsCC	ASL	Monthly
Asian Pacific Islander UsCC	Cambodian and Korean	Monthly
Latino UsCC	Spanish	Monthly
LGBTQIA2-S UsCC	ASL	Monthly
SALT Co-Chair and API UsCC	Korean	Monthly
External Quality Review Organization (EQRO) - Focus Groups	Spanish	Annually
Mental Health and Community Event and Clergy Meetings	Spanish	Quarterly
DMH Town Hall Special Events	Spanish, Closed Captioning/CART and ASL	Varies

Source: ARDI Division - Cultural Competency Unit

During FY 20-21, the Cultural Competency Unit coordinated the language assistance services for 23 different stakeholder groups. Most of these efforts required monthly coordination with language interpreter vendors and multiple departmental units. Additionally, several stakeholder meetings involved multiple languages and/or a combination of more than one type of accommodation based on requests received from the community.

TABLE 3: EXPENDITURES RELATED TO LANGUAGE ASSISTANCE SERVICES FY 20-21

LANGUAGE ASSISTANCE SERVICES (Meetings/Events)	
Language Interpreter Services - Spanish, Korean, Cambodian, Other languages as needed	
	TOTAL $102,235
Closed Captioning-CART (Communication Access Realtime Translation)	
	TOTAL $76,523
American Sign Language for Stakeholder Groups	
	TOTAL $8,222
Translations (Various threshold languages) – Documents: forms, surveys, informational brochures, handouts for Non-English speaking consumers, family members and community groups.	
	TOTAL $65,708
	GRAND TOTAL $252,688

Source: LACDMH Cultural Competency Unit

Table 3 summarizes the expenditures for language assistance services provided in various departmental stakeholder meetings and events. Most of the incurred expenditures were for the provision of multi-language interpreter services, followed by Closed Captioning/CART services.

III. Provision of bilingual staff and/or interpreters for the threshold languages at all points of contact

The LACDMH Help Line

Formerly known as the ACCESS Center, this 24/7 resource has been expanded and renamed as the "Help Line." The expansion of the Help Line includes the ACCESS Center, Emotional Support Services for LA County employees, and Veteran or Military Family Member Support. It serves as the primary entry point for callers seeking information regarding mental health services and supports. When callers request information related to mental health services and other social needs, the Help Line provides referrals to culture-specific providers and services that are appropriate and conveniently located.

The Help Line strives to meet the cultural and linguistic needs of callers by providing language assistance services in threshold and non-threshold languages at the time of first contact. Additionally, it provides equitable language assistance services to deaf and hard of hearing consumers and providers requesting ASL interpreter services for clinical appointments with psychotherapists and psychiatrists. The Help Line tracks the number of calls received in non-English languages. LACDMH's Help Line provides emergency and non-emergency services.

The Help Line facilitates a wide array of services such as:

- Deployment of crisis evaluation teams
- Information and referrals for Specialty Mental Health Services (SMHS)
- Language Line for interpreter services to serve the caller in their preferred language, including face-to-face American Sign Language interpreter services for clinic appointments
- After-hours gatekeeping of acute inpatient psychiatric beds
- After-hours DMH point of contact for the Patients' Rights Office (PRO) and special/critical incident reporting
- 24-hour notification to DMH service providers of after-hours activity
- Coordination of Out-of-County and Out-of-State referrals for Medi-Cal beneficiaries
- Collaboration with local Medi-Cal health management organizations (HMOs)
- Acts as a back-up Disaster Operations Center (DOC) providing assistance and crisis intervention following natural or man-made disasters.

TABLE 4: SUMMARY OF APPOINTMENTS FOR ASL SERVICES
FY 16-17 to FY 20-21

Fiscal Year (FY)	Number of Assigned Appointments
FY 16-17	1,242
FY 17-18	1,140
FY 18-19	983
FY 19-20	1,027
FY 20-21	629
TOTAL	5,450

Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date. Data Source: DMH, EOTD, ACCESS Center, FY 16-17 to FY 20-21

Table 4 presents the number of assigned ASL interpreter services appointments for the five prior FYs. For FY 20-21, the Help Line's ACCESS Center coordinated 629 requests for sign language interpreter services. The number of ASL appointments may vary based on the demand for ASL services requested by the deaf and hard of hearing community. One possible scenario is presented by consumers entering the system with more acute symptoms that require a greater frequency of treatment sessions. The decrease on number of requests may be due to the impact of COVID-19 pandemic and the stay-at-home orders for the majority of FY 20-21.

TABLE 5: FIVE-YEAR TREND IN NON-ENGLISH LANGUAGE CALLS RECEIVED BY THE ACCESS CENTER

Language	2017	2018	2019	2020	2021
Albanian	0	0	1	0	0
Amharic	1	0	2	0	0
Arabic	8	18	21	6	2
Armenian	128	65	32	32	3
Bengali	0	2	5	0	1
Burmese	0	2	2	0	0
Cambodian (Khmer)	10	26	19	7	0
Cantonese	46	73	59	35	7
Farsi	178	59	40	41	11
French	1	1	1	1	3
German	0	0	0	1	0
Hindi	0	1	1	2	0
Hmong	0	0	1	0	0
Italian	0	0	0	1	0
Japanese	2	6	6	3	2
Korean	140	224	149	113	21
Luganda	0	1	0	0	0
Mandarin	82	166	126	79	14
Persian	5	4	3	0	0
Polish	0	1	0	0	0
Portuguese	1	1	1	1	1
Punjabi	2	1	1	0	0
Russian	37	13	25	17	10
Sinhala	0	0	0	1	0
Spanish (LISMA)	2,303	1,370	1,373	896	289
*Spanish ACCESS Center	6,150	6,612	6,398	9,009	1,024
Tagalog	9	16	10	7	2
Thai	7	0	5	2	0
Urdu	0	1	1	0	1
Vietnamese	195	34	26	16	4
TOTAL	9,305	8,697	8,308	10,270 [RG12]	1,395

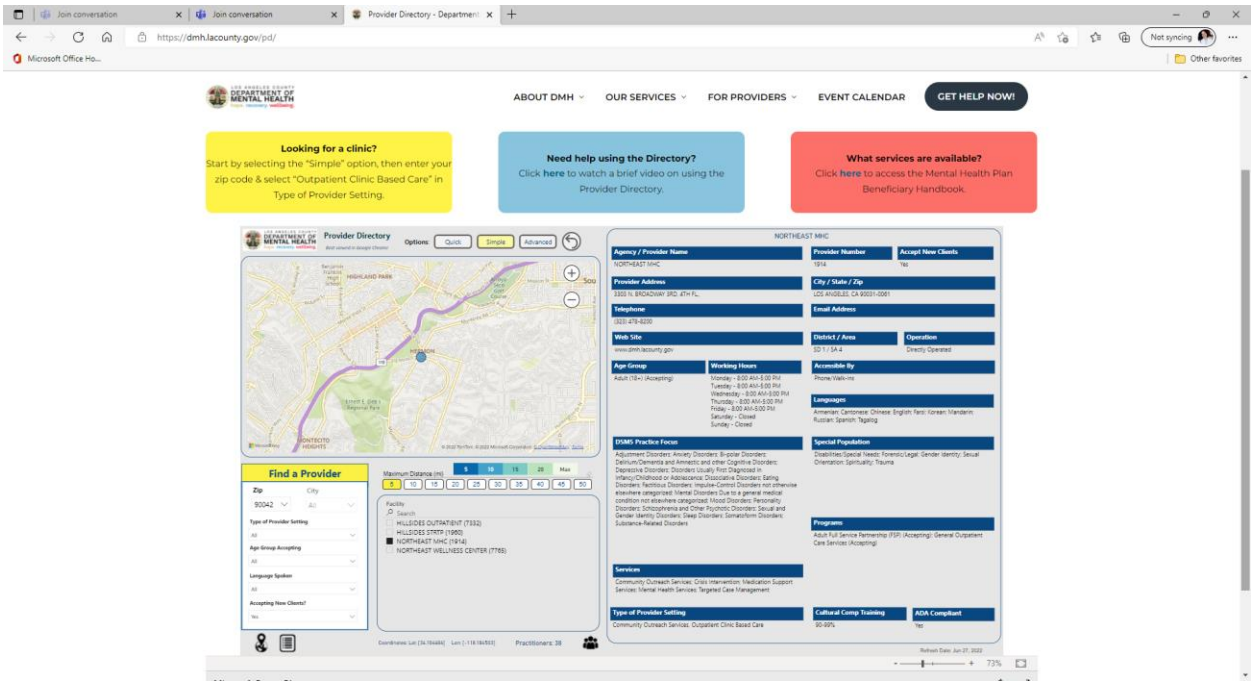
NOTE: ***** ACCESS Center Spanish speaking employee assisted with interpreter services. Data Source: Virtual Contact Center (VCC) effective 11/29/2013. Effective 10/13/2016, per the new Language Interpreter Services Master Agreement (LISMA), telephone interpreter services are provided by the following: Language Line Services Inc., TransPerfect Translations International, Inc., and Worldwide Interpreters, Inc.

Table 5 summarizes the total number of non-English language calls received by the ACCESS Center, from CY 2017 through CY 2021. A total 29 language communities have remained active in accessing the ACCESS Center services. Over the past five years, most of the requests for non-English language calls, other than Spanish, were for Korean

(N=647), followed Mandarin (N=467), Farsi (N=329), Vietnamese (N=275), Armenian (N=260), and Cantonese (N=220).

Service Area Provider Directory

The Provider Directory is a primary tool developed by LACDMH to search for service providers in geographic locations that would be most convenient and accessible to consumers. Users can access information about geographically accessible LACDMH providers by typing in their zip code. They can also refine their search specifying the maximum traveling distance. Once these stipulations are filled out, the system will generate a listing of all providers in closest proximity. Once users select their provider of choice, the Provider Directory will present practical information such as the provider's location, hours of operation, type of setting, Specialty Mental Health Services provided inclusive of specialized programs, languages in which services are offered, age groups served, special populations, ADA compliance, availability for new cases, and percentage of staff who have completed annual cultural competence training. The screenshot below is an example of a search result by a user. The Provider Directory can be accessed by the public via Internet at https://dmh.lacounty.gov/pd. LACDMH staff can also access this tool using the Provider Locator feature in the Intranet at https://lacounty.sharepoint.com/sites/DMH/SitePages/DMH%20Provider%20Directory.aspx



Language Interpreter Services

Language interpreter services are offered and provided to LEP consumers free of charge. LACDMH Policy No. 200.03, Language Translation and Interpreter Services, specifies the procedures to be followed by DO programs when language interpreter and translation

services are needed ***(See Criterion 7 Appendix, Attachment 3: LACDMH Policy on Language Translation and Interpreter Services.)*** The procedure for procurement of language interpreter services for meetings and conferences is also outlined in this policy. The language assistance services addressed in this policy include face-to-face, telephonic, and interpreter services for the deaf and hard of hearing as well as translation services. LACDMH Policy No. 200.02, Interpreter Services for the Deaf and Hard of Hearing Community, includes procedures to request emergency and non-emergency sign language interpreter appointments.
(See Criterion 7 Appendix, Attachment 4: LACDMH Interpreter Services for the Deaf and Hard of Hearing Community.)

The "Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services" outlines clinical documentation guidelines, which are located under the Rehabilitation Option and Targeted Case Management Services." These guidelines indicate how linguistic needs of consumers are to be documented. Pages 11 and 12 delineate the following instructions pertinent to documentation of language-related assistance:

"Special[RG13] client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):

- **Visual and hearing impairments**
- **Client's whose primary language is not English -** Clients should not be expected to provide interpretive services through friends or family members. (See LACDMH Policy #200.03, "Language Interpreters", for further information.) Oral interpretation and sign language services must be available free of charge (State Contract).

  NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or must be a service intervention. The assistance must be claimed in accordance with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.

  NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.

- **Cultural and/or linguistic considerations -** When special cultural and/or linguistic needs are present, there must be documentation in the assessment, client treatment plan or initial progress note indicating the plan to address the cultural and/or linguistic needs.
  - If an exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled.

    NOTE: Culture is defined as "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or

linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics. Culture dictates:

- How health care information is received
- How rights and protections are exercised
- What is considered to be a health problem
- How symptoms and concerns about the problem are expressed
- Who should provide treatment for the problem, and
- What type of treatment should be given

(*U.S. Department of Health and Human Services, Office of Minority Health (2013); The National Culturally and Linguistically Appropriate Services (CLAS) Standards.*)

Cultural considerations may include but are not limited to racial/ethnic/national origin, religious/spiritual background or affiliation, gender/sexual orientation, other cultural considerations expressed by the consumer."

Additionally,[RG14] the Short-Doyle/Medi-Cal Organizational Provider's Manual highlights that the clinical assessment is "important in beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a whole person. The clinical assessment enables the reader to see the role of culture and ethnicity in the client's life and documents the impact of significant supports, living situation, substance use, etc. on the mental health of the client. The Assessment identifies the client and his/her family's strengths and identifies the stages of change/recovery for the client. The formulation collected in an assessment (allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery" (p. 16).

A section titled "New Client Assessment Requirements" has been added, which specifies preferred language and linguistic needs as key areas of must to be assessed as follows:

- Assessor Information (LACDMH)
  - Name
  - Discipline
- Identifying Information and Special Service Needs (LACDMH)
  - Name of Client
  - Date of Birth
  - Gender
  - Ethnicity
  - Preferred Language (p.17)
  - Other relevant information
- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma (p. 19).

(See Criterion 7 Appendix, Attachment 5: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services

Under the Rehabilitation Option and Targeted Case Management Services)

Change of Provider (COP) Form

To monitor that consumers are receiving mental health services in their preferred languages, LACDMH tracks the incidence of language as a reason for change of provider requests generated by consumers. The Patients' Rights Office (PRO) works closely with service providers from the eight SAs and collects requests received for changing providers. This information is recorded, analyzed, and tracked to monitor the number of system-wide requests for COPs, reasons for the requested changes, and the rates of approved requests. Examples of culture-related reasons for consumers to request a change of provider include:

- Age
- Gender
- Language
- Does not understand me
- Insensitive/unsympathetic
- Treatment concerns
- Medication concerns
- Uncomfortable
- Not a good match

TABLE 6: REQUESTS FOR CHANGE OF PROVIDER BY REASON AND PERCENT APPROVED FY 18-19 to FY 20-21

Reason(s)[1]	FY 18-19		FY 19-20		FY 20-21	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
1. Time/Schedule	235	87%	136	92%	N/A	N/A
2. Language	144	89%	129	94%	32	63%
3. Age	85	89%	61	90%	14	43%
4. Gender	246	94%	156	90%	52	65%
5. Treating Family Member	32	94%	27	93%	1	0%
6. Treatment Concerns	430	90%	267	88.0%	88	53%
7. Medication Concerns	276	87%	62	87%	0	0%
8. Lack of Assistance	427	86%	290	88%	117	57%

Reason(s)[1]	FY 18-19		FY 19-20		FY 20-21	
	Number of Requests	Percent Approved	Number of Requests	Percent Approved	Number of Requests	Percent Approved
9. Want Previous Provider	89	83%	72	86%	20	45%
10. Want 2nd Option	155	89%	101	92%	30	50%
11. Uncomfortable	613	90%	438	90%	116	62%
12. Insensitive/ Unsympathetic	398	90%	292	91%	90	56%
13. Not Professional	309	91%	229	92%	71	52%
14. Does Not Understand Me	509	89%	354		121	59%
15. Not a Good Match	693	90%	585	91%	196	66%
16. Other	509	87%	502	9%	214	62%
17. No Reason Given	109	92%	95	84%	20	50%
Grand Total	5,259	89%	3,797	90%	17	59%

Note: Multiple reasons may be given by a consumer.

Data Source: LACDMH, Patients' Rights Office (PRO), July 2022

*FY20-21 only includes Directly Operated COP data.

Table 6 presents a summary of the number of requests for Change of Provider by reasons and percent approved for FYs 18-19, 19-20, and 20-21. Data on the requests for COP is based on monthly COP logs submitted to PRO. According to the FY 20-21 data, the most frequent reason for a COP request was "Other" (N=214) followed by "Not a Good Match" (N=196), and the least frequent reason for a COP request was "Treating a Family Member" (N=1).

IV. Required translated documents

In accordance with Federal and State guidelines, LACDMH supports the translation of clinical forms and informational materials into the threshold languages. LACDMH Policy and Procedure 200.03: Language Translation and Interpreter Service outlines standards regarding language translation and interpreter services to ensure that under no circumstances is a beneficiary denied access to mental health services due to language barriers. This policy emphasizes that non-English or LEP consumers have the right to receive language assistance services in their primary or preferred language at no cost to them. It also delineates the step-by-step procedures to be followed by service providers. The policy also provides definitions regarding the difference between

language interpreter and language translation services and identifies the Los Angeles County threshold languages.

Furthermore, LACDMH Policy No. 602.01, Bilingual Bonus, specifies that bilingual certified employees will be contacted when the Department needs language translation and interpretation services. It also directs programs needing language translation and interpretation services to complete a Request for Interpretation/Translation Services (RITS) form, which should be sent to a supervisor at the level of Program Manager or above. The RITS form must be signed by the Program Manager and submitted to the Ethnic Services Manager for the tracking of forms, brochures, and other materials translated at the program level.
(See Criterion 7 Appendix for Policies cited in this section and Attachment 7: Request for Interpreter and Translation Services Form.)

The CCU provides technical support to Directly Operated and Legal Entities/Contracted providers who seek information on the procedures to be followed for language translation completion and quality review for accuracy and cultural meaning. LACDMH's mechanism for ensuring accuracy of translated materials is field testing. Field testing takes place via document reviews by bilingual certified staff, consumers, family members, or consumer caretakers who volunteer to read and comment on the linguistic and cultural meaningfulness of the translated documents. Edits gathered from the reviewers are then provided to the contracted vendor for the finalization of the translated documents.

~~Furthermore, the~~ Implementation of the Speakers Bureau (SB) has further expanded the Department's capacity to create culture-specific informational materials in the threshold languages for the diverse communities of LA County. These resources have been incorporated into the LACDMH webpage providing information on mental health resources in response to the COVID-19 pandemic. SB members have also been called upon to assist with the field testing of various public-facing materials such as program flyers, brochures, and consumer satisfaction surveys, among many others. Speaker Bureau members contribute their cultural and linguistic expertise to ensure cultural and language nuances, communication appropriateness, and clinical accuracy of reviewed materials.

TABLE 8: SAMPLE LACDMH FORMS, BROCHURES AND WEBPAGE RESOURCES TRANSLATED INTO THE THRESHOLD LANGUAGES

Forms, Brochures and Webpage Resources	THRESHOLD LANGUAGES															
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
ACCESS Brochure	X	X		X	X	X	X			X		X	X		X		X
ACCESS Center Flyer "We are Here to Help"	X	X		X	X	X	X			X		X	X		X		X
Acknowledgement of Receipt						X							X				
Alleviating Fear and Anxiety During Essential Trips in Public		X				X				X			X			X	
Authorization for Request or Use/Disclosure of Protected Health Information (PHI)	X	X	X	X	X	X	X			X	X	X	X		X		X
Beneficiary Problems Resolution Process	X	X		X	X	X	X			X		X	X		X		X
Beneficiary Satisfaction surveys (State)				X	X	X						X	X		X		X
Brief Universal Prevention Program Survey v2: Age 6-11		X				X				X			X				
Brief Universal Prevention Program Survey v2: Age 12+		X				X				X			X				
Brief Universal Prevention Program Survey v2: Parents		X				X				X			X				
Caregiver's Authorization Affidavit				X		X				X		X	X		X		
Child and Family Team Meetings Brochure						X							X				
Client Congress Flyer	X	X		X	X	X	X			X		X	X		X		X
Consent for Services	X	X		X	X	X	X			X		X	X		X		
Consent for Telemental Health Services				X		X				X		X	X		X		
Consent to Photograph/Audio Record				X		X				X		X	X		X		
Coping with Stress During Infectious Disease Outbreaks	X	X				X	X	X	X	X		X	X	X	X	X	X
Coping with the Loss of a Loved One	X	X				X	X	X	X	X		X	X	X	X	X	X
CPS Handout						X							X				
FCCS Brochure	X	X			X	X	X			X		X	X		X		X
FSP brochures	X	X		X	X	X	X			X		X	X		X		X
Adult FSP Client Satisfaction Survey	X	X		X	X	X	X			X		X	X		X		X
Grievance and Appeal Forms	X	X		X	X	X	X			X		X	X		X		X

Forms, Brochures and Webpage Resources	THRESHOLD LANGUAGES																
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
Guide to Medi-Cal Mental Health Services	X	X		X	X	X	X			X		X	X		X		X
Hope, Wellness and Recovery	X	X		X	X	X	X			X		X	X		X		X
INN 4 TMS Client Satisfaction Survey	X	X		X		X	X			X		X	X	X	X	X	X
LACDMH Advance Health Care Directive Acknowledgement Form				X		X				X		X	X		X		
LACDMH Notice of Privacy Practices						X							X				
LACDMH Signage for New HQ Building						X							X				
LACDMH Strategic Plan						X							X				
Maintaining Health and Stability During COVID-19		X				X				X			X			X	
Mental Health Promoters/Promotores de Salud Mental Brochure						X							X				
Multidisciplinary Assessment Teams Brochure						X							X				
My Wellness Toolbox						X							X				
Notice of Action A (Assessment)	X	X		X	X	X	X					X	X		X		X
Notice of Action E (Lack of Timely Service)	X	X		X	X	X	X					X	X		X		X
Older Adult FSP Annual Client Satisfaction					X	X	X						X				
Outpatient Medication Review	X	X		X	X	X	X			X		X	X		X		X
PIER Early Psychosis Program Brochure	X	X		X		X	X			X		X	X	X	X	X	X
PIER Early Psychosis Program Flyer	X	X		X		X	X			X		X	X	X	X	X	X
Promotores Survey						X							X				
Request for Change of Provider	X	X		X	X	X	X			X		X	X		X		X
Roybal CHC brochure						X							X			X	
SA Provider Directories	X	X	X	X	X	X	X			X	X	X	X		X		X
Staying Connected during Physical Distancing		X				X				X			X			X	
Supportive Counseling Services						X							X				
Transitional Age Youth FSP Brochure	X	X			X	X	X			X			X		X		X
Telemental Health Services Brochure						X							X				
Understanding the Mental Health and Emotional Aspects of COVID-19		X				X				X			X			X	

Forms, Brochures and Webpage Resources	THRESHOLD LANGUAGES																
	Arabic	Armenian	Cantonese*	Cambodian	Other Chinese	English	Farsi	Japanese	Khmer	Korean	Mandarin*	Russian	Spanish	Simplified Chinese	Tagalog	Traditional Chinese	Vietnamese
Your Wellbeing on Your Terms - Online COVID-19 resource						X							X				
Maintaining Health and Stability during COVID-19 - Online resource		X								X			X			X	
Alleviating Fear and Anxiety during Essential Trips in Public - Online COVID-19 resource		X								X			X			X	
Coping with Stress during Infectious Disease Outbreaks - Online COVID-19 resource	X	X		X				X		X		X		X	X	X	X
Staying Connected during Physical Distancing - Online COVID-19 resource	X	X		X		X		X		X		X		X	X	X	X
Coping with the Loss of a Loved One - Online COVID-19 resource	X	X		X		X		X		X		X		X	X	X	X

* Cantonese and Mandarin threshold language are covered under Other Chinese in written form

Data Sources: Quality Assurance Division and ARDI Division - Cultural Competency Unit

Criterion 7 Appendix

Attachment 1: LACDMH Policy 602.01 – Bilingual Bonus

602.01 Bilingual Bonus

Attachment 2: List of LACDMH Bilingual Certified Staff

LACDMH Bilingual Certified Staff CY 20

Attachment 3: LACDMH Policy 200.03 – Language Translation and Interpreter Services

200.03 Language Translation & Interp

Attachment 4: LACDMH Policy 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community

200.02 Interpreter

Attachment 5: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services

1047808_2018-10OrgManual_1_.pdf

Attachment 6: Consumer Satisfaction Perception Report – Spring 2020

Consumer Satisfaction Percepti

Attachment 7: Request for Interpretation and Translation Services Form

CC P&P 602 01 Bilingual Bonus RITS.d

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

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

CULTURAL COMPETENCE PLAN UPDATE – FY 20-21

Criterion 8

Adaptation of Services

August 2022

Criterion 8: Adaptation of Services

I. Consumer-driven/operated recovery and wellbeing programs

The Los Angeles County Department of Mental Health (LACDMH) is committed to supporting and enhancing consumer-driven services and wellbeing programs that are recovery-focused and rich in peer involvement. Below are some examples:

2. Peer Run Centers (PRC): The LACDMH Peer Resource Walk-In

The LACDMH PRC mission is to create heart-forward connections with every visitor, following the model "by peers for peers." The PRC is not only a comfortable, safe, and non-judgmental environment for all who come in, but is also a place with intention. The Peer staff and volunteers use their own lived experiences with mental health treatment, homelessness, incarceration, domestic violence, and other life challenges, to make visitors feel welcomed, accepted, and supported. Visitors leave with appropriate community referrals they need while also developing a positive connection with LACDMH and the Peers at the Center.

Staff and Peer volunteers are available to offer linkage and warm handoffs to community organizations that can help address visitor needs. Collaboration with other public and private social service agencies is a vital component of this program. Social service departments and organizations are also invited to the Center to provide office hours and workshops to encourage the engagement of visitors. The PRC is staffed in part by Wellness Outreach Worker (WOW) Volunteers from all sectors of the County who bring resources from their Service Areas and lived experience to share with the community. Additionally, utilizers of the PRC provide programmatic input and recommendations through the Unhoused Advisory Committee.

The PRC is also strategically staffed with employees who speak, read, and write in English, Spanish, and Korean and match the demographic and linguistic needs of the neighborhood. PRC staff prioritizes creating a physical space that provides an open and welcoming environment for all community members. The PRC is located on the street level of the LACDMH headquarters; therefore, all visitors have direct access from the street. Also, the PRC places posters, signs, and sidewalk boards outside that show community resources, programs, and events of the day. Often, PRC staff stand by the front door engaging, and inviting individuals to check out the PRC and its programs. The PRC staff also outreach to local homeless encampments to provide information ~~and~~ support, and to encourage individuals to visit the PRC. There are five (5) laptops, free Wi-Fi, phones, and charging stations available for public use. Diverse community resource information is available in English, Spanish, Korean, and many other key languages in Los Angeles County. The PRC is equipped with emergency clothing, snacks, and hygiene kits for visitors.

Additionally, the PRC offers multiple peer support, educational, and recreational groups that are open to all community members, beyond LACDMH consumers. All visitors can join anonymously without any registration, evaluation, or screening. Although it is recommended, visitors are not required to sign in or reveal their identity to access these resources. In response to COVID-19, PRC staff members with lived experience have been providing seven (7) different online Peer Support Groups, which are available to all community members. The goal of these online support groups is to address social isolation and provide a means for participants to stay engaged in wellbeing activities. The contents of each group are planned and designed to embrace all community members with a common goal of promoting mental health issues and connecting the participants to available community resources. PRC staff focus on developing a peer-to-peer relationship with the visitors before making any recommendations, providing resources, or doing things for them.

PRC projects have contributed to LACDMH's provision of culturally and linguistically competent services by focusing on minimizing barriers to access services. To make services culturally and linguistically accessible to communities, the PRC is strategically staffed with employees who speak, read, and write in English, Spanish, and Korean and match the demographic and linguistic needs of the neighborhood. The PRC prioritizes creating a physical space that provides an open and welcoming environment for all community members. The PRC's physical layout, staff composition, procedures for outreach and engagement, and in-person/online groups encourage visitors to experience the services and resources before requiring any commitment. Staff are skilled at building relations with visitors at a pace that is not intrusive, overwhelming, or demanding.

This approach has encouraged many reluctant individuals to access available services and resources and has resulted in connecting many of them to needed services. The PRC commits first to providing quality information and services before requesting their buy-in. Once individuals are open to receiving mental health services, PRC staff work closely with local providers to ensure a warm handoff. Furthermore, once an individual accesses mental health services, they are still encouraged to stay connected with PRC activities.

Many PRC visitors are already connected with a LACDMH provider. They utilize the PRC as an option for Peer Support and to supplement the services they are receiving. Sometimes, individuals may come to the PRC for advocacy regarding the services they are receiving. PRC staff work diligently with service providers to ensure individuals are receiving services to best meet their needs. The PRC services are based on the commitment to find effective ways to engage the community. The PRC offers all services and resources in-person and online to reduce accessibility issues. The PRC staff are constantly engaging visitors and participants and requesting feedback regarding service needs and recommendations. The PRC encourages

regular visitors to transition from utilizers to participants to advance to the role of peer supporters.

TABLE 1: PRC STRATEGIES RELATED TO CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES FY 20-21

Strategy Description	Status/ Progress	Monitoring/ Outcomes/Findings
1) PRC Online Peer Support Groups • Healthy Relationship • Phenomenal Women's Group • Word-Up • Art @ Home • Poetry • Spanish Healthy Relationship • Work Readiness • Spanish Word-Up	• During the COVID-19 pandemic, PRC transitioned in-person support groups to online support groups so it could connect with individuals who were further isolated and disconnected from the resources due to the crisis. • PRC has provided individual education in English, Spanish, and Korean on how to loan/receive free devices and use a computer and online meeting apps. This was done with the goal to reduce the disparities for individuals who lack access to devices, and education to utilize the computer. • The online groups have been in place since March 2020.	• On average, 10-20 participants join each group consistently. The PRC started with three online support groups in March 2020 and increased the number of groups to meet the increasing need of the community. • Two groups are being held in Spanish. • DMH WOW Volunteers assist PRC staff in facilitating these groups.
2) Peer Kinnect	• In addition to the online groups, PRC staff shared contact information with PRC visitors who needed individual peer support. • Staff contacted the individuals regularly to provide check-in, peer support, and resources. • It was provided in English, Spanish, and Korean.	• PRC continues to make regular calls to visitors who need individual peer support.
3) Korean Speaking Clergy Roundtable	• PRC staff has been participating and providing in-person and online space for Korean-speaking Clergy Roundtable. During the COVID-19 pandemic, the PRC planned and	• Over 80 participants (Korean speaking) participated in a mental health seminar.

Strategy Description	Status/ Progress	Monitoring/ Outcomes/Findings
	participated in online mental health resources delivery through an online seminar with the clergy members to Korean speaking community in June 2020.	• A PRC staff presented on communication and stress management skills in Korean.
4) Homeless Outreach Event	• Each quarter, the PRC hosted community-based homeless outreach agencies and unhoused community members Homeless agencies conducted CES surveys and provided information on shelters and housing information, to connect unhoused individuals to housing resources.	• Over 60 visitors came and participated in each event. • Homeless Health Care and PATH began to use PRC as one of their connection points for unhoused individuals. • Both agencies regularly (every other week) stationed their staff for outreach
5) Winter Shelter Pick-up	• PRC collaborated with the Los Angeles Homeless Services Authority (LAHSA) and became a winter shelter pick-up location.	• Each day, an average of three to five persons received transportation from the PRC to the local winter shelter
6) Holiday and Cultural Celebrations	• 2019 Korean Mental Health Resource Fair • 2019 Harvest Festival • 2019 Thanksgiving Celebration Lunch • 2019 End of Year Celebration and Resource Event • 2020 Super Bowl Party and Resource Event	• Approximately 40 participants and reporters from Korean media disseminated mental health resources. • Approximately 80 participants and Homeless Outreach Mobile team, WOW, and Homeless Healthcare shared resources • Approximately 170 participants from the local community participated in events • Approximately 100 participants and Coordinated Entry System (CES) screenings
7) Unhoused Advisory Committee	• Prior to COVID-19, monthly meetings were held where unhoused individuals provided feedback regarding PRC services, resources, and events.	• On average, approximately 20 regular utilizers of the PRC participated.
8) Community Outreach	• PRC staff visited various local community organizations and resources to learn more about	• The PRC has developed an extensive resource directory that is constantly being

Strategy Description	Status/ Progress	Monitoring/ Outcomes/Findings
	the services they offer and to provide information regarding potential PRC collaborations.	updated. PRC staff have developed connections and expertise in local resources.

2. TAY Drop-in Centers

Drop-In Centers are designed to be entry points to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY, ages 16-25, who may be homeless or in unstable living situations. TAY are often experiencing complex trauma as victims of abuse in their homes, streets, and in their communities. The complex trauma experienced by TAY may manifest in their inability to maintain relationships, keep jobs, or stay in school, often putting them at risk of unemployment, school drop-out, incarceration, and homelessness. Without early intervention, TAY are at risk of experiencing mental disorders that may impair their daily activities and functioning. Drop-In Centers have a strong emphasis on outreaching TAY who are difficult to engage and would otherwise remain unserved, by linking TAY to a range of resources that promote stability and self-sufficiency. Drop-In Centers operate daily including evenings and some weekends.

These Centers are also entry points to the mental health system for homeless youth or youth experiencing unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which youth can find temporary safety and opportunities to build trusting relationships with staff members who connect them to the services and supports they need. Drop-In Centers also assist in meeting the youths' basic needs such as nutrition, hygiene facilities, clothing, a mailing address, and a safe place to rest. Generally, these centers operate during regular business hours. MHSA funding allows for expanded hours of operation during evenings and weekends when access to these centers is even more crucial.

TABLE 2: LOCATION OF DROP-IN CENTERS BY SERVICE AREA

Service Area (SA)	Agency/ Drop-In Center Name	Address
1	Penny Lane Centers – Yellow Submarine	43520 Division Street Lancaster, CA 93535
2	The Village Family Services -TVFS TAY Drop-In Center	6801 Coldwater Canyon Blvd. North Hollywood, CA 91606
3	Pacific Clinics – Hope Drop-In Center	13001 Ramona Blvd. Irwindale, CA 91706

4	Los Angeles LGBT Center – Youth Center on Highland	1220 N. Highland Ave. Los Angeles, CA 90038
5	Daniel's Place - Step-Up on Second Street, Inc.	1619 Santa Monica Blvd. Santa Monica, CA 90405
6	Good Seed Church of God in Christ, Inc.- Good Seed Youth Drop-in Center	2814 W. Martin Luther King Jr. Blvd. Los Angeles, CA 90008
7	Penny Lane Centers – With A Little Help from My Friends	5628 E. Slauson Ave. Commerce, CA 90040
8	Good Seed Church of God In Christ, Inc. Good Seed on Pine Youth Drop-In Center	1230 Pine Avenue Long Beach, CA 90813

2. Service Extenders

Service Extenders are peer volunteers with lived experience, whose personal journeys inspire other consumers. Being a part of the Older Adult interdisciplinary team, they receive specialized training to serve as members of the team and are paid a stipend. They understand their communities, speak their language, and are culturally sensitive to consumers' needs. Service extenders provide supportive services, which help consumers comply with treatment and remain independently in the community. They also assist in navigating the mental health system. Service extenders receive supervision from professional clinical staff within the program in which they are placed.

Having Service Extenders who speak clients' languages and are culturally competent and sensitive to their needs facilitates the establishment of rapport, connection, and trust. This enhances access and encourages clients to remain in the services they need and to feel supported. Service Extenders, who are often peers in recovery, inspire other clients through their personal journeys and help them navigate the mental health system. LACDMH Older Adult clients are a culturally diverse group, and to provide culturally sensitive and appropriate services, Service Extenders are a culturally diverse group, including individuals of Latino, African Americans, Armenian, Russian, Iranian, Chinese, and Filipino heritage.

II. Responsiveness of Mental Health Services

LACDMH actively engages in culturally relevant outreach targeting underserved communities in other to increase accessibility to services, fight stigma, and reduce mental health disparities. The efforts summarized below highlight the Department's responsiveness to the cultural and linguistic needs of our communities via traditional and non-traditional approaches in service delivery.

1. Capacity Building Projects by the Underserved Cultural Communities (UsCC) Unit in collaboration with the seven UsCC subcommittees

The seven UsCC subcommittees include:

- Black and African Heritage

- American Indian/Alaska Native (AI/AN)
- Asian Pacific Islander (API)
- Access for All
- Eastern European/Middle Eastern (EE/ME)
- Latino
- Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, Asexual, and Two Spirit (LGBTQIA2-S)

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

Summary of projects by UsCC subcommittee for FY 20-21

A. Black and African Heritage Underserved Cultural Communities Subcommittee Projects

1) Empowering the Black and African American Family, A Wellness Conversation Series in Service Area 3 Project. A Facilitator was hired to develop a Wellness Conversation Series that included outreach to the Black and African American community and addressed important topics that influence the wellness of Black and African American residents in Service Area 3. This project aimed to increase awareness about mental health to decrease mental health related stigma and encourage early access of services. The objective of this project was to increase awareness and dialogue surrounding mental health issues, signs, and symptoms; provide multidisciplinary psychoeducation on mental health challenges experienced by Black and African American adults and youth; and destigmatize the topic of mental health in these communities. The goal was to have a monthly Wellness Conversation to decrease stigma about mental health issues and increase awareness of healthy coping strategies, and to connect community members to supportive resources and services needed to improve opportunities for healing and wholeness in their lives.

Outcomes:

- In total, three Wellness Conversations were held in Service Area 3.
- Topics included: Supporting Black Parents, Cannabis in the Black Community, and Supporting Black LGBTQIA+.
- For the Wellness Conversation on Supporting Black Parents, 66% of attendees identified as Black and African American, 14% identified as Latino or Latinx, 7% identified as White, and 13% as other groups not previously mentioned.

- For the Wellness Conversation on Cannabis in the Black Community, 45% of attendees identified as Black and African American, 30% as Latino or Latinx, 19% as White, and 6% as other groups not previously mentioned.
- For the Wellness Conversation on Supporting Black LGBTQIA+, 70% of attendees identified as Black and African American, 15% as Latino or Latinx, 8% as White, and 7% as other groups not previously mentioned.
- 250 individuals completed the pre-test and 150 completed the post-test.
- Post-test results indicated that the Wellness Conversation Series were effective (80% of attendees stated that they felt empowered and confident as a result).

2) Black and African American Village Elders Mental Health Project (currently in progress). The purpose of the Black and African American Village Elders Mental Health Project is to build a cadre of Community Service Leaders (CSLs) that have the knowledge and capacity to recognize and respond to signs of social isolation and disconnection from community amongst Black and African American elders and their caregivers. CSLs will present community seminars specifically to these populations. This project involves two components. The first component will include recruitment of CSLs, followed by the facilitation of a forum for the CSLs that focuses on how to work with and assist the Black and African- American elder population, as well as their caregivers, with regards to mental health awareness and signs and symptoms of isolation and depression. The second component involves CSLs conducting community mental health seminars to outreach and engage elders and their caregivers.

Outcomes:

- This project is still in process and outcomes will be shared once completed.

B. <u>American Indian/Alaska Native (AI/AN) Underserved Cultural Communities Subcommittee Projects</u>

1) American Indian/Alaska Educational Outreach and Engagement Toolkit. The purpose of the AI/AN Outreach and Engagement Toolkit project was to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles County, as well as increase community member engagement in the LACDMH stakeholder process. The first phase of this project included the recruitment of AI/AN community members, peers, and family members into a Cohort. The second phase of this project included the development of an Outreach and Engagement Toolkit including a training video. The final phase of this project included a Community Wellness Forum on 12/11/2021 where a panel of Cohort members shared their experiences participating in the Cohort and presented the Toolkit and training video.

Outcomes:

- In total, 25 community members throughout all eight Service Areas of Los Angeles County participated in the Cohort and identified as either AI/AN, Native American, or Indigenous, and represented over 20 different tribal nations and Indigenous communities.
- Eight two-hour Cohort meetings were held throughout September-November 2021.
- Cohort members completed a pre-test and a post-test, which reflected the following outcomes:
  - Question, "How aware are you of services available in Los Angeles County for AI/Ans and/or Indigenous individuals?" Pre-test reflected 38.7% of Cohort members responded "a lot" as compared to 47.6% in the post-test.
  - Question, "To what extent do you think it would be helpful for AI/ANs and/or Indigenous individuals to engage in cultural practices to help with mental health challenges (i.e., traditional medicines, traditional ceremony, drumming, etc.)?" Pre-test reflected 90.3% of Cohort members responded "very helpful" as compared to 100% in the post-test.
- In total, 26 community members attended the Community Wellness Forum.

2) American Indian/Alaska Native Community Mental Health Needs Assessment
   The purpose of the AI/AN Community Mental Health Needs Assessment Project was to outreach and engage the AI/AN population into a discussion regarding the needs of their community, as well as reduce stigma associated with mental health services. This project aimed to increase awareness of the mental health needs of AI/AN individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. Additionally, this project had a goal of increasing community member involvement in the LACDMH stakeholder process. The first phase of this project included outreach of AI/AN community members, in particular individuals with lived experience (i.e., consumers, family members of consumers, etc.), into a series of focus groups to assess the mental health needs of AI/AN individuals, identify gaps in access to mental health services, and identify how to engage community members into mental health services. The second phase included hosting an AI/AN Community Mental Health Forum made up of leaders and providers who were brought together into a learning collaborative to discuss the needs of the community.

   Outcomes:

   - In total, five focus groups were held throughout August 2021 focused on the following communities: Indigenous youth, two-spirit community members, Indigenous elders, parents/caregivers of children with special needs, and one for the general Indigenous community.

- 65 unique/unduplicated community members participated in the focus groups including 12 Indigenous youth, five two-spirit community members, six Indigenous elders, six parents/caregivers, and eight from the general community.
- In total, 21 community members attended the Indigenous Community Mental Health Forum.
- Needs most consistently identified by community included: more Native/Indigenous and individuals of color providers, more cultural competency training, increased understanding of historical trauma, visibility and resources, increased access to services, aging mastery programs, navigating systems, transportation, knowledge of cultural contributions, medication management, inclusive spaces, support groups and parenting classes, and advocacy for children.

American Indian/Alaska Wellness Forums Project (currently in progress). The purpose of the Wellness Forums project is to engage, empower, and enlist the AI/AN community into conversations about mental health and traditional forms of healing. Attendees of the Wellness Forums are given the opportunity to learn more about some of the unique mental health needs of the AI/AN community and the traditional forms of healing that are practiced by AI/AN community members. The final Forum was be held on 6/25/2022. Forum topics included Grief, Loss, and Resilience; Awareness, Treatment, and Recovery from Depression; Emotional Wellbeing and the Brain; and Mental Health and Stigma.

Outcomes:

- As of June 1st, 2022, six of the seven Wellness Forums have been conducted.
- Final outcomes will be shared once the project is completed by July 31st, 2022.

C. <u>Asian Pacific Islander (API) Underserved Cultural Communities Subcommittee Projects:</u>

1) Asian Pacific Islander – Sharing Tea, Sharing Hope: This project focused on outreaching the API community using a mobile Tea Cart service, or virtual tea salons via Zoom with the goal of creating space to provide education about signs and symptoms of mental illness, mental health resources to reduce mental illness related stigma, and gaps in mental health service delivery through the sharing of tea. Bilingual API individuals were recruited and trained as "Community Listeners" to engage API community members at various outreach events to discuss mental health and provide information on mental health issues and services focusing on the Cambodian (Khmer), Chinese (Mandarin or Cantonese), Filipino (Tagalog), Vietnamese, and Korean communities. Outreach events focused on areas across Los Angeles County where there are large concentrations of API community members.

Outcomes:

- 192 Sharing Tea Sharing Hope participant surveys were collected from four different events.
- Community members from nine API cultural communities/nationalities participated: Chinese (49), Japanese (4), Korean (3), Vietnamese (9), Filipino (53), Indian (1), Malaysian (3), Indonesian (2), Thai (1), and Multi-ethnic (31).
- The project reported success reaching sub-populations that are normally very difficult to reach, including: monolingual API, over 50 years old, immigrant or mixed status community members.
- 29% of participants increased familiarity with the topic of mental health
- 27% of participants increased their knowledge of mental health signs and symptoms of common mental health issues impacting the API community.
- 27% of participants increased their awareness of the stigma surrounding mental health in the API community.
- 53% increase in awareness of mental health resources in the community.

2) Asian Pacific Islander Families – Our Stories and Our Journey on Mental Health Recovery and Resilience Project This project was designed to reach out to various API communities (e.g., Cambodian, Chinese, Filipino, Korean, South Asian, Vietnamese) in their own spoken language with audio-visual presentations that promote mental wellness and recovery, and to reduce stigma about mental health issues and recovery. Since some of the most vulnerable sectors of the API community may not read or write in their own languages, printed materials may not be very helpful for them. Hence, the project aimed to compile and adapt existing mental health information and recovery stories into an audio-visual format to reach more community members. This project involved collaborations with members of API communities to create culturally and linguistically relevant resources in the members' own voices. The audio-visual format, such as narrated Power Point presentations (with audio and video segments), could be shared via social media (such as: YouTube; WeChat) and in waiting rooms of clinics to de- mystify mental health issues.

Outcomes:

- This project is still in process and outcomes will be shared once completed.

D. <u>Access for All Underserved Cultural Communities Subcommittee Projects:</u>

1) Access For All Mental Health Needs Assessment for the Physically Disabled Community: The objective of the Physically Disabled Community Mental Health Needs Assessment Project was to outreach and engage individuals within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aims to increase connections with mental health providers

and provide opportunities to address concerns about mental health services. This project targeted physically disabled community members from the eight Service Areas across Los Angeles County. The Consultant outreached to individuals within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LACDMH.

Outcomes:

- Developed flyers and other promotional materials and utilized social media platforms to recruit participants with physical disabilities across eight Service Areas.
- Developed Resource Guide with Countywide resources for physically disabled community and posted at the LACDMH website.
- Of the 40 individuals with physical disabilities initially recruited for the focus groups, 35 attended.
- Facilitated nine virtual focus groups, which ended on May 30, 2022.
- Awaiting final summary report due on June 30, 2022, which will include mental assessments' outcomes, feedback, and recommendations.

2) Access For All Mental Health Assessment for the Blind, Partially Sighted, and Visually Impaired Community. The objective of the Blind, Partially Sighted, and Visually Impaired Community Mental Health Needs Assessment Project was to outreach and engage individuals within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aimed to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project targeted blind, partially sighted, and visually challenged community members from the eight Service Areas across Los Angeles County. The Consultant outreached to individuals within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LACDMH.

Outcomes:

- Developed flyers and other promotional materials, and utilized social media platforms to recruit blind, partially sighted and visually impaired individuals across eight Service Areas.
- Developed Resource Guide with Countywide resources for the blind, partially sighted, and visually impaired individuals and posted at the Department of Mental Health (DMH) website.
- Recruited 41 blind, partially sighted, and visually impaired individuals to participate in the focus groups.

- Facilitated nine virtual focus groups, which ended on May 30, 2022.
- Awaiting final summary report due on June 30, 2022, which will include mental assessments' outcomes, feedback, and recommendations.

3) Access For All Mental Health Needs Assessment for the Deaf and Hard of Hearing Community The objective of the Deaf and Hard of Hearing Community Mental Health Needs Assessment Project was to outreach and engage individuals within this population into a virtual discussion regarding the mental health needs of this community, as well as to reduce the stigma associated with mental health services. Additionally, this project aimed to increase connections with mental health providers and provide opportunities to address concerns about mental health services. This project targeted deaf and hard of hearing community members from the eight Service Areas across Los Angeles County. The Consultant outreached to within this community and engaged them in virtual focus groups to assess their mental health needs. Additionally, the consultant identified gaps in accessibility to mental health services and determined how to effectively engage community members into mental health services provided by LACDMH.

   Outcomes:
   - Developed flyers and other promotional materials and utilized social media platforms to recruit deaf and hard of hearing individuals across eight Service Areas.
   - Developed Resource Guide with Countywide resources for the deaf and hard of hearing community and posted at the Department of Mental Health (DMH) website.
   - Recruited 45 deaf and hard of hearing individuals to participate in the focus groups.
   - Facilitated nine virtual focus groups, which ended on May 30, 2022.
   - Awaiting final summary report due on June 30, 2022, which will include mental assessments' outcomes, feedback, and recommendations.

E. <u>Eastern European/Middle Eastern (EE/ME) Underserved Cultural Communities Subcommittee Projects</u>**:**

1) Armenian Virtual Mental Health Symposiums Project: A Trainer was hired who specializes in providing mental health services to the Armenian population. This Trainer was responsible for implementing the Virtual Armenian Community Symposiums project. The purpose of the Virtual Community Symposiums project was to engage, empower, and support the Armenian community in conversations about mental health and traditional forms of healing. Attendees of the Virtual Community Symposiums were given the opportunity to learn more about some of the unique mental health needs of the Armenian community and the traditional forms of healing that are practiced by Armenian community. Three major virtual symposiums were completed and included various Armenian Mental Health

Professionals and professionals from other fields. Symposium topics included Depression, Anxiety, PTSD from the 44-Day War in Nagorno Karabagh, and healing issues within Armenian Youth, domestic violence, substance abuse issues within the Armenian Community, etc.

Outcomes:

- A total of 113 participants attended the Community Symposiums.
- The first symposium was held on December 5, 2021, from 2-6pm, and was attended by 38 participants. The first part of the presentation was on education about depression. This was followed by a presentation on Substance Abuse and information on intimate partner violence. Important information was provided on core substance use issues, chemical changes, and treatment levels.
- A total of 113 pre/posts tests were given. However, the pre/post tests were challenging to complete for many reasons including technical difficulties as well as concerns around providing feedback and ideas through a manual testing system; participants usually just share their thoughts and opinions among each other after a given event/presentation/lecture/symposium.

- Overall, the feedback from the participants was extremely positive and appreciative. individuals sent emails expressing that these were topics that were important and relevant in the Armenian community and more of these educational programs need to be conducted.
- There are a few important facts about the Armenian community which must be taken in consideration:
    - Virtual Community Symposiums are not very accepted in the Armenian community since they prefer to attend in person events where there is also an opportunity to interact and socialize.
    - To increase community members' participation within the EE/ME subcommittee, it is crucial that community members realize the benefits of this subcommittee and what it can do for the community.

2) Russian Mental Health Media Outreach Campaign: Consultant was contracted to develop a mental health media and social media outreach campaign for the Russian community that resides in LA County. This project aimed to broadcast 12, 90-second Public Service Announcements (PSAs). The 12 PSAs were developed in Russian and three in English. The media campaign involves the following components. Component number one is a TV media campaign. Component number two is a social media campaign. The Russian Mental Health PSAs aired on various Russian television stations in Los Angeles County on daily basis. Specifically, the PSAs aired on the Russian-Armenian TV station, ARTN, four times a day and Russian TV Station, RTN, two times a day. The PSAs were shortened by the TV Stations from 90 to 30 seconds as needed, to fit the guidelines of the TV stations. The PSAs are advertised and boosted via Facebook, Instagram, Twitter, and other social networking platforms

for a period of 12 months. The PSAs included Russian celebrities, health, and mental health professionals, including psychologists or social workers, known professionals from different fields, influencers, and community leaders to promote mental health awareness and at the same time encourage the Russian population in Los Angeles County to seek and take advantage of the multitude of services provided by LACDMH.

Outcomes:

- A total of 12 PSAs were aired on TV and posted on social media.
- The consultant communicated with Russian Mental Health providers and community members to determine the subject matter of the PSAs.
- There has been a great deal of positive feedback about the PSAs from the Russian speaking community members. Community members have been contacting the TV station and Vendor expressing gratitude, stating that the airing of the PSAs has been done at an appropriate time, given the current war between Russia and Ukraine.
- The airing started on August 1, 2021 and is scheduled to be completed on July 31, 2022.
- PSAs topics included: Depression, Anxiety, Post Traumatic Stress Disorder, PTSD, parenting, LGBTQ Issues, intergenerational conflict, acculturation issues, etc.
- Final Project Summary with outcomes will be provided when the projected is completed at the end of September 2022.

3) The Farsi Poetry Night Mental Health Virtual Outreach Project: A Consultant was contracted to develop and implement the virtual Poetry Night Mental Health Outreach Project. This project targeted Farsi speaking adults and older adults residing in Los Angeles County. This project consisted of virtual Poetry Night events two times a month, for 10 consecutive months. Poetry is an important part of the Iranian culture and is traditionally used as a tool to help individuals heal from their mental and emotional problems. The Poetry Night Mental Health Outreach Project or “Shabeh Sher” will provide a place for Farsi speaking adults to get together and interact with one another. It provided a safe space for them to share their emotional and mental health issues in a culturally appropriate and acceptable manner. Poetry night events were facilitated by a poetry expert, who brought in poems to share and discuss.

Outcomes:

- The vendor reported that the Virtual Poetry Night Classes have been going well. There has been great deal of positive feedback from the community over the Virtual Poetry Night MH classes.
- During the poetry events, community members learned more about themselves through the teachings of Persian master poets and philosophers. Participants had opportunities to write their own poetry, share original poetry, and present

their favorite poems. Poems often resembled the plight of Persian individuals, Persian history, love, different human emotions, and other topics.

- The poetry workshops were advertised on a local Farsi speaking Radio station, KIRN 670AM.
- Flyers and all outreach materials continued to be utilized by the Vendor for advertisement purposes to increase participant attendance.
- Project began on July 1, 2021 and will be completed on August 31, 2022. Project summary report will be provided when the project is complete.

4) Mental Health Needs Assessment for the Arabic Speaking Community through Virtual Focus Groups: The objective of the Arabic focus groups was to engage the Arabic speaking population into a virtual discussion regarding the needs of the community, as well as reduce stigma associated with mental health services. This project aimed to increase awareness of the mental health needs of Arabic speaking individuals, increase connections with mental health providers, and provide opportunities to address concerns about mental health services. This project targeted both leaders and providers within the Arabic speaking community, as well as community members. Individual interviews are conducted as well as a community meeting. The project has been completed in two phases. The first phase included the Consultant outreaching to the Arabic speaking community members to assess the needs of the community, identify gaps in access to mental health services, and identify how to engage community members into mental health services provided by LACDMH. The second phase involved the Consultant conducting a community meeting with Arabic speaking professionals and community leaders, who were brought together virtually (i.e., Zoom, Skype) into a learning collaborative to discuss the needs of the community.

Outcomes:

- Certain challenges have been shared by the Consultant including the individual needs assessment interviews being conducted confidentially as members wished to remain anonymous due to stigma attached to mental health within this community. For this reason, interviews took a long-time to complete and the project ended later than the projected date.
- The Final Project Summary with outcomes will be provided when the projected is completed at the end of June 2022.

F. <u>Latino Underserved Cultural Communities Subcommittee Projects:</u>

1) Latino Older Adults Outreach and Engagement**:** This project targeted the Latino Older Adult community at large by promoting mental health literacy, increasing mental health service utilization and education, and reducing mental health stigma. A Focus group was created for Latino Older Adults to help identify resources most useful to their specific population group and provide feedback (User-Centered Design) throughout the creation of health resource booklet that is being distributed to Latino older adults throughout Los Angeles County. Through a series of workshops, this project provided

support to Latino Older Adults, their family members, and caregivers via culturally appropriate workshops focused on enhancing the overall wellbeing using a holistic perspective. Workshop topics addressed physical, mental, emotional, social, and spiritual issues and concerns of Latino older adults. Common mental health topics discussed, such as depression and anxiety, provided information on the role loneliness particularly due to COVID-19, immigration status, physical health issues, and other social determinants play in the development and/or worsening of common mental health conditions. Participants learned new ways of improving their mental health and overall well-being through the engagement in prayer/spiritual practices, use of technology to connect with loved ones, exercise, and mental health therapy. Additionally, the workshops aimed to increase awareness and knowledge related to mental health illness, combat stigma and discrimination towards Latino Older Adults, as well as educate and provide them, their families, and caregivers with mental health resources. By providing these workshops in Spanish, the project built and strengthened resilience in Latino Older Adults who face the challenges and barriers associated with potentially experiencing mental health difficulties as they age.

Outcomes:

- This project is still in process and outcomes will be shared once completed.

2) The Latino Garment Workers Outreach Project: The goal of the Latino Garment Worker Project was to outreach, educate, and increase knowledge pertaining to mental health services and resources. To accomplish this, the project sought to provide support to Latino garment workers via culturally respectful workshops (either in-person or virtual) focused on enhancing emotional wellbeing from a holistic perspective and increase awareness and knowledge related to mental health illness and combat stigma and discrimination towards the immigrant Latino community. The workshops and materials were translated and made available in English, Spanish, and in indigenous languages (K'iche, Mixtec, Zapoteca, or Q'anjob'al) appropriate to the target community. In addition, this project also had the objective of educating the Latino garment worker community on how to access mental health services (virtually and in-person) and understand some of the cultural biases associated with experiencing a mental health condition in the Latino community as well as provide the garment worker community with resources and information regarding available in-person and remote services in Los Angeles County geared towards the Latino community.

Outcomes:

- This project is still in process and outcomes will be shared once completed.

G. <u>Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning Intersex, Two Spirit (LGBTQI2-S) Underserved Cultural Communities Subcommittee Projects:</u>

1) Non-Binary and Intersex Mental Health Survey Project: The purpose of the Non-Binary and Intersex Mental Health Survey Project was to remove barriers to mental health services for the non-binary and intersex communities in Los Angeles County

by conducting research to identify barriers, opportunities, and best practices for servicing this community. This project included a community survey, including focus groups, of the non-binary and intersex communities to promote mental health services, reduce stigma and barriers to mental health services, and increase the capacity of the public mental health system in Los Angeles County. As non-binary and intersex identities are becoming more visible and understood by the public, there remains very little data and research around mental health and related issues/challenges regarding non-binary and intersex individuals.

Outcomes:

- In total, 20 community members participated in the focus groups. Of those participants, 17 identified as non-binary and three as intersex.
- Two different surveys were conducted: Survey one yielded 296 usable entries and survey two yielded 300 usable entries.
- 58% of survey respondents stated that they are currently receiving or have received mental health care services in the past.
- 80% of survey respondents reported that they had virtually accessed Los Angeles County services (of any kind).
- 65% of survey respondents reported that they had encountered barriers to care while trying to access mental health services.
- 23% of survey respondents stated that they had stopped utilizing Los Angeles County mental health services due to discrimination based off gender identity.
- 30% of survey respondents reported having an affirming experience around gender identity while utilizing Los Angeles County mental health services.
- 93% of survey respondents felt that telehealth is a beneficial tool to assist in affirming gender identity during medical appointments.

2) LGBTQIA2-S Youth Innovation Lab and Fellowship Project: The purpose of the LGBTQIA2-S Youth Innovation Lab and Fellowship Project was to reduce mental health access barriers for LGBTQIA2-S youth by recruiting Youth Fellows throughout Los Angeles County to meet and develop user-centered, innovative strategies for outreach and engagement of this marginalized population. This project included outreach and engagement of 15 LGBTQIA2-S Youth Fellows into a Youth Innovation Lab, which took place during one week in August 2021. During the Lab, the Fellows divided into groups of three or four based on interests and developed innovative strategies for reducing mental health access barriers for their community, worked on building stronger social connections, and developed tools and resources to be shared with other LGBTQIA2-S youth, as well as clinicians and providers. Following the Lab, Youth Fellows prototyped their strategies in their communities.

Outcomes:

- In total, 15 Youth Fellows participated in and completed the Lab.

- Youth Fellows completed a pre-test and a post-test utilizing a Likert scale from 1 to 5 with 1 being Strongly Disagree and 5 being Strongly Agree. The following outcomes were reported:
    - Question, “If I have a concern or a problem, I know what to do and who to talk to.” The average post-lab answer increased from 3.87 to 4.64.
    - Question, “I am comfortable seeking mental health assistance when needed, regardless of my sexual orientation or gender identity.” The average post-lab answer increased from 3.33 to 4.21.
    - Question, “I feel safe when accessing mental health services.” The average post-lab answer increased from 3.07 to 3.64.
    - Question, “When I am in distress, I practice healthy coping mechanisms.” The average post-lab answer increased from 3.4 to 4.14.
- The Lab and Fellowship survey results show an overall positive impact on participants both quantitatively and qualitatively.
- The strategies the Youth Fellows developed were found to be innovative in their approaches to violence prevention and LGBTQIA2S+ mental health advocacy.
- Following the completion of the Lab, several challenges arose that impacted the success of the prototyping phase as follows:
    - Youth Fellows’ availability had significant changes due to work schedules, school being back in session, mental health factors, and personal tragedies.
    - More than one Fellow shared that they lost someone close to them in the Months of September or October, and several were overwhelmed by the pandemic and other compounding stressors.
    - Multiple Fellows were unable to be contacted after the Lab, and after weeks of no communication or response they were let go from the prototyping phase.
    - Of the four groups, one was able to successfully complete the prototyping phase. This group managed to successfully conduct a prototype and gain insight about their strategy: Compassion For Them, with the idea of a Trans & Nonbinary Youth Resources Fair. The group conducted an online survey and a developed a flyer to promote it. They received a total of 32 responses. As an incentive, they raffled off ten $20 Starbucks gift cards for participants. Some findings included the following:
        - Prospective participants in a resource fair were slightly more interested in live programming, but many open to a hybrid in-person/virtual set up
        - The ideal time to host an event like this would be weekend afternoons or mornings
        - Beyond job opportunities and medical services, prospective participants are interested in know-your-rights workshops, trans and nonbinary art showcase or gallery, and panels featuring various trans and nonbinary speakers

        - Participants recognized that a resource fair like this would directly or indirectly support their mental health.
    - Suggestions were gathered on how to increase participation in future projects utilizing this model such as
        - Restructuring how incentives are provided during the entire Lab and Prototyping process (i.e., provide half of the stipend at the end of the Lab and the other half after the prototype is completed).
        - Consider how the funding for the Group Prototypes could be increased
        - State exact dates for Prototyping when recruiting applicants for the Lab, instead of utilizing vague statements dates, i.e., "within a month after the Lab."

3) LGBTQIA2-S Youth Mental Health Community Engagement Campaign: The purpose of the LGBTQIA2-S Youth Mental Health Community Engagement Campaign was to reduce mental health access barriers for LGBTQIA2-S youth by creating content that would reach and inspire youth to promote mental health services, reduce stigma related to mental health services for LGBTQIA2-S youth, and increase the capacity of the public mental health system in Los Angeles County. The campaign included production and distribution of five 15-60 second videos via social media platforms including TikTok and Instagram. These five videos served as the centerpiece of the engagement efforts and were focused on highlighting local Los Angeles County LGBTQIA2-S history. The campaign ran for 12 weeks during October-December 2021.

   Outcomes:
   - In total, 5 Youth content creators participated in the campaign.
   - Analytics from the initial campaign via TikTok and Instagram showed a reach of 36,316 accounts and 5,007 likes.
   - The videos were also shared via three larger accounts (@Pride, @LGBT, and @LGBTQ) and analytics showed this led to an additional reach of 2,164,936 as well as 2,300,113 views and 64,449 likes.
   - Combined with the reposts, the campaign had an overall reach of 2,201,252 accounts across TikTok and Instagram.
   - Youth content creators completed a pre-test and a post-test utilizing a Likert scale from 1 to 5 with 1 being Strongly Disagree and 5 being Strongly Agree. The following outcomes were reported:
       - Question, "If I have a concern or a problem, I know what to do and who to talk to." The average post-lab answer increased from 4.2 to 4.8.
       - Question, "I am comfortable seeking mental health assistance when needed, regardless of my sexual orientation or gender identity." The average post-lab answer increased from 3.8 to 4.8.
       - Question, "I feel safe when accessing mental health services." The average post-lab answer increased from 3.6 to 4.4.

- Question, “When I am in distress, I practice healthy coping mechanisms.” The average post-lab answer increased from 3.8 to 4.6.

4. Black LGBTQIA2-S Family Unity Project: The purpose of this project was to develop tools, resources, and educational videos to help Black and African American caregivers in working with their LGBTQIA2-S identified youth as well as help providers and clinicians in engaging and working with the Black LGBTQIA2-S community. This project involved two components. The first included outreach and engagement of 20 Black and African American parents and caregivers of LGBTQIA2-S identified youth, as well as the youth themselves into a Collaborative. Collaborative members participated in two-hour weekly meetings over a period of eight weeks during October-December 2021 to develop a Toolkit, including two training videos, designed to assist Black parents and caregivers in working with their LGBTQIA2-S identified youth. The second component involved Collaborative members hosting a Community Wellness Forum on 2/26/2021 with the purpose of further building community connections and sharing personal testimonials regarding their experiences during the Collaborative meetings and providing attendees with a copy of the Toolkit.

   Outcomes:
   - In total, 24 community members attended the Community Wellness Forum.
   - As of June 1st, 2022, outcomes from the pre-test and post-test are being aggregated by the Facilitator.
   - Final outcomes will be shared once the project is completed by June 30th, 2022.

2. **Promotores de Salud/Health Promoters and United Mental Health Promoters Program**

On September 1, 2020, [EW15]the Board of Supervisors instructed LACDMH to expand the Promotores de Salud Mental Health Program to additional culturally diverse populations, including African American, American Indian/Native American, Asian/Pacific Islander, and Latinx. This expanded program was renamed United Mental Health Promoters. LACDMH staff visited the Cultural Competency Committee (CCC), Underserved Cultural Communities (UsCC), the Service Area Leadership Teams (SALT) and Faith-Based Advocacy Council (FBAC) meetings to promote the opportunity for potential candidates to apply for these County positions. Staff listened to community stakeholders, adapted elements of the UMHP job announcement to amplify its efforts for effective culture-specific recruitment. Staff planned for an equitable distribution of available positions throughout the Service Areas, by examining quality improvement reports and the needs of diverse cultural communities. (Refer to CR 6 for further details.)

The program's sustainable capacity is guided by the formation and convening of a Promotores de Salud Mental Advisory Council, which is comprised of diverse stakeholder groups. It consists of one Promotor for each of the eight Service Areas, two supervisors representing the north and south regions respectively, and the two Speakers Bureau directors and LACDMH Ethnic Services Manager. Additional representation in the advisory council consists of three seats for parents and/or consumers as well as two seats for Community-Based Organizations (CBO) and Faith-Based Organizations (FBO) leadership. During CY 2021, the Promotores de Salud Mental advisory council convened once per month to review proposed program changes, growth strategies, and improved ability to respond to community. Additionally, the Promotores de Salud Mental and United Mental Health Promoters program increased its outreach by being an integral component of the LACDMH Speakers Bureau. This integration effectively increased the ability program to serve culturally and linguistically diverse communities alongside the clinicians, Faith-Based Liaisons, and Mental Health Clinical Specialty leads members of the bureau.

During the COVID-19 pandemic, the program made a significant contribution to the community at large through the development of the LACDMH Promotor Technology Tool Guide designed to assist reduce the challenges of operating digital devices. This guide is a step- by- step instruction to help community members with non-existing or limited technology knowledge understanding how to download the MS Teams application via either telephone or computer. The toolkit enabled community members to connect and participate in various departmental stakeholder meetings such as the CCC, UsCC, SALT, Mental Health Commission, and consumer group convenings. The toolkit was released to the community in September 2020 and made available in English and Spanish.

LACDMH recognizes the leadership of Promotores de Salud Mental in connecting underserved communities with the Department's efforts to reach out to the most vulnerable and underserved populations, especially during COVID-19 times. For example, the CCC invited the Promotores to deliver a presentation on the Promotor Technology Tool Guide. The program was praised for developing a highly valuable and needed tool to facilitate connections of the community to the Department. The CCC also appreciated that the toolkit could also decrease COVID-19 isolation and frustration by delivering a way for community members to connect with loved ones.

LACDMH supports the role of Promotores de Salud Mental as members of our system of care and welcomes them to actively participate in the established stakeholder process. Promotores de Salud Mental have established active memberships in the Latino UsCC as well as the CCC. Both committee meeting agendas include a segment during which the members discuss the needs of the underserved communities they represent as related to the pandemic and social unrest. Promotores

shared their direct knowledge and understanding of community cultural and linguistic needs during these meetings.

3. Community Ambassadors Network Program (CAN)

The CAN program was designed to hire, train, and certify community members as "lay" mental health workers in the neighborhoods where they reside. In this capacity, the Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community members with resources relevant to their needs. All the Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical, and spiritual wellbeing of underserved communities. The CAN Program prioritizes support of communities who self-identify as Black, Asian, Indigenous and individuals of Color, all of which have been disproportionately impacted by systemic racism and inequality. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in most disenfranchised communities.

As of February of 2021, 213 individuals were part of the Community Ambassador Network (CAN) Program. This included six (6) new community members hired in 2021, 84 new community members hired through the CARES ACT, as well as 123 INN 2 peers, navigators, parent partners and Promotores who became part of the CAN Program. One hundred and forty-six (146) individuals were active Ambassadors, and of those active 21 are Senior level CAN.

INN 2 program managers were asked to complete a hiring and training document which tracked the following information: 1) CANs ethnicity or racial identity; multiracial ambassadors were asked to list all, 2) language(s) spoken aside from English.

Languages Spoken by CAN

- 41.3% of the Ambassadors did not answer the language question. It was not clear whether the information was not available or if these individuals spoke only English
- The most prevalent language spoken (aside from English) was Spanish (49.3%)
- 7.5% (16/213) of CAN speak Khmer
- Other languages spoken by CAN included ASL, Hebrew, Basic Hindi, Laotian, Thai, Tagalog, and Tongan

Racial/Ethnic Identities of CAN

- 6.6% (14/213) of the Ambassadors identify as multiracial
- 47.9% (102/213) of CAN identify as Latino/Latinx, Latino or Mexican
- 15.5% (33/213) of CAN identify as Black and/or African American

- 10.3% (22/213) of CAN identify as Asian, Cambodian, Filipino, East Indian, or Tongan (Asian/Pacific Islander)
- 4.7% (10/213) of CAN identify as White
- 14.6% (31/213) of CAN chose not to answer or the question was left blank
- One person described their ethnicity as Italian

Outreach activities, training/education and linkages with resources and support were collected in the INN2 Health Outcomes Management (iHOMS) System. During the COVID-19 pandemic, the system was modified so INN2 providers were able to designate if their outreach/engagement and activities and/or participant linkages with resources/supports were COVID-related. The following reporting of outcomes summarized COVID-related outreach and referrals associated with the CARES ACT between October 1 - December 31, 2020.

The data included aggregated counts and percentages across all INN2 agencies. These were not de-duplicated numbers, and participants could have received more than one linkage or referral. Similarly, outreach activities had not been de-duplicated by agency.

- 114,813 community members were reached through a total of 895 COVID-related community events and outreach, group activities and social media
- 3,435 COVID-related referrals were made for resources and supports, and 1,057 INN2 participants were successfully linked with supports. As many as 87% of COVID-19 related referrals were marked as successful linkages by INN2 providers
- Almost all (95%) CAN have participated in a training about COVID-19, and 77 CAN have also participated in training on the Community Resilience Model (CRM)
- 2,059 INN2 partners and/or community members have received COVID-related trainings or education

The following reporting of outcomes summarized COVID-related outreach and referrals between January 1 - February 28, 2021. The data included aggregated counts and percentages across all INN2 agencies. These were not de-duplicated numbers, and participants may have more than one linkage or referral. Similarly, outreach activities had not been de-duplicated by agency. Since the beginning of this year:

- 44,476 community members were reached through a total of 764 COVID-19related community events and outreach, group activities and activities on social media
- Providers created a total of 119 email outreach, posts and stories on Facebook and Instagram to spread information about COVID-19 testing and vaccines, INN2 and upcoming events and groups, which amassed approximately 17,065 views

- 2,159 COVID-19 related referrals were made for resources and supports, and 615 INN2 participants were successfully linked with supports. 90% of COVID-19 related referrals were marked as successful linkages by INN2 providers
- 2,628 INN2 partners and/or community members received COVID-19 related trainings or education
- INN2 staff and CAN led 583 COVID-related education and testing efforts in the community. A total of 1,078 persons have been tested for COVID-19 at 32 testing events where CAN volunteered. COVID-19 education efforts and outreach, often conducted by CAN, included business canvassing and providing PPE and Resources and Relief Flyers
- Almost all CAN participated in a training about COVID-19, and 57 active CAN also participated in training on the Community Resilience Model (CRM)

Preliminary Lessons Learned

- The CAN deep and trusted connections to their communities allowed them to make quick inroads to assess need and provide resources
- Ambassadors appreciated and benefitted from formal training to support their work (for example, CRM, COVID-19 trainings, Mental Health First Aid, etc.)
- Ambassadors were eager to understand pathways to long-term employment in their roles.

4. LACDMH 24/7 Help Line

LACDMH's Help Line continued to provide 24/7 services via its general ACCESS functions, Emotional Support Line for COVID-19, Veterans Warm Line, and the Wellbeing Line for healthcare and first responders. For the months of November and December 2020, the Help Line experienced an increase of calls. Specifically, the Emotional Support Line received approximately 4,500 calls. It was estimated that about 5% of these calls were addressed in a language other than English.

From its inception, the Wellbeing Line has served over 1,500 county employees, first responders, teachers, and school staff. Wellbeing Line staff provided emotional support and referrals to a variety of resources. The feedback received from Wellbeing Line callers has been very positive. Some examples include:

- Grateful for the space to be able to express thoughts and feelings
- Appreciated support in thinking about the meaning and purpose of life
- Felt heard and supported while navigating how to return to work safely
- More confident in managing self-care while caring for others
- Thankful for the help requesting mental health services through providers

Wellbeing Line: Quick Facts

- Over 1,500+ County employees and first responders were served
- Callers reach out every day to connect with L.A. County Wellbeing Line listeners for a variety of needs. Some call just needing someone to talk to. Others are looking for help with anxiety, grief, and other powerful emotions.

Others just need help figuring out how to ask for mental health services. Whatever the wellbeing need, CAN are ready to help
- The Wellbeing Line serves County Employees and external first responders with emotional support, trained listeners, and wellbeing resource referrals
- The Wellbeing Line has expanded its services to teachers and school staff in L.A. County to help them practice self-care despite massive changes
- Wellbeing Line Staff have expanded the services they provide, helping connect more L.A. County first responders and employees with resources like the Wellbeing4LA Learning Center
- The L.A. County Wellbeing Line with re-launch with Chat and Text options in early 2021

County Employees have been accessing countless services and supports through the line. Below are some of the key challenges they shared that Wellbeing Line staff have been helping them work through:
- Hard to balance work and everything else (pandemic and self-care)
- Feeling burned out, fatigued and at risk
- Communicating with clients and needing to be in contact with them is stressful
- Not knowing how long the pandemic will last creates more stress.
- Feeling lonely/ isolated and missing colleagues at work
- Holding family members accountable for their behaviors regarding safety measures around COVID
- Processing grief around friends and family who have died
- Dealing with racial inequities and injustices in systems of care

County employees and first responders provided feedback about the Wellbeing Line as a support:
- Grateful for the space to be able to express thoughts and feelings
- Appreciated support in thinking about the meaning and purpose of life when work is changing
- Felt heard and supported while navigating how to return to work safely
- More confident in managing self-care while caring for others
- Thankful for the help requesting mental health services through providers

Call Center Modernization

The Los Angeles County Department of Mental Health's 24/7 ACCESS line has been expanded and named the "Help Line" and it serves as the primary entry point for mental health services and support within the County. It offers services to callers through three (3) distinct lines: the ACCESS Center, Emotional Support Services, and Veteran or Military Family Member Support. As part of the Call Center Modernization, the plan is to develop a modern Call Center (i.e., LACDMH Help Line) that serves as the hub to access services within the LACDMH system of care. The Call Center provides end-to-end assistance in an efficient and user-centered manner such as:

- Information & Referral
- Centralized Appointment Scheduling
- Warmline/Emotional Support
- Hotline/Crisis Response

The Call Center shall provide easy and equitable access for all individuals and the right care at the right time with efficient internal processes and be coordinated across systems. In addition, it should be culturally and linguistically relevant.

In first year of implementation, the Call Center Modernization plans to engage with stakeholders from the Community Leadership Teams (CLT) to obtain feedback regarding how to design the Call Center to meet the needs of various cultural and linguistic groups. Specifically, this year we met with small CLT workgroups to address deaf and hard of hearing needs through the Help Line. Also, Emotional Support Line was stood up as a response to COVID-19 to address stress and anxiety within the LA County community.

Although the ACCESS Center already provided services in multiple-languages and scheduled interpreter appointments throughout the county, it is hoped that in the Call Center Modernization, this work to provide culturally and linguistically competent access to care is expanded upon. By designing the modernized Call Center with cultural and linguistic needs of our consumers as a core central point, LACDMH hopes to engage consumers who have typically found it difficult to reach out for help. The Call Center will be designed in the most engaging and user-centered way, to provide more easily accessible access to services thereby increasing access to mental health disparities and eliminating disparities.

There are roughly 80 staff in ACCESS, 30 for the Emotional Support Line, and 30 for the Veterans Line. Staffing on all lines are made up of community health workers, RNs, psychiatric technicians, and mental health clinicians. The Emotional Support Line and Veterans Line also have administrative level peers. In the process of working with HR, Finance, and CEO to obtain additional positions.

For the staff trainings related to cultural competence, there are no mandated CC related trainings at this time. Staff are trained in Recovery Oriented Cognitive Therapy (CT-R) approach, Vicarious Trauma, Psychological First Aid, Domestic Violence, and Suicide Prevention. Staff do receive the link to the DMH+UCLA Well-being for LA Learning Center in their orientation packet. This resource has access to several Diversity trainings. LACDMH is in the process of developing of formal training plan.

TABLE 3: LACDMH HELP LINE PROJECTS AND STRATEGIES RELATED TO CULTURAL COMPETENCEAND ELIMINATION OF DISPARITIES FY 20-21

Projects and Strategies	Status/ Progress	Monitoring/ Outcomes/Findings
1) Access to Care User Experience Design: quantitative and qualitative recommendations based on user feedback to ensure its Call Center, and all points along the journey to accessing services, meet the needs of those seeking care.	Completed in FY 20-21	• Need to clarify DMH's role in mental health care and develop consistency in messaging • Need to improve communication of what happens after contacting the DMH Help Line for services (e.g., in situations of a mental health referral) • Need to re-design the DMH Provider Directory and on-line tools so community/clients can self-navigate
2) Obtain Stakeholder feedback by working with the CLT's	In Process	• Met with the CLT on 7/16/21 for initial feedback and to develop a plan for future engagement. • Conducted multiple workgroup meetings to identify needs of the community in the design of the call center/DMH Help Line • In the process of incorporating feedback into a prototype for the new Help Line which will include language options being the first prompt when calling the Help Line.

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TABLE 4: CONSUMERS SERVED, FY 20-21

Languages	Number of Calls
Afghan, Pashto, Pusho	1
American Sign Language (ASL)	49
Arabic	30
Armenian	143
Bengali	18
Bulgarian	8
Burman or Burmese	2
Cambodian	13
Cantonese	67
Choctaw	1
Dutch	3
English	49,752
Ethiopian	9
Farsi	161
French	6
German	1
Greek	4
Hebrew	11
Hindi	5
Hungarian	2
Ilacano	8
Ilongot	1
Italian	1
Japanese	11
Korean	107
Lao	8
Mandarin	152
Other	46
Other Chinese Languages	11
Other Non-English	15
Other Sign Language	14
Pakistani	1
Polish	3
Portuguese	18
Punjabi	3
Romanian	7
Russian	58
Samoan	2
Serbo-Croatian	1
Sinhalese	2

Languages	Number of Calls
Spanish	4,809
Swahili	1
Swedish	1
Tagalog	63
Taiwanese	1
Thai	9
Toisan	2
Tonga	1
Turkish	3
Ukranian	3
Unknown	10,143
Urdu	7
Vietnamese	63
Grand Total	**65,861**

TABLE 5: LANGUAGES USED BY STAFF IN SERVICE PROVISION

Program	Languages Used by Staff in Service Provision (In addition to English)
ACCESS	Armenian, Cantonese, Cambodian, Korean, Mandarin, Spanish, and Tagalog
Veterans/Military Families	Spanish and Armenian
Emotional Support	Spanish, Norwegian, Korean, Taiwanese, Cambodian/Khmer and Armenian

5. LACDMH Speakers Bureau

Speakers Bureau was implemented in April 2020 as a resource to serve the community during and beyond COVID-19 times as a joint effort between the Chief of Psychology Team and the Cultural Competency Unit. Approximately, 75 licensed clinicians were recruited to serve as Subject Matter Experts (SME). They carry out the functions of the Speakers Bureau in addition to the demands of their usual work. The Speakers Bureau was also enriched by partnerships with LACDMH Health Promoters/Promotores de Salud, Faith-Based Liaisons, and Clinical Specialty Treatment Leads. Speakers Bureau members identify with the underserved communities served by LACDMH because they are active, engaged members of these communities and thus reflect the concerns, culture and language of their respective communities. Collectively, they facilitate culturally competent interventions, problem-

solve and assist communities in navigating the complexities often associated with access to competent care and resources, during and beyond the COVID-19 pandemic.

A. Speakers Bureau Mission Statement

To provide highest quality in clinical, culturally and linguistically appropriate solutions. To identify and develop SME for public speaking, media, Town Halls and community meetings, and other public speaking interventions.

- Identify and support relevant and competent solutions to the COVID-19 pandemic and other mental health emergencies that will decrease human suffering, social isolation, and stigma
- Provide reliable information and practical tools necessary for individuals, families, and communities to practice mental/physical safety and experience emotional wellbeing
- Ensure access to available resources by connecting community members to crisis intervention and mental health services to ameliorate the incidence of trauma; cultural and health disparities, domestic, child, and/or elderly abuse; depression; anxiety; addiction; and other mental health concerns

B. Areas of Linguistic Expertise

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Hindi
- Korean
- Additional languages being pursued
- Laotian
- Mandarin
- Russian
- Spanish
- Tagalog
- Vietnamese
- Thai
- Urdu

C. Areas of Cultural Expertise

The cultural expertise of the SB reflects communities experiencing health disparities and communities that have been historically and systemically disenfranchised. For example:

- African American
- American Indian and Alaska Native
- Central American

- Immigrant communities
- Lesbian, Gay, Bisexual, Transgender, Queer and Questioning, Intersex, Asexual and Two-Spirit Communities (LGBTQIA2-S)
- Multi-Racial and Multi-Ethnic
- Older Adults
- Persons Experiencing Homelessness
- Persons with Physical and Developmental Disabilities
- Spirituality and Faith-based
- Veterans

D. Speakers Bureau Activities

Examples of Speakers Bureau activities include:
Participation in Town Halls and Board of Supervisors press conferences
Community events sponsored or co-sponsored by LACDMH
Print, radio, and television media interviews
Production of Public Service Announcements
Presentations and trainings in the community
Development of COVID-19 and other mental health-related materials
Consultation services
Mental support (COVID-19 and social unrest) for Community-Based and Faith-Based Organizations

E. Speakers Bureau Accomplishments during its First Year of Operation

SB members are highly committed to serve our communities during these challenging times; and do so above and beyond the demands of their usual work responsibilities.

- Provision of services to Los Angeles County Board Offices; educational organizations; community-based, faith-based, and non-profit organizations; professional associations; private business; LACDMH programs; and other governmental agencies
- Speaker Bureau services totaling 711 distinct activities that outreached to 52,723 Los Angeles County residents across all Service Areas. Some of these activities had statewide impact
- On-going mental health outreach and support to 33 Faith-Based Organizations by engaging 2,260 community members via 99 distinct activities
- Mental health support to 27 Community-Based Organizations, thereby serving 1,656 community members through 62 distinct activities
- Collaboration with 13 Government Agencies via 84 activities, which outreached to 3,582 individuals
- Cultural and linguistic expertise for the development of several LACDMH media campaign products inclusive of billboards, Metro and bus line advertisements, and radio and TV spots

F. Examples of Media Products Developed with the Cultural and Linguistic Expertise of the Speaker Bureau Members


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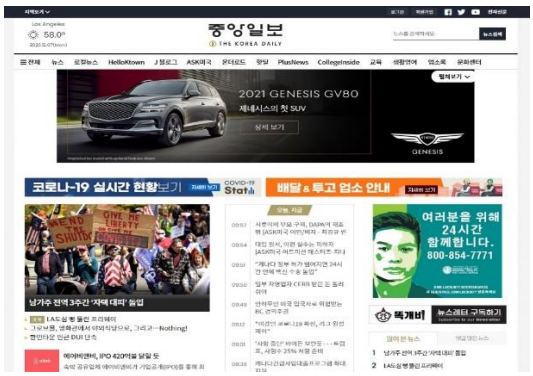

6. Linkage Programs: Jail Transition and Linkage Services, Mental Health Court Programs, and Service Area Navigation

These linkage programs focus on connecting persons involved with the criminal justice system to essential services such as mental health and housing.

The Jail Transition and Linkage Services Program addresses the needs of individuals in collaboration with the judicial system by providing outreach, support, advocacy, linkage, and interagency collaboration in the courtroom and in the jail. Jail transition and linkage staff work with the MHSA Service Area Navigators as well as service providers to assist incarcerated individuals with accessing appropriate levels of mental health services and support upon their release from jail, including housing, benefits, and other services as indicated by individual needs and situations.

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

The Community Reintegration Program (CRP) offers an alternative to incarceration for defendants who have a mental health conditions and co-occurring substance use. The goal of the CRP is to reintegrate consumers into the community with the skills and resources necessary to maintain stability and avoid re-arrest. The CRP provides admission to two (2) specialized mental health contract facilities for justice--involved individuals who have a mental illness and voluntarily accept treatment in lieu of incarceration. The CRP provides mental health screening, triage, assessment, and linkage to community-based mental health services for offenders with mental health conditions who are being released from the California Department of Corrections and Rehabilitation. CRP staff collaborate with the Probation Department on release planning for individuals identified for upcoming release from prison. The staff also work alongside specialized community mental health agencies and Directly Operated programs to assist them with re-entry to their communities.

The Service Area Navigators assist individuals and their family members to access mental health and other supportive services. In this role, the navigators engage in joint planning efforts with community partners, community-based organizations such as schools, faith-based organizations, other County departments, health service programs, and self-help as well as advocacy groups, with the goal of increasing access to mental health services and strengthening the network of services.

7. Technological Advances: VSEE Utilization in Telemental Health

LACDMH utilizes VSEE as its technological platform to provide the following services virtually:

- Psychiatry
- Therapy
- Case Management
- Peer and Community Health Workers
- Pharmacists
- Nursing
- Education and Supervision

VSEE facilitated telemental health services and have expanded the Department's accessibility for consumers to experience minimal, if any, disruption to treatment throughout the COVID-19 pandemic.

1) LACDMH continues to assist clients obtain cell phones and data plans for them to participate in Telehealth services.
2) Each Directly Operated clinic has identified a VSEE Champion and back up contact person to assist answering questions and finding trouble-shooting solutions for staff and consumers.
3) The Department simplified Telehealth service access for clients and participants by providing a browser-based link for calls into group sessions. Clients are no longer required to download and configure software.
4) VSEE offers on-demand access to mental health services via dynamic scheduling. This method effectively leverages an automated scheduling system to provide real-time matching of available providers with clients seeking appointments.
5) Dedicated Telehealth Kiosks were installed at designated sites, offering clients the option to either engage in Telehealth services from home, or at select DMH facilities.
6) Additionally, LACDMH continues to conduct weekly staff Telehealth training to comprehensively address all levels of Telehealth literacy. This effort has had a tremendous impact in providing Telehealth skills and knowledge to staff, which in turn helps them deliver quality Mental Health services to clients.
7) The Department's commitment to continued Telehealth excellence is evident at monthly management meetings, where dedicated attention is given to address access and utilization issues and formulate strategies to effectively maintain a quality Telehealth presence for LA County clients post COVID-19.

8) LACDMH plans to integrate the VSEE Telehealth software with its Electronic Health Record (HER) system, continue to expand the number of providers performing Telehealth throughout the County, and leverage customer satisfaction surveys and Telehealth usage data to understand unmet needs, identify barriers, and guide further expansion. If desired by the client, LACDMH will continue to leverage cultural and linguistic capacity by matching clients with providers based on language and culture.

8. Service Partnerships (FSP) Program Redesign

During CY 2020 and part of CY 2021 LACDMH underwent a process to transform its FSP program. The FSP redesign builds a more responsive system to serve highest acuity clients. LACDMH amended existing Legal Entity (LE) agreements to include outcomes oriented FSP program elements for current FSP providers. This restructuring better addresses the mental health needs of vulnerable children and adults in Los Angeles County and moved FSPs from an "existing slot-based" approach to a team-based model with modified program parameters and performance-based criteria.

The redesign focused on the following three elements:

<u>The salary and staffing</u>

- Standardized rates to bring contracted provider staff salaries closer to parity with counterparts in LACDMH clinics
- Multidisciplinary team/population approach rather than individual caseloads and "slots"
- Recommended team-based staffing model reflecting lower staff: client ratio
- Additional staffing to enable Child FSP providers to engage in Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS)

<u>Population</u>

- Integrating all current specialty FSP into one FSP model with the exception of Housing FSP
- Removal of "at-risk" population for FSP-focus on high acuity
- Two age groups: Child (0-20) and Adult (21+)
- Enhanced services and supports to ensure successful transitions from levels of care

<u>Outcomes</u>

- Providers incentivized to meet retention targets
- Providers incentivized to achieve priority client outcomes related to increasing stable housing, increasing mental health stability, and decreasing involvement with the justice system
- Utilizing data, and consumer/provider feedback to drive continuous FSP improvements

- Enhanced training and technical assistance to support FSP providers in achieving outcomes

III. Quality of Care: Contracted Providers

LACDMH Contractual Agreement

Section 8.15.3 of the LACDMH Legal Entity Contract instructs prospective Contractors to provide services that are consistent with the Department's Cultural Competence Plan and all applicable Federal, State, and local regulations, manuals, guidelines, and directives. Specifically,

- Contractors shall ensure that 100% of staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors receive annual cultural competence training
- Contractors shall monitor, track, document and make available upon request, by Federal, State or County government entities, the annual cultural competence training completed by their staff
- Contractors shall complete and submit an attestation of annual cultural competence training completed by 100% of staff to the Ethnic Services Manager (psbcc@dmh.lacounty.gov) by March 23rd of every Calendar Year

See Attachment 1: LACDMH Legal Entity Contract

In addition, per the Federal Managed Care Network Adequacy Final Rule requirements, 100% of direct service practitioners (psychotherapists, psychiatrists, case managers, etc.) must complete cultural competence training within the past 12 months to meet annual reporting requirements. This information needs to be entered and updated quarterly into the application https://lacdmhnact.dynamics365portals.us/ based on each practitioner specifying the hours of cultural competence training completed. This information is due quarterly on the following dates of every Calendar Year.

An extensive list of regulatory legislations is cited in the contractual agreement. The most significant guidelines for culturally and linguistically competent service delivery include:

The California Welfare and Institutions Code, Section 5600

- Mental health services shall be based on person-centered approaches and the needs of priority target populations. Services shall also be integrated and inclusive of assertive outreach to homeless and hard-to-reach individuals and evaluated for effectiveness

Title IX

- Objectives and strategies need to be in place to improve the organization's cultural competency
- Population assessment needs and service provider/organization assessments are to be conducted to evaluate cultural and linguistic competence capabilities
- Specialty mental health services listings need to be made available to beneficiaries in their preferred language
- Cultural competence trainings need to be made available for all staff including administration and management

LACDMH Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services

New Client Assessment Requirements:

(State Contract unless otherwise noted):

- Assessor Information (LACDMH)
  - *Name*
  - *Discipline*
- Identifying Information and Special Service Needs (LACDMH)
  - *Name of Client*
  - *Date of Birth*
  - *Gender*
  - *Ethnicity*
  - *Preferred Language*
  - *Other relevant information*
- For Children, Biological Parents, Caregivers and Contact Information (LACDMH)
  - *Names*
  - *Contact Information (phone or address)*
  - *Other relevant information*
- Presenting problem(s): The client's chief complaint, history of presenting problem(s), including current level of functioning, relevant family history and current family information
  - *Precipitating Event/Reason for Referral*
  - *Current Symptoms/Behaviors including intensity, duration, onset and frequency*
  - *Impairments in Life Functioning*
- Client Strengths: Documentation of the beneficiary's strengths in achieving client plan goals
  - *Client strengths to assist in achieving treatment goals*
- Mental Health History: Previous treatment, including providers, therapeutic modality (e.g., medications, psychosocial treatments) and response, and inpatient admissions. If possible, include information from other sources of clinical data, such as previous mental health records, and relevant psychological testing or consultation reports
  - *Psychiatric Hospitalizations including dates, locations, and reasons*
  - *Outpatient Treatment including dates, locations, and reasons*

- *Response to Treatment, Recommendations, Satisfaction with Treatment*
- *Past Suicidal/Homicidal Thoughts or Attempts*
- *Other relevant information*

- Risks: Situations that present a risk to the beneficiary and/or others, including past or current trauma

NOTE: Examples of risks include (DHCS Information Notice No.: 17-040):

- ✓ History of Danger to Self (DTS) or Danger to Others (DTO)
- ✓ Previous inpatient hospitalizations for DTS or DTO
- ✓ Prior suicide attempts
- ✓ Lack of family or other support systems
- ✓ Arrest history if any
- ✓ Probation status
- ✓ History of alcohol/drug abuse
- ✓ History of trauma or victimization
- ✓ History of self-harm behaviors (e.g., cutting)
- ✓ History of assaultive behavior
- ✓ Physical disabilities (e.g., limited vision, deaf, wheelchair bound) which make the client vulnerable to others; and
- ✓ Psychological or intellectual vulnerabilities (e.g., intellectual disability (low IQ), traumatic brain injury, dependent personality).

- Medications: Information about medications the beneficiary has received, or is receiving, to treat mental health and medical conditions, including duration of medical treatment. The assessment shall include documentation of the absence or presence of allergies or adverse reactions to medications, and documentation of an informed consent for medications
  - *Medication*
  - *Dosage/Frequency*
  - *Period Taken*
  - *Effectiveness, Response, Side Effect, Reactions*
  - *Other relevant information*
- Substance Exposure/Substance Use: Past and present use of tobacco, alcohol, caffeine, CAM (complementary and alternative medications) and over the counter, and illicit drugs
- Medical History: Relevant physical health conditions reported by the client or a significant support person. Include name and address of current source of medical treatment. For children and adolescents: include prenatal and perinatal events and relevant/significant developmental history. If possible, include other medical information from medical records or relevant consultation reports
  - *Doctor's name and contact information*
  - *Allergies*
  - *Relevant medical information*
  - *Developmental History (for children)*
  - *Developmental milestones and environmental stressors (for children)*

- Relevant conditions and psychosocial factors affecting the client's physical health and mental health; including, as applicable, living situation, daily activities, social support, cultural and linguistic factors and history of trauma or exposure to trauma
  - *Education/School history, status, aspirations*
  - *Employment History/Vocational information including means of financial support (for adults)*
  - *Legal/Juvenile court history and status*
  - *Child abuse/protective service information (for children)*
  - *Dependent Care Issues (for adults)*
  - *Current and past relevant Living Situations including Social Supports*
  - *Family History/Relationships*
  - *Family strengths (for children)*
  - *Other relevant information*
- Mental Status Examination
  - *Mental Status Examination*
- Clinical formulation based on presenting problems, history, mental status examination and/or other clinical data
  - *Clinical formulation*
- A diagnostic descriptor consistent with the clinical formulation
  - *Diagnostic descriptor*

- A code from the most current ICD code set shall be documented consistent with the diagnostic descriptor
  - *ICD diagnosis code*
  - *Specialty Mental Health Services Medical Necessity Criteria*
- Signature of a staff person allowed to perform a Psychiatric Diagnostic Assessment per the Guide to Procedure Codes
  - *Staff signature, discipline/title, identification number (if applicable) and date*

For additional details, see Attachment 2: Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services

IV. Quality Improvement and Quality Assurance

1. The Consumer Perception Survey (CPS)

LACDMH's Quality, Outcomes, and Training Division (QOTD) shares the responsibility with providers to maintain and improve the quality of services and delivery infrastructure. In addition to being required by State and Federal mandates, a regular assessment of consumers' experience of services received and their providers is essential for improvement and innovation within LACDMH.

The Quality Improvement Unit is responsible for the formal reporting on the annual measurement of consumer perception of satisfaction in eight areas, namely: Overall

Satisfaction, General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcomes of Services, Perception of Functioning, and Perception of Social Connectedness. The Mental Health Consumer Perception Survey (CPS) forms map on to each of these specific domains. CPS data is gathered once a year in May or June.

CPS forms were developed for each age group. The Youth Services Survey (YSS) form is administered to consumers ages 13 to 17 years. The Youth Services Survey for Families (YSS-F) form is administered to family/caregivers of consumers aged 0 to 17 years. The Adult Mental Health Statistics Improvement Program (MHSIP) Consumer Survey form is administered to consumers aged 18 to 59 years. The Older Adult CPS is administered to consumers aged 60 years and older.

The survey items that are common across the two sets of age groups are as follows:
YSS-F

- I felt my child had someone to talk to when he/she was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- My child gets along better with family members
- My child is doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

YSS

- I felt I had someone to talk to when I was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- I get along better with family members
- I am doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

Adult survey (ages 18-59 years)

- The location of services was convenient for me
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems
- I do better in school and/or work
- My symptoms are not bothering me as much

Older Adult survey (ages 60 years and over)

- The location of services was convenient
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems
- I do better in school and/or work
- My symptoms are not bothering me as much

LACDMH conducts consumer satisfaction surveys once a year. The CPS Survey is utilized and administered to consumers served in randomly selected Outpatient Clinics.

Like the trend from Spring 2020, fewer surveys were completed during the Spring 2021 survey period. Most surveys came from Adults (52.1%), followed by Families (29.1%), Youth (9.8%), and Older Adults (9.0%). Surveys were collected from 10.9% of the consumers who received services from outpatient and day treatment programs during the one-week survey period. Most surveys were completed in English or Spanish, and respondents indicated high satisfaction with language availability. Service Area (SA) 2 had the highest number of completed surveys, and SA 5 had the lowest number of completed surveys.

For Spring 2021, the percent of individuals that reported being very satisfied remained high for several domains. Families and Youth had the highest scores for the Cultural Sensitivity domain, with 96.8% and 90.4% of respondents agreeing or strongly agreeing with the items in that domain. Adults had the highest scores in the Quality & Appropriateness domain (92.5%), and Older Adults had the highest scores in the General Satisfaction domain (95.9%).

Over a quarter of Families (28.6%) and over half of Youth (67.5%) reported being on medication for emotional or behavioral problems. Youth had the highest medication rates in SA 5 (100%) and SA 2 (87.9%), and Families had the highest medication rates in SA 8 (35.8%). Of those prescribed medications, most Families (88.2%) and about half of Youth (50.6%) reported they were told about medication side effects.

Trends for the common items across all four survey versions fluctuated across the last three survey periods (November 2019, June 2020, and June 2021). Families tended to have the highest percentage of respondents that agreed or strongly agreed with common items for the last three survey periods. Youth and Families had similar percentages for June 2020 and then decreased considerably for Youth in June 2021. Older Adults improved percentages on most items from June 2020 to June 2021. Adult scores tended to be lower for most items and decreased from June 2020 to June 2021. The lowest percentage that agreed or strongly agreed for all age groups was for the functioning item related to doing better in school and/or work, indicating this is

a continued area for improvement.

The following figures summarize Age Group Comparison of Common Survey Items:

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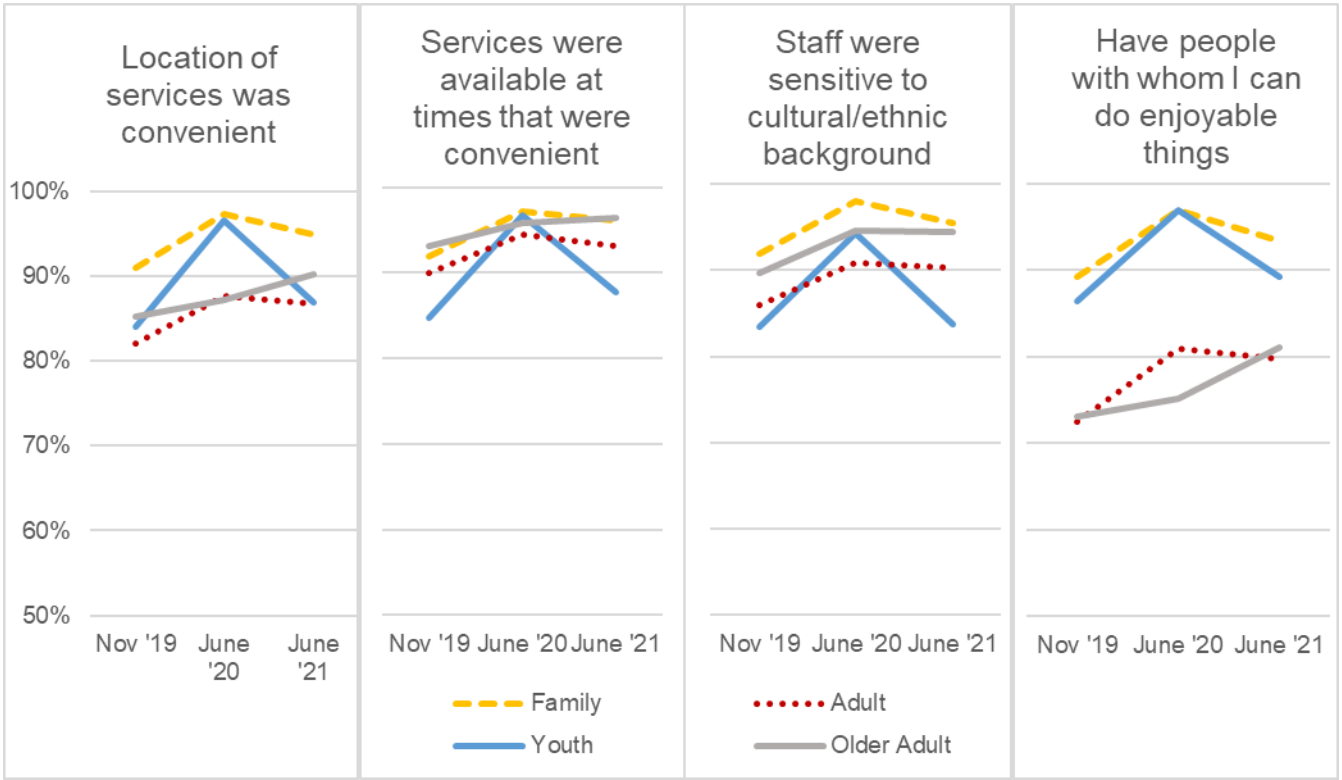
FIGURE 1: AGE GROUP COMPARISON OF ACCESS, CULTURAL SENSITIVITY, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME



Data Source: Consumer Perception Survey data, November 2019, June 2020, and June 2021.

Figure 1 shows four of the CPS items common to the Families, Youth, Adult, and Older Adult surveys from November 2019 to June 2021. The percentages above

reflect the number of respondents selecting either Agree or Strongly Agree for each item.

Families had the highest percentages on all four items compared to the other three age groups for all three time periods except for November 2019 and June 2021, where Older Adults were higher on “Services were available at convenient times.” Older Adults were the only age group whose scores increased or stayed the same over time on all items. Notably, Older Adults and Adults had much lower scores on the item “I have individuals with whom I can do enjoyable things” compared to Youth and Families.

Adults and Youth tended to have lower percentages, particularly for November 2019 and June 2021. Youth had the lowest percentage on the “Services were available at times that were convenient” and “Staff were sensitive to my cultural/ethnic background” items in November 2019 and June 2021. Adults also had the lowest percentage on the “Location of services was convenient” item at all three time periods except for June 2020, where they were slightly higher than Older Adults.

FIGURE 2: AGE GROUP COMPARISON OF OUTCOMES, FUNCTIONING, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME

Data Source: Consumer Perception Survey data, November 2019, June 2020, and June 2021.

Figure 2 shows the other four of the CPS items common to the Families, Youth, Adult, and Older Adult surveys from November 2019 to June 2021. The percentages above reflect the number of respondents selecting either Agree or Strongly Agree for each item.

Youth and Families tended to have the highest percentages of agreement with the support and doing better in school or work items in November 2019 and June 2020. From June 2020 to June 2021, Youth and Families percentages decreased for all items. Although Youth and Families scores tend to be higher than those of Adults and Older Adults, Youths had lower percentages on the getting along with family members and doing better in school or work than Older Adults. Like the other common items above, older adults were the only age group to increase over time on most items. For Older Adults, only the doing better in school or work item decreased slightly (less than a percentage point).

FIGURE 3: TRENDING DATA – PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND"

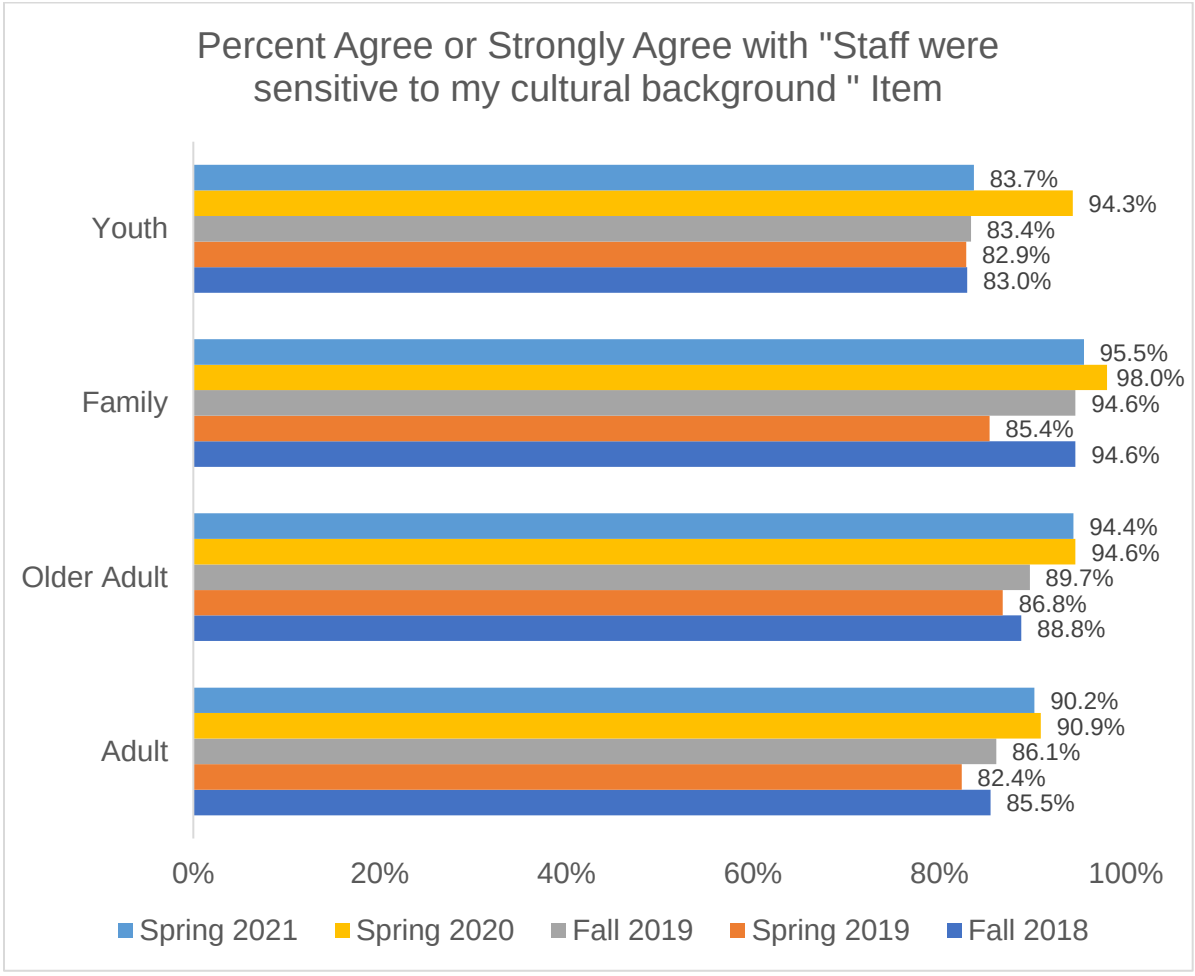


Figure 3 summarizes the percentage of survey participants who endorsed agree or strongly agree to the item “Staff being sensitive to their cultural ethnic/background” across five CPS data collection periods, from Fall 2018 to Spring 2021. The highest percentage of agree responses was received from Family/caregivers of consumers for the Spring 2020 at 98%. The lowest percentage was received from Adults for the Spring 2019 at 82.4.%.

FIGURE 4: PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM “WRITTEN MATERIALS PROVIDED IN MY PREFERRED LANGUAGE”

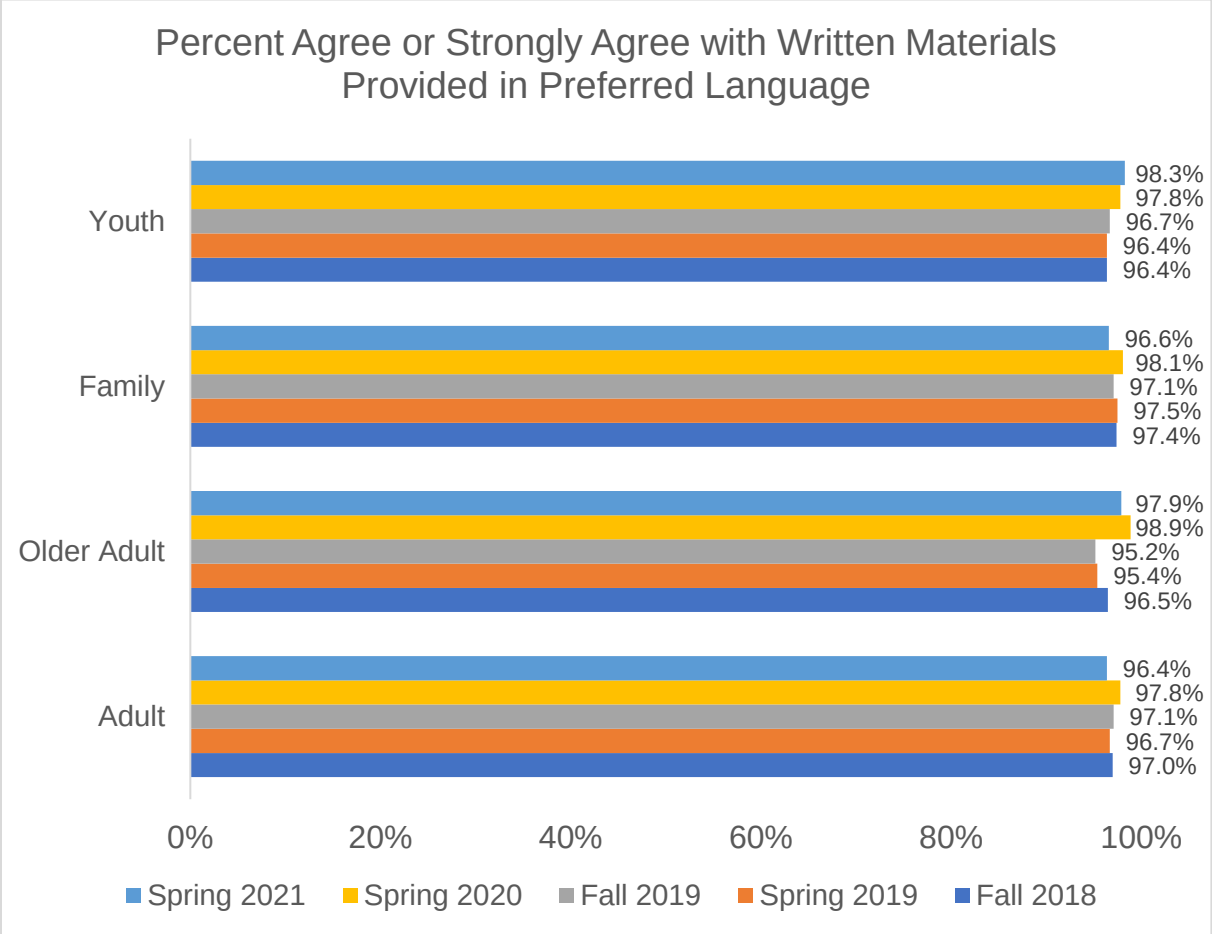


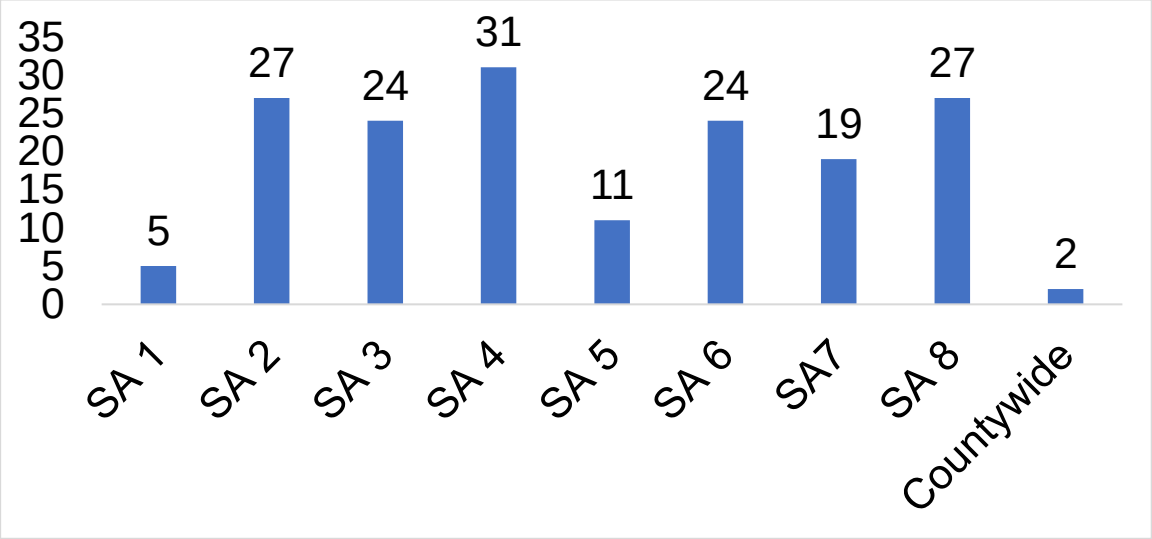
Figure 4 summarizes the percentage of survey participants who endorsed agree or strongly agree to the availability of written materials in their preferred language. Across the five CPS data collection periods, from Fall 2018 to Spring 2021, the highest percentage of agree responses was received from Older Adults for the Spring 2020 survey at 98.9%. The lowest percentage was from Older Adults for the Fall 2019 at 95.2%.

Statewide, the annual administration of CPS is a premier source for information on client satisfaction. Clients and their families are encouraged to rate the quality of their services and openly share what aspects of their outpatient treatment are going well or needs improvement. Although not required by State, LACDMH recognizes the role qualitative feedback plays in continuous quality improvement by prompting a provider-led thematic analysis that parallels their CPS data collection.

Open-Ended Comments Collection Survey

An Open-Ended Comments (OEC) Collection survey was developed to guide providers through evaluating the OEC comments they received from clients who completed a CPS form(s) in Spring 2021. OEC Collection surveys were submitted to the QI unit from June 24, 2021, to August 2, 2021. CPS forms gathered open-ended comments from LACDMH's youth, families, adult, and older adult clients. The QI unit received 119 OEC Collection surveys, with many providers completing OEC Collection surveys for up to six programs. Of note, Service Area (SA) 4 had the highest number of providers who completed a collection survey (Figure 1).

FIGURE 5: NUMBER OF PROGRAMS WITH COMPLETED OEC COLLECTION SURVEYS BY SERVICE AREA



Note: Countywide providers deliver services throughout the county, not just in one designated SA. Data source: Spring 2021 Consumer Perception Survey (CPS) Open-Ended Comments (OEC) Collection survey.

Provider-led Thematic Analysis

Providers were instructed to work collaboratively on their OEC Collection survey with their internal quality improvement team and Program Managers/Directors for their respective programs to:

1. Identify comments that fell into specific categories, namely: accessibility of

services, general customer service, staff supervision or coaching, treatment outcomes, types of services offered, facility concerns, service equity, and other.
2. Organize their clients' comments into three categories: positive comments, negative comments, and general/recommendation comments.
3. Develop Providers were instructed to work collaboratively on their OEC Collection survey with their internal quality improvement team and Program Managers/Directors for their respective programs.

All completed OEC Collection surveys were submitted to the QI unit through Microsoft Forms survey software. The OEC Collection surveys were reviewed by internal QI staff and sorted into the identified categories. The findings are summarized in the following report.

Open-Ended Comments Summary Report

The OEC Summary Report was completed to assess qualitative feedback collected from clients Department-wide. Adult clients made up the largest proportion of comments at 31% (N=93). Child clients made up 26% (N=80) and Transition Age Youth (TAY) made up 24% (N=74) of the comments. Older Adult clients made the smallest number of comments at 19% (N=56).

Client Demographics

Most providers who completed the OEC Collection survey received client comments (81%, N=96). Only 19% (N=23) reported not receiving client comments. Figure 2 shows the number of providers who reported receiving client comments. The number of comments reported by a single provider ranged from one to 151, with 1,792 client comments reported.

Summary of Findings

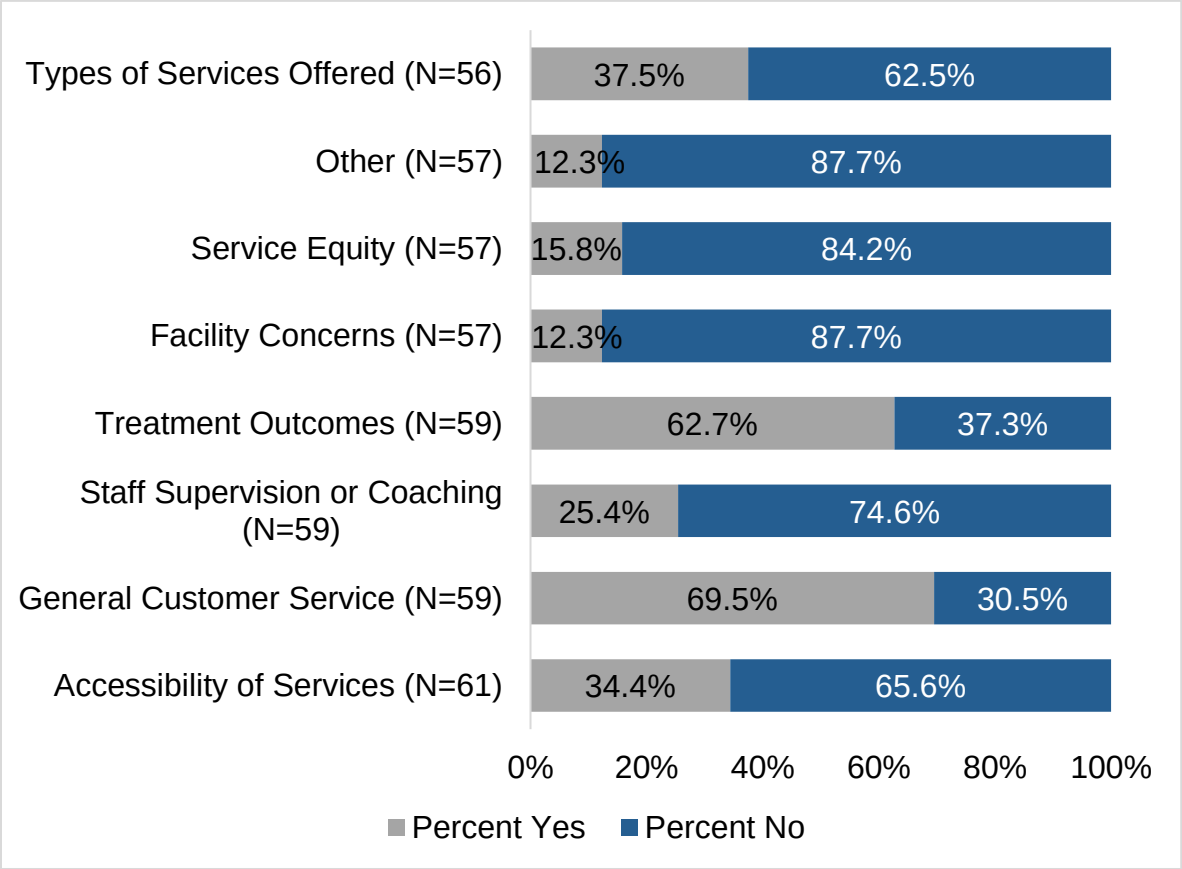
The summary report that follows is organized by category, starting with an overview of providers with completed OEC Collection surveys. Figure 1 represents SA participation, the format used to survey clients, and the number of providers who received client/family comments.

Any identifying information was removed to maintain confidentiality. It is important to note that the organization of client comments is subjective. There may be variances among providers submitting the comments and QI staff reviewing the comments.

Overall Comments

The providers' report of client comments fell into the eight designated categories (Figure 2).

FIGURE 6: OVERALL COMMENTS BY CATEGORY



Data source: Spring 2021 CPS OEC Collection survey

- *Accessibility of Services*
  Accessibility of Services (N=61) had the highest number of responses with 34.4% (N=21) of providers reporting accessibility-related comments. Comments included wanting to be seen for appointments or services more often, including increased evening and weekend hours. Clients reported an appreciation for telehealth services and wanting to return to in-person services. One client commented on frequent cancelations and another client wanted services closer to their home.

- *General Customer Service*
  General Customer Service (N=59) had the highest percentage of comments of the eight categories with 69.5% (N=41) of providers reporting receipt of comments in this category. All but one comment classified in the general customer service category were positive. Client comments noted the kindness, respectfulness, and caring displayed by both clinical and support staff. The one comment noted a poor interaction with a front office staff member.

- *Staff Supervision or Coaching*
  Staff Supervision or Coaching (N=59) category had 25.4% (N=15) of responding providers confirm receipt of this category of comments. Several client comments noted clinicians and staff were knowledgeable and helpful. However, two client comments suggested a need for increased cultural awareness and one requested a specific specialty in adoption trauma.

- *Treatment Outcomes*
  Treatment Outcomes (N=59) had the second-highest percentage of comments at 62.7% (N=37). Client comments identified in this category were all positive. Clients noted general satisfaction, improvement in specific symptoms, and named specific clinicians as being essential to their progress.

- *Types of Services Offered*
  Types of Services Offered (N=56) had the third-highest percentage of comments at 37.5% (N=21). Generally, clients indicated they were pleased with the services offered. They identified groups, medication services, and support from treatment teams as the most helpful. There were requests for more groups, family therapy, and substance abuse treatment.

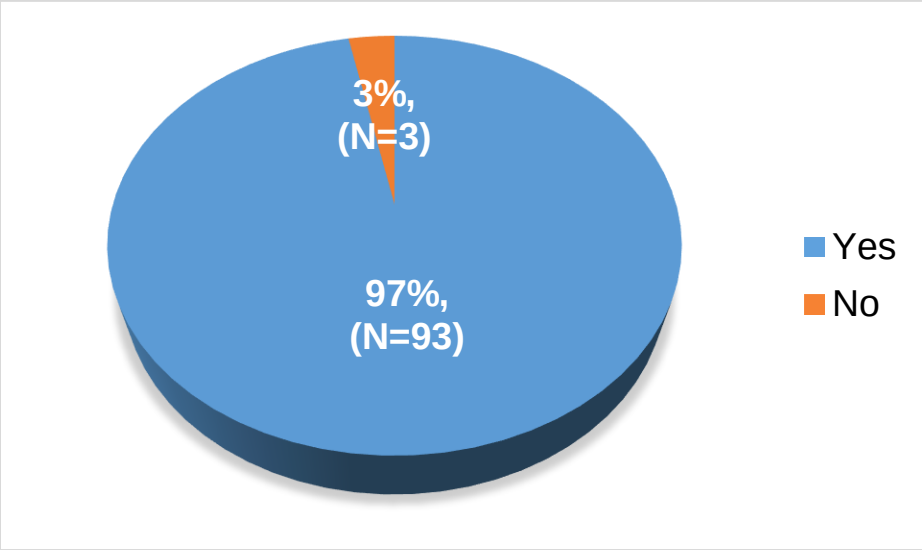
- *Service Equity*
  Service Equity (N=57) had the second-lowest percentage of comments at 15.8% (N=9). Most client comments identified by providers remarked on good cultural sensitivity and availability of services in a preferred language. However, there were several requests to increase Spanish-speaking providers and one for a clinician of a client's same race/ethnicity, though the race/ethnicity was not indicated.

- *Facility Concerns*
  Facility Concerns (N=57) and other categories (N=57) each had the lowest percentage of comments at 12.3% (N=7). Regarding facilities, two client comments indicated a need for increased parking. One reported the building needed repair, one reported the building was not accessible for those living with disabilities, and one reported feeling unsafe with homeless encampments near the building. Other categories identified by providers included telehealth versus in-person services, changes in therapists, gratitude, and overall communication.

Positive Comments

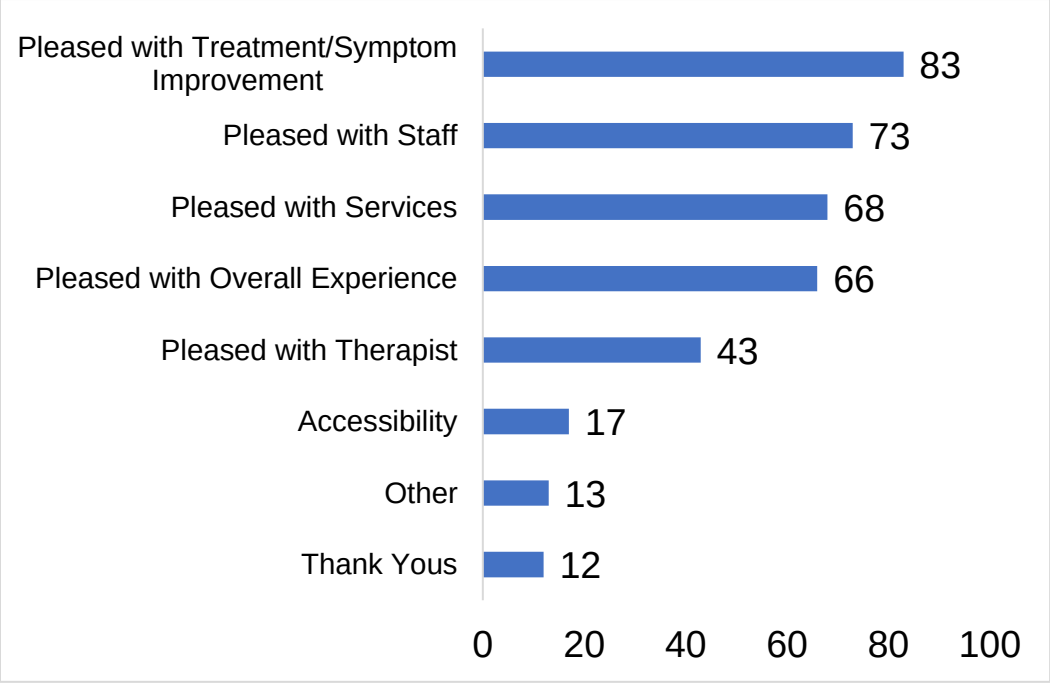
Positive comments were defined as comments on the good qualities of the program's elements, staff, environment, support, etc. Some examples include, "My therapist is great," "My doctor answers my questions," "The lobby has lots of fun toys for kids," or "Thank you for using video appointments." There were 375 positive comments recorded in the OEC Comment survey. Figure 3 reports the number of providers who identified positive comments and Figure 4 describes the number of provider-identified positive comment counts by most frequently occurring categories.

FIGURE 7: NUMBER OF PROVIDERS THAT IDENTIFIED POSITIVE CLIENT COMMENTS



Data source: Spring 2021 CPS OEC Collection survey

FIGURE 8: NUMBER OF POSITIVE CLIENT COMMENTS BY CATEGORY

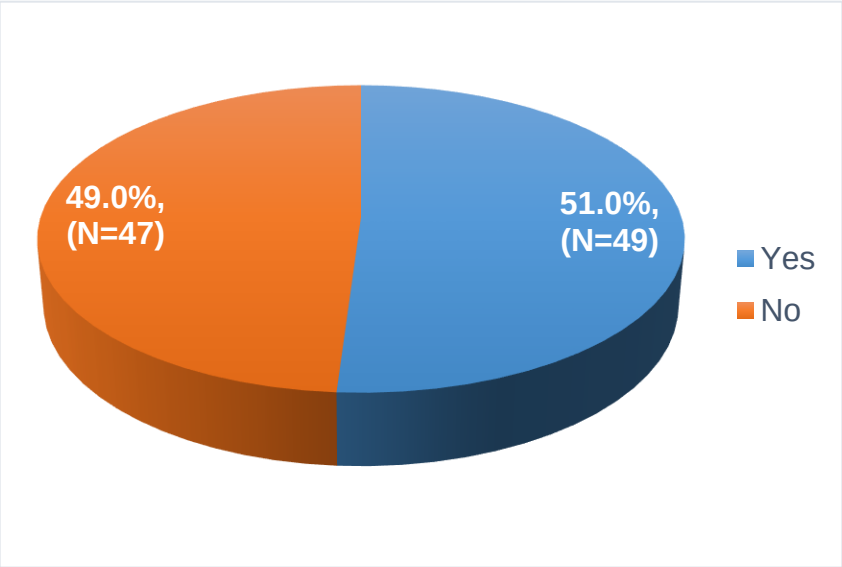


Data source: Spring 2021 CPS OEC Collection survey

Negative Comments

Negative comments were defined as comments on issues, concerns, negative experiences, unhappiness with staff, the program, the environment, etc. Some examples include, "The staff is very rude," "There is not enough parking," or "My provider never calls me back." There were 87 negative comments recorded in the OEC Collection survey. Figure 5 reports the number of providers who identified negative comments and Figure 6 describes the number of provider-identified negative comment counts divided into the most frequently occurring categories.

FIGURE 9. NUMBER OF PROVIDERS THAT IDENTIFIED NEGATIVE CLIENT COMMENTS



Data source: Spring 2021 CPS OEC Collection survey

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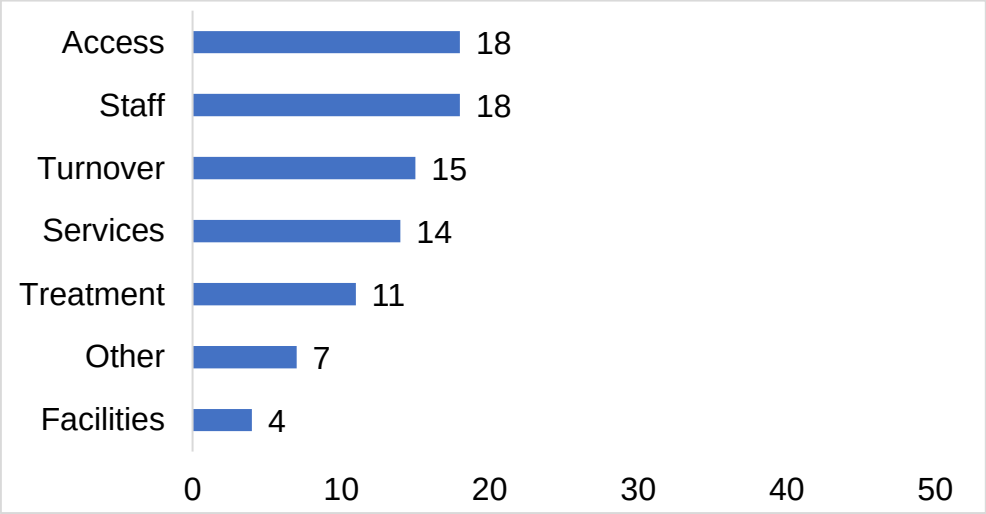
FIGURE 10: NUMBER OF NEGATIVE CLIENT COMMENTS BY CATEGORY

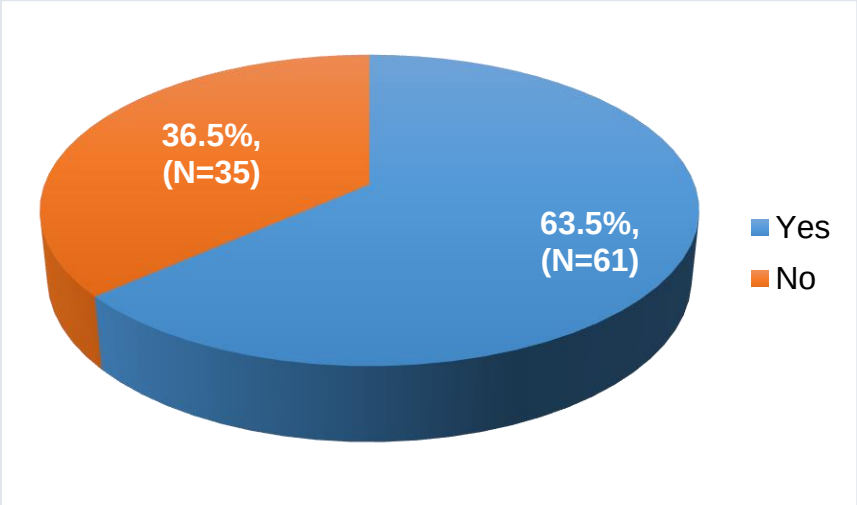


Data source: Spring 2021 CPS OEC Collection survey

General/Recommendation Comments

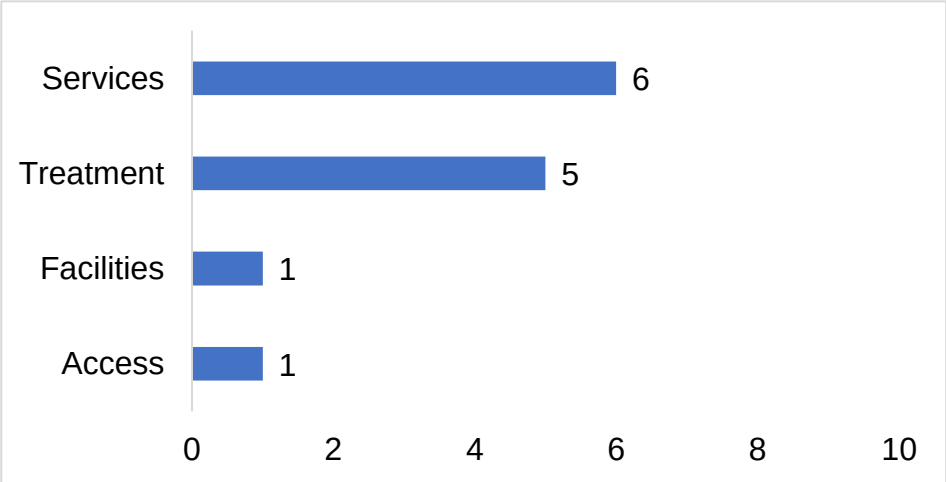
General/Recommendation comments were defined as relatively neutral comments about suggestions for change. Some examples include, "Please add more groups for teens," "Can you put more toys in the lobby?" "There should be a snack machine," or "Video appointments should be shorter." There were 13 general/recommendation comments recorded in the OEC Collection survey. Figure 7 reports the number of providers who identified general/recommendation comments and Figure 8 describes the number of provider-identified general/recommendation comment counts by most frequently occurring categories.

FIGURE 11: NUMBER OF PROVIDERS THAT IDENTIFIED GENERAL/RECOMMENDATION CLIENT COMMENTS



Data source: Spring 2021 CPS OEC Collection survey

FIGURE 12: NUMBER OF GENERAL/RECOMMENDATION CLIENT COMMENTS BY CATEGORY



Data source: Spring 2021 CPS OEC Collection survey

Provider-Led Action Plans

Providers were asked to briefly describe their Action Plans to address comments from clients/caregivers. Of the 119 respondents to the survey, 108 entered some type of plan. The plans tended to vary widely depending on the type of comments received. Many of the plans indicated sharing the comments with Executive and managerial staff, QI and Quality Assurance (QA) staff, clinicians, and other program staff. Many of the plans also discussed addressing the comments directly with action or meeting individually with the client/caregiver. For those providers

who reported only positive comments, several respondents indicated a plan to share the comments with staff to boost morale.

Summary of the OEC Collection Survey

The OEC Collection survey aimed to facilitate the review of consumer experiences of youth, families, adult, and older adult populations. The OEC Summary Report was completed to assess qualitative feedback collected from consumers in overall, positive, negative, and general/recommendation comments. Report findings are distributed to participating providers to assist with further development and improvement of services provided to consumers throughout Los Angeles County.

Nearly all comments regarding general interaction with staff were positive, yet there was a need for continued efforts for cultural awareness and specialty interventions. There were requests for more groups, family therapy, substance abuse treatment, additional Spanish-speaking providers, and additional efforts to align with client/families' preferences culturally or linguistically. There were reoccurring facility concerns about adequate parking and safety, maintaining buildings, and adhering to standards that make buildings accessible to persons living with disabilities.

Nearly all responding providers reported the receipt of positive comments. Positive comments tended to focus on the client's/caregiver's perception of symptom improvement and functioning, feeling staff was kind and supportive, services were comprehensive and high-quality, and having a good overall experience.

Half of the providers responding to the survey reported receiving negative comments from clients. Most of the negative comments focused on the ability to access appointments, having a poor match with treatment providers, and the high staff turnover rate.

General/Recommendation comments were the least occurring category identified by the responding providers. Clients that commented were seeking a return to in-person treatment and services. There were requests to expand group treatment and services, such as anger management, Dialectical Behavior Therapy (DBT), and school services. Clients also suggested expanding to weekend hours and adding clocks to rooms.

Finally, providers appear to use the information collected in the comments and make plans to address client/caregiver concerns directly. Comments are shared widely from Executives to front office staff. Also, positive comments tend to be shared with staff to improve morale.

Recommendations

- Outcomes from the Summary OEC Report should be reviewed at the provider-level and with each site's QIC and leadership team.
- Outcomes should be reviewed with clinical and support staff for staff education and collective involvement in improving service delivery for consumers.
- Providers should consider surveying their client community to identify and prioritize the improvement needs.
- Providers should consider options to expand their service hours to meet the needs of clients/caregivers.
- Providers should make available options of services to meet the client/caregiver's need, which includes telehealth, in-person, or a combination of services.
- Providers should explore and increase opportunities for clinician and staff cultural awareness. Clinicians should also have the opportunity to expand their knowledge and practice of specialty areas.
- Provider should explore opportunities to add or increase the availability of groups, family therapy, and substance abuse treatment.
- Providers should explore their ability to expand increase their number of Spanish-speaking providers and efforts to match a client with providers of their ethnicity, if the client so desires.
- Providers should assess their facilities for repairs and upgrades and review their safety protocols and staffing for adequacy.
- Action plans should be considered by each site's QI, management team, and Program Managers to target individualized areas for improvement.
- This report should be made available for public review by clients, their families, and other LACDMH stakeholders.

2. Performance Improvement Projects (PIPs)*

As a part of the External Quality Review Organization (EQRO) requirements and mandated by the Code of Federal Regulations, Title 42, the Quality Improvement (QI) program is responsible for collaborating on SA QI projects and PIPs. Title 42 C.F.R. § 438.240(d) requires LACDMH to conduct a clinical and non-clinical PIP, which must be validated and reviewed by an EQRO annually.

The OAO-QIU is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. Each year, the OAO-QIU conducts a Clinical and Non-clinical PIP. The PIPs ensure that selected administrative and clinical processes are reviewed to improve performance outcomes.

A. Non-Clinical Performance Improvement Project (Non-clinical PIP)

In the FY 2020-21 non-clinical PIP *Closing the Gap Between the Access to Care Beneficiaries Receive and What is Expected*, the Quality Improvement (QI) and Quality Assurance (QA) Units worked collaboratively to evaluate LACDMH's newly implemented timely access monitoring process. The study population

included Directly Operated (DO) and Legal Entity (LE)/Contracted providers with over five referrals and timely appointments falling in the 69% and below range at three data collection points between May 2020 and January 2021. The providers in this study adequately represent LACDMH's outpatient network and received approximately 3,054 initial requests for routine services.

Objective 1: Establish a demographic profile (i.e., size, modes of service delivery, location, etc.) of providers who struggle to meet DMH timeliness standards for clients/families seeking child services.
Upon review of the data, it was observed there was a need beyond the children's programs, and system-wide timely access required intervention. Therefore, the target population includes individuals from all age groups who could be experiencing mental health symptoms ranging from mild to severe mental health symptoms. The study population also encompassed potential consumers who urgently need connections to services, resources, and support. This includes high-risk consumers where immediate help could save lives or mitigate high-cost service utilization.

In the PIP study data evaluation period, May 2020 through January 2021, the MHP received 77,350 initial routine service requests of which 64,793 (83.8%) were timely and 12,557 (16.2%) were untimely. This and the following totals are not exclusive to beneficiaries and may include insured or indigent consumers. Child referrals totaled 27,428 (35.5%) with 19,383 (70.7%) timely and 8,045 (29.3%) untimely. Transition Age Youth totaled 13,814 (17.9%) with 11,950 (86.5%) timely and 1,864 (13.5%) untimely. Adults totaled 32,034 (41.4%) with 29,453 (91.9%) timely and 2,581 (8.1%) untimely. Older adults totaled 4,374 (5.7%) with 4,007 (91.6%) timely and 367 (8.4%) untimely. The average percentage of requests resulting in an appointment May 2020 through January 2021 was 69.3%.

Referrals for initial routine services were received through one of four systems. From May 2020 to January 2021, the contractor Service Request Log (SRL) web service system received 43,179 referrals. The average percentage of SRL requests resulting in an appointment was 74%. The IBHIS SRL received a total of 52,691 referrals. The average rate of IBHIS SRL requests resulting in an appointment was 82.7%. The Katie A. Enterprise Monitoring System (KAEMS) received 14,419 referrals. The average percentage of KAEMS requests that resulted in an appointment was 45.3%. The Service Request Tracking System (SRTS) received 13,367 referrals. The average percentage of SRTS requests resulting in an appointment was 27.4%.

Objective 2: Implement a required QI Plan of Correction process for providers with timeliness in the 69% or less range, including identifying internal and external

factors contributing to their untimely appointments and establishing an action plan.
The QA Unit implemented a timely access monitoring process consisting of notifying DMH mental health provider programs with a 1) email if the quarterly timely access performance was between 70-79%, 2) an email with a request to complete a Plan of Correction if the quarterly performance was below 69%, and 3) an email with a request to complete a Plan of Correction and teleconference call with QA if the quarterly performance was below 59%.

The Quality Improvement (QI) Unit collaborated with QA to monitor the rate of change made by providers performing at 69% or below from May 2020 through January 2021. QI tracked the quarterly timely access performance for initial requests for routine performance and monitored the themes of interventions implemented by the providers.

Findings
All providers were rated for timeliness on routine appointments. The PIP focus was placed on the providers with the lowest timeliness performance to have the highest impact on beneficiary access. Baseline data was determined to be Cohort A, Cohort B, and Cohort C. The number of providers in the group with a 69% and below rating was 50.

With the range of improvement seen among the A, B, and C cohorts (+ 40 PP, 32.2 PP, and +30.7 PP, respectively), it is concluded that the implementation of the timely access monitoring process appears to have a positive impact on the study population. Timeliness rates were trending upwards within three months. Ideally, a review of any change in the number of requests for referrals during the full measurement period would provide additional support to the impact of the interventions. SA improvements mirrored the improvements seen system wide.

Overall, timely access to care monitoring effectively promoted the implementation of impactful interventions. Engaging in timely access to care monitoring and quality improvement processes improved the timely access ratings of providers who fell below 69%. The LE/Contracted and DO providers took a quality improvement approach to timely appointments by reviewing internal and external factors and developing an Action Plan to address their specific challenges.

Results from the survey suggest providers benefit from 1) program-specific strategies, 2) immediate capacity adjustments such as increasing intake slots or clinician caseloads, 3) administrative changes such as revising referral and intake workflows, and 4) SRTS/SRL or timeliness standard training and monitoring for staff. Child/TAY providers may have unique needs compared to other age groups

served. This group would likely benefit from further exploration of their specific challenges to timely access.

This non-clinical PIP concluded in September 2021. Valuable work will continue improving timely access to care with the continued work of the Access to Care Leadership Committee and QA's established access to care monitoring process.

B. Clinical PIP

The Clinical Performance Improvement Project entitled "Improving the Use of Medication-Assisted Treatment (MAT) for Consumers with Co-Occurring Mental Health Disorders and Substance Use (COD)" occurred from Quarter 2 of FY 20-21 to the end of Quarter 2 of FY 21-22. The improvement strategy was focused on increasing the administration of medication-assisted treatment (MAT), or medications used to manage cravings, to consumers with Alcohol Use Disorders (AUDs) and Opioid Use Disorders (OUDs). Interventions included the MAT medications used to treat AUDs and OUDs (i.e., buprenorphine, naltrexone, acamprosate, and disulfiram) and Integr8Recovery, a group treatment model designed to provide cognitive-behavioral skills and education on MAT for consumers with CODs. Overall, findings indicated that the rate of hospitalization for consumers receiving MAT generally decreased over time from baseline. These rates significantly differed from the baseline to the final measure. The percent of consumers receiving MAT who were re-hospitalized within 30 days of discharge varied over time and ultimately decreased slightly from baseline to the final remeasure. For re-hospitalization rates, the sample sizes were so small that these findings were not statistically significant. LACDMH will continue this project as a quality improvement project (QIP) and will select a new clinical PIP topic at the close of the project in February 2022. The initial pilot versions of the interventions resulted in mixed outcomes. Due to small sample sizes and delayed implementation due to the COVID-19 pandemic, these results should be interpreted with caution. Data analysis regarding the interventions will continue with ongoing implementation, although the PIP will be discontinued.

Objective 1: Increase the number of consumers receiving MAT overall.

The number of consumers receiving MAT increased from 438 in the baseline period of the PIP (Q2 FY 20-21) to 587 in the final period (Q2 FY 21-22). Although there was a slight dip in Q1 FY 21-22, the number generally increased over time. The percentage of consumers receiving MAT out of the total consumers served increased from 0.6% to 0.8% from baseline to final remeasure, significantly smaller than the goal of four percent.

Objective 2: Increase the number of consumers with identified alcohol use disorder (AUD) and opioid use disorder (OUD) receiving MAT.

The number and percentage of consumers with AUDs and OUDs receiving MAT increased from baseline to the final measure, although the percent increase did

not achieve the PIP target of five percent. AUD prescription rates had an initial increase from Q2 FY 20-21 to Q3 FY 20-21 and were steadier over time. OUD rates generally increased slowly over time, slightly decreasing at the final measure. The AUD and OUD MAT prescription rates were statistically significant changes from baseline to the final measure.

Objective 3: Increase the number of prescribers that are eligible to prescribe MAT.
The number of prescribers eligible to administer buprenorphine, a MAT that requires an X-waiver from the Drug Enforcement Agency (DEA), increased from 47 in Q2 FY20-21 to 72 following the first training in Q3 FY 20-21. Due to staff turnover, this number decreased to 65 by the final remeasure.

Objective 4: Increase the number of prescribers administering MAT to at least one consumer.
Early pilot data from the MAT mentorship pilot groups at Edelman Mental Health Center and the Women's Re-Integration Program show promising results about these programs generally increasing the number of consumers receiving MAT prescriptions from baseline. The percent of prescribers administering MAT to at least one consumer increased over time and met the target percent increase of five percent from baseline to final measure. At the end of this PIP, over half of the prescribing staff in LACDMH have prescribed MAT to at least one consumer with COD, and we anticipate that number will increase with greater mentorship.

Source: Annual Report on Quality Improvement, Reporting Period: July 1, 2020, to December 31, 2021

3. Grievances and Complaints

As mandated by the State Department of Health Care Services (DHCS) Program Oversight and Compliance, the Quality Improvement Division facilitates the annual evaluation of beneficiary Grievances, Appeals, and State Fair Hearings. Grievances and appeals are collected and reviewed by the Patients' Rights Office (PRO) and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required for Medi-Cal beneficiaries only.

LACDMH monitors grievances, appeals, and requests for State Fair Hearings and their resolution. The following tables summarize the number and percentage of inpatient and outpatient grievances and appeals by category and disposition.

<u>Beneficiary Problem Resolution</u>
Grievances, appeals, expedited appeals, state fair hearings, expedited fair hearings, Notice of Actions (NOAs), and requests for change of provider are consumer and provider activities that LACDMH monitors, evaluate for trends, and report to the Departmental Quality Improvement Council. This is an on-going Quality Improvement Work Plan monitoring activity, as specified by our DHCS contract.

Notices of Action

NOAs are required when any of the following actions occur with a Medi-Cal beneficiary

- NOA-A: Denial of Services Following Assessment
- NOA-B: Reduction of Services
- NOA-C: Post Service Denial of Payment
- NOA-D: Delay in Processing a Beneficiary Grievance or Appeal
- NOA-E: Lack of Timely Services

In accordance with Title 9, CCR, Chapter 11, Subchapter 5, and the MHP Contract, LACDMH must have problem resolution processes that enable beneficiaries to resolve problems or concerns about any issues related to performance, including the delivery of SMHS. The Department is required to meet specific timeframes and notification requirements related to these processes.

As mandated by the DHCS, Program Oversight and Compliance (2012-2013), the QID facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. As an MHP, LACDMH shall insure that a procedure is in place where by issues identified as a result of grievance, appeal, or expedited appeal processes are transmitted to the MHP's QIC, the MHP's administration, or another appropriate body within the MHP (DHCS, Oversight and Compliance 2012-2013).

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TABLE 6: INPATIENT AND OUTPATIENT GRIEVANCES AND APPEALS FOR LACDMH MEDI-CAL BENEFICIARIES BY CATEGORY, FY 20-21

Category	Process			
	Grievance	Exempt Grievances	Appeal	Expedited Appeal
ACCESS				
Service not Available	0	0		
Service not Accessible	2	0		
Timeliness of Services	1	0		
24/7 Toll-Free ACCESS Line	0	0		
Linguistic Services	0	0		
Other Access Issues	0	0		
ACCESS – Total by Category	**3**	**0**	**N/A**	**N/A**
Percent	**2.0%**	**0%**	**N/A**	**N/A**
QUALITY OF CARE				
Staff Behavior Concerns	**48**	**0**		
Treatment Issues or Concerns	**35**	**0**		
Medication Concern	**6**	**0**		
Cultural Appropriateness	**0**	**0**		
Other Quality of Care Issues	**0**	**0**		
QUALITY OF CARE – Total by Category	**89**	**0**	**N/A**	**N/A**
Percent	**61%**	**0%**		
CHANGE OF PROVIDER – Total by Category	**4**	**0**	**N/A**	**N/A**
Percent	**3.0%**	**0%**		
CONFIDENTIALITY CONCERN – Total by Category	**1**	**0**	**N/A**	**N/A**
Percent	**0%**	**0%**	**N/A**	**N/A**
OTHER				
Financial	0	0		
Lost Property	4	0		
Operational	4	0		
Patients' Rights	7	0		
Peer Behaviors	15	0		
Physical Environment	1	0		
Other Grievance not Listed Above	19	0		
Other – Total by Category	**50**	**0**	**N/A**	**N/A**
Percent	**34%**	**0%**	**N/A**	**N/A**
Grand Totals	**147**	**0**	**N/A**	**N/A**

Note: Data above reflects the grievances and appeals for/by Medi-Cal beneficiaries. Data Source: LACDMH, ABGAR Form FY 20-21, prepared by PRO in October 2021.

Submission of Grievances and/or Appeals received by LACDMH from Medi-Cal beneficiaries reported as "Exempt Grievances" are grievances received over the telephone or in person by the Plan, or a network provider of the Plan, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt.

The reported 147 Grievances received by LACDMH for FY 2020-21 were received via mail, therefore were not reported as "Exempt Grievances" and were resolved within the State's established timeframes. Of those 147 Grievances received none were "Appealed" for this reporting period, therefore table for FY 20-21 is at zero for "Appeals" and "Expedited Appeals" in all categories.

TABLE 7: INPATIENT AND OUTPATIENT GRIEVANCE DISPOSITIONS FOR LACDMH MEDI-CAL BENEFICIARIES, FY 20-21

Category	Grievance Disposition		
	Grievances Pending as of June 30	Resolved	Referred
ACCESS			
Service not Available	0	0	0
Service not Accessible	2	2	0
Timeliness of Services	1	1	0
24/7 Toll-Free Line	0	0	0
Linguistic Services	0	0	0
Other Access Issues	0	0	0
ACCESS – Total by Category	3	3	0
Percent	**2.0%**	**2.0%**	**0%**
QUALITY OF CARE			
Staff Behavior Concerns	48	48	0
Treatment Issues or Concerns	35	35	0
Medication Concern	6	6	0
Cultural Appropriateness	0	0	0
Other Quality of Care Issues	0	0	0
QUALITY OF CARE – Total by Category	**89**	**89**	**0**
Percent	**61%**	**61%**	**0%**
CHANGE OF PROVIDER – Total by Category	**4**	4	**0**
Percent	**3.0%**	**3.0%**	**0%**
CONFIDENTIALITY CONCERN – Total by Category	1	1	**0**
Percent	**0%**	**0%**	**0%**
OTHER			
Financial	0	0	0
Lost Property	4	4	0

Operational	4	4	0
Patients' Rights	7	7	0
Peer Behaviors	15	15	0
Physical Environment	1	01	0
Other Grievance not Listed Above	19	19	0
OTHER – Total by Category	50	50	**0**
Percent	**34%**	**34%**	**0%**
Grand Totals	147	147	**0**

Of the 147 received Grievances all were within the Mental Health Plan (MHP) and within the MHP's jurisdiction. Grievances are "Referred" to the appropriate agency or department outside the MHP when these are outside the jurisdiction. For the reporting period of FY 20-21, all 147 received and reported Grievances were within the MPH and its jurisdiction.

TABLE 8: INPATIENT AND OUTPATIENT APPEAL DISPOSITIONS AND TOTAL NOTICE OF ADVERSE BENEFIT DETERMINATION/NOTICE OF ACTION ISSUED, FY 20-21

Category	APPEAL DISPOSITION			EXPEDITED APPEAL DISPOSITION			NOABD/NOA
	Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Expedited Appeals Pending as of June 30	Decision Upheld	Decision Overturned	Total Number of NOABD/NOAs Issued
Appeals resulting from NOABD NOA							
Denial Notice	0	0	0	0	0	0	0
Payment Denial Notice	0	451	222	0	0	0	2,176
Delivery System Notice	0	0	0	0	0	0	722
Modification Notice	0	0	0	0	0	0	3
Termination Notice	0	0	0	0	0	0	1
Authorization Delay Notice	0	0	0	0	0	0	0
Timely Access Notice	0	0	0	0	0	0	2,715
Financial Liability Notice	0	0	0	0	0	0	8
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	1
Total	0	451	222	0	0	0	5,626

Data Source: LACDMH, ABGAR Form FY 20-21, prepared by PRO in October 2021.

For the reporting period of FY 20-21 there were a total 5,626 Notice of Adverse Benefit Determination/Notice of Action Issued (NOABD/NOAs), of these 673 Appeals were received for “Payment Denial Notice” a resolution was either Upheld (N=451) or Overturned (N=222). No Appeals are Pending as of June 30, 2021.

Furthermore, of the total number of NOABD/NOAs issued N=0 was received as “Expedited Appeal” therefore this category was reported at zero for all NOABD/NOA categories for the reporting period of FY 20-21.

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Criterion 8 APPENDIX

Attachment 1: LACDMH Legal Entity Contract

LACDMH Legal Entity
Contractual Agreemer

Attachment 2: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services

1047808_2018-10OrgManual_1_.pdf [EW16]