

COVER SHEET

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due July 28, 2010 to:**

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

**PLANNING, OUTREACH AND ENGAGEMENT
DIVISION**

CULTURAL COMPETENCY UNIT

**2010
CULTURAL COMPETENCY
PLAN REQUIREMENTS**

Criteria 1 – 8



**COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PLANNING, OUTREACH AND ENGAGEMENT DIVISION**

CULTURAL COMPETENCY UNIT

2010 CULTURAL COMPETENCY PLAN REQUIREMENTS

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2010 CULTURAL COMPETENCE PLAN REQUIREMENTS LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

The Los Angeles County Department of Mental Health (LACDMH) is guided by a vision of hope, wellness and recovery that calls upon us to make Los Angeles' communities better by providing services, partnering with consumers, families, and community groups and strengthening the capacity of communities to support recovery and resiliency. We improve the lives of thousands of people each year because we believe treatment works and recovery is possible.

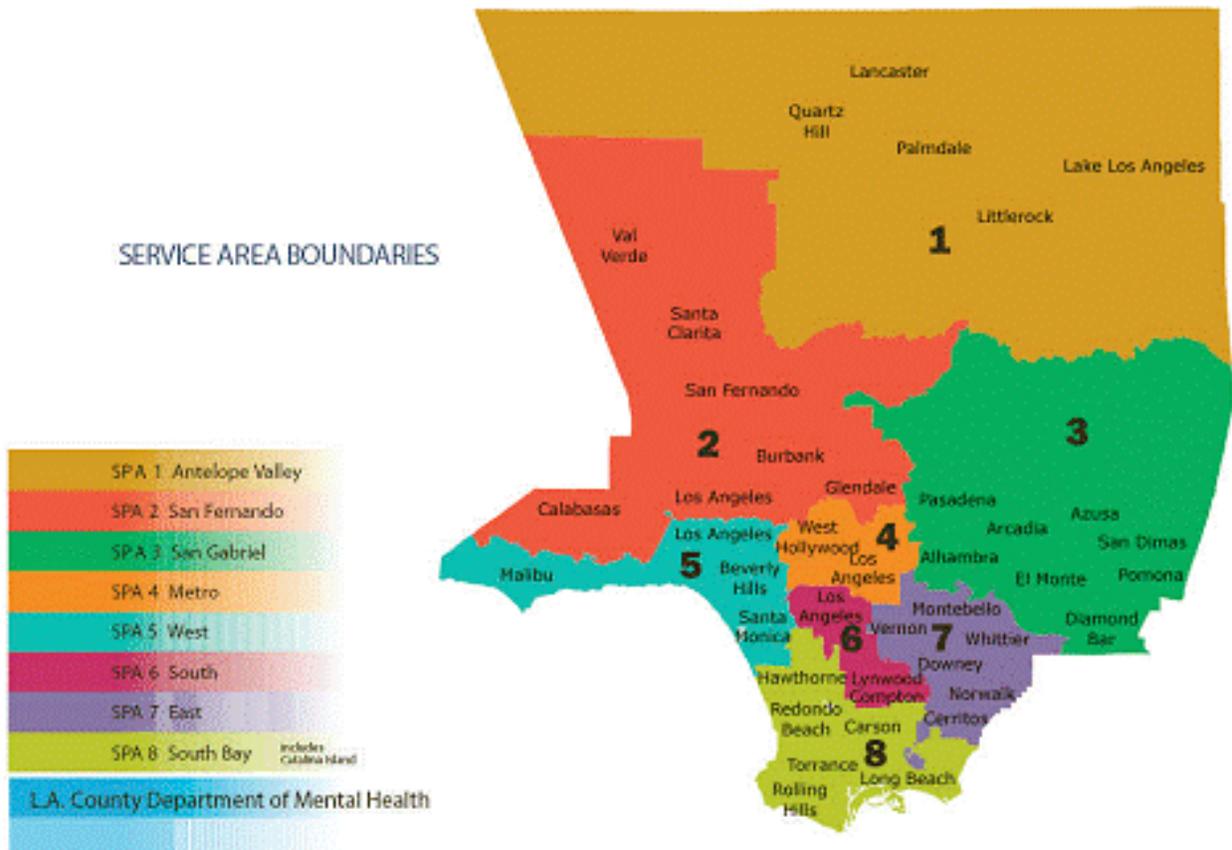
We are committed to cultural competence and better access for underserved and inappropriately served ethnic and cultural populations as a critical component towards achieving our vision of hope, wellness and recovery. We believe it is essential to collaborate with under-represented ethnic community members to examine and enhance the cultural relevance of our programs. We work collaboratively with consumers, family members, parents/caregivers, providers, cultural brokers, advocates, other county departments, community groups and a number of planning bodies and organizations to ensure that each of the five MHPA plans and other LACDMH services and programs are delivered in culturally appropriate ways, honor the differences within diverse communities and address disparities in access to services, particularly disparities affecting ethnic, cultural and under-served communities.

As the largest county mental health department in the United States, LACDMH directly operates more than 75 program sites and more than 100 co-located sites with the Department of Children and Family Services, Department of Health Services, Department of Public Social Services, the Probation Department, Mental Health Court, Los Angeles Police Department, Los Angeles County hospitals and jails. We contract with more than 1,000 providers, including non-governmental agencies and individual practitioners who provide a spectrum of mental health services to people of all ages to support hope, wellness, and recovery.

The mental health services we provide include screenings and assessments, outpatient services, group and individual mental health services, case management, crisis intervention, medication support, peer support and other recovery services, such as Wellness Centers and Client-Run Centers. Services are provided in multiple settings, including clinics, schools, hospitals, county jails, juvenile halls and camps, mental health courts, board-and-care homes, as well as in the field and in homes where consumers reside. Special emphasis is placed on addressing co-occurring mental health disorders and other health problems such as addiction. LACDMH also provides counseling to victims of natural or man-made disasters, their families and emergency first responders; and we are responsible for protecting patients' rights in all public and private hospitals and programs providing mental health care and treatment, and all contracted community-based programs. LACDMH also serves as the public guardian for individuals gravely disabled by mental illness and handles conservatorship investigations for the County.

Los Angeles County is one of the nation's largest and most diverse counties. Covering more than 4,000 square miles, including 88 different cities and more than 130

unincorporated communities, the County is home to more than 10 million residents, a number exceeded by only eight states. Due to its large geographic size, Los Angeles County departments divide services into eight regions called “Service Areas.” The eight Service Area (SA) regions include: SA 1 (Antelope Valley), SA 2 (San Fernando), SA 3 (San Gabriel), SA 4 (Metro), SA 5 (West), SA 6 (South), SA 7 (East), and SA 8 (South Bay/Harbor).



Dozens of languages are spoken by the County’s residents, and LACDMH aims to provide its services in at least thirteen threshold languages. Our own planning processes included those from many ethnic and racial communities including members from African-American, Armenian, American Indian/Alaskan Native, Cambodian, Chinese, Hispanic, Latino, Korean, Persian, Russian, Tongan, and Western European heritages. Los Angeles County is the only county to designate, track and monitor ethnic targets by age groups and by Service Area for Full Services Partnerships in the Community Services and Support Plan (CSS).

At times, the size and cultural diversity of Los Angeles County presents enormous challenges to providing services that are relevant, effective and of high quality to all community members who could benefit. These challenges are particularly acute when fiscal changes in the larger economy continuously threaten the capacity of our system to continue to provide services. Fortunately, in November 2004, California voters

passed Prop 63 Mental Health Services Act (MHSA) to improve and transform the delivery of mental health services and treatment across the State of California. Since that time, LACDMH has used the passage of MHSA to transform how it provides services, in particular to under-represented ethnic populations that are inadequately or inappropriately served.

Key Role of the Mental Health Services Act

LACDMH continues to work collaboratively with consumers, family members, parents/caregivers, providers, cultural brokers, advocates, other county departments, community groups and a number of planning bodies and organizations to ensure each of the five MHSA plans is committed to the following concepts:

1. Promotion of recovery for all who struggle with mental illness
2. Achievement of positive outcomes for all who receive mental health services
3. Delivery of services in culturally-appropriate ways, honoring the differences within diverse communities; and
4. Delivery of services in ways that address disparities in access to services, particularly disparities affecting ethnic, cultural and under-served communities

Planning for Prevention and Early Intervention (PEI) as well as Community Services and Support (CSS), Workforce, Education and Training (WET), Innovation, and Capital Facilities & Technology plans were completed and approved by the State and the MHSA Oversight and Accountability Commission.

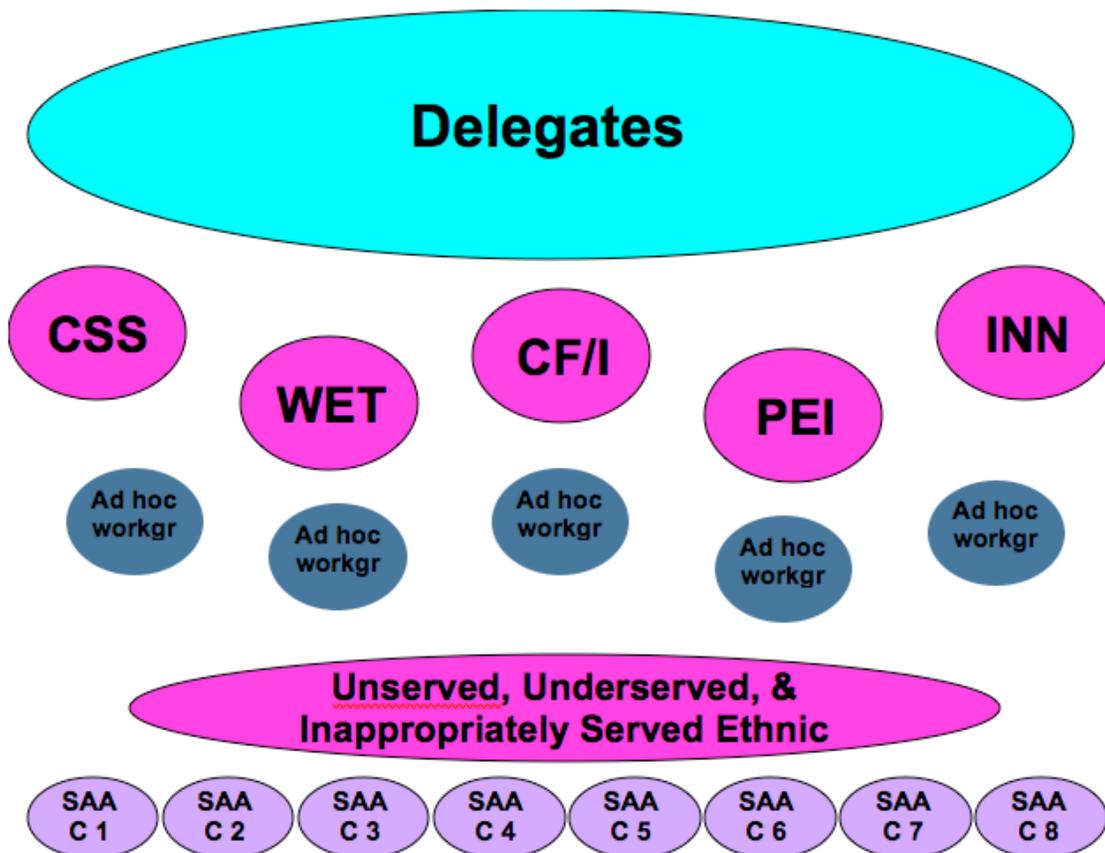
The development of our MHSA Stakeholder Process was a critical juncture in how we began to develop systems of cultural competency in our planning processes and services, thus we feel it is important to provide some background on that planning process. The Delegate Stakeholder Process was an ongoing monthly planning collaborative supported by age-specific and topic-specific workgroups that consisted of LACDMH consumers, parents, family members/caregivers, community leaders and cultural brokers, members of the Mental Health Commission, law enforcement, education, faith leaders and other County departments. The group of stakeholders was essential in creating and developing the five substantive plans that each county is required to submit to the State for approval before it is eligible to receive MHSA funds.

The venue was an open public forum, and community participation was encouraged. At these meetings, a facilitator led participants to a shared understanding of complex issues and related budget details so that appointed delegates representing more than 40 different stakeholder groups could vote and reach consensus on key components of whichever MHSA plan was currently under development. The delegates served as an advisory and planning body that made recommendations for new MHSA plans, and important decisions were made democratically using the adopted “Gradients of Agreement” below:

Gradients of Agreement

Endorse	Endorse with a minor point of contention	Agree with reservations	Abstain	Stand aside	Formally disagree, but will go with majority	Formally disagree with request to be absolved from implementation	Can't go forward
<i>I like it</i>	<i>Basically I like it</i>	<i>I can live with it</i>	<i>I have no opinion</i>	<i>I don't like this, but I don't want to hold up the group</i>	<i>I want my disagreement noted in writing, but I'll support the decision</i>	<i>I don't want to stop anyone else, but I don't want to be involved in implementation</i>	<i>We have to continue the conversation</i>

As stakeholders, they participated in three levels of opportunities to be involved in MHSA-related items: as decision makers, as idea generators and as commentators. The Delegates groups ended in April of 2010 as all five MHSA plans have been approved.



In addition to the Stakeholders, LACDMH developed a System Leadership Team (SLT) as an advisory group. This group was expanded when the Delegates group ended in April 2010 to include 50 members carefully selected to cover more than 65 stakeholder perspectives, including diverse organizational affiliations such as the Mental Health Commission, LACDMH directly-operated and contract providers, DHS/Healthcare and hospitals, Los Angeles County Probation/DPSS/DCFS, advocacy groups/NAMI and Consumer Coalition and other consumer groups, LA Gay/Lesbian Center, veterans, UREP, SEIU, community and faith-based organizations, and educational institutions. The SLT also includes perspectives from different walks of life such as consumers, family members, caregivers, community members; representatives for the different age groups: children, TAY, adult and older adult; ethnic representation by representatives from the UREP Leadership Team that represents the voices of African-American, American Indian/Alaskan Native, Asian/Pacific Islander, Eastern European/Middle Eastern, Latino and others. SLT members represent multiple system and diversity perspectives. The SLT helped to monitor the implementation of the County of Los Angeles' MHSA Plans and to provide ongoing advice on structural changes undertaken to assist with the transformation of the public mental health system. (Criterion 1, Attachment 7, New Systems Leadership Team Roster Profile)

How this Cultural Competency Plan was Developed

In order to complete this plan, the Cultural Competence Unit and the Cultural Competence/Ethnic Services Manager compiled information and data from many parts of our mental health system through meetings, interviews and surveys. We received input from the Cultural Competence Committee, Executive Management Team (EMT), and MHSA Implementation Team for the content of this Plan. Of particular note, we conducted extensive interviews with each of the District Chiefs, which head the activities of each of our eight Service Areas. Those interviews captured the multitude of activities, impacts and lessons learned at the local community level. In addition, we conducted a survey of our legal entity contract providers to capture their cultural competency activities and commitment. The Legal Entity Survey is provided in full as an attachment.

Our commitment to cultural competency extends system-wide. As such, cultural competency is not a distinct initiative or project that is vulnerable to isolation. Instead, we have made great efforts to integrate our commitment to cultural competency as essential to the manner in which we provide services and do our daily work. Therefore, this report attempts to outline as best possible the multiple and overlapping ways we continue to integrate cultural competency into our mental health system. At times, the program and service strategies and their impacts are easy to identify and parse out; at other times, culturally competent practices are deeply integrated into the work, so we describe the work as a whole and how it contributes to cultural competency.

CRITERION 1
COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

In an effort to enhance the quality and capacity of mental health services and supports, LACDMH has created and continues to develop policies, procedures and practices that incorporate the recognition and value of racial, ethnic and cultural diversity within the County Mental Health System. Most significant among them is the inclusion of cultural competency into our mission and strategic plans, from which all of our policies follow to be in alignment with the County's overall vision.

The mission of the LACDMH states: "Enriching lives through partnership designed to strengthen the community's capacity to support recovery and resiliency is our Mission. DMH works with its stakeholders and community partners to provide clinically competent, culturally sensitive and linguistically appropriate mental health services to our clients in the least restrictive manner possible. We tailor our services and support to help clients and families achieve their personal goals, increase their ability to achieve independence and develop skills to support their leading the most constructive and satisfying life possible." LACDMH's vision, mission and values are included as Criterion 1, Attachment 1.

The LACDMH Strategic Plan, which is available at the site review, has three out of six goals dedicated specifically to increasing cultural competency and reducing disparities. They are as follows:

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

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

Goal III: Enhance the community's social and emotional well-being through collaborative partnerships.

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

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

- Strategy 1: Train mental health staff in evidence-based, promising, emerging and community-defined mental health practices.
- Strategy 2: Recruit, train, hire and support mental health clients and family members at all levels of the mental health workforce.
- Strategy 3: Create and provide a safe and nurturing work environment for all employees that supports and embodies client-centered, family-focused, community-based, culturally and linguistically competent mental health services.
- Strategy 4: Identify and support best practices for recruitment and retention of diverse and well-qualified individuals to the mental health workforce.

Located in the next section, Criterion 1, Table 1 is a list of policies and procedures that reflect our efforts to fully incorporate the recognition and value of racial, ethnic and cultural diversity within the County Mental Health System. In addition to the policies listed in Table 1, LACDMH has gathered inspirational vignettes and created a report entitled, "Transformations: How the Mental Health Services Act is Changing Lives in Los Angeles" to show how the MHSA has touched the lives of real people and families throughout Los Angeles County since California voters passed Proposition 63 in 2004. The stories illustrate how MHSA is helping to provide support for children, adults and families with mental illness. The goal of the Transformations report is to highlight the transformative ways in which LACDMH is providing services. Thanks to MHSA, LACDMH is doing something more fundamental and effective than simply treating mental illness. We are helping people improve their quality of life, develop resilience,

attain a higher level of education or land a better job. The hope is to help people and their families rebound from crisis and be able to live productive, fulfilling and meaningful lives. The report will be available during the site review.

LACDMH believes it is essential to collaborate with members of under-represented ethnic communities to examine and enhance the cultural relevance of its programs. Collaboration helps to address and minimize the undesired consequences of programs that are an inadequate match to the needs of the communities they serve. One such study that was completed entitled, “Voices of Under-Represented Ethnic Population Communities in Los Angeles County on Wellness, Resilience and Recovery,” was a joint effort between LACDMH and the Center for Multicultural Development (CMD) of the California Institute for Mental Health (CiMH). LACDMH set out to examine the cultural relevance of three core MHS program concepts: wellness, resilience and recovery. LACDMH consulted with 100 cultural brokers from ethnic communities to review and, as necessary, rewrite the definitions of these concepts for their communities. This report outlines the process followed in this effort and presents findings, lessons learned and recommendations so they are available to support planning and delivery of culturally relevant services and reduces disparities. The report will be available during the site review.

LACDMH has hosted several multicultural events, such as the Bebe Moore Campbell UREP Celebration for Minority Mental Health Awareness Month, entitled “Honoring Cultural Pathways to Wellness” and the Black Los Angeles County Client Coalition, Inc. 2nd Annual Community Mental Health Recovery & Wellness Cultural Forum entitled “Education is Key” Rehabilitation through Education. We have sponsored numerous conferences for UREP groups. In addition, there are annual Hope and Recovery Conferences for English, Spanish and Asian Pacific Islanders consumers.

In addition to LACDMH’s own policies and procedures, according to a 2010 survey LACDMH conducted of its legal entities, three-fourths of all legal entities have statements and documents that reflect that all services should be culturally competent; have promotional and educational materials that are culturally sensitive and accessible to all consumer target groups; gather information about the demographics of the targeted consumer group; and/or plan, develop and implement culturally appropriate service delivery models. The results of this survey are included as Criterion 1, Attachment 2.

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system will be available on site during the compliance review.

See Criterion 1, Table 1 for the list of policies, procedures, and practices that will be available during site the review.

Criterion 1, Table 1
List of Policies, Procedures & Practices Related to
Cultural and Linguistic Competence

Policies/Procedures and Other Documents	
Mission Statement and Statements of Philosophy	<ul style="list-style-type: none"> • LACDMH Mission Statement • Los Angeles County Annual Report • LACDMH Code of Organizational Conduct, Ethics, & Compliance
Strategic Plans	<ul style="list-style-type: none"> • LACDMH Strategic Plan
Policy and Procedure Manuals	<ul style="list-style-type: none"> • Policy No. 104.8 – Clinical Records Guidelines • Policy No. 111.1 – Accessibility • Policy No. 111.8 – Health, Safety, and Rights • Policy No. 202.1 – Crisis & Emergency Evaluation by Outpatient MH Facilities • Policy No. 202.17 – Hearing Impaired MH Access • Policy No. 202.21 – Language Interpreters • Policy No. 301.1 – Service Area Advisory Committees • Policy No. 602.1 – Bilingual Bonus • Policy No. 609.5 – Employee Trainings Minimum Standards
Human Resource Training and Recruitment Policies	<ul style="list-style-type: none"> • Los Angeles County Human Resources Policies <ul style="list-style-type: none"> • Employee Health and Safety • Workplace Violence • Drug- Free Workplace • Equal Employment Opportunity (EEO) Non-Discrimination • Sexual Harassment • American with Disabilities Act (ADA) Compliance Program • Diversity Policy/Cultural Awareness • Filing Complaints on Policy Issues • LACDMH memo dated 6/15/10, Non-Discrimination on the Basis of Disability • LACDMH Policy 602.1 Bilingual Bonus
Contract Requirements	<ul style="list-style-type: none"> • Legal Entity contract forms: Legal Entity agreement; • Negotiation package for legal entities
Other Key Documents	<ul style="list-style-type: none"> • LACDMH Cultural Competency Organizational Assessment Follow-Up 2008 • LACDMH Report “Voices of Under-Represented Ethnic Population Communities in Los Angeles County on Wellness, Resilience and Recovery” • LACDMH Report “Transformations: How the Mental Health Services Act is Changing Lives in Los Angeles” • 2010 Cultural Competency Legal Entity Web-based Survey

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system. The county shall include the following in the CCPR:

A. A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities. (2 pages)

The following describes the practices and activities that LACDMH uses to engage in community outreach and involvement efforts that inform many facets of our work:

MHSA

As described in the preamble, LACDMH used the entire MHSA process to actively engage multiple constituencies and stakeholders in the planning process. Please see the response to Criterion 1, Section II, B for a more detailed description of how that process played out in each of the MHSA plans.

Under Represented Ethnic Populations (UREP)

During the planning phases of MHSA, the UREP Work Group consisted of 56 culturally diverse mental health professionals and community and client advocates who made recommendations to the LACDMH. This workgroup met extensively to develop guiding principles and recommendations for LACDMH and MHSA services. These recommendations were instrumental in establishing the Department's MHSA values and strategies in working with under-represented ethnic groups and are included as Criterion 1, Attachment 3: UREP Guiding Principles.

In June 2007, LACDMH established an internal UREP workgroup unit within the Planning Division to address the ongoing needs of targeted ethnic and cultural groups. The UREP unit has established sub-committees dedicated to working with the various under-represented ethnic populations in order to address their individual needs. These groups are: African/African-American; American Indian/Alaskan Native; Asian Pacific Islander; Eastern European/Middle Eastern and Latino. The UREP Subcommittees identified cultural sub-populations and maintains an organizational structure to address issues pertinent to mental health services for underserved ethnic populations. Each UREP Subcommittee is comprised of DMH, legal entity contract providers, consumers, family members and cultural brokers; and provides an avenue for the MHSA Planning Team to pose questions, get cultural information, and disseminate information to agencies serving specific populations. Each subcommittee has a staff liaison from the Planning Division, and is co-chaired by a community leader and a high-level LACDMH staff person. Each UREP Subcommittee had voting representation at the Delegate meetings. Now that the Delegates have concluded, the UREP Leadership Group has a representative on the expanded System Leadership Team. In Criterion 1, Section II, B, the more recent activities of the UREP

workgroup are detailed. UREP continues to serve as a critical institution within LACDMH that promotes active inclusion and meaningful engagement of these under-represented ethnic groups.

Outreach & Engagement

LACDMH considers Outreach & Engagement (O&E) to be critical activities that help us achieve our vision of hope, wellness and recovery in a culturally competent manner. Our aim is for the O&E work to create an infrastructure that supports the commitment to form partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations and other County departments to achieve the promise of MHSA.

Each of the county's eight Service Areas conducts specialized outreach and engagement to reach under-represented ethnic populations (UREP). Designated O&E staff receive direction from Service Area District Chiefs to target prominent and underserved ethnic communities. O&E activities primarily consist of educating communities about mental health and MHSA, organizing Service Area Advisory Committees (SAACs), and integrating consumer involvement into the mental health planning process. Examples of UREP outreach include: participation and outreach at community-based fairs; "Ask a Psychiatrist" night with ethnic communities; and outreach to ethnic faith communities.

The Department carries out tracking of O&E activities in each Service Area such as presentations on diverse mental health topics and informational booths in health fairs and the information is compiled into an annual report (Criterion 1, Attachment 4) that shows the type of O&E activity, the community/cultural groups outreached to, number of persons reached, and the language utilized by the O&E Team to outreach to them. The annual report also includes Medi-Cal and Quality Improvement data to guide planning of O&E activities in each Service Area

B. A narrative description of the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services. (2 pages)

LACDMH's relationship with and engagement of its diverse constituencies has evolved and deepened over time. MHSA's emphasis on inclusion of underserved and inappropriately served groups and of clients, parents and family members helped to create formal structures within our work to ensure that these perspectives were consistently solicited, expected and incorporated into our normal course of business. Below we detail what the main formal structures look like:

MHSA Stakeholder Process

As detailed in the preamble, the Stakeholder Process was an ongoing monthly planning collaborative that consisted of the Mental Health Commission, Children's Commission, First 5, consumers, parents, family members/caregivers,

community leaders and cultural brokers, law enforcement, education, faith leaders, and other Los Angeles County departments. The group of stakeholders was essential in creating and developing the five substantive plans that each county is required to submit to the State for approval before it is eligible to receive MHSA funds. Within each of the MHSA plans, we also had specific mechanisms for soliciting and incorporating input from diverse stakeholders. More detailed descriptions follow:

- *Community Services and Support (CSS)* – LACDMH has involved its Under Represented Ethnic Populations subcommittees in providing recommendations to reduce ethnic disparities in FSP programs. In addition, each age group conducts technical assistance and support with providers where linguistic capacity and needs are reviewed with the provider.
- *Workforce Education and Training (WET)* – The Workforce Education and Training Advisory Committee is comprised of members representing various expertise, consumers, family members, UREP constituents, professional and para-professionals. It continues to recommend ethnic and linguistic priorities for WET program implementation. To ensure a greater representation of ethnicity served by the public mental health system, WET has continuously established multiple ad-hoc focus groups to gather information necessary to address the needs of the public mental health system as a whole, with an emphasis on ethnicities served.
- *Prevention and Early Intervention (PEI)* – The MHSA PEI Plan addresses the diversity of nearly 10 million individuals, taking into consideration age, race/ethnicity, language, culture, sexual orientation, immigration history, mental health, economic status, geography, and other key factors. Diversity issues and issues pertaining to the allocation of funds across planning areas and cultural populations have been discussed in the meetings. Additional formal community input into and review of the PEI Plan has been accomplished through the PEI Ad Hoc Advisory Groups and Service Area Ad Hoc Steering Committees and PEI Plan public hearings where UREPs are represented. The UREP Subcommittees have identified cultural sub-populations and maintain an organizational structure to address issues pertinent to mental health services for underserved ethnic populations. Each UREP Subcommittee is comprised of LACDMH, contract providers, consumers, family members, and cultural brokers; and provides an avenue for PEI to pose questions, get cultural information, and disseminate information to agencies serving specific populations. In addition the UREP Subcommittees provided input on how to improve the qualifying process for community practices to qualify as a CDE (Community-Defined Evidence).
- *Innovation (INN)* – The process and structures used to develop the Innovation Plan are described in detail under UREP in the next section, as we used its pre-existing Leadership Team to represent the needs and interests of that focal population.
- *IT/Capital Facilities* – IT and Capital Facilities Plan was reviewed and approved by several stakeholder groups that play oversight roles in the

planning, development, and implementation of MHSA-related activities. The members of these committees represent the interests of mental health services stakeholders in Los Angeles County. These stakeholder groups are: the MHSA System Leadership Team (SLT); the MHSA Stakeholder Delegates Committee; and the Capital Facilities Advisory Group. Of particular note, consumers, parents and family members were particularly active in generating ideas and identifying opportunities for the use of technology in support of consumers and their families. Their input significantly shaped project plans and strongly influenced considerations regarding consumer-focused security and privacy, access to computer resources and information, computers skills-building and technical assistance needs.

Under Represented Ethnic Populations (UREP)

The five UREP Subcommittees include the African/African-American; American Indian/Alaskan Native; Asian Pacific Islander; Eastern European/Middle Eastern and Latino. The UREP Subcommittees have developed a structure that includes voting, minimum expectations for membership, meeting frequency and term of office for co-chairs. Please refer to Criterion 1, Attachment 5 for the UREP Committee Leadership, Coordination and Accountability Structure. Each UREP group had a delegate and alternate (Criterion 1, Attachment 6) at the Delegate stakeholder group and UREP representation at the System Leadership Team (SLT), (Criterion 1, Attachment 7), where service and funding recommendations are provided that are culturally competent for each of their respective communities. They also play an integral role in the planning and implementation of MHSA plans such as PEI, WET, and Innovation. Each of the group is co-chaired by a LACDMH high level staff (program head and above) and a community-based representative, which have been elected by each of the respective committees. UREP groups are comprised of community leaders, cultural brokers, providers, consumers, parent and family/caregiver advocates, and LACDMH employees. The SLT has expanded with the end of the Delegate Planning Process to include a seat for the UREP Leadership Group.

The UREP Leadership Group (comprised of delegates, alternates and co-chairs from all five UREP groups) meets on a bi-monthly basis in order to ensure inclusion of UREP voices in LACDMH's planning process and to create the opportunity for leaders of UREP communities to organize themselves around issues essential to building capacity for these ethnic communities. Each group is currently implementing their respective capacity building projects, described in Criterion 3, Section III, B, 1. The UREP Leadership Group, in its advisory role as one of the Innovation Plan workgroups, was instrumental in developing the Integrated Service Management Model (ISM) model which incorporated natural support systems and non-traditional services in learning how to integrate health, mental health, and substance abuse services in a culturally relevant manner (described in detail in Criterion 3, Section III, B, 1).

C. A narrative, not to exceed two pages, discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services. (2 pages)

Under Represented Ethnic Populations (UREP)

To address capacity building needs and priorities, each of the five sub-committees has been allotted one-time funding totaling \$1,060,000 to focus on CSS-based capacity-building projects to increase capacity in a manner that serves their under-represented ethnic groups. 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 and aim to be implemented within this fiscal year. Please refer to the full description of these projects listed in Criterion 3, Section III, B, 1.

MHSA Plans

- *Workforce Education and Training (WET)* – Several WET programs support the County’s mandate to strengthen our relationships with community organizations/partners. More specifically, in Attachment 11: WET Action Plan # 7 “Training for Community Partners”, WET will promote establishing effective collaboration and mutual-learning partnerships. Currently such endeavors include the faith-based organizations and community colleges programs. The faith-based community partnership begins with countywide cross-training of clergy and mental health clinical staff and develops into Service Area-specific and community-relevant (accounting for linguistic, cultural and religious needs) roundtable pilot trainings. This collaboration addresses the potential of bridging pastoral counseling in the recovery process.

The community colleges partnership showcases both MHSA programs and the power of social inclusion for individuals recovering from mental illness, specifically community college students. Such forums are planned throughout Los Angeles County in community colleges that are embedded in underserved/unserved communities. Planning and implementation of this Program includes ethnic client coalition organizations and mental health agencies, both contracted and directly operated. Lastly, a Community Partnership collaboration with the Department of Health Services is also anticipated and will augment the work already planned by the other MHSA Programs such as Innovation.

For example, on October 27, 2010, LACDMH partnered with the Los Angeles Harbor College (LAHC) Special Programs and Services Department to offer a full-day educational experience for students, mental health clients, family members, DMH staff and LAHC faculty. Entitled “Education and Employment: Cornerstones of Mental Health,” the event explored ways in which to optimize mental health and life success through community college. More than 180 people attended, including 124 client and family participants, 31 college faculty and students, and 16

monolingual Spanish or Cambodian speakers (who took advantage of available interpretation services).

- *Prevention and Early Intervention (PEI)* – Because PEI programs are largely evidence-based practices, considerable effort has been placed on identifying agencies that need training and technical assistance in sustaining these programs. In the initial roll out of PEI programs, Los Angeles County is working with more than 100 contracted agencies, including those that serve specific UREP and cultural populations, to provide services for six initial practices:
 - Triple P – Positive Parenting Program
 - CBITS – Cognitive Behavioral Intervention for Trauma in Schools
 - DTQI – Depression Treatment and Quality Improvement
 - Seeking Safety – an intervention for trauma and substance abuse
 - CPP – Child-parent Psychotherapy
 - TF-CBT – Trauma-focused Cognitive Behavioral Treatment

The full list of Evidence-Based Practices is listed in Criterion 3, Section III, A. For each practice, PEI has developed a training protocol and support package to insure that agencies and rendering providers conduct the practice in a model-adherent manner.

Incubation Academy

At the request of the LAC Board of Supervisors, the Department of Mental Health has developed an Incubation Training Academy to assist community-based organizations to become eligible to contract with the Department, especially those from UREP communities. Funded by both CSS and PEI, the goal of the Incubation Academy is to build capacity within the mental health system. A broad base of service providers helps the LACDMH to meet the needs of Los Angeles County's diverse communities. Features of the Incubation Academy include:

- Sessions taught by subject matter experts
- Overview of Los Angeles County and its Department of Mental Health
- Explanation of the Mental Health Services Act contracting process
- Tips on successfully implementing and sustaining mental health programs.

The Incubation Academy is intended for community organizations that have never contracted with the LACDMH and have an interest in providing mental health services to a wide range of populations in a wide range of settings. Topics are geared toward executive-level staff such as Executive Directors, CEOs, CFOs, and Program Directors, but the trainings are open to everyone. The five UREP Subcommittees collaborate with outreach to their community-based organizations for purposes of encouraging attendance to Incubation Academy sessions from UREP community-based organizations.

Community organizations that attend Incubation Academy go through a step-by-step process of development, planning and implementation of contracts with LACDMH which in general terms includes an overview of LACDMH and MHSAs Plans, MHSAs proposal process and completion of a negotiation package. We have now held two sessions, and approximately 157 agencies have attended the Incubation Academy sessions for 2010. The majority of attending organizations are from ethnic and other cultural communities. (Please see Criterion 1, Attachment 8, Agenda and Incubation Academy Attendance Lists for 2010).

Coalición Latina de Salud Mental (Latino Client Coalition)

As an example of the ways LACDMH supports community capacity building within specific populations, the Planning Division sponsored a total of 16 Latino consumers from the Coalición Latina de Salud Mental and from Latino self-help groups to participate in the California State University, Long Beach (CSULB) Community Scholars Program, a leadership development and organizational capacity building program offered by the CSULB's Center for Community Engagement. The program targets Spanish-speaking immigrants involved in advisory boards, community councils, and/or grassroots voluntary associations. The program is a fellowship consisting of three 30-hour courses to be provided over a 12-month period, so that participants enter as a cohort, learn from each other, develop their networks, and create a stronger community amongst themselves. CSULB's College for Continuing Professional Education provides a formal Certificate to participants who complete each of the 30-hour courses. This is the first such curriculum developed and offered in Spanish in the nation. A more detailed description of the course can be found in Criterion 1, Attachment 9.

D. Share lessons learned on efforts made on the items A, B, and C above.

- Working with underserved and unserved ethnic/cultural communities is like peeling an onion – there are layers and layers of challenges, needs and demands for services. It takes courage, tenacity, commitment and hard work to stay focused to explore and seek resources to respond.
- Planning and Stakeholder involvement is a daunting task in a county as large and diverse as Los Angeles. While there are eight SAACs (Service Area Advisory Committees) in each of the eight Service Areas, representation communication and coordination can be very challenging.
- Working with unserved and underserved ethnic and cultural communities requires a high level of dedication and skills, focus, resources and the right mix of resources at the right time.
- Through the work with the five UREP Subcommittees and the UREP Leadership Committee, subpopulation needs are being identified. While this demonstrates the positive outcome of outreach and engagement, the need for response has stretched the system and overwhelmed existing resources.
- Having adequate resources to focus on initiatives and respond to emerging community needs is a challenge as the demands far outstrip the availability of resources.

- Perhaps, with the advent of the PEI Statewide Initiatives: Anti-Stigma, Suicide Prevention and School Mental Health Initiative, it will be an opportunity to collaborate with community members, civic leaders, neighbors and friends to promote early identification, appropriate care and community wide acceptance and support for mental wellness. The magnitude and depth of needs among all populations especially ethnic populations requires investment of resources, community involvement, partnership and support.
- In both WET and PEI, we learned that LACDMH needed to obligate legal entities to create databases for accurate data reporting to the State. Notably, we needed to require the elimination of all “Other” responses to any of the data fields, as this response is too general and does not adequately provide relevant information. For example, the thirteen threshold languages capture the large majority of the population, but the “other” primary languages account for 4.2% of the population or roughly 420,000 individuals. Without the ability to disaggregate that data, we cannot see which other languages need to be addressed. We also learned that we need to improve participant screening tools to ensure a higher percentage of enrolled participants attend offered trainings. Lastly, we learned that we need to integrate tracking tools (such as Learning Management Training Tracking System) to provide demographic and other relevant information essential to the reporting of outcomes.

E. Identify county technical assistance needs.

- We need guidance on which disparities should be prioritized when there are limited resources. What parameters should be used to make this determination?
- What is the standard of adequate and effective Stakeholders involvement and representation? When have we satisfactorily met the standard?
- How can we establish the true costs of providing services for ethnic/cultural groups especially those who are LEP or monolingual so that such services are adequately reimbursed and sustained?
- We need technical assistance on how to designate racial and ethnic categories in a way that honors the distinct needs and assets of specific communities. For example, stakeholders from our Eastern European/Middle Eastern racial and ethnic groups are advocating to not be lumped with Caucasian as an ethnic category. LACDMH would like technical assistance to develop an advocacy plan so these ethnic/racial communities can have their own designation.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

The county shall include the following in the CCPR:

- A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county’s racial, ethnic, cultural, and linguistic populations**

The county Cultural Competence/Ethnic Services Manager (CC/ESM) reports to the Deputy Director, Program Support Bureau and has direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial and ethnic populations within the county. The CC/ESM promotes and coordinates quality and equitable care as it relates to racial and ethnic populations with both county-operated and contracted mental health programs. The staff position reviews service utilization data and actively participates in local mental health planning and projects that respond to the needs of the county's racial and ethnic population. This includes reviewing and commenting on numerous major State's proposed policies and legislative proposals, which would impact human resources development, ethnic specific services, and other related areas.

The Executive Management Team (EMT) recognizes the role and function of the CC/ESM within the organization by allocating sufficient time for the performance of job responsibilities and duties. Additionally, the EMT promotes the CC/ESM's influence in policy and program change by considering and following the CC/ESM's recommendations for changes in human resources, ethnic and culturally specific services and all other related areas.

Please see Criterion 1, Attachment 10 for EMT Member Roster; Criterion 1, Table 2 below which outlines the roles and responsibilities of the CC/ESM; and Criterion 4, Table 1, Cultural Competency Committee Organizational Chart which identifies Gladys Lee as the CC/ESM for LACDMH.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

Gladys Lee, LCSW, serves as District Chief of the Planning Division which houses the Cultural Competency Unit, the Outreach & Engagement (O&E) Unit and the Under Represented Ethnic Populations (UREP) Unit., in addition to her responsibilities for MHSA Stakeholders Planning and deliberation. This position enables the District Chief to oversee and be responsible for cultural competence and to promote the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations. The CC/ESM is connected to the Director and the EMT through her direct supervisor who is Deputy of the Program Support Bureau. The CC/ESM also meets regularly with the Director of LACDMH to review, promote and seek solutions to issues that impact UREP groups, consumers and community.

The ESM is also involved in a variety of state activities. One example is the State DMH-funded project to design Full Service Partnership (FSP) Implementation Tool Kits (ITK) with the goal of ensuring cultural relevance of FSP programs. The FSP ITK contains three domains:

1. Principles with Universal relevance
2. Culturally-relevant Approaches to Utilization & Access of Services
3. Specific Population Best Practices & Cultural Considerations

Criterion 1, Table 2 below outlines the roles and responsibilities of the CC/ESM.

Criterion 1, Table 2 Cultural Competence/Ethnic Services Manager Roles & Responsibilities	
1	Development and implementation of cultural competency planning
2	Identifies local and regional cultural mental health needs of ethnically and culturally diverse populations
3	Participates and advises on planning, policy, compliance and evaluation
4	Promotes the development of appropriate mental health services
5	Participates in the development of planning documents, contracts, proposals, and grant applications
6	Participates as an official member of the local mental health management/leadership team
7	Tracks penetration and retention rates
8	Cultivation of network organizations
9	Active advocacy, consultation and support of relationship with consumer and family organizations
10	Attends trainings for the promotion of cultural competence in the mental health system
11	Attends regional ESM & State meetings

IV. Identify budget resources targeted for culturally competent activities. The county shall include the following in the CCPR.

A. Evidence of a budget dedicated to cultural competence activities

The amount of funding provided for culturally competent related services and activities is immeasurable. Culturally competent service funding is embedded in all programs including but not limited to, personnel, salaries and benefits, training, etc. This budget is by no means inclusive of all the funds that is dedicated to culturally competent related services and activities but will provide a general idea of funding designated for culturally competent activities that are not embedded into program/agency budgets. Criterion 1, Table 3 outlines the various budget categories for cultural and linguistic competence activities.

**Criterion 1, Table 3
Cultural Competency Budget**

Budget Service	Interpretation/ Translation	Reduction of Disparities	Outreach	CC MHS	\$ Incentives	Budget
CSS						
POE Translation Services						250,000
WET						
Training and Technical Assistance						
Interpreter Training Program						100,000
Training for Community Partners						225,000
Career Pathways						
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System (Peer Training)						841,607
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System						1,523,520
Expanded Employment and Professional Advancement Opportunities for Family Members Advocates in the Public Mental Health System						567,047
Financial Incentive						
Tuition Reimbursement Program						1,058,445
Associate and Bachelor Degree – 20/20 and/or 10/30 Program						1,481,824
Stipend Program for Psychologist, Master level Social Workers, Marriage & Family Therapists, Psychiatric Nurse Practitioners and Psychiatric Technicians						2,518,000
Loan Forgiveness Programs						1,228,700
PEI						
School-based Services						8,606,785
Family Education and Support Services						11,324,296
At-risk Family Services						10,780,932
Trauma Recovery Services						26,790,611
Primary Care & Behavioral Health						5,475,984
Early Care & Support for TAY						9,017,928
Juvenile Justice Services						10,663,120
Early Care & Support for Older Adults						9,026,660
PLANNING						
Outreach & Engagement						
Other Personal Supplies (\$5,000/Service Area)						40,000
Food (\$3,000/Service Area)						24,000
Promotional Items (\$2,000/Service Area)						16,000

MHA						
Interpreter Trainings						5,772
Translation (SR)						150,000
UREP						
Latino UREP						660,000
African/African American UREP						100,000
American Indian UREP						100,000
Eastern European/Middle Eastern UREP						100,000
Asian/Pacific Islander UREP						100,000
Trainings						
Training Division						137,790
Planning Division						54,000
LBHI						15,000
Pacific Clinics						10,000
Staff Positions, Salaries and Benefits						
Mental Health Clinical District Chief						173,701
Senior Secretary III						70,806
Senior Community Mental Health Psychologist						126,061
Senior Community Mental Health Psychologist						126,061
Training Coordinator, Mental Health						104,525
Training Coordinator, Mental Health						104,525
Training Coordinator, Mental Health						104,525
Mental Health Service Coordinator I						88,393
Intermediate Typist-Clerk						46,036
HUMAN RESOURCES						
Bilingual Bonus						1,494,000
ACCESS CENTER						
Translation Services						15,795
Interpreters (including Lifesigns)						75,000
GRAND TOTAL						\$108,172,576.00

Legal Entity Contract Providers

Because LACDMH contracts with more than 124 legal entities to provide services, we conducted a survey of our legal entities to assess their budget allocations related to the delivery of culturally and linguistically competent services by answering the following question: *“Does your Legal Entity have a dedicated budget for the following services?”*

Table 5: Budget Items for Cultural Competence Services and Activities

Does your legal entity have a dedicated budget for the following?	Yes	No
Training staff to provide culturally and linguistically competent services	59.6%	40.4%
Incentives for bilingual staff	53.9%	46.1%
Programs/services designated for particular ethnic client groups	35.2%	64.8%
Programs/services designated for particular language client groups	53.4%	46.6%
Programs/services for particular cultural groups (such as physically disabled, veterans, hearing or visual impairment)	31.4%	68.6%

More than half of all legal entities indicated that they had a dedicated budget for training staff to provide cultural and linguistic competent services, provide incentives for bilingual staff and provide programs/services that are designated for particular language client groups. One third of all legal entities indicated that they had a dedicated budget for program/services designated for particular ethnic client groups, and/or programs/services for particular cultural groups (e.g., physically disabled, veterans, hearing/visually impaired, LGBTQ). A full report of the Legal Entities Survey is provided as an attachment in Criterion 1, Attachment 2.

B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

- 1. Interpreter and translation services**
- 2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities**
- 3. Outreach to racial and ethnic county-identified target populations**
- 4. Culturally appropriate mental health services**
- 5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers**

Table 3 entitled “Cultural Competency Budget” provides an overview of the major LACDMH programs that contain funding dedicated for cultural competence activities. The following is a general discussion of some of the most salient budget elements:

1) Interpreter and Translation Services

Seeking the participation of monolingual and limited English proficiency consumers, family members and caretakers in diverse MHSA processes, the Planning, Outreach and Engagement Division allocated \$150,000 for Interpreter/translation service in FY 2009-2010. The majority (43%) of the interpretation/ translation services were dedicated to MHSA related meetings such as Stakeholders', Delegates, Mental Health Commission, MHSA Innovation Plan, public hearings and System Leadership Team. Beyond these regularly scheduled meetings, LACDMH spent nearly 50% on events and meetings from diverse programs for which interpreter or translation services were requested. The chart below summarizes payments made by type of event or meetings.

Table 5: Interpreter/Translation Expenses by Type of Event, FY 2009-2010

Type of Event / Project	Actual Expense
FSP Brochures	\$ 1,810
Innovations Plan Meetings	\$ 4,600
MHSA Stakeholders Meetings	\$ 12,903
Mental Health Commission Meetings	\$ 5,600
Older Adult Systems of Care Meetings	\$ 2,520
Public Hearings	\$ 4805
System Leadership Team (SLT) Meetings	\$ 4,240
Other (Meetings/events that were not ongoing)	\$ 27,839
TOTAL	\$ 64,317

In terms of threshold language, 75% of the total allocation was spent on providing interpretation/translation to Spanish speaking consumers and 21% for Korean interpretations/translations during Stakeholders Meetings. Another 3% of the funding was used to translate the FSP Brochure into Cambodian (Khmer). Some funding was also allocated for Tagalog interpretation/translation. See chart below for complete summary of payment made by Threshold Languages.

Table 6: Interpreter/Translation Expenses by Language Requested

Threshold Language	Actual Expense
Cambodian	\$ 1,810.00
Korean	\$ 13,330.67
Spanish	\$ 48,085.22
Tagalog	\$1,091.67
TOTAL	\$ 64,317.56

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities

Table 3, “Cultural Competency Budget” displays the funding allocated by diverse LACDMH Programs. The Table section labeled WET specifies the nine (9) Workforce, Education and Training strategies categorized under the themes of training and technical assistance, career pathways, and financial incentives. Nine and a half million dollars (\$9,544,143) have been dedicated to the expansion of cultural competency and linguistic capability in our current workforce. The PEI Division has identified 13 projects and 51 evidence-based practices (EBP’s) and allocated \$91,686,316 to fund eight (8) projects targeting the following specific services: school-based, family education, trauma recovery, primary care and behavioral health, early care and support for TAY and older adults, juvenile justice and at-risk family services.

The Planning Division has also itemized funding for cultural competency activities under its UREP and Outreach and Engagement (O&E) Units. Fully described in Criterion 3, each of the five UREP Subcommittees is currently implementing one-time funding projects totaling \$1,060,000.00 for their specific communities as follows:

- American Indian- (\$100,000.00) awarded for the development of a learning collaborative that explores integration of Native American healing practices into western service methodologies
- African/ African American- (\$100,000.00) for a Resource Mapping Project with web capability and development of mental health brochures in African languages: Amharic, Somali, Swahili, Ibo and Yoruba
- Asian/ Pacific Islander- allocated \$100,000.00 for training of API limited English proficiency and monolingual consumers on leadership and advocacy; and development of an API consumer council

- Eastern European/ Middle Easterner- \$100,000.00 allocated for mental health brochures in four different languages: Arabic, Armenian, Farsi and Russian
- Latino- \$220,000.00 originally awarded for the mental health training and supervision of six Promotores de Salud (Health Promoters) to conduct outreach, engagement, linkage and self-help groups within the Latino community. Due to the size and distribution of the Latino population in L.A. County, the original amount for the Promotores de Salud Project was tripled (\$660,000.00) in order to test out the model in three separate locations with a total of 18 Promotores de Salud.

3. Outreach to racial and ethnic county-identified target populations

The Planning Division's Outreach and Engagement (O&E) Unit works closely with the Service Area-based O&E coordinators. Because outreach and engagement is one of the primary approaches to reduce disparities, funding in the amount of \$80,000 has been set aside in this fiscal year to provide O&E coordinators with promotional items, snacks and refreshments, and professional items necessary for them to conduct their functions in promoting mental health awareness and education, linkage of community members to LACDMH services and other services in the community as well as networking with diverse community based organizations.

4. Culturally appropriate mental health services

As previously stated, funding for the provision of cultural appropriate mental health services is embedded in all LACDMH programs and extends beyond service delivery unto personnel, salaries and benefits, and trainings for staff. Some additional examples include:

- Our ACCESS Center invests over \$90,000 in interpretation and translation services to carry their operations.
- The Training Division has identified cultural competence training expenses totaling \$216,790.

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers

The Human Resource Division budget includes approximately 1.5 million dollars for staff members who have been tested and certified for oral, reading and written proficiency in languages other than English. Furthermore, the imminent implementation of our Innovation Plan project for UREP populations -- Community-Designed Integrated Service Management Model (ISM) discussed in depth in Criterion 3, will soon add a \$25 million of funding to the cultural competence budget for LACDMH. The ISM model promotes the integration of culture-specific formal and non- traditional service providers and community-based organizations to integrate physical health, mental health and substance abuse.

Criterion 1 Attachments:

Attachment 1: LACDMH Vision, Mission and Values

Attachment 2: 2010 Cultural Competency Plan- Legal Entity Survey

Attachment 3: UREP Guiding Principles

Attachment 4: Outreach & Engagement Annual Report

Attachment 5: UREP Committee Leadership, Coordination and Accountability Structure

Attachment 6: Stakeholder Delegate Roster

Attachment 7: New Systems Leadership Team Roster

Attachment 8: Incubation Academy Agenda and Attendance Lists for 2010

Attachment 9: Cal State Long Beach Leadership Training

Attachment 10: EMT Member Roster

Attachment 11: WET Action Plan

CRITERION 2
UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

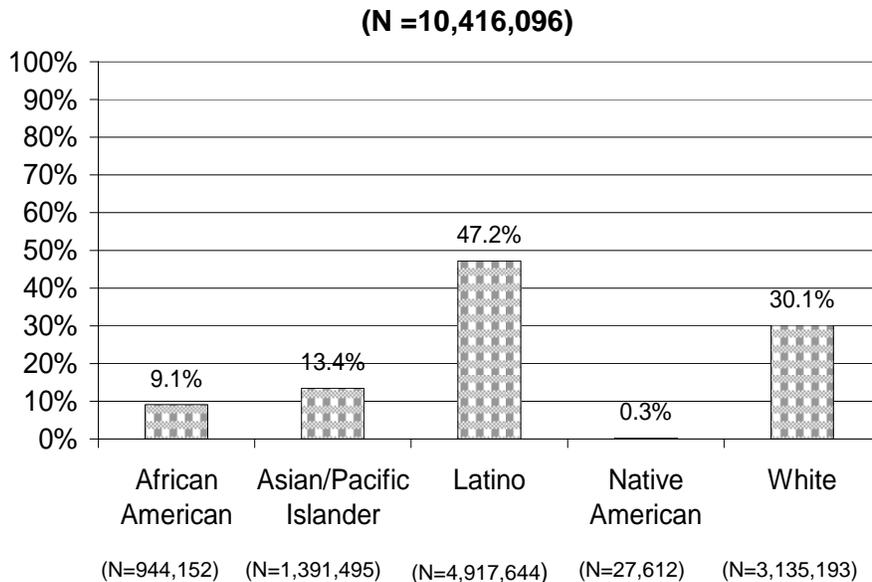
The county shall include the following in the CCPR:

- A. Summarize the county’s general population by race, ethnicity, age, and gender (may be a narrative or as a display of data). Other social/cultural groups may be addressed as data is available and collected locally.**

Los Angeles County consists of 88 legal cities and covers approximately 4,400 square miles. In 2009 the estimated population was 10,416,096. Los Angeles County is the largest County in the United States by population size. It has the highest population density in the country at an average of 2,551 people per square mile as compared with 236 in California and 96 in the US.

Figure 1 shows the estimated countywide **ethnic breakdown** for Los Angeles. The majority of the population in Los Angeles--or almost half--is Latino (47.2%), followed by Whites who comprise almost a third of the population (30.1%). A much smaller percentage of Asian/Pacific Islanders (13.4%) and African Americans (9.1%), and a very small percentage of Native Americans (less than 1% of the population) comprise the remainder of the population.

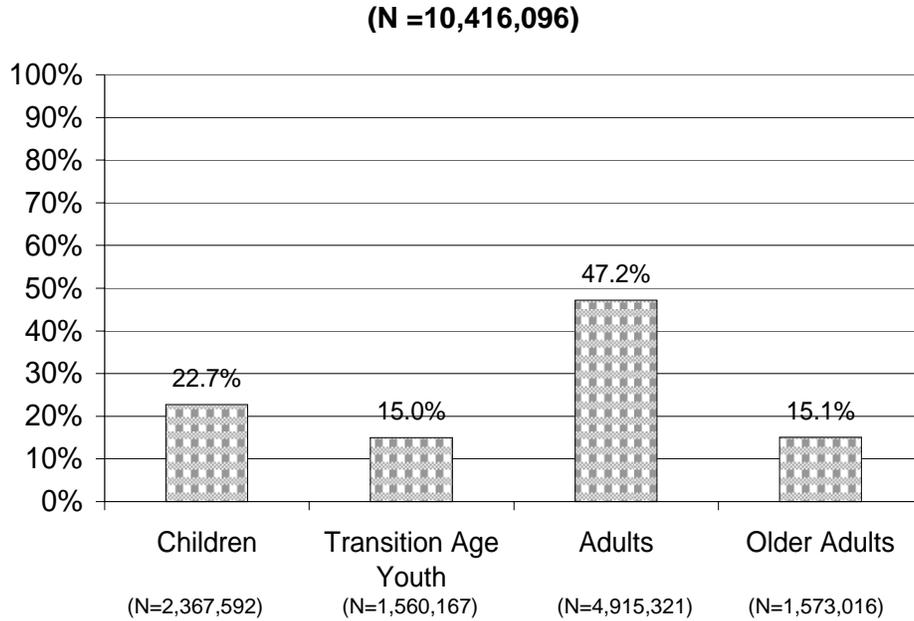
**Figure 1: Los Angeles Countywide Estimated Population by Ethnicity
CY 2009**



Data Source: 2009 Population and Poverty Estimates provided by John Hedderson, Walter McDonald Associates, Sacramento, California.

Figure 2 shows that more adults than children live in Los Angeles County. Persons 26-59 years old comprise the largest **age group** (47.2%), followed by children age 0-15 and under (22.7%), older adults, or persons aged 60 years and older (15.1%), and Transitional Age Youth or persons aged 16-25 years old (15%).

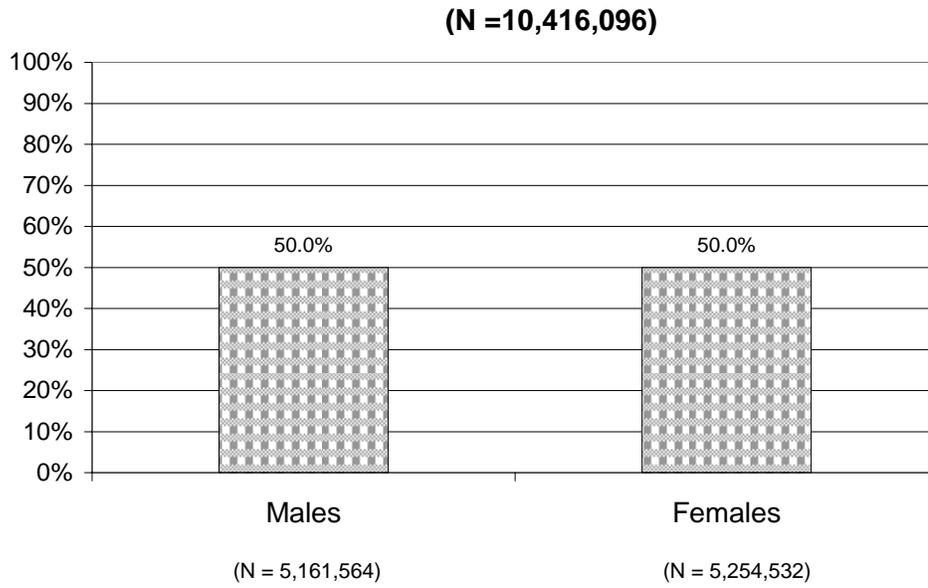
**Figure 2: Los Angeles Countywide Estimated Population by Age-Group
CY 2009**



Data Source: 2009 Population Estimates by John Hedderson, Walter McDonald Associates, Sacramento, California.

Figure 3 shows that an equal percentage of **males** and **females** live in the county.

**Figure 3: Los Angeles Countywide Estimated Population by Gender
CY 2009**



Data Source: 2009 Population Estimates by John Hedderson, Walter McDonald Associates, Sacramento, California.

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

The county shall include the following in the CCPR:

A. Summarize Medi-Cal population by race, ethnicity, language, age, and gender (other social/cultural groups)

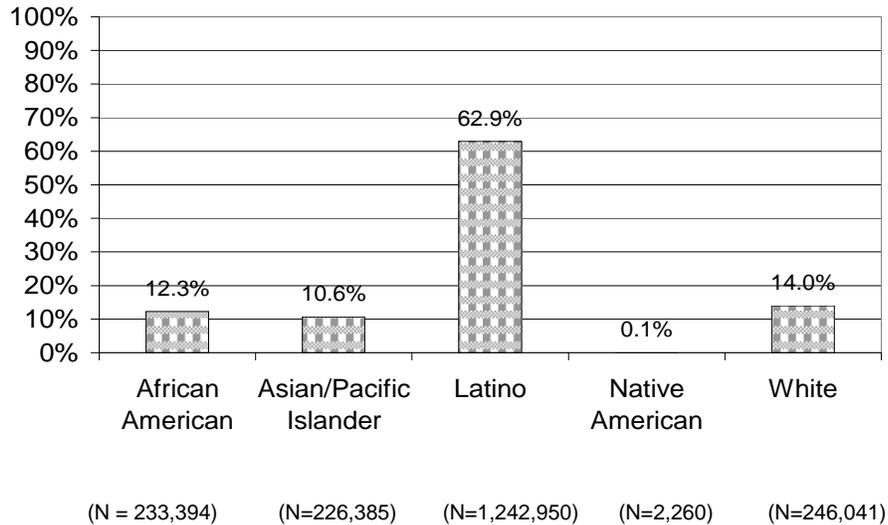
Out of the over 10.4 million population in Los Angeles County, nearly 20% were enrolled in Medi-Cal (N = 2,030,535) and eligible for mental health benefits and services in the month of March 2010.

Ethnicity

Figure 4 shows majority of the population enrolled in Medi-Cal is Latino at 62.9%, followed by Whites at 14.0%, African American at 12.3%, Asian/Pacific Islander at 10.6% and Native American at .1%.

Figure 4: Countywide Estimated Population Enrolled in Medi-Cal by Ethnicity March 2010

(N = 1,951,030)



Note: Excludes 'missing' Medi-Cal Enrolled by Ethnicity (N=79,505)
 Data Source: California State MEDS File – March 2010

Language

Table 1 shows majority of the population enrolled in Medi-Cal is English speaking at 834,416, followed by Spanish speaking at 777,748.

**Table 1: Countywide Estimated Population Enrolled in Medi-Cal by LACDMH Threshold Language
March 2010**

(N = 1, 807,904)

	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Russian	Spanish	Tagalog	Vietnamese	Total
Countywide	3,043	57,234	8,214	26,793	834,416	10,596	20,025	16,971	8,815	10,276	777,748	10,944	22,829	1,807,904
	0.2%	3.2%	0.5%	1.5%	46.2%	0.6%	1.1%	0.9%	0.5%	0.6%	43.0%	0.6%	1.3%	100%

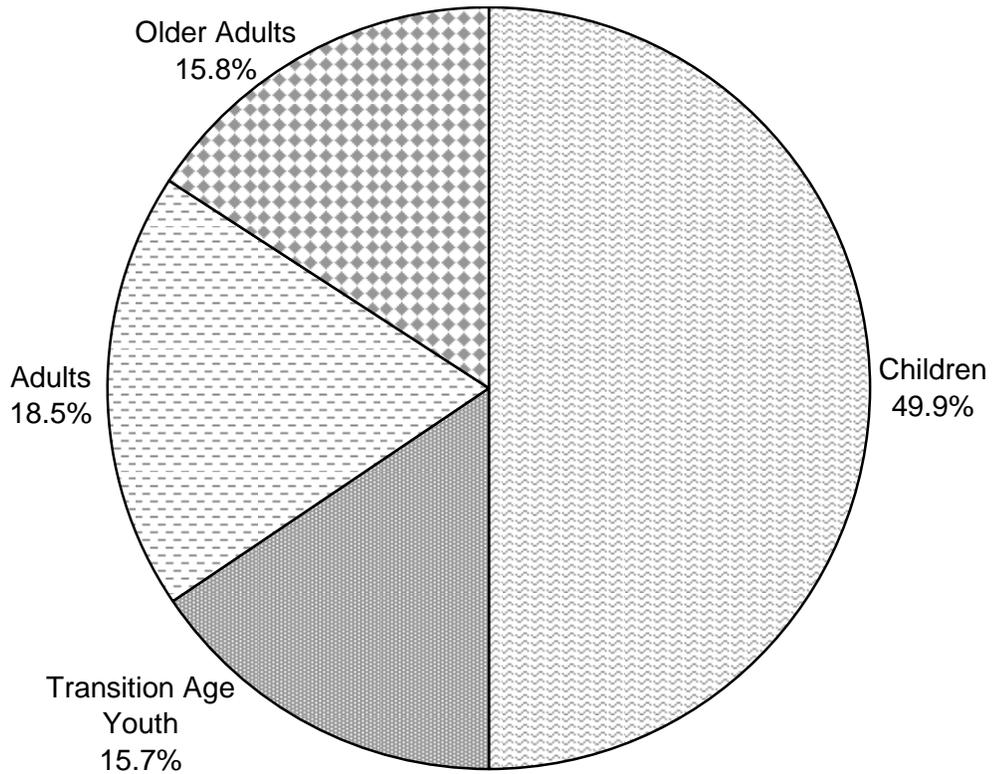
The Countywide Medi-Cal Enrolled Population Who Speak the Threshold Languages per the State MEDS file, March 2010, is 1,807,904, for 13 languages. A Threshold Language is the primary language of 3,000 Medi-Cal Beneficiary or 5% of the Medi-Cal Beneficiary Population, whichever is lower, in an identified geographic area (Title 9, CCR, Section 1810 (f)(3)). Table 1 excludes missing language data (N=225,850).

Age Group

Figure 5 shows nearly half of the population enrolled in Medi-Cal are children at 49.9%, adults at 18.5% and both TAY and older adults at about 16%.

**Figure 5: Countywide Estimated Population Enrolled in Medi-Cal
by Age Group
March 2010**

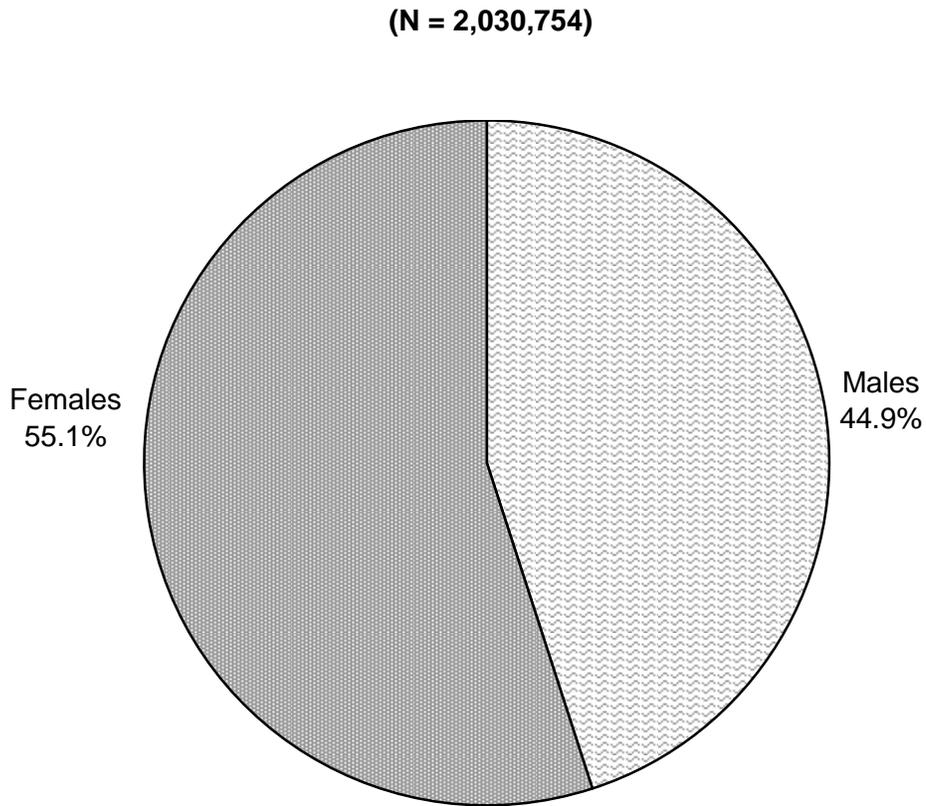
(N = 2,030,754)



Gender

Figure 6 shows more than half of the individuals enrolled in the Medi-Cal program are females at 55.1% as compared with 44.9% males.

**Figure 6: Countywide Estimated Population Enrolled in Medi-Cal
by Gender
March 2010**



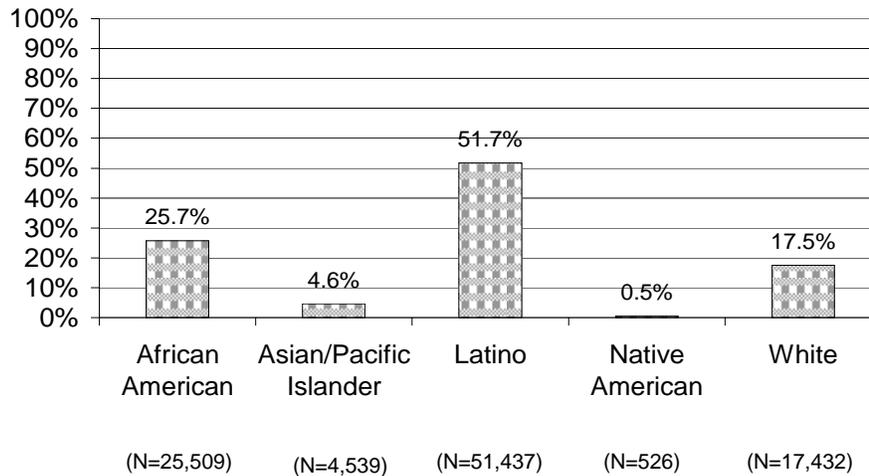
Medi-Cal Approved Consumers Served in Outpatient Short Doyle/Medi-Cal Facilities in FY 2009-2010

Ethnicity

Figure 7 shows Latinos were 51.7% of the consumers served in Outpatient Short Doyle/Medi-Cal facilities, followed by African Americans at 25.7%, Whites at 17.5%, Asian/Pacific Islanders at 4.6% and Native Americans at .5%.

**Figure 7: Countywide Med-Cal Approved Consumers Served in Outpatient Short Doyle/Medi-Cal Facilities by Ethnicity
FY 2009-2010**

(N = 103,943)



Language

Table 2 shows approximately 73.5% English speaking, 22% Spanish speaking, 0.8% Armenian speaking, 0.8% Cambodian speaking, 0.7% Vietnamese speaking, 0.6% Korean speaking, 0.5% Cantonese speaking, 0.3% Mandarin speaking, 0.2% Tagalog speaking, 0.2% Farsi speaking, 0.1% Russian speaking, 0.1% Other Chinese and 0.1% Arabic speaking consumers were served in FY 2009-10.

**Table 2: Countywide Medi-Cal Approved Consumers Served in
Outpatient Short Doyle/Medi-Cal Facilities by LACDMH
Threshold Languages
FY 2009-2010**

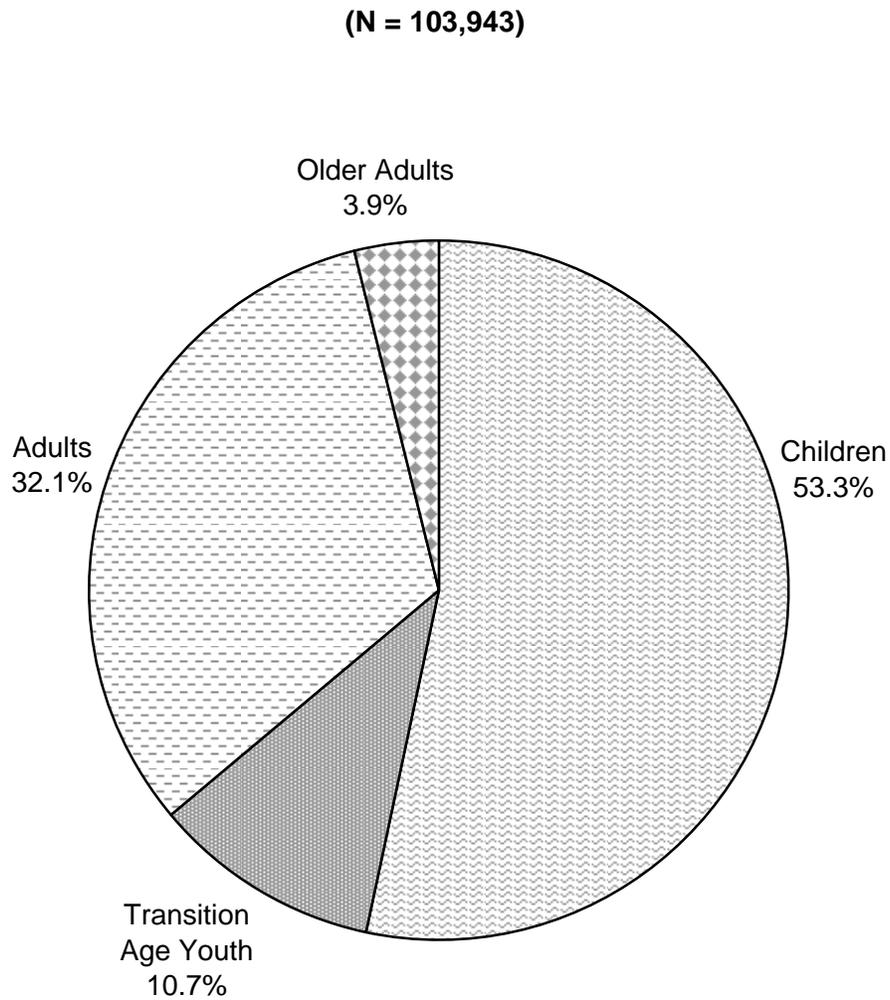
Countywide Threshold Languages for LAC-DMH	Medi-Cal Approved Consumers Served FY 2009-10	
Arabic	69	0.1%
Armenian	797	0.8%
Cambodian	850	0.8%
Cantonese	476	0.5%
English	74,636	73.5%
Farsi	188	0.2%
Korean	621	0.6%
Mandarin	350	0.3%
Other Chinese	110	0.1%
Russian	139	0.1%
Spanish	22,301	22.0%
Tagalog	234	0.2%
Vietnamese	760	0.7%
Total	101,531	100.0%

Note: Excludes "Other" language data (N = 2,412)

Age Group

Figure 8 shows children were 53.3% of the consumers, followed by adults at 32.1%, TAY at 10.7% and older adults at 3.9%.

Figure 8: Countywide Medi-Cal Approved Consumers Served in Outpatient Short Doyle/Medi-Cal Facilities by Age Group FY 2009-2010

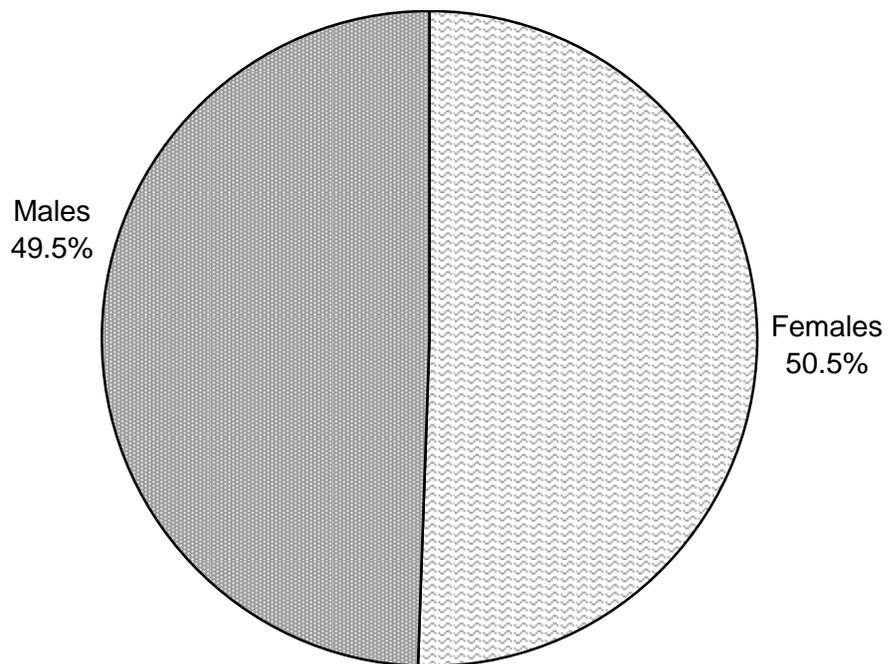


Gender

Figure 9 shows females were 50.5% of the consumers served compared with males at 49.5%.

**Figure 9: Countywide Consumers Served in Outpatient Short
Doyle/Medi-Cal Facilities by Gender
FY 2009-2010**

(N = 103,919)



B. Provide an analysis of disparities as identified in the above summary

By Ethnicity

The disparity by ethnicity among Medi-cal population as compared with consumers served in Outpatient facilities in FY 2009-2010 is for Latinos and Asian/Pacific Islanders.

Latinos are 62.9% of the Medi-Cal population but only 46.5% of the consumers served. Similarly, Asian/Pacific islanders are 10.6% of the Medi-Cal population but only 4.1% of the consumers served.

By Age Group

Children and older adults are the two age groups that show disparity among Medi-Cal population.

Children are 49.9% of the Medi-Cal population but only 41.8% of the consumers served. Similarly, older adults are 15.8% of the Medi-Cal population but only 4% of the consumers served.

By Gender

Gender disparity among Medi-Cal population is among females. Females are 55.1% of the Medi-Cal population but 49.4% of the consumers served.

Disparities in Medi-Cal Population Estimated with SED/SMI and Consumers Served

In order to get more precise estimates of disparity among Medi-Cal enrolled population, the actual number of Medi-Cal enrolled population estimated with Serious Emotional Disturbance (SED) and Serious mental Illness (SMI) were compared with the number of Medi-Cal approved consumers served in FY 2009-10. The results are presented in Tables 3-6.

Table 3 shows estimated disparity by ethnicity. Approximately 10,397 Asian/Pacific Islanders, 36,959 Latinos, and 2,226 Whites enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in FY 2009-10 (indicated by a positive number and in blue).

Table 3: Estimated Disparity by Ethnicity Among Medi-Cal Population FY 2009-2010

Ethnicity	Medi-Cal Enrolled Population Estimated with SED & SMI		Medi-Cal Approved Consumers Served FY 2009-10		Estimated Disparity Among Medi-Cal Enrolled Population
	Count	Percentage	Count	Percentage	
African American	17,344	12.3%	25,509	25.7%	(17,344–25,509) = - 8,165
Asian/Pacific Islander	14,936	10.6%	4,539	4.6%	(14,936–4,539) = 10,397
Latino	88,396	62.9%	51,437	51.7%	(88,396–51,437) = 36,959
Native American	181	0.1%	526	0.5%	(181– 526) = - 345
White	19,658	14.0%	17,432	17.5%	(19,658 – 17,432) = 2,226
Total	140,515	100.0%	99,443	100.0%	(140,515 –99,443) = 41,072

Note: Excludes "Other" ethnic group

Table 4 shows estimated disparity for the 13 LACDMH threshold languages. Approximately 36,029 Spanish speaking, 3,496 Armenian speaking, 1,523 Cantonese speaking, 1,314 Korean speaking, 952 Vietnamese speaking, 923 Mandarin speaking, 632 Russian speaking, 607 Farsi speaking, 587 Tagalog speaking, 551 Other Chinese speaking, and 159 Arabic speaking population enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in their language in FY 2009-10 (indicated by a positive number and in blue).

Table 4: Estimated Disparity by LACDMH Threshold Languages Among Medi-Cal Population FY 2009-2010

Countywide Threshold Languages for LAC-DMH	Medi-Cal Enrolled Population Estimated with SED & SMI		Medi-Cal Approved Consumers Served FY 2009-10		Estimated Disparity Among Medi-Cal Enrolled Population
Arabic	228	0.2%	69	0.1%	(228 - 69) = 159
Armenian	4,293	3.2%	797	0.8%	(4,293 - 797) = 3,496
Cambodian	616	0.5%	850	0.8%	(616 - 850) = - 234
Cantonese	2,009	1.5%	476	0.5%	(2,009 - 476) = 1,523
English	62,581	46.2%	74,636	73.5%	(62,581 - 74,636) = - 52,588
Farsi	795	0.6%	188	0.2%	(795 - 188) = 607
Korean	1,502	1.1%	621	0.6%	(1,502 - 621) = 1,314
Mandarin	1,273	0.9%	350	0.3%	(1,273 - 350) = 923
Other Chinese	661	0.5%	110	0.1%	(661 - 110) = 551
Russian	771	0.6%	139	0.1%	(771 - 139) = 632
Spanish	58,330	43.0%	22,301	22.0%	(58,330 - 22,301) = 36,029
Tagalog	821	0.6%	234	0.2%	(821 - 234) = 587
Vietnamese	1,712	1.3%	760	0.7%	(1,712 - 760) = 952
Total	135,592	100.0%	101,531	100.0%	(135,592 - 101,531) = 34,061

Table 5 shows estimated disparity by age-group. Approximately 19,705 older adults, 17,365 children, and 6,108 TAY who are enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in FY 2009-10 (indicated by a positive number and in blue).

**Table 5: Estimated Disparity by Age Group Among Medi-Cal Population
FY 2009-2010**

Age Group	Medi-Cal Enrolled Population Estimated with SED & SMI		Medi-Cal Approved Consumers Served FY 2009-10		Estimated Disparity Among Medi-Cal Enrolled Population
Children (0-15)	72,807	51.8%	55,442	53.3%	(72,807- 55,442) = 17,365
Transition Age Youth (16-25)	17,178	12.2%	11,070	10.7%	(17,178 – 11,070) = 6,108
Adults (26-59)	26,722	19.0%	33,328	32.1%	(26,722 - 3.3,328) = - 6606
Older Adults (60+)	23,808	16.9%	4,103	3.9%	(23,808 – 4,103) =19,705
Total	140,515	100.0%	103,943	100.0%	(140,515-103,943) = - 9,572

Table 6 shows estimated disparity by gender. Approximately 11,485 males and 25,111 females enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in FY 2009-10 (indicated by a positive number and in blue).

**Table 6: Estimated Disparity by Gender Among Medi-Cal Population
FY 2009-2010**

Gender	Medi-Cal Enrolled Population Estimated with SED & SMI		Medi-Cal Approved Consumers Served FY 2009-10		Estimated Disparity Among Medi-Cal Enrolled Population
Males	62,926	44.8%	51,441	49.5%	(62,926 – 51,441) = 11,485
Females	77,589	55.2%	52,478	50.5%	(77,589 – 52,478) = 25,111
Total	140,515	100.0%	103,919	100.0%	(140,515 – 103,919) = 36,596

Note: Excludes "Unknown gender" (N = 24)

The SED & SMI Medi-Cal approved groups that are estimated to have **unmet needs/disparities** include:

- **Asian/Pacific Islanders, Latinos and Whites**, with a significantly larger number of Latinos underserved (Table 3);
- Enrollees who speak **11/13 threshold languages** except for English and Cambodian, with **Spanish** speaking enrollees considerably more underserved than other threshold speaking groups (Table 4);
- **Children age 0-15 years old, TAY and older adults** (Table 5); and
- **Both genders**, with a significantly larger number of females underserved (Table 6).

III. 200% of Poverty (minus Medi-Cal) population and service needs

The county shall include the following in the CCPR:

- A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social /cultural groups may be addressed as data is available and collected locally)**

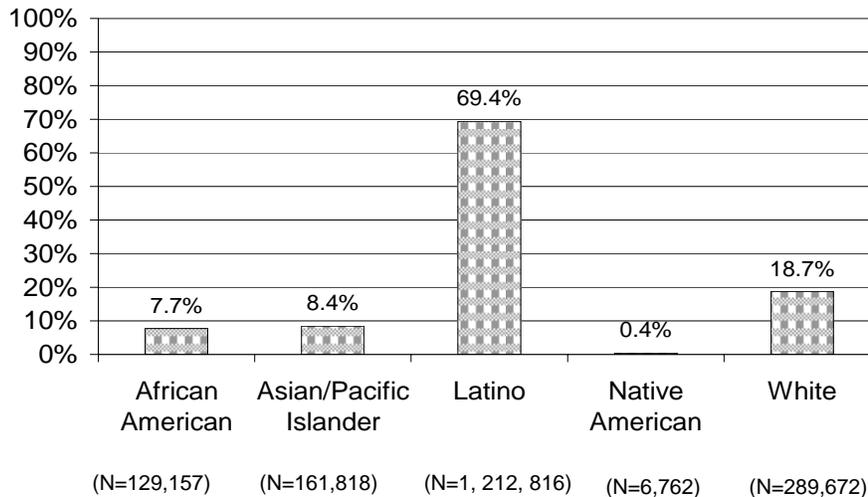
This population was calculated by subtracting the number of Medi-Cal enrolled population from the 200% Federal Poverty Level (FPL) population.

Ethnicity

Figure 10 shows Latinos are the majority of the non Medi-Cal enrolled population at 69.4%, followed by Whites at 18.7%, Asian/Pacific Islanders at 8.4%, African Americans at 7.7% and Native Americans at .4%.

Figure 10: Countywide Non-Medi-Cal Population Living At or Below 200% FPL by Ethnicity CY 2009

(N = 1,800,225)



Language

Figure 11 shows English (756,326) and Spanish (695,434) speaking individuals as the majority of the non Medi-Cal enrolled population living below the 200% FPL, followed by the various languages of the API population (215,726).

**Figure 11: Countywide Non-Medi-Cal Population Living At or Below 200% FPL by LACDMH Threshold Languages
CY 2009**

LACDMH Threshold Languages	Non Medi-Cal Population	
Arabic	15,326	0.9%
Armenian	1,546	0.1%
Cambodian	2,807	0.2%
Cantonese	-8,424	-0.5%
English	756,326	42.0%
Farsi	18,794	1.0%
Korean	53,450	3.0%
Mandarin	-2,276	-0.1%
Other Chinese	68,334	3.8%
Other Threshold Languages	99,680	5.5%
Russian	8,093	0.4%
Spanish	695,434	38.6%
Tagalog	77,226	4.3%
Vietnamese	13,909	0.8%
Countywide	1,800,225	100%

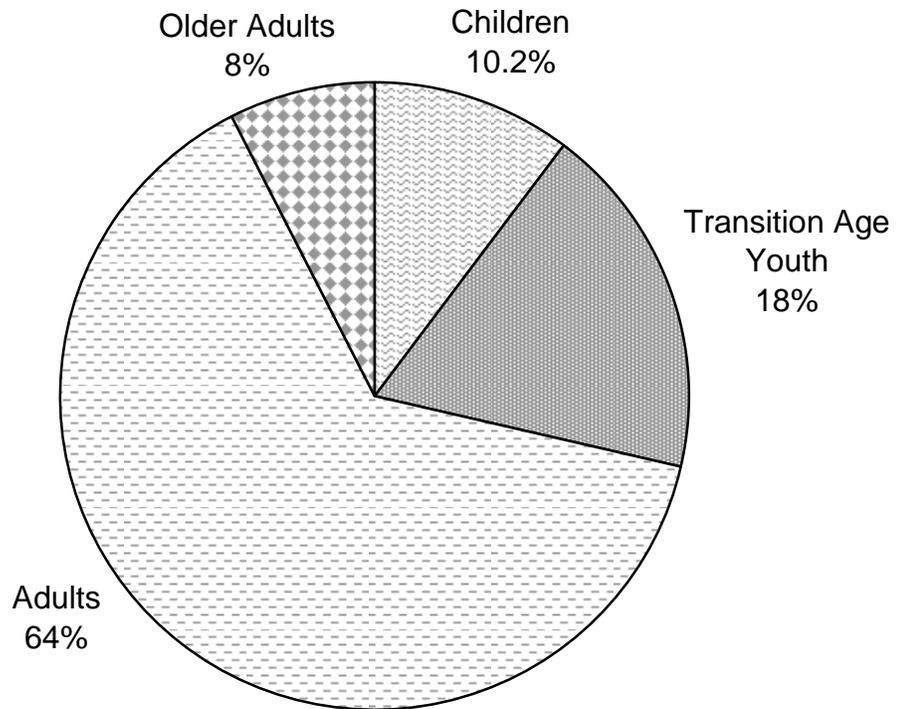
¹ Includes non-missing data for age-group, gender and ethnicity in the State MEDS file. ² Working Poor Population = Population Living at or Below 200% Poverty Minus Medi-Cal Eligible Population.
Data Source: Poverty Estimates for 2008 provided by John Hedderson, Walter McDonald Associates, 2009 and Urban Research - GIS Section/ISD/SSSD, State MEDS File, October 2009. Tables prepared by Data-GIS Unit, Quality Improvement Division, Program Support.

Age Group

Figure 12 shows adults are the majority of the non Medi-Cal enrolled population that are living at or below 200% FPL at 63.9%, followed by TAY at 18.4%, older adults at 7.5% and children at 10.2%.

**Figure 12: Countywide Non-Medi-Cal Enrolled Population Living At or Below 200% FPL by Age Group
CY 2009**

(N = 1,800,226)

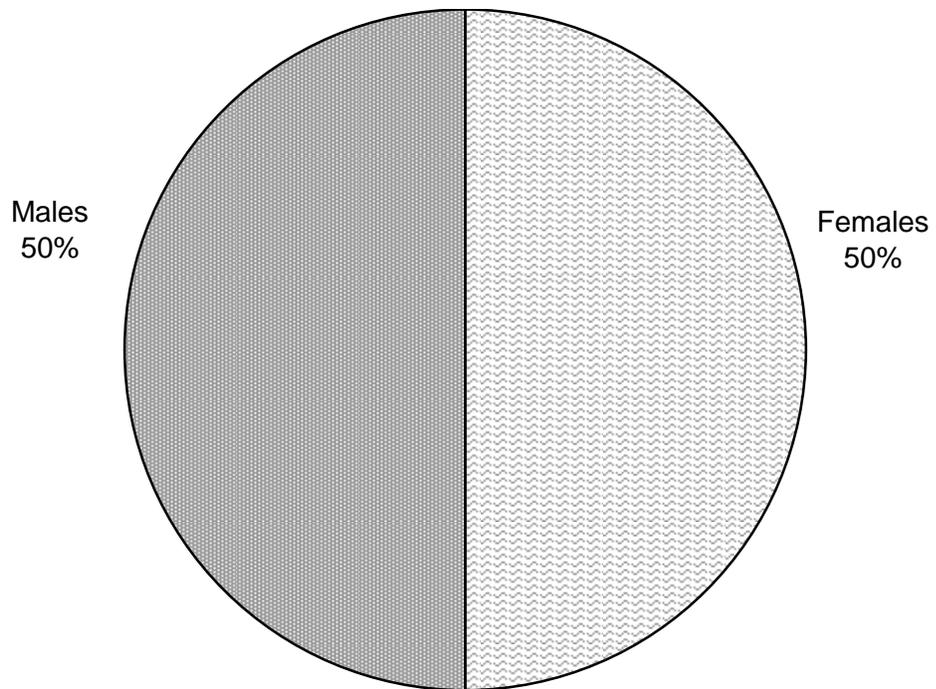


Gender

Figure 13 shows males and females are both at 50% of the non Medi-Cal enrolled population living at or below 200% FPL.

**Figure 13: Countywide Non-Medi-Cal Enrolled Population Living At or Below 200% FPL by Gender
CY 2009**

(N = 1,800,226)



B. Disparities in Non Medi-Cal Enrolled Population Living At or Below 200% FPL as Compared with SED/SMI Consumers Served

By Ethnicity

The greatest disparity by ethnicity among non Medi-Cal enrolled population living at or below 200% FPL with SED & SMI is among Latinos and Asian/Pacific Islanders.

Latinos are 90,961 of the non Medi-Cal population living at or below 200% FPL with SED & SMI, however only 22,473 of the consumers served. Similarly, Asians/Pacific Islanders are 12,136 of non Medi-Cal population living at or below 200% FPL with SED & SMI, but only 1,945 of the consumers served.

Table 7 shows the Latino and White Working Poor were the most non Medi-Cal consumers served in the county’s outpatient Short Doyle/Medi-Cal Facilities in FY 2009-2010 with about 17.3%% more Latinos (43.8%) served than Whites (26.5%). Almost one fifth of the Working Poor population served were African Americans (25.2%). Only 3.8% served were Asian/Pacific Islanders with an even smaller percentage served who were Native Americans (0.7%).

Table 7: Unmet Need by Ethnicity Among Non Medi-Cal Population Living at or Below 200% FPL FY 2009-2010					
Ethnicity	Non Medi-Cal Population Estimated with SED & SMI		Non Medi-Cal Consumers Served¹¹		Estimated Unmet Need¹²
African American	9,686	7.2%	12,915	25.2%	(9,686 – 12,915) = -3,229⁹
Asian/Pacific Islander	12,136	9.0%	1,945	3.8%	(12,136 – 1,945) = 10,191
Latino	90,961	67.4%	22,473	43.8%	(90,961 – 22,473) = 68,488
Native American	507	0.4%	353	0.7%	(507 – 353) = 154
White	21,725	16.1%	13,571	26.5%	(21,725 – 13,571) = 8,154
Total	135,015	100.0%	51,257	100.0%	(135,015 – 51,257) = 83,758

Note: Excludes 1,948 Non-Medi-Cal Consumer “other” ethnic group consumers.

⁹ A negative number indicates that the estimated need for mental health services has been met.

¹¹ Includes Non Medi-Cal consumers served in Outpatient Short Doyle/Medi-Cal Facilities such as consumers served by County General Funds (CGF) etc.

¹² A positive number indicates number of Non Medi-Cal population whose need for mental health services has not been met.

By Language

The greatest disparity by language among non Medi-Cal population living at or below 200% FPL with SED & SMI is among Spanish and English speaking consumers.

Table 8 shows that English and Spanish were the two most spoken **threshold languages** by SED and SMI Working Poor in FY 2009-2010. About 40% of Working Poor speak English (44.5%) or Spanish (41.5%). Barely 4% of Working Poor speak one of the seven Asian languages, 3.1 % speak Armenian.

The majority of SED and SMI Working Poor served in outpatient Short Doyle/Medi-Cal Facilities were English-speaking (78.4%). About one fifth of enrollees served were Spanish speaking (19%). Only about 2% served spoke an Asian language, with the remainder of consumers served speaking other threshold languages.

Table 8: Unmet Need by Threshold Language Among Los Angeles County Non Medi-Cal Working Poor Population FY 2009-2010					
Countywide Threshold Languages	Non Medi-Cal Working Poor Population Estimated with SED & SMI		Non Medi-Cal Consumers Served¹¹		Estimated Unmet Need¹²
Arabic	260	0.2%	34	0.1%	(260 - 34) = 226
Armenian	4,030	3.1%	232	0.4%	(4,030 - 232) = 3,798
Cambodian	520	0.4%	192	0.4%	(520 - 192) = 328
Cantonese	1,820	1.4%	78	0.2%	(1,820 - 78) = 1,742
English	57,857	44.5%	40,533	78.4%	(57,857 - 40,533) = 17,324
Farsi	780	0.6%	94	0.2%	(780 - 94) = 686
Korean	1,430	1.1%	256	0.5%	(1,430 - 256) = 1,174
Mandarin	0	0.0%	121	0.2%	(0-121) = - 121⁹
Other Chinese	650	0.5%	67	0.1%	(650 - 67) = 583
Russian	650	0.5%	68	0.1%	(650 - 68) = 582
Spanish	53,956	41.5%	9,812	19.0%	(53,956 - 9,812) = 44,144
Tagalog	780	0.6%	140	0.3%	(780 - 140) = 640
Vietnamese	1,560	1.2%	99	0.2%	(1,560 - 99) = 1,461
Total¹³	124,294¹³	100.0%	51,726	100.0%	(124,294 - 51,726) = 72,568

⁹ A negative number indicates that the estimated need for mental health services has been met.

¹¹ Includes Non Medi-Cal consumers served in Outpatient Short Doyle/Medi-Cal Facilities such as consumers served by County General Funds (CGF) etc.

¹² A positive number indicates number of Non Medi-Cal population whose need for mental health services has not been met.

¹³ Excludes "Other" Non Threshold Languages spoken by working-poor population (N = 1,479).

By Age Group

Adults and TAY are the two age groups that show the greatest disparity among non Medi-Cal population living at or below 200% FPL with SED & SMI. Adults are approximately 86,318 of the non Medi-Cal population, however only 29,570 of the consumers served. Similarly, of the 24,817 TAY non Medi-Cal population, there were only 11,192 of the consumers served.

Table 9 shows that the majority, or about two thirds, of SED & SMI Working Poor were **adults** 26-59 years old (63.9%) in FY 2009-2010. **Transition Age Youth** aged 16-25 years old comprised one fifth (18.4%) of the Working Poor population, while **children** age 0-15 years old comprised about 10.2 % and **older adults** comprised about 7.5%.

Adults age 26-59 years old were the most served Working Poor population in outpatient Short Doyle/Medi-cal Facilities in FY 2009-2010 at 55.6%, followed by Transition Age Youth at 21.0%, children 0-15 years old at 19.2%, and older adults at 4.2%.

Table 9: Estimated SED/SMI, Consumers Served and Unmet Need by Age Group Among Los Angeles County Non Medi-Cal Working Poor Population FY 2009-2010					
Age Group	Non Medi-Cal Enrolled Working Poor Population Estimated with SED & SMI		Non Medi-Cal Consumers Served¹¹		Estimated Unmet Need
Children (0-15)	13,712	10.2%	10,223	19.2%	(13,712 – 10,223) = 3,489¹⁰
Transition Age Youth (16-25)	24,817	18.4%	11,192	21.0%	(24,817 – 11,192) = 13,625¹⁰
Adults (26-59)	86,318	63.9%	29,570	55.6%	(86,318 – 29,570) = 56,748¹⁰
Older Adults (60+)	10,168	7.5%	2,220	4.2%	(10,168 – 2,220) = 7,948¹⁰
Total	135,015	100.0%	53,205	100.0%	(130,015 – 53,205) = 76,810¹⁰

* Excludes 21 consumers with missing data on age.

¹⁰ A positive number indicates number of Non Medi-Cal Working Poor population whose need for mental health services have not been met.

¹¹ Includes Non Medi-Cal consumers served in Outpatient Short Doyle/Medi-Cal Facilities such as consumers served by County General Funds (CGF) etc.

By Gender

Both genders show disparities for non Medi-Cal population living at or below 200% FPL with SED & SMI. Females are 67,464 of the non Medi-Cal enrolled population, however only 26,113 of the consumers served. Similarly, males are 67,551 of the non Medi-Cal enrolled population, but only 27,078 of the consumers served.

Table 10 shows that almost equal number of **males** and **females** were SED & SMI Working Poor in FY 2009-2010 with about 2% more males than females served in outpatient Short Doyle/Medi-Cal Facilities.

Table 10: Estimated SED/SMI, Consumers Served and Unmet Need by Gender Among Los Angeles County Non Medi-Cal Working Poor Population FY 2009-2010					
Gender	Non Medi-Cal Enrolled Working Poor Population Estimated with SED & SMI		Non Medi-Cal Consumers Served ¹¹		Estimated Unmet Need
Males	67,551	50.0%	27,078	50.9%	(67,551 – 27,078) = 40,473 ¹⁰
Females	67,464	50.0%	26,113	49.1%	(67,464 – 26,113) = 41,351 ¹⁰
Total	135,015	100.0%	53,191	100.0%	(135,015 - 53,191) = 81,824¹⁰

* Excludes 'missing' gender data on consumers served.

¹⁰ A positive number indicates number of Non Medi-Cal Working Poor population whose need for mental health services have not been met.

¹¹ Includes Non Medi-Cal consumers served in Outpatient Short Doyle/Medi-Cal Facilities such as consumers served by County General Funds (CGF) etc.

Tables 7-10 above provide detailed analyses of estimated unmet (as indicated by a positive number and in blue) need by ethnicity, language, age-group and gender among the Working Poor population. The SED & SMI Working Poor groups that are estimated to have an **unmet need** include:

- **Asian/Pacific Islanders, Latinos, Native Americans and Whites**, with a larger number of Latinos underserved (Table 7);
- Working Poor who speak **12/13 threshold languages** except Mandarin (Table 8);
- **All 4 age groups** (Table 9); and
- **Both genders** (Table 10).

IV. MHSA Community Services and Supports (CSS) population assessment and service needs

The county shall include the following in the CCPR:

- A. From the county’s approved CSS plan, extract a copy of the population assessment (including updates). Summarize population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

Please note: The CSS plan did not present data by language. Therefore, the comparison between 2003 and 2009 is not available. Please see table15 for client utilization by language for FY 2009-2010.

Table 11 describes the change in estimated population between 2003 and 2009 by ethnicity.

Ethnic distribution of total estimated population by ethnicity stayed relative similar between 2003 and 2009. Population living at or below 200% FPL declined 2.96% among African Americans, 1.5% among Asian/Pacific Islanders, .13% among Native Americans, and 2% among Whites. However, the Latino population living at or below 200% FPL increased 6.6% between 2003 and 2009.

Table 11: 2003 and 2009 Estimated Countywide Total Population and Population Living at or Below 200% FPL by Ethnicity

Ethnicity	County Wide Estimated Total Population				Countywide Estimated Population Living at or Below 200% FPL			
	2003		2009		2003		2009	
	N	%	N	%	N	%	N	%
African American	966,835	9.70%	944,152	9.06%	447,482	12.72%	364,446	9.76%
Asian / Pacific Islander	1,329,210	13.33%	1,391,495	13.36%	401,518	11.42%	370,349	9.92%
Latino	4,609,970	46.23%	4,917,644	47.21%	2,052,916	58.37%	2,426,069	64.96%
Native American	30,720	0.31%	27,612	0.27%	13,321	0.38%	9,180	0.25%
White	3,035,467	30.44%	3,135,193	30.10%	601,601	17.11%	564,582	15.12%
Total	9,972,202	100%	10,416,096	100%	3,516,838	100%	3,734,626	100%

Table 12 describes the change in estimated population between 2003 and 2009 by age group.

The distribution of total estimated population by age group increased for all age groups except children between 2003 and 2009. The percentage of children declined 2.2%, while TAY increased .94%, adults 3.4% and older adults 1.3%.

The distribution of estimated population living at or below 200% FPL between 2003 and 2009 by age group showed a decline for all age groups except children. The percentage of children living at or below 200% FPL increased 13.1%, while the TAY population decreased .75%, adults 5.5%, and older adults .6%.

Table 12: 2003 and 2009 Estimated Countywide Total Population and Population Living at or Below 200% FPL by Age Group

Age Group	County Wide Estimated Total Population				County Estimated Population Living at or Below 200% FPL			
	2003		2009		2003		2009	
	N	%	N	%	N	%	N	%
Children	2,485,090	24.92%	2,367,592	22.73%	678,182	19.28%	1,138,654	32.38%
TAY	1,466,904	14.71%	1,560,167	15.65%	612,288	17.41%	585,904	16.66%
Adults	4,582,527	45.95%	4,915,321	49.29%	1,735,831	49.36%	1,540,601	43.81%
Older Adults	1,437,681	14.42%	1,573,016	15.77%	490,537	13.95%	469,376	13.35%
Total	9,972,202	100%	10,416,096	104.45%	3,516,838	100%	3,734,535	106.19%

Table 13 describes the change in estimated population between 2003 and 2009 by gender.

The distribution of the total estimated population between 2003 and 2009 decreased for males .87% and increased for females .87%.

The distribution of estimated population living at or below 200% FPL increased for males 2.3% and decreased for females 2.3%.

Table 13: 2003 and 2009 Estimated Countywide Total Population and Population Living at or Below 200% FPL by Gender

Gender	County Wide Estimated Total Population				County Estimated Population Living at or Below 200% FPL			
	2003		2009		2003		2009	
	N	%	N	%	N	%	N	%
Males	4,902,840	49.17%	5,161,564	48.30%	1,584,154	45.04%	1,769,196	47.37%
Females	5,069,362	50.83%	5,244,532	51.70%	1,932,684	54.96%	1,965,430	52.63%
Total	9,972,202	100%	10,416,096	100%	3,516,838	100%	3,734,626	100%

Table 14 describes the number of clients served by ethnicity in FY 2005-2006 to FY 2009-2010. Out of the 122,075 clients served, 45,510 (37.28%) were Latinos, 34,841 (28.54%) African Americans, 28,802 (23.59%) Whites, 6,789 (5.56%) Asians, and 689 (.56%) Native Americans.

Table 14: Clients Served by MHSA from FY 05-06 to FY 09-10 by Ethnicity		
Ethnicity	# of Clients	% of Clients
African American	34,841	28.54%
Asian	6,789	5.56%
Latino	45,510	37.28%
Native American	689	.56%
White	28,802	23.59%
Other than specified	5,444	4.46%
Total*	122,075	100%

*Note: Total includes Direct Service Programs under MHSA. May not include the additional 46,500 clients served under Cross-Cutting Programs.

Table 15 describes the number of clients served by age group in FY 2005-2006 to FY 2009-2010. Out of the 122,075 clients served, 71,163 (58.29%) were adults, 21,455 (17.58%) children, 19,393 (15.89%) TAY and 10,064 (8.24%) older adults.

Table 15: Clients Served by MHSA from FY 05-06 to FY 09-10 by Age Group		
Age Group	# of Clients	% of Clients
Children	21,455	17.58%
TAY	19,393	15.89%
Adults	71,163	58.29%
Older Adults	10,064	8.24%
Total*	122,075	100%

*Note: Total includes Direct Service Programs under MHSA. May not include the additional 46,500 clients served under Cross-Cutting Programs.

Table 16 describes the number of clients served by gender in FY 2005-2006 to FY 2009-2010. Out of the 122,075 clients served, 62,242 (50.99%) were females, and 59,803 (48.99%) males.

Table 16: Clients Served by MHSA from FY 05-06 to FY 09-10 by Gender		
Gender	# of Clients	% of Clients
Males	59,803	48.99%
Females	62,242	50.99%
Unknown	30	.02%
Total*	122,075	100%

*Note: Total includes Direct Service Programs under MHSA. May not include the additional 46,500 clients served under Cross-Cutting Programs.

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations

The county shall include the following in the CCPR:

A. Which PEI priority population(s) did the county identify in their PEI plan?

The following 6 populations are identified in Los Angeles county's PEI plan:

1. Underserved cultural populations
2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
4. Trauma-exposed
5. Children/youth at risk of school failure
6. Children/youth at risk or experiencing juvenile justice involvement

B. Describe the process and rationale used by the county in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

Los Angeles County engaged in a community planning process to develop the PEI plan and to select its PEI priority populations. The process occurred predominantly at the Service Area (SA) level to capture the concerns of local communities. The eight service areas, or geographic areas within Los Angeles County, have distinct and varying demography, geography, resources, and other factors that make it critical for PEI services to be specific to regional and community-based needs. Furthermore, State PEI guidelines stressed that Stakeholders be included in the planning process from a variety of social sectors, age groups and special populations. Finally, the guidelines suggested that counties base their PEI Plan upon solid data that indicated which areas and PEI priority populations had the greatest needs.

In order to ensure that the Los Angeles County Department of Mental Health (LACDMH) was proceeding in fashion consistent with the PEI Guidelines and in accordance with Stakeholder inputs, three advisory groups were formed at various stages during the planning process:

- **Plan-to-Plan Advisory Group** This Group was formed to advise the LACDMH regarding strategies for the planning process, the role of the members was to provide the guidance and necessary expertise to represent the required and recommended sectors for PEI planning.

- **Guidelines Advisory Group** This Group developed a set of guidelines on how to develop service area PEI plans in an inclusive, consistent, and effective manner.
- **Plan Development Advisory Group** This Group was created to provide guidance for the countywide community forum targeted at special populations and to review the *Evidence-based Practices and Promising Practices Resource Guide for Los Angeles County (v.1.0, 2009)*.

The following represents the stages in planning that took place over the last two years. The community planning process was undertaken in three phases: (1) Outreach and Education, (2) Needs Assessment, and (3) Plan Development.

PHASE 1: OUTREACH AND EDUCATION

The first phase started in the summer of 2007 with pre-planning activities and continued through winter 2008. Active involvement by community stakeholders – consumers, parents, caregivers, family members, sector members, and other concerned individuals – in the PEI planning process was critical to developing effective, representative, and culturally appropriate PEI services.

PHASE 2: NEEDS ASSESSMENT

In order to create a plan that was comprehensive, it was essential that LACDMH compile data and generate accurate information from a wide range of sources. To gather this information, the Department employed six different needs assessment strategies: recommendations from CSS planning documents, community surveys, service area data profiles, key individual interviews, focus groups, and community forums countywide. Each of these six strategies built on the knowledge gained through earlier strategies. Through each strategy, the questions being asked and answered became more specific and the depth of knowledge increased. Input gathered at various stages in the planning process was analyzed in order to provide direction on which priority populations and age groups were to be targeted in a given project. Additional input was achieved informally through regular meetings with various stakeholder groups who provided oversight and guidance through the many aspects of project development. Finally, a comprehensive statistical and demographic study of risk factors in Los Angeles County was conducted to complete the community needs assessment for PEI. Decision-making bodies (such as, the Service Area Advisory Committees, MHSA Stakeholder Delegates, and LACDMH staff) were asked to examine the gathered information collectively so that there emerged a clearer picture of the county's PEI

needs. As each needs assessment strategy was completed, the information was summarized and made available to the public through the MHSA PEI website.

PHASE 3: PEI PLAN DEVELOPMENT

Plan development procedures were designed to build upon the community needs assessment in a feedback loop to stakeholders. A series of events and meetings were held to achieve this goal and to orient the stakeholders to the responsibilities involved in making their recommendations for Los Angeles County residents. Throughout this, stakeholders were asked to adopt a role consistent with planning for public mental health services and in the absence of conflicts of interests.

- **PEI Roundtable.** On October 2, 2008, the Department held the Los Angeles County PEI Roundtable. The purpose of the Roundtable was (1) to provide an introduction to the MHSA and PEI Plan, (2) to summarize “What We’ve Learned So Far” through results from the needs assessments activities to date; and (3) to enable different sector groups to exchange information about PEI and their priority populations. Outcomes of the Roundtable activities included:
 - ❖ Convened the Roundtable attended by over 350 individuals
 - ❖ Developed and distributed copies of the reports Vulnerable Communities in Los Angeles County – Special Edition for PEI Roundtable and Selected Findings from the Key individual Interviews
 - ❖ Enabled nine breakout groups organized by sectors and age groups to engage in initial discussion on PEI priority populations
 - ❖ Posted a video of the Roundtable on the LACDMH website, together with the handouts.
 - ❖ Posted questions and answers asked at the Roundtable on the LACDMH website.

- **Teach-Ins.** From November to December 2008, the Department co-sponsored, together with the SAACs, a “PEI teach-in” in each service area to provide an introductory training for interested stakeholders regarding Evidence Based Practices (EBPs), Promising Practice (PPs), emerging practices, and CDEs. Outcomes of the teach-ins included:
 - ❖ Conducted PEI teach-ins in each of the eight service areas attended by over 190 individuals.
 - ❖ Developed a PowerPoint: Understanding Evidence-Based Practices presented at all of the teach-ins.
 - ❖ Distributed educational materials on EBPs, PPs, and EPs to attendees.

- ❖ Developed a webcast of the teach-ins posted on the LACDMH website for those unable to attend a live presentation.
- **Ad Hoc Steering Committee Deliberations.** The Service Area PEI Ad Hoc Steering Committees were formed in fall 2008 and began meeting as early as November 2008 through the end of March 2009. A ninth steering committee for the special countywide populations was also formed in early 2009. In order to proceed with project-building, all of the community assessment information was made available to a group of ad hoc steering committees who further refined population, age, and program selections. Outcomes of the Ad Hoc PEI Steering Committee activities include:
 - ❖ Provided updates and technical assistance to the Steering Committee meetings as needed.
 - ❖ Utilized independent consultants to act as facilitators for each of the Steering Committees during the voting process.
 - ❖ Developed an evaluation tool to determine the rank importance of each priority population for a service area based on findings from the service area data profiles, key individual interviews, focus groups, and community forums; tallied the scores; compiled the results; and identified each Service Area's top priority populations for each age group.
 - ❖ Developed an evaluation tool to determine ranking of each EBP and PP on a service area's menu of options relative to their identified priority population and subpopulation needs; tallied the scores; compiled the results; and identified each Service Area's top EBP and PP programs.
 - ❖ Obtained recommendations regarding specific PEI programs to be implemented in the service areas and countywide.

CRITERION 3
**STRATEGIES AND EFFORTS FOR REDUCING
RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC
MENTAL HEALTH DISPARITIES**

**I. Identify unserved/underserved target populations (with disparities):
The county shall include the following in the CCPR:**

- **Medi-Cal population**
- **Community Services Support**
- **Workforce, Education, and Training**
- **Prevention and Early Intervention**

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Using FY 2008-09 and 2009-10 data, the target populations with disparities within the above selected populations are:

- Medi-Cal population
 1. Asian/Pacific Islanders
 2. Latinos
 3. Children, ages 0-15
 4. Transition Age Youth (TAY), ages 16-25
 5. Older adults over the age of 60
 6. Communities that speak the following threshold languages: Arabic, Armenian, Cantonese, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog and Vietnamese
 7. Women
- Community Services and Support (CSS) Plan (same as Medi-Cal listed above because the populations served overlap)
 1. Asian/Pacific Islanders
 2. Latinos
 3. Children, ages 0-15
 4. Transition Age Youth (TAY), ages 16-25
 5. Older adults over the age of 60
 6. Communities that speak the following threshold languages: Arabic, Armenian, Cantonese, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog and Vietnamese
 7. Women
- Workforce, Education, and Training (WET)
 1. Asian/Pacific Islanders
 2. Latinos
 3. Older adults over the age of 60

4. Communities that speak the following threshold languages: Arabic, Armenian, Cantonese, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese.
- PEI Priority Populations with Disparities:
 1. Underserved Cultural Populations
 - a. GLBTQ
 - b. Deaf/Hard of Hearing
 - c. Blind/Visually impaired
 - d. American Indian/Alaskan Native
 2. Individuals Experiencing Onset of Serious Psychiatric Illness
 - a. Young Children
 - b. Children
 - c. Transition Age Youth (TAY)
 - d. Adults
 - e. Older Adults
 3. Children/Youth in Stressed Families
 - a. Young Children
 - b. Children
 - c. TAY
 4. Trauma-exposed
 - a. Veterans
 - b. Young Children
 - c. Children
 - d. TAY
 - e. Adults
 - f. Older Adults
 5. Children/Youth at Risk for School Failure
 - a. Young Children
 - b. Children
 - c. TAY
 6. Children/Youth at Risk of or Experiencing Juvenile Justice
 - a. Children
 - b. TAY

1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the county used to identify and target the population(s) (with disparities).

In order to provide planners with an overview of where high-risk communities were located, a collection of bio-psycho-social and demographic variables was assembled which had relevance to the PEI mission. In particular, 24 key indicators were chosen to provide measures of important aspects of the six PEI priority populations and two PEI key community needs (Stigma and Discrimination and Suicide Risk). Each indicator was selected on the basis of its face validity and/or its appearance in the research literature linking it with a PEI population or community need. For this reason, the indicators, along with the underlying geography, helped identify vulnerable populations and/or specific areas at high risk for contributing to behavioral and social problems.

PEI Priority Populations
Underserved Cultural Populations <ul style="list-style-type: none"> ▪ Ethnicity ▪ Primary Language ▪ Linguistic Isolation
Individuals Experiencing Onset of Serious Psychiatric Illness <ul style="list-style-type: none"> ▪ Mental Health Treatment Penetration Rate ▪ Depressive Disorders ▪ Co-Occurring Disorders (COD)
Children/Youth in Stressed Families <ul style="list-style-type: none"> ▪ Poverty ▪ Unemployment Rate ▪ Disrupted Families ▪ A Safe Play to Play
Trauma-exposed Individuals <ul style="list-style-type: none"> ▪ Child Abuse ▪ Elder and Dependent Adult Abuse ▪ Homelessness ▪ Posttraumatic Stress Disorder (PTSD) Rates
Children/Youth at Risk for School Failure <ul style="list-style-type: none"> ▪ 4-year Dropout Rates ▪ High School Graduation Rates ▪ English Fluency ▪ 3rd Grade Reading Level
Children/Youth at Risk of or Experiencing Juvenile Justice Involvement <ul style="list-style-type: none"> ▪ School Discipline ▪ Juvenile Felony Arrests ▪ Youth on Probation
Key PEI Community Mental Health Needs
Stigma and Discrimination <ul style="list-style-type: none"> ▪ Language Capacity of Mental Health Providers
Suicide Risk <ul style="list-style-type: none"> ▪ Deaths by Suicide ▪ Mental Health Emergency Statistics

For each indicator, we attempted to gather data on race and ethnicity. As data were gathered, we allocated numbers across service area and Public Use Microdata Areas (PUMAs). This effort yielded some of the smallest units of analyses ever attempted in a community needs assessment for LA County. This allowed LACDMH to identify communities (i.e. aggregated census tracts) who were particularly at-risk for a mental health disorder, school problem, etc. This statistical approach was supplemented by qualitative information we got from the focus groups and expert interviews. Doing this allowed us to see where information sources converged.

II. Identified disparities (within the target populations). The county shall include the following in the CCPR

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI's priority/targeted populations).

Please note that the disparities are the same for Medi-Cal and CSS as the populations are the same.

Disparities from Medi-Cal and CSS populations

The disparity by ethnicity among Medi-cal population with estimated SED/SMI as compared with consumers served in Outpatient facilities in FY 2009-2010 is for Latinos and Asian/Pacific Islanders.

Latinos are 88,396 of the Medi-Cal population with estimated SED/SMI but only 51,437 of the consumers served. Similarly, Asian/Pacific islanders are 14,936 of the Medi-Cal population with estimated SED/SMI but only 4,539 of the consumers served. Please see Criterion 2, Table 3.

Eleven of the 13 LACDMH threshold languages show disparities (all except Cambodian and English). According to Table 4 in Criterion 2, approximately 36,029 Spanish speaking, 3,496 Armenian speaking, 1,523 Cantonese speaking, 952 Vietnamese speaking, 923 Mandarin speaking, 1,314 Korean speaking, 632 Russian speaking, 607 Farsi speaking, 551 Other Chinese speaking, 587 Tagalog speaking, and 159 Arabic speaking population enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in their language in FY 2009-10.

Children and Older Adults are the two age groups that show the greatest disparity among Medi-Cal population with estimated SED/SMI especially for Older Adults. Children are 72,807 of the Medi-Cal population with estimated SED/SMI but only 55,442 of the consumers served. Similarly, Older Adults are 23,808 of the Medi-Cal population with estimated SED/SMI but only 4,103 of the consumers served. TAYs also show disparities as 17,178 of them are in the

Medi-Cal population with estimated SED/SMI but only 11,070 of the consumers served. Please see Criterion 2, Table 5.

Gender disparity among Medi-Cal population with estimated SED/SMI is among females. Females are 77,589 of the Medi-Cal population with estimated SED/SMI but 52,478 of the consumers served. Please see Criterion 2, Table 6.

Disparities from WET populations

Criterion 2, III B, Table 4 shows estimated disparity for the 13 LACDMH threshold languages. Eleven of the thirteen threshold languages (the exceptions are Cambodian and English) have estimated disparities. Approximately 26,217 Spanish speaking, 3,264 Armenian speaking, 1,455 Cantonese speaking, 853 Vietnamese speaking, 802 Mandarin speaking, 625 Korean speaking, 564 Russian speaking, 513 Farsi speaking, 484 Other Chinese speaking, 447 Tagalog speaking, and 125 Arabic speaking population enrolled in Medi-Cal and estimated with SED/SMI were not served with mental health services in their language in FY 2009-10.

Disparities from PEI populations

The PEI Ad Hoc Advisory Groups identified four groups under the PEI Priority Populations - Underserved Cultural Populations, namely, the American Indian/Alaskan Native, GLBTQ, deaf/hard of hearing and blind/visually impaired. Specific evidence-based programs, promising practices, and community-defined evidence practices were identified for these populations group. In general, the eight Service Area PEI Ad Hoc Steering Committees did not target specific population groups, but rather selected programs that served all groups and/or had proven track records for culturally appropriate effectiveness in serving a specific racial/ethnic group.

1. Underserved Cultural Populations
 - a. GLBTQ
 - b. Deaf/Hard of Hearing
 - c. Blind/Visually impaired
 - d. American Indian/Alaskan Native
2. Individuals Experiencing Onset of Serious Psychiatric Illness
 - a. Young Children
 - b. Children
 - c. Transition Age Youth (TAY)
 - d. Adults
 - e. Older Adults
3. Children/Youth in Stressed Families
 - a. Young Children
 - b. Children

- c. TAY
- 4. Trauma-exposed
 - a. Veterans
 - b. Young Children
 - c. Children
 - d. TAY
 - e. Adults
 - f. Older Adults
- 5. Children/Youth at Risk for School Failure
 - a. Young Children
 - b. Children
 - c. TAY
- 6. Children/Youth at Risk of or Experiencing Juvenile Justice
 - a. Children
 - b. TAY

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified

The strategies identified in the CSS Plan were in response to the results of an expansive community needs and strengths assessment process. More than 2,000 people participated and produced almost 1,000 pages of data and recommendations regarding the challenges and issues affecting the various age groups, ethnic populations, and other special populations across the County. We feel it is important to provide you with this context for understanding the strategies we chose.

In particular we want you to be aware of the following themes that emerged for the UREP groups, summarized here:

African/African-American

- Children: somewhat available but could use more services
- Adults: somewhat available but could use more services
- Older Adults: needing more services because they are almost non-existent
- Underserved populations within A/AA community: LGBTQ, homeless, undocumented immigrants, deaf/hearing impaired, and adults of transitional age (55-64), and other unspecified populations

American Indian/Alaskan Native

- Lack of funding
- Inadequate transportation
- Wide geographic dispersion

- Barriers between client-provider relationships due to lack of cultural sensitivity
- Inappropriate service delivery
- Lack of awareness of mental health centers to access services
- Need for traditional healing activities

Asian and Pacific Islander

- Cultural Competence
- Services for indigent and uninsured
- Consumer Leadership Development and Training
- Integrated system of Care for API individuals and families with the most severe mental health needs and those at risk: crisis intervention, creative housing, comprehensive pre-vocational and vocational training, consumer-run business enterprises, benefits and community resource coordination, older adult day care/club house, children and TAY bicultural parenting support
- Need extra time for monolingual populations that is usually not accounted for in billing
- Culturally competent staff who speak the appropriate language
- Evidence-based treatment approaches for API
- Redefine “medical necessity” to allow for early intervention
- Safe living arrangement
- Lack of transportation
- Residential status

Latino

- Need for more services for the children and adult populations
- Children: services for coping with sexual and gender orientation differences
- Adults: more innovative programs in crisis intervention, transitional housing to permanent shelter
- Develop a more linguistically and culturally appropriate approach to serving Latinos
- Improve quality of services
- Increase advocacy, especially for immigrant populations

These themes informed the table below. Additionally, this information provided a starting point for the five countywide workgroups to begin their work to provide recommendations to the stakeholder delegates. Through intensive dialogue and analysis, the countywide workgroups identified the following priority issues for each of the four age groups to be addressed by the first iteration of the CSS Plan:

Children	TAY	Adults	Older Adults
Children being removed from their families by the Department of Children and Family Services because of mental health issues affecting the children, other family members, or both.	Young people involved in child welfare and probation systems because of mental health issues. The lack of support and services for these youth as they transition out of these systems	The frequent cycle suffered a many adults struggling with mental health issues that see people cycled between homelessness, institutionalization, incarceration, and emergency rooms.	Lack of understanding and commitment for addressing mental health issues among the older adult population from policy makers, clinicians, community leaders and others.
Children suffering, because their parents or caregivers, including teen parents, have SED or severe and persistent mental illness.	Invisibility: many transition age youth, who suffer from mental health issues are highly transient and therefore present challenges for developing trusting relationships that can lead to effective services and supports being provided	Co-occurring disorders, particularly substance-abuse disorders	Significant differences in needs and issues affecting younger, older adults (60-65) and older adults
School issues, including: truancy, expulsions and suspensions from schools, violent behaviors at schools, and school failures	Transition age youth and their families who suffer from co-occurring disorders, particularly substance abuse disorders	Lack of adequate transition facilities to help people move out, of institutional settings and into more community-based settings	Lack of the basic resources and infrastructure for a system of care for older adults
Children and youth who are involved with the Juvenile Justice System because of mental health issues	Transition age youth, who are homeless and who lack safe, affordable permanent housing	Adults were homeless and who lack affordable permanent housing	Lack of effective data documenting the needs of this population
Children, youth and their families who suffer from co-occurring disorders, particularly substance abuse disorders	Frequent lack of family engagement in issues affecting TAY	In many communities, lack of awareness and acceptance of mental health issues	Multiple barriers to accessing services (e.g. providing effective services to people who are homebound)
Lack of cultural awareness and culturally competent services and supports The desire to address in concrete ways, issues of disparities in access to services and disparities in outcomes.	Lack of cultural awareness and culturally competent services and supports The desire to address in concrete ways, issues of disparities in access to services and disparities in outcomes.	Lack of cultural awareness and culturally competent services and supports The desire to address in concrete ways, issues of disparities in access to services and disparities in outcomes.	Lack of cultural awareness and culturally competent services and supports The desire to address in concrete ways, issues of disparities in access to services and disparities in outcomes.

Please note that because Los Angeles is such a large and diverse county, we determined that our mental health system must embed cultural competency in all that we do. While only a few of the following strategies point to specific ethnic and cultural populations or are aimed at reducing specific disparities, we know that the majority of those served in the strategies listed here are from underserved and inappropriately served ethnic and cultural populations. We are confident that the targeted populations with disparities will benefit from the strategies listed and that the system as a whole will increase its cultural competency as it was the basis of our planning, even though the end result may not appear to have been organized that way.

Below are the strategies identified in the respective MHSA Plans:

CSS Strategies

1. Full Service Partnerships (FSP) – FSPs provide services to the established CSS focal populations through a “whatever it takes” commitment to support the individual receiving services to make progress on their particular pathway to recovery and wellness. Because the Stakeholders identified ethnic parity as a high priority, they have chosen the allocations for Full Service Partnerships as the first set of investments for which they will set targets by ethnicity, age group and service area. LA County is the only county to have added ethnic targets for each age group by service area. Our FSPs are organized by age groups: Child, Transition Age Youth (TAY), Adult and Older Adult. More detailed information regarding the FSP programs for specific age groups is provided in the sections that follow.
2. Outreach and Engagement (O&E) – LACDMH conducts O&E within each of the eight service areas. Our O&E efforts provide a critical bridge between LACDMH and the specific needs of underserved ethnic and cultural communities. Our aim is for the O&E work to create an infrastructure that supports the commitment to forming partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations, and other County Departments to achieve the promise of the Mental Health Services Act. As stated in the Community Program Planning, strong emphasis is placed on outreach and engagement to underserved, unserved, inappropriately served, and hard-to-reach ethnic populations. The O&E Team is comprised of 13 front-line O&E coordinators who are under the direct supervision and guidance of the Service Area District Chiefs. Each of the eight Service Areas has one or two designated O&E coordinators serving their specific communities with focused outreach and engagement in the form of mental health education, linkage to mental health services as well as other community-based services and support. In doing O&E work, the coordinators aim at promoting mental health awareness and accurate information while decreasing the stigma associated with needing, seeking and receiving mental health services.

3. UREP – The UREP Work Group consisted of 56 culturally diverse mental health professionals and community and client advocates who made implementation recommendations to the LACDMH on MHSA Plans. The UREP unit within the Planning Division has established sub-committees dedicated to working with the various under-represented ethnic populations in order to address their individual needs. These groups are: African/African-American; American Indian /Alaskan Native; Asian Pacific Islander; Eastern European/Middle Eastern and Latino. The UREP Subcommittees have identified cultural sub-populations and maintain an organizational structure to address issues pertinent to mental health services for underserved ethnic populations. Each of these groups utilized one-time CSS funds for capacity-building projects designed specifically to meet the needs of their cultural communities. These five projects are detailed in Section III, B, 1.

WET Strategies

1. County of Los Angeles Oversight Committee – One objective of the Oversight Committee is to ensure the County’s compliance with WET protocols and review how the ethnic minority and linguistic staffing needs of the County are being met.
2. Recovery-Oriented Supervision Trainings – A key component of the Recovery-Oriented Supervision curriculum is the incorporation of cultural competency topics such as how one’s cultural perspective affects service delivery.
3. Interpreter Training Program – This program includes an intensive 3-day training for individuals who provide interpreting services in mental health settings, as well as a 1-day training for the mental health providers on how to best use interpreters. Both components also include technical assistance and follow-up support to all participants. The curriculum was developed in collaboration between the National Latino Behavioral Health Association and the National Asian American Pacific Islander Mental Health Association. This collaboration ensures the curriculum addressed a wide range of cultural issues that are specific to interpreting in a mental health setting.
4. Training for Community Partners – One objective of the trainings for community partners is to train them to recognize the signs of mental illness and how to access care for the individual in a culturally appropriate manner.
5. Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System – One objective of this training is to recruit and attract ethnically and linguistically diverse individuals, with a target of at least 50% of participants being from unserved and/or underserved ethnic communities.
6. Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System – One objective of the training is to assist in accessing

- employment for parent advocates, child advocates and caregivers in the public mental health system with particular emphasis on increasing the number of parent advocates, child advocates and caregivers from underserved ethnic communities representing the 13 threshold languages.
7. Expanded Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System – One objective of the training is to assist family member advocates to access employment in the public mental health system with particular emphasis on increasing advocates to serve currently unserved and underserved communities representing the 13 threshold languages.
 8. Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System – Studies would include designing research to target attracting more bilingual staff, as well as staff to serve ethnic minority communities.
 9. Tuition Reimbursement Program – Applicants for the Tuition Reimbursement Program who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority for the program.
 10. Associate and Bachelor Degree 20/20 and/or 10/30 Program – Priority will be given to staff that are bilingual and/or willing to work with under-represented communities in the County.
 11. Stipend Programs for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians – It is expected that 50% of the stipend students will be providing services to communities with bilingual and/or bicultural special needs.
 12. Loan Forgiveness Program – The Loan Forgiveness Program will be tailored to meet the need for a linguistically and culturally competent workforce.

PEI Strategies

PEI developed thirteen projects that address the needs, priority populations, special sub-populations, and PEI programs selected by the stakeholders. Each PEI project is comprised of the following components: Outreach and Education; Training and Technical Assistance; and Data Collection, Outcomes, Monitoring and Evaluation

1. Stigma and Discrimination Reduction – The Stigma and Discrimination Reduction Project will provide outreach and education to the broader community utilizing staff that have lived experience in mental illness through a three-fold plan: (1) family supports and education strategies; (2) client-focused strategies; and (3) community advocacy strategies.
2. Student Mental Health – The School Mental Health Project will initiate: (1) School Threat Assessment Response Teams (START) comprised of law enforcement officers and DMH clinicians working with school personnel and (2) a school mental health PEI demonstration project in service area 6 with large African-American and Latino populations.

3. *Suicide Prevention* – The Suicide Prevention Project will provide: (1) a program targeting at-risk Latina youth and their families; (2) a suicide hotline transformation and expansion of suicide prevention services; (3) information and education through web-based training of school personnel; (4) suicide prevention specialists teams; (5) an integrated care model to bring mental health services to primary care agencies.
4. *School-based Services* – The School-based Services Project will: (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress.
5. *Family Education and Support Services* – The Family Education and Support Project will build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies.
6. *At-risk Family Services* – The At-risk Family Services Project will: (1) provide training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) build skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provide support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.
7. *Trauma Recovery Services* – The Trauma Recovery Services Project will: (1) provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provide more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events.
8. *Primary Care and Behavioral Health* – The Primary Care and Behavioral Health Project will develop mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral.
9. *Early Care and Support for Transition-age Youth* – The Early Care and Support for Transition-Age Youth Project will: (1) to build resiliency, increase protective factors, and promote positive social behavior among TAY; (2) address depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness.
10. *Juvenile Justice Services* – The Juvenile Justice Services Project will: (1) build resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promote coping and life skills to youths in

the juvenile justice system to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system.

11. *Early Care and Support for Older Adults* – The Early Care and Support Project for Older Adults will: (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals.
12. *Improving Access for Underserved Populations* – The Improving Access for Underserved Populations Project will: (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals, blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.
13. *American Indian Project* – The American Indian Project will: (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness.

It is anticipated that a significant proportion of the target population served in each strategy will be from underserved or inappropriately served ethnic or cultural communities.

In addition, PEI has identified Evidence-Based Practices (EBPs) for PEI populations with identified target age groups, whether these are considered prevention or early intervention and the ethnic/cultural groups these EBPs serve. Below is a chart of all of the EBPs:

PEI PROGRAMS				
Program Name		Ages Served	Prevention (P) / Early Intervention (EI)	Cultural Evidence EBP= Evidence-based Practice; PP = Promising Practice CDE = Community-Defined Evidence
1	Advice Line project	All ages	PEI	Pilot project designed for use with all ethnic groups.
2	Aggression Replacement Therapy (ART)	12-17	PEI	PP designed for use with all ethnic groups.
3	Alternatives for Families aka Abuse Focused Cognitive Behavioral Therapy for Child Physical Abuse	6-12	EI	PP designed for use with all ethnic groups. Strong support for use with African-Americans.
4	American Indian Life Skills	13-17	P	PP designed for use with Native Americans.
5	Asian American Family Enrichment Network (AAFEN) Program	13-18	PEI	CDE designed for Asian (particularly Chinese, Korean, and Vietnamese) immigrant parents and/or primary caregivers of teenage children
6	Brief Strategic Family Therapy (BSFT)	10-18	PEI	EBP designed for use with all ethnic groups. Strong support for use with Latinos.
7	Center for the Assessment and Prevention of Prodromal States (CAPPS)	16-25	PEI	CDE designed for use with all ethnic groups; services available in Spanish.
8	Caring for our Families (CFOF)	5-11	EI	CDE designed for Cambodian and Korean immigrant and refugee families.
9	Child-Parent Psychotherapy	0-7	EI	EBP designed for use with all ethnic groups. Strong support for use with Latinos.
10	Cognitive Behavioral Intervention for Trauma in Schools (CBITS)	10-14	PEI	EBP designed for use with ethnic minorities and immigrants. Support for use with Latinos, African-Americans, and Native Americans.
11	Cognitive Behavioral Therapy (CBT) for Depression (with antidepressant medication)	18-55	EI	EBP designed for use with all ethnic groups. Modified for use with Latinas and African-Americans.
12	Cognitive Behavioral Therapy for Late Life Depression (LLCBT)	55+	EI	EBP designed for use with all ethnic groups. Demonstrated effectiveness among Latinos, Chinese, and African-Americans.
13	Crisis Oriented Recovery Services (CORS)	All Ages	EI	PP designed for use with all ethnic groups.
14	Early Detection and Intervention for the Prevention of Psychosis (EDIPP)	12-25	PEI	PP designed for use with all ethnic groups.
15	Early Risers Skills for Success	6-12	EI	EBP designed for use with all ethnic groups. Strong support for use with African-Americans
16	Families and Schools Together (FAST)	4-12	P	EBP designed for use with all ethnic groups. Strong support for use with African-Americans and Native Americans.

PEI PROGRAMS				
Program Name		Ages Served	Prevention (P) / Early Intervention (EI)	Cultural Evidence EBP= Evidence-based Practice; PP = Promising Practice CDE = Community-Defined Evidence
17	Family Coping Skills Program (FCSP)	Adults	P	Emerging practice developed for use with Latinas.
18	Functional Family Therapy (FFT)	11-18	EI	EBP designed for use with all ethnic groups.
19	Gatekeeper Case-Finding Model	55+	P	Emerging practice designed for use with all ethnic groups.
20	GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services	15-25	PEI	CDE designed for use with African-Americans.
21	Group Cognitive Behavioral Therapy (CBT) for Major Depression	Adults	EBP	EBP designed for use with all ethnic groups. Modified for use with Latinos and African-Americans.
22	Improving Mood – Promoting Access to Collaborative Treatment (IMPACT)	60+	EI	EBP designed for use with all ethnic groups.
23	Incredible Years (IY)	3-12	PEI	EBP designed for use with all ethnic groups. Support for use with African-Americans, Asians, and Latinos. Adapted for use with Koreans.
24	Interpersonal Psychotherapy (IPT) for Depression	12-18	PEI	Designed for use with all ethnic groups. Modified for use with Latinos.
25	LIFE (Loving Intervention for Family Enrichment) Program	10-17	EI	CDE designed for Latino families with monolingual (Spanish) parents
26	Live Well, Live Long, Steps to Mental Wellness	60+	PEI	EBP designed for use with all ethnic groups.
27	Making Parenting a Pleasure	0-8	P	PP designed for use with all ethnic groups.
28	Mothers and Babies Course “Mamás y Bebés”	16-35 – Mothers with babies 0-2	PEI	PP designed for use with Latinas.
29	Maternal Wellness	Mother and infants	PEI	CDE designed for low income, ethnic minority, high-risk women and infants.
30	Multidimensional Family Therapy (MDFT)	11-18	PEI	EBP designed for use with all ethnic groups. Strong support for use with African-Americans.
31	Multisystemic Therapy (MST)	11-18	EI	EBP designed for use with all ethnic groups. Support for use with African-Americans.
32	Nurse Family Partnership (NFP)	Pregnancy-2	PEI	EBP designed for use with all ethnic groups. Support for use with African-Americans.
33	Nurturing Parenting Program	5-18	PEI	PP designed for use with all ethnic groups. Strong support for use with Latinos; some support for use with Native Americans.
34	Olweus Bullying Prevention Program	6-14	P	PP designed for use with all ethnic groups.

PEI PROGRAMS				
Program Name		Ages Served	Prevention (P) / Early Intervention (EI)	Cultural Evidence EBP= Evidence-based Practice; PP = Promising Practice CDE = Community-Defined Evidence
35	Parent-Child Interaction Therapy (PCIT)	3-6	EI	EBP designed for use with all ethnic groups. Adapted for use with Latinos.
36	Positive Directions	10-17	EI	CDE designed for use with all ethnic groups and services delivered in Spanish.
37	Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)	60+	PEI	EBP designed for use with all ethnic groups. Support for use with African-Americans.
38	Prolonged Exposure Therapy for Posttraumatic Stress Disorders (PE-PTSD)	18-65+	EI	EBP designed for use with all ethnic groups. Support for use with African-Americans.
40	Psychogeriatric Assessment and Treatment in City Housing (PATCH)	60+	EI	Designed for use with all ethnic groups.
41	<i>Promotores de salud para nuestra tercera edad</i> (Health Promoters for our Third Age or Community Health Workers for Latino Older Adults)	55+	P	CDE designed for use with Latinos.
42	Psychological First Aid for Students and Teachers	5-18 Teachers	PEI	CDE designed for use with all ethnic groups.
43	Reflective Parenting Program (RPP)	Pregnant women & parents of 2-12	EI	CDE designed for use with all ethnic groups; has curriculum for Spanish-speaking parents.
44	Seeking Safety	15-55	EI	PP designed for use with all ethnic groups. Support for use with African-Americans.
45	Strengthening Families	3-16	PEI	Designed for use with all ethnic groups. Support for use with African-Americans and Latinos.
46	System Navigators	16+	P	Pilot project designed for veterans and their families of all ethnic groups.
47	Trauma Focused Cognitive Behavioral Therapy (TF-CBT)	3-18	EI	EBP designed for use with all ethnic groups.
48	Trauma-Focused CBT (TF-CBT): "Honoring Children, Mending the Circle"	3-18	EI	EBP designed for use with all ethnic groups. Adapted for use with Native Americans.
49	Triple P– Positive Parenting Program	0-18	PEI	EBP designed for use with all ethnic groups.
50	UCLA Ties Transition Model (TTM)	0-8	PEI	CDE designed for use with all ethnic groups; services provided in English & Spanish; serves diverse adoptive situations, including transracial single parent, and gay & lesbian individuals and couples.

PEI PROGRAMS				
Program Name		Ages Served	Prevention (P) / Early Intervention (EI)	Cultural Evidence EBP= Evidence-based Practice; PP = Promising Practice CDE = Community-Defined Evidence
51	Why Try? Program	6-18	PEI	CDE designed for low-income, minority youth.

B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:

I. Medi-Cal population

II. 200% of poverty population

III. MHSA/CSS population

IV. PEI priority population(s) selected by the county, from the six PEI priority populations

Please note that because Los Angeles is such a large and diverse county, our mental health system must embed cultural competency in all that we do. Many strategies are embedded in programs and services. These include:

1. Outreach and Engagement
2. Community education to increase mental health awareness and decrease stigma
3. Multi-lingual/multicultural materials
4. Collaboration with faith-based and other trusted community entities/groups
5. School-based services
6. Field-based services
7. Programs that target specific ethnic and language groups
8. Designating and tracking ethnic targets for FSP
9. Flexibility in FSP enrollment such as allowing “those living with family” to qualify as “at-risk of homelessness”
10. Countywide FSP Networks to increase linguistic/cultural access
11. Integrated Supportive Services
12. Co-location with other county departments (DCFS, DPSS, DHS)
13. Interagency Collaboration
14. Consultation to gatekeepers
15. Trainings/ case consultation
16. Provider communication and support
17. Multi-lingual/multi-cultural staff development and support
18. EBPs/CDEs for ethnic populations
19. Investments in learning (e.g. Innovation Plan)

I. Summary of Program/Service Strategies for addressing disparities identified in Criterion 2 within the Medi-Cal and MHSA/CSS populations:

1. Latinos
 - a. All FSP programs (including the TAY and Infant FSP – Young Mothers and Babies, Mamas y Bebes program)
 - b. UREP Capacity Building Project for Latinos (Promotores de Salud)
 - c. Outreach & Engagement
2. Asian Pacific Islanders
 - a. Adult and Child FSP programs (including the API Mental Health Alliance for Adults and API Collaborative for Children)
 - b. UREP Capacity Building Project for APIs
 - c. Outreach & Engagement
3. Children
 - a. Child FSP program
 - b. Katie A
4. TAY
 - a. TAY FSP program
 - b. TAY and Infant FSP program – Young Mothers and Babies, Mama y Bebes
5. Older Adults
 - a. Older Adult FSP Program
 - b. FCCS
 - c. Service Extenders
6. Threshold Languages
 - a. All FSP programs
 - b. All UREP Capacity Building Projects
 - c. Outreach & Engagement
 - d. All WET strategies
7. Women
 - a. All FSP Programs (including the TAY and Infant FSP program, Young Mothers and Babies FSP Program, Mamas y Bebes)
 - b. CalWORKs

What follows is a more detailed description of each of the program/service strategies named above for the Medi-Cal and CSS population.

Full Service Partnerships (FSPs)

FSPs provide services to the established CSS focal populations through a “whatever it takes” commitment to support the individual receiving services to make progress on their particular pathway to recovery and wellness. Because the Stakeholders identified ethnic parity as a high priority, they have chosen the allocations for Full Service Partnerships as the first set of investments for which they will set targets by

ethnicity, age group and service area. LA County is the only county to have added ethnic targets for each age group by service area in these programs. Our FSPs are organized by four age groups: Child, Transition Age Youth (TAY), Adult and Older Adult.

Child FSP – The Children's Full Service Partnership is a mental health service program for children ages 0 – 15 and their families who would benefit from an intensive in-home program designed to address the total needs of the child, including his or her family, who is experiencing significant, emotional, psychological and behavioral problems that are interfering with the child's well being. Below are data regarding the number of consumers served by ethnic target and focal population:

CHILD CONSUMERS SERVED BY FULL SERVICE PARTNERSHIP PROGRAM

TOTAL NUMBER OF CONSUMERS SERVED BY FISCAL YEAR							
Ethnicity Targets	White 124	Latino 1232	African American 252	Asian 113	Native American 8	Other n/a	Total 1729
FY 08-09	236	1400	517	97	10	33	2293
FY 09-10	255	1610	569	125	11	32	2602
Difference	7%	13%	9%	22%	9%	-3%	12%

A comparative analysis reveals a steady increase in servicing targeted populations identified by the Los Angeles County stakeholder process for all UREP groups.

CHILD FSP - FOCAL POPULATIONS

TOTAL NUMBER OF CONSUMERS SERVED FOR FISCAL YEAR 08-09							
Focal Population	White	Latino	African American	Asian	Native American	Other n/a	TOTAL
0-5	46	287	97	10	0	7	447
Probation	19	117	86	7	0	3	232
DCFS	133	788	288	64	8	21	1302
School	38	208	46	16	2	2	312
TOTAL:	236	1400	517	97	10	33	2293

TOTAL NUMBER OF CONSUMERS SERVED FOR FISCAL YEAR 09-10							
Focal Population	White	Latino	African American	Asian	Native American	Other n/a	TOTAL
0-5	49	309	103	12	2	6	481
Probation	20	146	83	9	0	1	259
DCFS	155	949	335	85	8	20	1552
School	31	206	48	19	1	5	310
TOTAL:	255	1610	569	125	11	32	2602

LACDMH also supported the formation of a countywide network for the API Child FSP, similar to the API Mental Health Alliance discussed in the Adult FSP section. The API Child Collaborative serves API children ages 0-15 and their families and are designed to address the total needs of families whose children (and possibly other family members) are experiencing significant emotional, psychological or behavioral problems interfering with their well being. Languages spoken by API Child Collaborative staff include: Cantonese, Chiu Chow, Khmer/Cambodian, Korean, Mandarin, Tagalog, Taiwanese, Vietnamese, and other Asian languages depending on staffing.

The API Child Collaborative agency partners include:

- Asian Pacific Counseling & Treatment Center – Los Angeles/Main Center (Service Area 4)
- Asian Pacific Counseling & Treatment Center – San Fernando Valley Center (Service Area 2)
- Asian Pacific Family Center – San Gabriel Valley (Service Area 3)
- Koreatown Youth & Community Center (Service Area 4)
- Pacific Asian Counseling Services, Long Beach Office (Service Area 8)
- Pacific Asian Counseling Services, Los Angeles Office (Service Area 5)

The API Child Collaborative is capable of services beyond the scope of traditional clinic-based outpatient mental health services. Those participating will have the support of a service provider 24 hours a day, 7 days a week and access to a plethora of API languages.

Transition Age Youth (TAY) FSP – These programs are designed for TAY aged 16-25 who need intensive services with 24/7 staff availability to help individuals address emotional, housing, physical health, transportation, and other needs to function independently in the community. Below are data regarding the number of TAY consumers served by ethnic target and focal population:

TAY PERCENT OF FOCAL POPULATION

FOCAL POPULATION	FY 2008-09 Goal	FY 2008-09 Actual # Served	FY 2008-09 Percentage of Goal Met
HOMELESS	237	605	255%
AGING OUT	352	415	118%
LONG TERM INST	350	182	52%
1ST PSYCH BREAK	233	304	130%

FOCAL POPULATION	FY 2009-10 Goal	FY 2009-10 Actual # Served	FY 2009-10 Percentage of Goal Met
HOMELESS	240	614	256%
AGING OUT	356	443	124%
LONG TERM INST	354	217	61%
1ST PSYCH BREAK	236	311	131%

ETHNIC TARGETS	FY 2008-09 Goal	FY 2008-09 Actual # Served	FY 2008-09 Percentage of Goal Met
WHITE	142	166	117%
LATINO	746	486	65%
AFRICAN AMERICAN	149	292	196%
ASIAN PACIFIC ISLANDER	126	52	41%
AMERICAN INDIAN	9	11	122%
OTHER - UNKNOWN	-	30	-

ETHNIC TARGETS	FY 2009-10 Goal	FY 2009-10 Actual # Served	FY 2009-10 Percentage of Goal Met
WHITE	145	187	129%
LATINO	754	498	66%
AFRICAN AMERICAN	151	312	207%
ASIAN PACIFIC ISLANDER	127	54	43%
AMERICAN INDIAN	9	8	89%
OTHER - UNKNOWN	-	39	

During Fiscal Year (FY) 2008-09 the TAY FSP program served 1052 unduplicated youth and young adults. Focal populations (see Table above) established for this age group are not mutually exclusive as most TAY served in this program met the criteria for several of the focal populations. It is important to note that ethnic targets set for the TAY FSP program from its inception differed significantly from the actual demand for this service where client ethnicity is concerned. The demand for services for African-American consumers far exceeded the ethnic target; this is thought to be due to factors which include referral sources (child welfare and juvenile justice); relatively less stigma associated with mental health and help-seeking behaviors; higher likelihood to be homeless and therefore more amenable to needed mental health services and supports. While in relative contrast, the demand for TAY FSP services for Latino consumers is consistently lower than their targets in terms of the percentage of slots used in comparison to the slots designated for this ethnic population. Although many factors contribute to this underutilization; those most likely having a greater impact include stigma and discrimination associated with mental illness; reluctance to pursue public services and benefits due to immigration status; and less likely to be homeless. During FY 2009-2010 the TAY FSP program experienced a slight growth in clients served; and little change in meeting the initial ethnic targets. Given the overall demand for TAY FSP services, the structure of contracts with service providers, and the Service Area variances in Los Angeles County, meeting ethnic targets will be an ongoing challenge.

This is the first full fiscal year in which TAY Field-Capable Clinical Services (FCCS) was offered; thus providing a “intermediate level” treatment intervention option for consumers transitioning from or reluctant to enroll in the FSP program. Services to older TAY (e.g. TAY over 21 years of age) present another challenge in meeting focal and ethnic targets. In addition to the challenges previously mentioned, these young adults tend to have more intensive service needs yet fewer benefits and supports options than those TAY under 21. During this FY, LAC-DMH arranged training for six (6) TAY FSP programs in the Transition to Independence Process (TIP) Model for the primary purpose of introducing manualized, proven methods for serving the TAY populations. Concurrent with these efforts, the TAY Division implemented Anti-Stigma and Discrimination and Suicide Prevention programs to its outreach and engagement strategies. It is hoped that all of these efforts will result in increased demand for, utilization of, and benefit from mental health services and supports for the SED/SPMI TAY population.

TAY and Infant FSP – Young Mothers and Babies FSP or “Mamas Y Bebes”

The Young Mothers and Babies Full Service Partnership Program, “Mamas y Bebes”, is designed to meet the mental health needs of young Latina mothers (ages 14 to 25) and their babies or young children (ages 0-5) in their homes with 24-hour access to mental health resources and supports. Client goals and interventions focus on psycho-education, therapy and intensive case management to facilitate the

development of safe, nurturing and responsive dyadic relationships between at-risk mothers and their children.

“Las Mamas” meet FSP criteria for services due to one or more of the following:

- risk of/current homelessness;
- currently involved with or aging out of the child mental health, welfare, or juvenile justice system and needing more intensive services;
- leaving long term institutional care or recurrent psychiatric hospitalizations;
- experiencing a first psychotic break; and/or,
- experiencing a co-occurring substance abuse disorder in addition to a mental health disorder.

“Los Bebés” ages Birth to Five meet FSP criteria when they are:

- at-risk of expulsion from preschool;
- involved with DCFS or at risk of being detained by DCFS with an identifiable mental health issue; and,
- with a parent or caregiver who has a serious emotional disturbance or severe and persistent mental illness along with substance abuse or co-occurring disorders.

The program is organized with Spanish language capacity among the multidisciplinary staff, with the intent of being able to serve the entire family residing in the home. This includes monolingual Spanish-speaking grandparents who are often involved in the raising of the grandchild. The goals of the program include the prevention of homelessness and foster placement by DCFS for the young children, the stabilization of the TAY mother and the parent/child dyad, and the healthy physical and emotional development of the young child in order to break the cycle of abuse, neglect, psychiatric disturbance and out-of-home placement. This unique program is run by the directly-operated Roybal Family Mental Health Center in East Los Angeles and is the only one of its kind in Los Angeles County at this time.

Adult FSP – Adult Full Service Partnership (FSP) programs are designed for adults ages 26-59 who have been diagnosed with a severe mental illness and would benefit from an intensive service program. Unique to FSP programs are a low staff to client ratio, a 24/7 crisis availability and a team approach that is a partnership between mental health staff and consumers. Below are data regarding the number of adult consumers served by ethnic target and focal population:

ADULT CONSUMERS SERVED BY FULL SERVICE PARTNERSHIP PROGRAM

TOTAL NUMBER OF CONSUMERS SERVED BY FISCAL YEAR							
Ethnicity Targets	White 426	Latino 1409	African American 330	Asian 422	Native American 24	Other n/a	Total 2611
FY 08-09	1317	971	1363	176	47	111	3985
FY 09-10	1889	1175	1967	259	58	189	5537
Difference	30%	17%	31%	32%	19%	41%	20%

ADULT FSP FOCAL POPULATIONS

TOTAL NUMBER OF CONSUMERS SERVED FOR FISCAL YEAR 08-09 BY FOCAL POP.							
Focal Population	White	Latino	African American	Asian	Native American	Other n/a	TOTAL
Homeless	622	349	787	57	32	56	1903
Jail	138	197	214	15	5	13	582
IMD	120	86	87	29	1	5	328
State Hospital	12	6	18	3	0	0	39
PES	18	21	13	1	0	1	54
UCC	4	6	7	0	0	1	18
County Hospital	84	79	82	16	2	8	271
FFS	227	114	89	29	5	11	475
Living w/ Family	92	113	66	26	2	16	315
TOTAL	1317	971	1363	176	47	111	3985

TOTAL NUMBER OF CONSUMERS SERVED FOR FISCAL YEAR 09-10 BY FOCAL POP.							
Focal Population	White	Latino	African American	Asian	Native American	Other n/a	TOTAL
Homeless	762	458	1045	65	42	39	2411
Jail	198	137	304	29	3	27	698
IMD	200	142	169	32	2	16	561
State Hospital	218	11	34	5	0	3	271
PES	10	15	12	1	2	2	42
UCC	2	7	6	3	0	1	19
County Hospital	112	105	122	32	2	26	399
FFS	275	152	162	48	3	41	681
Living w/ Family	112	148	113	44	4	34	455
TOTAL	1889	1175	1967	259	58	189	5537

As shown in the tables above, the number of UREP consumers served categorized by focal population show increased adult FSP utilization when comparing FY 08-09 and FY 09-10.

API Mental Health Alliance

As an example of how LACDMH has adapted the FSP programs for cultural, ethnic and linguistic needs, we implemented the API Adult FSP programs through the API Mental Health Alliance. In 1997, following the tradition of innovative and culturally competent services, DMH and the Asian Pacific Policy and Planning Council (A3PCON), Mental Health Committee initiated a county-wide, inter-agency collaboration, API Mental Health Alliance that has been providing outreach and access to services for more than 1,000 API individuals with severe and persistent mental illness. The consortium includes the following agencies:

- Asian Pacific Counseling & Treatment Center
- Asian Pacific Family Center, Pacific Clinics
- Asian Pacific Residential & Treatment Center
- DMH Coastal AP Mental Health
- DMH Long Beach AP Family Center
- Pacific Asian Counseling Services
- Special Service for Groups

With the advent of the MHSA, API Alliance was a natural fit for the Full Service Programs because the collaborative has the fiscal, organizational and cultural

structures to recruit, train and coordinate a corps of bi-lingual, bi-cultural staff and consumers to outreach and provide field-based services to API consumers. The FSP teams are designed to respond to the cultural and linguistic needs of clients across geographic boundaries in Los Angeles County. As each consumer has an assigned team to work collaboratively to address multiple needs, the team may comprise of staff from multiple fields (substance abuse, art/family/psycho therapy, case management, psychiatry) and between agencies. The team follows the consumers through various settings (jail, hospital, transitional and semi-independent residential settings, home) with the goal of helping them establish and follow their wellness and recovery plans. Mental health services are on-site and/or in the office with consumers and appropriate family caregivers. Crisis intervention is available 24 hours a day, 7 days a week in the appropriate language of the consumer. The Alliance is able to provide services in these languages: Korean, Japanese, Samoan, Mandarin, Cantonese, Chiu Chow, Vietnamese, Hmong, Khmer, Thai, and Tagalog. This countywide network has been able to respond effectively to the multiple linguistic needs of our diverse API population in Los Angeles County.

Older adult (60 and older) – Older Adult Full Service Partnerships (OA FSPs) are comprehensive, intensive services for persons aged sixty and above who have been diagnosed with a mental illness and are interested in participating in a program designed to address their emotional, physical and living situation needs. FSP Programs are capable of providing an array of services beyond the scope of traditional outpatient services.

Older Adult FSP programs place an emphasis on providing services that are primarily field-based and which are culturally and linguistically appropriate. More than 50% of clients served in OA FSPs are members of UREP groups. Continuing efforts will focus on increasing the number of bi-lingual staff providing service to these consumers. Primary languages of OA FSP consumers include English, Spanish, Vietnamese, Cantonese, Mandarin, Tagalog, Cambodian, Russian, Farsi, Arabic and others.

Older Adult Consumers Served by FCCS in FY09-10

Older Adults Served	Ethnicity							
	AA	AI	API	Latino	Other	Unk	White	Total
52877	9377	277	7609	15781	1288	1520	26384	62236
84.96%	15.07	0.45	12.23	25.36	2.07	2.44	42.39	100.01

Older Adults Served	Gender			
	Female	Male	Unk	Total
52877	44596	17600	40	62236
84.96%	71.66	28.28	0.06	100

Service Extenders – Several of our Older Adult FCCS programs have Service Extenders who are clients in recovery, family members, or other interested individuals who volunteer to serve as members on multi-disciplinary FCCS teams. Their role is to act as a “bridge” between clinical teams and older adults. A primary role they play is that of information gatherer, as they often learn things about the client which the clinical team may not have access to, and can then share this information with the team to better serve the client. For example, they:

- Provide home visits to our older adult clients to provide relationships and decrease isolation. These can include activities such as taking walks, shooting pool, getting nails done, or just talking. Also they make sure the client’s home is physically safe and the client has enough food;
- Provide support for family members of our older adult clients, including giving information about mental illness and available supports and resources;
- Accompany clients to resources and appointments in the community;
- Have phone conversations with clients;
- Act as a role model to the client while also learning from the client.

Currently, LACDMH has 22 Older Adult Service Extenders countywide, many of whom were recruited through our partnerships with other community organizations, including ethnically-based ones. The ethnicities of the Service Extenders include Hispanic, African-American, Euro-American, Chinese, Filipino, Iranian, Russian, Cambodian, and South Asian/Asian Indian. Their languages spoken in addition to English are: Spanish (4), Khmer (4); Mandarin (2); Tagalog (2); Vietnamese (1); Cantonese (1); Russian (1); and Farsi (1).

A series of six workshops have been developed to enhance the skills of our Older Adult Service Extenders:

1. Coping with the Holidays – the meaning of holidays, coping with holiday blues for ourselves and for clients;
2. Growing Old: Understanding Life Span Issues Part I - addresses developmental stages as we age;
3. Growing Old: Understanding Life Span Issues Part II – addresses memory loss, grief, the impact of aging on activities of daily living;
4. Coping with Challenging Situations Part I – engaging difficult clients and other issues of working in the field;
5. Coping with Challenging Situations Part II – assertiveness, setting boundaries, working with a multi-disciplinary team;
6. Self Care & Summing Up – managing stress, burnout, compassion fatigue.

The workshops began in November 2010 and will finish in May 2011. So far feedback has been extremely positive, and we've had approximately 25-30 attendees at each workshop.

Outreach and Engagement (O&E)

LACDMH considers Outreach and Engagement as critical activities that help us achieve our vision of hope, wellness and recovery in a culturally competent manner. 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 a community to talk about suicide may not be successful given the stigma associated with the topic, especially in certain ethnic communities. However, when our O&E Team goes into the community, they may approach the topic as “how to deal with the stress of the holidays” – a more accessible and less stigmatizing approach – and from this can build stronger relationships and ties within the community, which can open the doors later for deeper and focused interventions if needed.

Our aim is for the O&E work to create an infrastructure that supports the commitment to forming partnerships with historically disenfranchised communities, faith-based organizations, schools, community-based organizations, and other County Departments to achieve the promise of the Mental Health Services Act. As stated in the CSS Plan, strong emphasis is placed on outreach and engagement to underserved, unserved, inappropriately served, and hard-to-reach ethnic populations.

The O&E Team is comprised of 13 front-line O&E coordinators who are under the direct supervision and guidance of the Service Area District Chiefs. Each of the eight Service Areas has one or two designated O&E coordinators serving their specific

communities with focused outreach and engagement in the form of mental health education, linkage to mental health services as well as other community-based services and support. In doing O&E work, the coordinators aim at promoting mental health awareness and accurate information while decreasing the stigma associated with needing, seeking and receiving mental health services. Typically, the O&E coordinators are not clinical staff, but act as liaisons between the community and appropriate clinical staff.

O&E Coordinators engage in the following activities:

- Targeted Outreach Activities
 - Conduct one-on-one outreach focusing on mental health in Service Area
 - Attend community meetings in specific Service Area
 - Attend and conduct outreach at health fairs and/or conferences
- Networking, Collaborating and Partnering
 - Network with agencies, schools, providers, and community groups to possibly do presentations for consumers
 - Collaborate with various community organizations
 - Represent the Department at various meetings: CORE, Southeast Cities collaborative, SPA.
- Presenting Information and Educating Community
 - Conduct presentations to community members regarding community mental health resources and mental health education
 - Coordinate logistics for presentations and conduct follow-ups with agencies/organizations
 - Prepare presentation information about mental health services and/or topics requested by the host.
 - Develop handouts to distribute at presentations or events for community members
 - Educate community members on how to access resources for all groups in English and Spanish on mental health issues
 - Conduct online research to compile resources for parents and community members
- Providing and/or Linking to Resources
 - Provide guidance and support on mental health issues
 - Link consumers to mental health, health, transportation, and legal resources on as needed basis
 - Link community groups to the DMH Suicide Prevention and Anti-Stigma Teams
 - Act as liaisons between other government agencies DCFS, DPSS, Probation, DHS and Mexican Consulate.
- Specialized Activities
 - Service Area Navigation duty
 - Resource Libraries
 - Monitor provider agency contracts to assure budget and utilization of contract is in order

SAMPLE MULTICULTURAL O & E ACTIVITIES			
SA	Activity Description	Number Outreached	Group Outreached
1	DCFS Presentation on PEI & MHSA	31	African American, White, Latino
1	Presentation to the Hispanic Chambers Commerce on PEI & MHSA	72	African American, White, Latino
2	Ask the Psychiatrist in Spanish	18	Latino
2	Clergy Breakfast- Presentation on Mental Health Services	18	African American, White, Latino, Filipino
3	El Monte Rosemead Adult School- Presentation on DMH & Anti-Stigma	125	Chinese, Vietnamese, Latino
3	Tzuchi Foundation- Presentation to faith-based organizations on MHSA in Chinese	45	Chinese
4	Annual Korean Festival	42	API, Korean, White, Latino
4	Newmark High School Parent & Student Stress- Bilingual Presentation	9	American Indian, Latino
4	Project Homeless Connect 2011 in Spanish	121	Latino, American Indian
5	Celebration of Life-Senior and Family Festival	42	African American, API, Armenian, Persian, Russian, Irish, White, Latino
5	Ethiopian Community Meeting- Presentation on LACDMH Services	24	Ethiopian
5	Job Fair Booth	43	African American, American Indian, API, Armenian, White
5	Presentation on Mental Health and Recovery through Network	12	African American, White
6	LA Urban League Fair Booth	26	African American, Korean
6	LAPD National Night Out Fair Booth	40	Latino, African American
7	LACDMH Presentation at Calvary Baptist Church	27	White, Latino
7	Presentation on depression and MHSA for older adults in Spanish	20	Latino
7	Presentation on stress and relaxation in Spanish	30	Latino
8	South Bay Connect Day	200	Homeless African American, White, Latino
8	Community Fair – Pediatric Therapy Network	100	Latino
8	Modern House Call for Women	1000	Women
8	TAY Resource Fair with DCFS	200	Transition Age Youth

O&E is an ongoing activity of work conducted at the service area level. It is monitored and reported on a monthly basis. Please see Criterion 3, Attachment 1: O&E Team Orientation PowerPoint and Criterion 1, Attachment 4: O&E annual report for more information.

UREP Capacity-Building Strategies

To address capacity building needs and priorities, each of the five UREP sub-committees has been allotted one-time funding totaling \$1,060,000 to increase capacity in a manner that serves their under-represented ethnic groups. 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 through a participatory and consensus-based approach and aim to be implemented within this fiscal year. The following are the projects currently being implemented:

African/African-American – The capacity building projects identified for the AAA UREP group are the following:

- Resource Mapping Project: These funds will be used to identify and map leaders, resources, and agencies in Service Area 6 where there is a large African/African American population. The Resource Map can assist in outreaching to and working with African and African-American communities to seek appropriate care and avoid recidivism.
- Culturally Competent Brochures: Culturally competent materials with which to outreach and engage underserved, inappropriately served and hard to reach ethnic communities are needed. The purpose is to educate and inform these ethnically diverse communities about stigma, mental health education and programs offered. Brochures on mental health will be translated into five different African languages including Amharic, Swahili, Ibo, Yoruba, Somali and English.

American Indian/Alaskan Native – Building on work done in a 2008 collaboration with CiMH's Learning Collaborative, this project focuses on how to incorporate traditional healing and cultural practices into LACDMH services. Four interrelated strategies were outlined as a promising approach to support capacity-building within American Indian communities:

Strategy 1: Develop referral protocols and training

Strategy 2: Conduct research

Strategy 3: Engage in community dialogue

Strategy 4: Develop and draft LACDMH Policy

A two-year integrated work plan to implement each of the strategies was developed with community dialogue driving each step.

Asian Pacific-Islander – This project supports the development of an API Consumer Leadership Council representing diverse consumer interests throughout LA County. The project includes: 1) community outreach; 2) multi-lingual and multi-cultural approaches to engage a diversity of API mental health consumers; and 3) education

and training. Through these efforts, our goal is to expand and enhance the current API Client Coalition into a new API Leadership Council that reflects the diverse needs and diversity of the API populations.

Eastern-European/Middle-Eastern – This project will produce culturally competent materials with which to outreach and engage underserved and hard-to-reach families. The purpose is to educate and inform these ethnically diverse communities about the Mental Health Services Act and when and how to access services. MHSA brochures will be translated to four different languages (Arabic, Armenian, Farsi and Russian). The project includes promotional items such as pens, totes, key rings and sticky notes. All brochures and promotional items will include the DMH ACCESS number.

Latino – “Training for and Services Provided by Promotores de Salud” (Health Promoters) will increase the capacity of the public mental health system to deliver best practice recovery-oriented Outreach, Engagement and Linkage, and Self Help Groups by Promotores who will receive or have received mental health training and are culturally and linguistically competent in serving the needs of the Latino community. There are three goals for Promotores activities: 1) Conduction of outreach and engagement efforts that specifically target monolingual Spanish-speaking Latinos, who often lack information on mental health and services available in their communities; 2) Increase the enrollment of Latino families in Full Service Partnerships; 3) Develop and implement Spanish self-help groups for Latino individuals suitable for this level of intervention. As part of their outreach work, Promotores will address cultural misconceptions on mental health, stigma, and collaborate with System Navigators as well as FSP Programs in the linkage of Latinos to mental health services that are appropriate to their needs.

Implementation of the Katie A., Settlement Agreement in Los Angeles County

In 2002, a group of public interest law firms filed a class action lawsuit, (Katie A. v. Bonta) against Los Angeles County and the State of California. The suit alleged that the State and County had failed to provide adequate access to mental health services for children in the child welfare system and that, as a result, children were having poor outcomes. The following year, Los Angeles County entered into a settlement agreement in this matter, while the State case remains unresolved.

LACDMH and the Department of Children and Family Services (DCFS), along with the support of the Chief Executive Office (CEO), have since engaged in a substantial planning process and systems reform effort with the plaintiff attorneys and Katie A. Advisory Panel to improve systems integration and enhance the identification of children in need of mental health services and provide for an improved quality of mental health services for those children once they are identified.

More than 25,000 DCFS-involved children have now been screened for mental health concerns and referred to DMH staff that has been co-located in each of the 18 DCFS Regional Offices. These DMH Specialized Foster Care staff provide

consultation and service linkages to the County’s children’s provider network, which, in turn, has been augmented with significantly greater service capacity, such as Wraparound services and Therapeutic Foster Care, particularly for children needing intensive in home mental health services. Child Welfare and Mental Health staff are also being trained in a shared Core Practice Model to promote improvements in engagement, teaming, strengths and needs based assessment, service planning, and service delivery. The Departments are also conducting a Quality Services Review (QSR) Process, an intensive case review that examines systems operations and client and family outcomes.

In Fiscal Year 2009 – 2010, mental health services were provided to approximately 34,000 DCFS children, reflecting a penetration of 67% of the child welfare population, more than double the penetration rate of mental health services at the time of the settlement agreement.

Fiscal Year 2008-2009	%	Fiscal Year 2009-2010	%
White	11%	White	11%
Hispanic	50%	Hispanic	52%
Black	33%	Black	32%
American Native	>1%	American Native	>1%
Asian	2%	Asian	2%
Other	3%	Other	3%

The County also continues to expand the Wraparound program, building toward a capacity of 4,200 slots by 2014, representing a tripling of the capacity of this comprehensive mental health program.

CalWORKs Program

CalWORKs recipients are eligible to receive Supportive Services as part of their Welfare-to-Work plan in order to remove barriers to employment. Supportive Services include domestic violence services, substance abuse counseling, and mental health treatment. All CalWORKs participants are also Medi-Cal recipients and the vast majority are women. However, Medi-Cal is not billed for mental health services for CalWORKs participants who are receiving services as part of their Welfare-to-Work plan. Further, they are not required to meet medical necessity to receive mental health services funded by CalWORKs.

Mental health services available to CalWORKs recipients include:

- Crisis Intervention
- Individual and family assessment and treatment
- Individual, group, and collateral visits
- Specialized vocational assessments
- Life skills support groups
- Parenting effectiveness
- Medication management
- Case management, brokerage, linkage and advocacy

- Rehabilitation, support, vocational rehabilitation and employment services
- Home visits
- Community outreach

Outreach and education presentations are conducted in local DPSS offices where potential CalWORKs clients may be present. In addition, outreach is conducted at community-based agencies such as churches, community centers, and other local social service agencies to provide education on CalWORKs mental health services available to the local communities. Also, DPSS provides child care funding as part of a participant's Welfare-to-Work plan. Additionally, some DMH directly-operated and contracted clinics provide child watch services or children's socialization groups while their parents are participating in their own treatment services.

In order to reduce disparities, there are multi-lingual and multi-cultural case management and clinical staff throughout the CalWORKs program. Languages spoken include: Arabic, Armenian, Cantonese, Chiu Chow, English, Farsi, French, Haitian Creole, Hebrew, Hindi, Indonesian, Japanese, Khmer, Korean, Laotian, Mandarin, Portuguese, Russian, Samoan, Spanish, Tagalog, Thai, Tongan, and Vietnamese. DPSS staff who make referrals to DMH 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. This data is inclusive of participants referred for all supportive services – mental health, substance abuse, and domestic violence.

	FY 2008-09	%	FY 2009-10	%
Language	English	84%	English	84%
	Spanish	15%	Spanish	14%
	Other	1%	Other	2%
Ethnicity	White	13%	White	14%
	Hispanic	53%	Hispanic	55%
	Black	29%	Black	26%
	American Indian/Alaska Native	>1%	American Indian/Alaska Native	>1%
	Filipino	>1%	Filipino	>1%
	Asian/Pacific Islander	4%	Asian/Pacific Islander	4%
Gender	Male	10%	Male	11%
	Female	90%	Female	89%

II. Summary of Strategies for addressing disparities identified in Criterion 2 within the 200% poverty populations:

1. Innovation Plan – Integrated Service Management Model
2. 1115 Waiver/Low-Income Health Plan (LIHP)
3. Project 50

Innovation Plan

LACDMH’s Innovation Plan is designed to study four different ways to successfully integrate health, mental health and substance abuse services and heal the system fragmentation that is a major impediment to service quality and good outcomes. The other priorities of the Innovation Plan – to increase access to underserved groups, promote interagency collaboration and increase access to services – are also woven into the four models we proposed. All four models target underserved and inappropriately served UREP populations with priority for non Medi-Cal populations who are up to 200% of poverty. Nevertheless, one of the models stands out in particular with regard to cultural competency.

The Innovation Plan’s *Community-Designed Integrated Service Management Model* (ISM) envisions a holistic model of care whose components are defined by the community itself and also promotes collaboration and partnerships between regulated entities, contract providers, and community-based organizations to integrate health, mental health, substance abuse, and other needed care to support the recovery of consumers with particular attention to under-represented ethnic populations. This model will target uninsured populations from five UREP communities (i.e. African/African-American, American Indian/Alaskan Native, Asian Pacific Islander, Eastern-European/Middle Eastern, Latino). The estimated number from each group is listed in the table below:

UREP Group	Geographic Target	FY 11-12 Est. # of Families	FY12-13 Est. # of Families	FY13-14 Est. # of Families	Total # of Families
African/African-American	Service Area 6	232*	232	232	696
American Indian	Countywide	176	176	176	528
Asian/Pacific Islander	Countywide	320	320	320	960
Eastern European/Middle Eastern	Service Area 2 or 4	120	120	120	360
Latino	3 Service Areas with largest concentration of Latinos and lowest penetration rates	552	552	552	1656
Total		1400	1400	1400	4200

* These numbers include Outreach and Engagement individuals. 50% of the Outreach and Engagement clients will go on to be enrolled in the ISM.

The ISM model consists of discrete teams of specially-trained and culturally competent “service integrators” that help clients use the resources of both “formal” (i.e., mental health, health, substance abuse, child welfare, and other formal service providers) and “nontraditional” (i. e., community-defined healers) networks of providers, and who use culturally-effective principles and values. The ISM Model services are grounded in ethnic communities with a strong foundation of community-based, non-traditional, and natural support systems such as faith-based organizations, voluntary associations, and other service groups. In this model, ISM teams will integrate formal and informal provider and community-based resources through the following: 1) community-specific outreach and education; 2) community-specific enhanced engagement practices; 3) enhanced linkage and advocacy; and 4) harmonious intertwining of formal and non-traditional services and supports through facilitation of inter-provider clinical communication. ISM teams will work with each client to ensure service access, coordination, understanding, follow-up, and inter-provider clinical communication. The teams will consist of both service professionals and specially-trained peers who will meet regularly with clients and provide information, transportation, motivation, encouragement, and help with provider communication.

LACDMH is hopeful that the ISM model will help us learn effective approaches and identify effective mechanisms for integrating health, mental health and substance abuse services for the UREP population. This will point the way to creating new care models especially for the uninsured UREP population that may greatly improve outcomes, reduce disparities for UREP populations, enhance service efficiency, increase consumer satisfaction, and carry the recovery-oriented skills and values of the public mental health system into the dimensions of physical health and substance abuse services.

1115 Waiver/Low Income Health Plan (LIHP)

LACDMH will be implementing the Low Income Health Plan portion of the 1115 Waiver in collaboration with the County Department of Health Services (DHS). One implementation strategy is the integration of health and mental health services through co-location of mental health staff in primary care facilities. The target population will be uninsured childless adults at or below 133% of FPL. Approaches to service delivery will be targeted to the needs of clients. In general, LACDMH is developing several tiers for mental health/physical health service delivery. Tier 1 will include an array of mental health rehabilitation services shown to be effective for indigent adults with severe mental illness and high health needs. Tier 2 will include evidence-based services for those with moderate mental health and health needs. Tier 3 services will include innovative approaches to the use of technology to bring the expertise of specialty mental health providers to primary care providers. Planning is underway to determine the array of services for each tier, roles and responsibilities of DMH, DHS, PPPs (Public Private Partnerships providers) and DMH contracted agencies; the use of co-located programs to increase efficiency for

health and mental health integration; and the selection of PEI (Prevention and Early Intervention) services included in Tier 2 as well as administrative details related to enrollment and referrals to specialty care.

Project 50

Project 50 is a demonstration program to identify, engage, house and provide integrated supportive services to the 50 most vulnerable, long-term chronically homeless adults living on the streets of Skid Row. For LACDMH, it has been a successful way for us to reach African American populations who are indigent and to prevent their recidivism. Prior to enrollment into Project 50, 14 out of 68 participants had Medi-Cal. Since implementation, Project 50 was able to obtain Medi-Cal for an additional 35 participants. All other participants have a Medi-Cal application in progress or are in various stages of appeal. The average age of the participants is 54 years. Approximately 78% of the 68 participants are African-American, 9% Latino and 13% Caucasian. Nearly 80% are men and 20% are women.

The Board of Supervisors passed the motion to implement Project 50 in November 2007. Project 50 involves 3 phases: 1) Registry Creation, 2) Outreach Team, and 3) Integrated Supportive Services Team. Currently, Project 50 is operating in the third phase of the demonstration program:

Registry Creation: LACDMH Homeless Outreach and Mobile Engagement (HOME) team and Downtown Mental Health Center (DMHC) in collaboration with partner agencies and departments counted 471 homeless individuals and surveyed 350 in the Skid Row area over a ten-day period. Based on the vulnerability index developed by health experts in Boston, the team identified the 50 most vulnerable persons who had a 40% likelihood of dying within the next seven years unless they could be successfully placed in housing and provided appropriate medical care.

Outreach Team: Project 50 received specialized training provided by Common Ground of NYC. As they conducted outreach, the team maintained regular contact with identified individuals in efforts of establishing rapport and the goal of engaging these individuals in the services including transitional and permanent housing. By establishing a trusting therapeutic relationship with identified individuals, the team was able to assess needs, define the service goals, and reach agreement with the individual on a plan for service delivery. Finally, the team was able to connect and/or reconnect individuals to appropriate services and supports.

Integrated Supportive Services Team: The Integrated Supportive Services Team was an interagency collaboration for comprehensive care and services through a multi-disciplinary team that would provide integrated health, mental health, and substance abuse services for two years. The level of service is based on each individual's need. Supportive Services include:

- 1) Physical health care, mental health and substance abuse treatment;
- 2) Money management;
- 3) 24 Hour/7 day crisis services;
- 4) Recovery-based self-help and support groups;
- 5) Employment services;
- 6) Transportation services;
- 7) Education opportunities and;
- 8) Medication management; and
- 9) Benefit (re) establishment.

III. Summary of Strategies for addressing disparities identified in Criterion 2 within the MHSA/CSS population.

The strategies are the same as for the Medi-Cal population. Please see our response to that section for details.

IV. Summary of Strategies for addressing disparities identified in Criterion 2 within the PEI priority populations

Underserved and Inappropriately Served Ethnic Groups	PEI Strategy	PEI Programs
GLBTQ	Project 12. Improving Access to Underserved Populations	<ul style="list-style-type: none"> • Trauma Focused CBT • Gay/lesbian/Bisexual/Transgender Comprehensive HIV & At-Risk Mental Health Services (GLBT Champs) • Group Cognitive Behavioral Therapy for Major Depression
Deaf/Hard of Hearing	Project 12. Improving Access to Underserved Populations	<ul style="list-style-type: none"> • Nurse Family Partnership • Prolonged Exposure for Post-Traumatic Stress Disorder • Nurturing Parenting Program
Blind/Visually Impaired	Project 12. Improving Access to Underserved Populations	<ul style="list-style-type: none"> • Group Cognitive Behavioral Therapy for Major Depression
American Indian	Project 13. American Indian Project	<ul style="list-style-type: none"> • American Indian Life Skills • Trauma Focused Cognitive Behavioral Therapy: Honoring Children, Mending the Circle
Hispanic/Latino	Project 5. Family Education and Support	<ul style="list-style-type: none"> • Mamas y Bebés
	Project 11 Early Care & Support for Older Adults	<ul style="list-style-type: none"> • Promotores de Salud
	Project 12. Improving Access to Underserved Populations	<ul style="list-style-type: none"> • Family Coping Skills

Summaries for the PEI Strategies and the Evidence-Based Programs in the above chart can be found in Criterion 3, Section III, A.

IV. Additional strategies/objectives/actions/timelines and lessons learned

The county shall include the following in the CCPR:

A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. Note: New strategies must be related to the analysis completed in Criterion 2

Strategies Offered by LACDMH Legal Entities

Because LACDMH contracts with a large number of legal entity providers, we conducted a survey to determine the cultural competency activities of the providers. The results indicate four general strategies:

1. Issue specific groups in languages of ethnic consumers such as Spanish Speaking Domestic Violence Groups, Native American Alcoholics Anonymous groups, and parenting support groups in various languages.
2. Programs that target a specific underserved ethnic population such as those that target the mental health needs of Russian speaking communities; programs that target the mental health needs of Farsi speaking communities; and counseling groups for Armenian speaking clients.
3. Bilingual therapists
4. Use of interpreters.

Please see Criterion 1, Attachment 2: 2010 Cultural Competency Plan Legal Entities Survey for details.

1. Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI

Medi-Cal and CSS

Working Well – We learned that working with existing resources in the community, especially developing collaborations with other providers with linguistically – proficient staff helped us to maximize limited resources. To meet the demand that exists, it helped to build a resource network and to get to know key leaders in the community. In particular, we found that the model of pooling countywide resources made it possible to meet the diverse linguistic needs of the API population that is dispersed throughout the county.

Lessons Learned – Full Service Partnerships were CCS-funded programs where LACDMH developed service targets for specific ethnic groups. While LACDMH

developed targets for distinct geographic regions within Los Angeles County and providers developed plans involving outreach, engagement and partnerships within specific ethnic communities, the need for FSP services far outweighed the capacity. Consequently, in some communities FSP ethnic targets were skewed in the direction of those who most commonly come to the attention of law enforcement, who become homeless or who are psychiatrically hospitalized. Service Area District Chiefs, MHSA Age Lead Staff and the Ethnic Services Manager developed plans to enhance the capacity of providers to outreach, engage and serve specific ethnic communities. They did this by reviewing ethnic and language capacity as well as developing partnerships with organizations that work with specific ethnic populations. LACDMH did increase opportunities for those from ethnic populations by expanding one of the focal populations – those living with family members who would be at risk of homelessness, hospitalization or incarceration if they were not supported by family.

WET

Working Well – Due to the timely Request for Service (RFS) process required to implement each of the action plans, we have only had the opportunity to roll out five (5) of our strategies, to date. However, we have been pleased with the success of each of our programs, as detailed in Criterion Six of this Plan. We are definitely succeeding in screening candidates for each of the training programs who are bilingual and/or bicultural and in ensuring that cultural competency is interwoven into all curricula.

Lessons Learned – While we are successfully targeting our trainings and workforce opportunities towards individuals who are bilingual and/or bicultural, we are unable to guarantee that they are working in a location where their bilingual and/or bicultural abilities are able to be best used. For example, we could hypothetically have a Tagalog-speaking clinician who participates in the Stipend program, but who then works in a primarily African American community. A goal of ours is to identify ways to more strategically match language/cultural competency with areas of greatest need.

PEI

Working Well – There has been a collaborative effort with multiple parties involved in delivering the services, from educational institutions that developed the PEI EBPs and PPs, contract agencies, trainers, and evaluators to provide technical assistance, consultation, share experiences, and provide recommendations to ensure that the PEI programs are properly implemented and sustainable.

Lessons Learned – It has been a challenge to implement 52 different evidence-based practices, promising practices, community-defined evidence programs, and pilot programs in a timely manner. Thus far, the Department has implemented 24 of these programs. As we are rolling out these programs, we are identifying critical components that would have been helpful to have in place before the roll-out, if urgency and the need to get the services started as quickly as possible had not

been a driving issues. These include, but are not limited to, training protocols, training agreements with developers, outcome measures, technical assistance, monitoring plans, etc.

In addition to the above, we would like to share some lessons learned about conducting our Outreach and Engagement activities:

Outreach and Engagement

Working Well – Models such as the API Alliance work well for addressing diverse linguistic and cultural needs especially when the populations served are not geographically concentrated. Also, outreach and engagement activities are increasing the numbers of underserved and under-represented populations seeking mental health services. Each of the service areas is reporting successes in engaging more people and organizations in their local communities and is learning about what activities work and do not work in order to be more successful. We find that when clients are linked with providers who speak their language, service outcomes improve.

Lessons Learned – While outreach and engagement activities are increasing the numbers who come seeking mental health services, LACDMH often does not have the staff capacity to provide those services. There may not be service slots available, nor staff to fill the linguistic need. Staff are finding that it is difficult to be culturally competent without the linguistic competence, and bilingual staff who are called upon to translate but do not have clinical expertise can feel put upon and resentful of the time taken away from the jobs they have to do.

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities

The county shall include the following in the CCPR:

- A. List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).**
- B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.**

We chose to answer these questions together for ease of organization. In the charts below, we list the strategies provided by programs in Sections III and IV and summarize the status of those implementation efforts and the mechanisms that are in place or will be in place to measure and monitor their impacts on reducing the disparities.

FSP: Child

<u>Issue to Address</u>	<u>Implementation Status</u>	<u>Monitoring/Measures/Results/Findings</u>
<p>1. Workforce</p>	<p><u>FSP Site Visits to all 28 Legal Entities</u></p> <ul style="list-style-type: none"> ▪ FSP performance criteria requires agencies meet the linguistic needs of clients and their families ▪ 91% of programs visited met the linguistic needs of the families they serve ▪ FSP services were delivered in 11 different languages, which included (Spanish, English, Chiu Chow (Chinese dialect), Armenian, Tagalog, Khmer (Cambodian dialect), Japanese, Vietnamese, Cantonese, Mandarin, and Cambodian. <p><u>FSP Customer Satisfaction Survey</u></p> <ul style="list-style-type: none"> ▪ 94% Surveyed were able to receive services in their preferred language including English, Spanish, Cantonese, Korean, Cambodian, and Armenian 	<p><u>FSP Site Visits:</u></p> <ul style="list-style-type: none"> • FSP Program self-assessments will be sent to Child FSP programs on an annual basis to be completed and returned to Child Countywide MHSA Admin to monitor programmatic implementation which includes staffing roster and the linguistic capabilities of staff. This annual assessment will allow DMH to monitor Linguistic Capacity of Child FSP programs. • Technical Assistance and Supportive Site Visits will be conducted on an as needed basis as identified by Service Area Navigation Staff. <p><u>FSP Customer Satisfaction Survey:</u></p> <ul style="list-style-type: none"> ▪ Continue annual implementation and collection of randomized Child FSP Customer Satisfaction Surveys to monitor the linguistic capacity of services received by FSP clients
<p>2. Burn-out</p>	<p><u>FSP Site Visits</u></p> <ul style="list-style-type: none"> ▪ Roundtable portion of visits included questions about staff burn-out and supervision, client to staff ratio especially for agencies with a high number of multilingual clients including the API <p><u>Trainings</u></p> <ul style="list-style-type: none"> ▪ Skilled Dialogue - Honoring cultural beliefs and values to improve relationships with Latino children and families (Isaura Barrera) ▪ Impact of Immigration on the Parenting Process - Process of migration and its 	<p><u>FSP Site Visits:</u></p> <ul style="list-style-type: none"> • FSP Program self-assessments will be sent to all Child FSP programs on an annual basis to be completed and returned to Child Countywide MHSA Admin to monitor programmatic implementation which includes staffing roster and training needs. This annual assessment will allow

	<p>impact on Latino immigrant families (Chela Rios Munos)</p> <ul style="list-style-type: none"> ▪ Cultural Competency - Cultural diversity and competence with Latino population (Jorge Cherbosque) ▪ Gang Outreach and Engagement- Understanding the Latino culture and strategies of outreach for mental health services (Gilberto Saldate) ▪ Gangs, Youth Trauma, Domestic/Family Violence & Field Safety (Jorja Leap) ▪ Accessing Benefits for Immigrant Families and Caregivers- DPSS training to increase resource knowledge for un-served and underserved populations (Donald Nollar) ▪ Core Competence Model- Addresses supportive relationships at every level of program operation including how cultural and individual family factors affect the assessment of and intervention with the parent-child relationship. (Victor Bernstein) ▪ Emotional Intelligence and Diversity Skills in Clinical Practice- Increase awareness of one's own values and behaviors and how they impact interactions with clients and developing relationships and adopt the three areas of Intercultural Literacy (Jorge Cherbosca) ▪ Countywide Pilot Project Integrating Cultural Competency in Reflective Supervision- Builds on understanding the child within the context of the family system and the cultural community. (Mayra Mendez and Barbara Stroud) 	<p>DMH to monitor staff turn-over of Child FSP programs and gather feedback from providers on training needs.</p> <ul style="list-style-type: none"> • Technical Assistance and Supportive Site Visits will be conducted on an as needed basis as identified by Service Area Navigation Staff. <p>Trainings</p> <ul style="list-style-type: none"> • Evaluations are collected from all trainings to determine the applicability and relevance of content to services provided by Child FSP staff and managers. The feedback gathered from the training evaluations are used to inform planning for future trainings
<p>3. SA challenges</p>	<ul style="list-style-type: none"> • API slot allocations are flexible and centralized rather than tied to specific SA to meet the diverse and unique language needs of API clients. • <u>Provide consultation to SA navigators to increase recruitment of UREP populations.</u> • Monthly reports are available to FSP providers to help them monitor their slot allocation compliance and client flow • Monthly meetings with SA Child Navigators to ensure UREP populations are being served and to discuss SA needs. 	<ul style="list-style-type: none"> • Continue allowing flexibility of and centralizing API slot allocations to meet the diverse and unique language needs of API clients. • Continue distribution of monthly reports on slot utilization to providers and SA Navigators to assist with monitoring slot capacity and client flow. • Navigators are provided with quarterly reports for clients enrolled in FSP for over a year to assist with client flow • Continue facilitating monthly

		meetings with SA Navigators to ensure UREP populations are being served and to discuss SA needs.						
4. Stigma	<p>Countywide MHSA FSP Presentations</p> <ul style="list-style-type: none"> At DCFS meetings Countywide and specifically SAs 3 El Monte Site and 6 Compton Offices to explore barriers to Latino enrollment and address the disproportionate number of Latino DCFS clients; attendees were encouraged to refer clients that met criteria At Los Padrinos Juvenile Hall (SA 7), Barry J. Nidorf Juvenile Hall (SA 2), and Dorothy Kirby (SA 7) to explore barriers to Latino enrollment and address the disproportionate number of Latino Probation clients; attendees were encouraged to refer clients that met criteria – clients may return to the community in all eight SAs At the Stepping In Conference (SA 8) New Economics for Women (N.E.W.) community agency that began partnership with DMH; N.E.W. focuses on needs of Latino women and children Abriendo Puertas began partnership with DMH to provide services to the 0-5 population 	<p>Countywide MHSA FSP Presentations</p> <ul style="list-style-type: none"> Presentations to community based ethnic groups will be conducted on an “as needed” basis <p>Continue to monitor FSP enrollment through monthly reports generated by the FSP Referral Tracking Application which tracks enrollment by age, ethnicity, focal and target populations</p> <p>Organize and host trainings for Parent Partners employed by Child FSP programs. These trainings will include curriculum on Stigma Reduction</p> <p>Attend Countywide Parent Partner/Advocate meetings on a quarterly basis</p>						
5. Slot Allocation	<ul style="list-style-type: none"> Collaboration with SA District Chief to permit providers to go over 10% allocated slots for the purpose of ensuring that UREP populations are being served. Monthly meetings with SA Child Navigators to ensure UREP populations are being served. Monthly reports are available to FSP providers to help them monitor their slot allocation compliance and client flow. 	<p>Continue distribution of monthly reports on slot utilization to providers and SA Navigators to assist with monitoring slot capacity and client flow.</p> <p>Continue facilitating monthly meetings with SA Navigators to ensure UREP populations are being served.</p> <p>Total numbers of consumers served:</p> <table border="0"> <tr> <td>FY 08-09</td> <td>FY 09-10</td> </tr> <tr> <td>Latino: 1400</td> <td>Latino: 1610</td> </tr> <tr> <td>Asian: 97</td> <td>Asian: 125</td> </tr> </table>	FY 08-09	FY 09-10	Latino: 1400	Latino: 1610	Asian: 97	Asian: 125
FY 08-09	FY 09-10							
Latino: 1400	Latino: 1610							
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Katie A.		
	Implementation Status	Monitoring/Measures/Results/Findings
Katie A.	<p>More than 25,000 DCFS-involved children have now been screened for mental health concerns and referred to DMH staff that has been co-located in each of the 18 DCFS Regional Offices. These co-located staff provide triage and linkage services to our children’s mental health system.</p>	<p>In Fiscal Year 2009 – 2010, mental health services were provided to approximately 34,000 DCFS children, reflecting a penetration of 67% of the child welfare population, more than double the penetration rate of mental health services at the time of the settlement agreement. The County also continues to expand the Wraparound program, building toward a capacity of 4,200 slots by 2014, representing a tripling of the capacity of this comprehensive mental health program. Expanded training efforts have been underway and will continue to enhance the capacity to provide mental health services to the birth to five population. The Department has also launched a Core Practice Model training program for children’s mental health providers which promotes a trauma informed practice that is field based and focuses on client engagement, strength and needs based assessment, teaming with other departments and family stakeholders in order to improve client outcomes.</p> <p>DMH and DCFS have developed an electronic referral tracking system that provides reports of the numbers of children screened, the results of the screening, and the dates of referral to the DMH co-located staff and provision of mental health services. These reports indicate that approximately 60% of the children screened are identified as in need of further assessment, with about 5% of those</p>

		<p>being in need of urgent mental health services. The interval between the referral for mental health services and the provision of a mental health service activity is 3 days on average.</p> <p>DMH and DCFS are also conducting a Quality Services Review (QSR) Process, an intensive case review that examines systems operations and client and family outcomes. Child and family outcomes assessed through this process include child safety, emotional well-being, stability, permanency, health/physical well-being, and education status.</p>
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FSP: TAY

<u>Issue to Address</u>	<u>Implementation Status</u>	<u>Monitoring/Measures/Results/Findings</u>
1. Workforce (Lack of bilingual staff)	<ul style="list-style-type: none"> ▪ Identifying those agencies where this is an issue and helping them to implement strategies to address, such as, using translation services. ▪ Utilization of community-based organizations (non-MH) with which the client, but more often family member has established a relationship and thus has some level of trust. 	<ul style="list-style-type: none"> ▪ 100% successful in locating an FSP slot for any TAY consumer who has language needs.
2. Stigma	<ul style="list-style-type: none"> ▪ One staff member for PEI Anti-Stigma and Discrimination facilitates groups for TAY, their families and community based organization to reduce the stigma of participating in mental health treatment. 	<ul style="list-style-type: none"> ▪ The Anti-Stigma and Discrimination program is a new project therefore the impact has been limited. During fiscal year 09/10 ASD outreach and education was provided to 102 individuals. This program will be expanded during the next fiscal year.
3. Housing	<ul style="list-style-type: none"> ▪ Identify an ongoing funding source to subsidize housing. 	<ul style="list-style-type: none"> ▪ Some FSP clients are not eligible for subsidized housing or public benefits.
4. Access to mental health assessment and linkage in non-branded mental health settings	<p>* Assign mental health therapists and housing specialists to non-branded locations such as Transition Resource Centers, Drop-In centers, and other community based organizations to screen TAY for FSP and other mental health services and supports in an environment that is accessible and acceptable to TAY.</p>	<p>* A minimum of 427 TAY received services as a result of this effort during FY this fiscal year, and the TAY who were appropriate for TAY FSP were referred and linked to a TAY FSP provider.</p>
5. Co-occurring disorders	<p>* Enhanced the staffing pattern of the TAY Division to include a substance abuse counselor to work with TAY that may be unwilling or unable to engage in FSP and other mental health services as a result of substance use/and or abuse.</p>	<p>* The substance abuse counselor provided services to 65 unique TAY during fiscal year 09/10.</p>

TAY and Infant FSP: Young Mothers and Babies (Mamas Y Bebés)

	Implementation Status	Monitoring/Measures/Results/Findings
TAY and Infant FSP	<ul style="list-style-type: none"> • In order to address the high incidence of Latina teen mothers with serious psychological problems and subsequent emotional disturbance in the young children found in these families, the Specialized Young Mothers and Babies FSP was created in East Los Angeles, where 95% of the population is of Latino descent. The multi-disciplinary staff in this program is almost all bilingual Spanish speaking and work closely with both the pre-school and child development programs in the Service Areas, and with the special high schools for pregnant and parenting teens. • A goal for this program is to assure that all potential referral sources are aware of the program so young children in need can have access to the services. • In the coming year, now that the program is fully and appropriately staffed, all available slots for young children who meet target population should be utilized. • At Strive to Thrive National Conference on Infant and Early Childhood Mental Health, the Young Mothers and Babies FSP Program presented “Tracking Services and Outcomes” (SA7) • Pilot Project Integrating Cultural Competency in Target Population—using Community Defined Evidence (CDE) programs to increase infant –caregiver bonding through massage (SA7 Community Partnership) • Engage TAY FSP prospective clients in educational settings (such as California School Age Families Education) (CalSAFE) Teen Mothers High School Program in Montebello and Whittier Unified School Districts • Utilize current TAY FSP mothers in the program to outreach to their peers who may benefit from the program by sharing their experience and their progress. • Increase capacity among staff to address the co-occurring drug and alcohol issues of their clients and other members of the family with whom they live. • Improve the program’s capacity to assist the TAY moms to move towards independence, both financially and emotionally. 	<ul style="list-style-type: none"> • Staff to make presentations on the FSP program at all SA 7 middle schools and high schools with programs for pregnant and parenting teens, as well as all Head Start programs within a 20 mile radius of the program. • Staff to develop relationships with DCFS offices in the SA to assure the referral of appropriate young children in need of FSP services. • Continue to utilize program tracking measures to document client progress and share information at local and national conferences with mental health providers and community partners • Identify outcome measures for very young children, ages 0-3, to show progress as a result of interventions. • Track referrals from CalSAFE program affiliation which result in open FSP cases, currently 32% of program capacity • Develop more sensitive measures to assess and treat drug and alcohol abuse in the population. • Assist at least 50% of the enrolled youth to move towards vocational education or work, to improved capacity for independence

FSP: Adult

Issue to Address	Implementation Status	Monitoring/Measures/Results/Findings
<p>1. Workforce</p>	<p>Work with agencies to improve linguistic staff capacity and strategies for reaching target focal and ethnic populations through annual surveys Adult System of Care (ASOC) conducts with adult FSPs</p> <p><u>FSP Site Visits and Self-Assessments</u></p> <ul style="list-style-type: none"> ▪ An Annual Assessment Survey is sent to each FSP provider to gather information regarding program design, services and effectiveness. ▪ FSP performance criteria require agencies meet the linguistic needs of clients and their families. ▪ Site visits and onsite technical support made available to providers. 	<p><u>FSP Site Visits and Self-Assessments</u></p> <ul style="list-style-type: none"> ▪ 100% of program self-assessments indicate that FSP teams have the linguistic capacity to meet the clients' primary language need. ▪ 100% of program self-assessments indicate that FSP teams have the linguistic capacity to communicate with the clients' family /caregivers. ▪ FSP services are delivered in multiple languages, which included Spanish, English, Armenian, Arabic, Persian, Japanese, Vietnamese, Cantonese, Mandarin, and Cambodian.
<p>2. Burn-out</p>	<p>To balance caseload and prevent staff burn-out, ASOC works with providers to ensure that each FSP offers structured daily team meetings and uses team-based treatment approach. ASOC offers training regularly on the subject of: Field safety; Non-violent crisis intervention; Immigration resources; how to document services (this addresses whatever it takes approach and thinking outside the box); and burn-out prevention</p> <p><u>FSP Site Visits and Self-Assessments</u></p> <ul style="list-style-type: none"> ▪ Provide consultation and collaboration to providers to encourage and ensure that each FSP offers structured daily team meetings and the use of team-based treatment approach. ▪ Encourage and support collaboration between programs to disperse individual and programmatic staff demands. <p><u>Trainings</u></p> <ul style="list-style-type: none"> ▪ Field-Safety ▪ Non-Violent Crisis Intervention 	<p><u>FSP Site Visits and Self-Assessments</u></p> <ul style="list-style-type: none"> ▪ Although staff work independently in the field, they still do not feel isolated or unsupported. ▪ An example of program collaboration is the after-hours coverage that is shared between the teams of two clinics that helps each staff to reduce their on-call time by half.

	<ul style="list-style-type: none"> ▪ Immigration resources ▪ Benefits Establishment ▪ Recovery Oriented Documentation ▪ Conferences focused on the API and Latino populations ▪ Quarterly Intensive Services Programs meeting that provides community resources and best practice models 	
<p>3. SA Challenges</p>	<p>We send out monthly reports on the FSP slot utilization status (also post on the ASOC Share-point) to reduce the gap between the target and under/over utilization issues. Currently the target for the clients living with family is being met by API and Latino groups. However, we can continue to work with SA navigators to increase recruitment for the individuals living with family focal population as a strategy to enroll more FSP clients with these two under-utilization groups.</p> <p><u>Adult System of Care</u></p> <ul style="list-style-type: none"> ▪ Provide Service Areas monthly reports on FSP slot utilization status to reduce the gap between the target and under/over utilization issues. Currently, the target for the focal population “living with family members” is being met by API and Latino groups. ▪ Provide consultation to SA navigators to increase recruitment for individuals “living with family members” as a strategy to enroll more FSP clients with these two under-utilization groups. ▪ Monthly reports are available to FSP providers to help them monitor their slot allocation compliance. 	<p><u>Adult System of Care</u></p> <ul style="list-style-type: none"> ▪ Programs are allowed to exceed their allocated slots for clients “living with family members” to further meet the needs of Latino and API consumers. ▪ API slot allocations are flexible and not closely tied to Service Areas (SA) so that providers from one SA can serve an API client from another SA, especially if services are required in an Asian language. ▪ DMH Outreach Staff should regularly attend SA Impact Team meetings to help identify ethnic communities requiring outreach and engagement to encourage utilization of mental health services.
<p>4. Crosscutting Issues and processes – those that relate to more than one of the areas above or to all ethnic groups</p>	<p><u>Adult System of Care</u></p> <ul style="list-style-type: none"> ▪ Collaboration with DMH resources along the Quality of Life Areas (housing, employment/education, health, co-occurring disorders, and community integration) ▪ Recovery On A Roll (ROAR) meeting of directly operated clinic managers to address the needs and issues of FSP and other MHSA programs ▪ Intensive Services Providers (ISP) meeting with both directly operated and contracted program managers to address needs and issues of FSP and other MHSA program providers. 	<p><u>Adult System of Care</u></p> <ul style="list-style-type: none"> ▪ Collaboration with Countywide Resource Management, CHEERD, and the Office of the Medical Director. ▪ Workgroups focusing on the Quality of Life consumer needs, community resources and best practices of FSP and other MHSA programs.

<p>5. Stigma/ Cultural misunderstanding</p>	<p>Several family support groups have been implemented at various DMH sites to educate and provide support to Latino families on mental health issues.</p> <p>ASOC Support groups in Spanish Project provide information, support, referrals, advocacy and education to underserved Spanish speaking people in the County of Los Angeles and try to be a bridge between the community and mental health system. In addition, support group members participate in painting, dance and theater classes, which help them to feel empowered.</p> <p>During the year of 2010 the Support Groups in Spanish Project from ASOC have 15 support groups for consumers and family members in county way mental health settings (Wellness Centers) and in the community (schools, churches). The average of group attendees was 15 persons per session. For instance, our project attended almost 950 persons. In the same way, our Group Theater and group of paint participate in several events. Finally, last February, 37 support group facilitators were graduated after to take the 12 weeks of Support Group Facilitators & Leadership Training, coordinated by ASOC, SAA 7 Administration and Rio Hondo Wellness Center.</p>	<p>Support group facilitators have two questionnaires for evaluation (at entrance and after 3-4 months in group). They periodically give LACDMH filled questionnaires. In addition, we have a draft of a new form to evaluate support group members' evolution, and we are planning to implement it this year. The supervisor for group facilitators meets with them in monthly support group facilitators meetings for training and coordination. Supervisor also provides tutoring to facilitators and visits each group.</p>
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CalWORKs		
	<u>Implementation Status</u>	<u>Monitoring/Measures/Results/Findings</u>
CalWORKs	<p>During fiscal year 2009 – 2010, 14,527 CalWORKs participants were referred by DPSS for Specialized Supportive Services (SSS) which include mental health, substance abuse and/or domestic violence services. DMH provided mental health services for a total of 8074 clients via 17 directly-operated clinics and 31 contracted providers.</p> <p>Participants referred for SSS were 89% female, 55% Hispanic, 26% African American, 14% White, and 4% Asian/Pacific Islander. Eighty-four percent of those referred identified English as their primary language while fourteen percent indicated that Spanish was their primary language.</p>	<p>DMH conducts annual formal site visits and reviews of all CalWORKs mental health providers. Site visits include monitoring of DMH billing and documentation, ensuring compliance with DPSS performance standards, and identifying and providing any technical assistance or training for the agency. Informal site visits are conducted on an as-needed basis to provide additional assistance or address other needs of the agencies as they arise.</p> <p>DMH conducts countywide quarterly provider meetings to provide training, facilitate networking, and disseminate new information to CalWORKs providers. Additionally, smaller provider meetings are conducted on a monthly basis in the eight service areas. DPSS representatives attend and participate in these meetings.</p> <p>The DMH CalWORKs unit designs and conducts training curriculum that address topics unique to the provision of services to CalWORKs participants, i.e. employment-focused documentation, supported employment, and domestic violence.</p>

FSP: Older Adults

Issue to Address	Implementation Status	Monitoring/Measures/Results/Findings
<p align="center">Workforce (Bilingual staff employed by FSP programs):</p>	<ul style="list-style-type: none"> • Cultural Competency – based training were offered to staff to better meet the needs of UREP population • Involvement with ethnic-specific outreach, e.g. Asian Pacific Outreach Network to facilitate visits and discussions with community churches representing the UREP populations. • There is concerted effort among agencies to have team members, including psychiatrist, speak the client’s language. • Contracting with translator services, when necessary, to provide appropriate language skills. • Literature is available in Spanish. (<i>FSP Brochures etc.</i>) • Development of a Quality Assurance Board (QAB) to empower clients to share feedback regarding their care. A Spanish-speaking QAB is in development. 	<ul style="list-style-type: none"> • Staffs are more prepared and culturally competent to provide culturally-based services and to more easily engage UREP community. • Positive rapport is developed when a client can relate to staff, bilingually and biculturally. • By matching mono-lingual clients with agencies that have specific language capacity, the needs of some UREP populations are better served. • FSP providers now have the following language capacity: Spanish, Korean, Japanese, Mandarin, Cantonese, Khmer, Vietnamese, Tagalog, Ilokano, Visayan, Bengali, Gujarati, Hindi, Punjabi, Tamil, Urdu, and Farsi.
<p align="center">Burn-out:</p>	<ul style="list-style-type: none"> • Weekly Impact Unit Meetings have not only been utilized to receive Authorization for new clients but have been essential in providing support to providers by presenting challenging cases and receive support and feedback from other providers. • Case consultation is provided to assist staff with understanding cultural differences and with best practices for working with UREP populations. • Trainings have been provided to prevent burn-out, e.g. Field Safety, Co- 	<ul style="list-style-type: none"> • Providing supportive training and a means for staff to share their experiences in an understanding environment reduces the stress and potential burn-out of working with Older Adults, as well as with the UREP populations, which tend to be higher-need with fewer resources.

	Occurring Disorders, and Compassion Fatigue.	
SA Challenges:	<ul style="list-style-type: none"> At the weekly Impact Unit Meeting, providers have the opportunity to share their unique O&E strategies towards increasing enrollment among the UREP community. Providers in service areas with high FSP enrollment have been educated and monitored on their flow process which has opened up slots in those service areas. Older Adult administrative staff review provider data (24+ month reports, claims data, etc.) and reports have served as a tool to identify potential clients that may need to move to a lower level of care such as FCCS or Wellness. 	<ul style="list-style-type: none"> These strategies have assisted in increasing enrollment as well as making new slots available in service areas with high need. This review process ensures that clients continue to meet FSP criteria and create flow.
Stigma:	<ul style="list-style-type: none"> Agencies have developed a workbook and focused on Recovery Centered Clinical System (RCCS) which was initially developed to work with individuals with a diagnosis of mental health, and helps address the issue of self-stigma that can be prevalent in UREP populations. Ensuring that staffs are culturally competent to work with a client by sending experienced bilingual/ bicultural staff when providing outreach services. Agencies identify and consult with a community gatekeeper as to how to best proceed with members of UREP communities, send staff to UREP-specific community events, and have established partnerships with faith-based organizations and nutrition programs in UREP communities. 	<ul style="list-style-type: none"> The development of this workbook has shown to be effective and relevant to all people with or without a mental illness, thus, decreasing the stigma of mental health treatment in the Latino community (My Life: The Journey, 2007). Working with groups and individuals that the community respects and trusts helps obtain the 'buy-in' for mental health services.
Slot Allocation:	<p><u>FY 08-09</u></p> <ul style="list-style-type: none"> Total target number for OA FSP was increased to include new/additional slots from MHSA transformation. <p><u>FY 09-10</u></p> <ul style="list-style-type: none"> Total target number for OA FSP was increased to include new/additional slots from MHSA transformation. 	<ul style="list-style-type: none"> Target numbers for UREP populations were adjusted per service area to reflect accurate target population for fiscal year (SA 2, 5, 7). Target numbers for UREP populations were adjusted per service area to reflect accurate target population for fiscal year (SA 7, 8).

Additional Program/Service Strategies for Older Adults		
	Implementation Status	Monitoring/Measures/Results/Findings
Field Capable Clinical Services (FCCS)	Site visits to Older Adult FCCS programs are provided a minimum of twice yearly for the purposes of program review and technical support. Current efforts are focusing on the expansion of co-located programs that effectively promote collaboration between community based agencies such as senior centers and primary care settings, thus reaching older adult consumers who might otherwise not have been reached. Examples include: One Generation and Senior Links.	The FCCS Program Monitoring Tool has been recently modified to include programmatic review of the following additional elements: <ul style="list-style-type: none"> • Update of language capacity. * • Review of O & E to UREP populations. • Armenian, Bengali, Cantonese, Chinese, Farsi, Filipino, French, German, Gujarati, Japanese, Hindi Italian, Korean, Mandarin, Punjabi, Russian, Samoan, Spanish, Tagalog Tamil, Thai, Urdu, Vietnamese
Service Extenders	There has been a series of workshops developed for current Service Extenders to increase their skills to be effective members of multidisciplinary teams and to promote efficacy.	Evaluation of each workshop are completed by the Service Extenders, with highly favorable ratings for the first three workshops that have been conducted

Outreach & Engagement

	Status of Implementation Efforts	Measuring/Monitoring/Results/Findings
<ol style="list-style-type: none"> 1. Targeted Outreach Activities 2. Networking, Collaborating, Partnering with other community-based organizations 3. Presenting information and educating the community 4. Providing and Linking to Resources 5. Specialized Activities 	These activities are ongoing and specific to the community needs and populations of each service area. Please see Outreach and Engagement Annual Report, Criterion 1, Attachment 4 for more detail.	All Service Areas are expected to reach minimum monthly goals for events, planned meetings and UREP-targeted outreach events. In addition, all Service Areas are expected to reach specific audiences a minimum number of times per year. Those audiences are: consumers/family/parents/caregivers, community-based organizations, providers, clergy/faith community, education, law enforcement, and the community at large. O&E staff report on outreach and engagement activities on a monthly basis at the O&E meeting of the Planning Division.

UREP Capacity-Building Projects

	Status of Implementation Efforts	Measuring/Monitoring/Results/Findings
Latino – Training for and Services Provided by Promotores de Salud	Instead of funding one agency at \$220,000 to train six (6) promotores, two additional agencies were funded to increase the pool of promotores de salud trained in mental health outreach and linkage. \$660,000 awarded to three agencies (\$220,000 each), will support a total of 18 Promotores de Salud. Implementation of project started on February 1, 2011.	Quantitative data collected will include # of trainings, follow-ups, demographic info, activities, etc. They will be collected through various logs used by the Promotores in their daily work. Qualitative data sources will include community member satisfaction surveys or testimonials and performance evaluations. The Latino UREP Subcommittee will act in an advisory capacity and quarterly reviews of progress of the project will be conducted.
American Indian/Alaska Native – Paper entitled, “Restoring Urban Traditional Healing to Create Spiritual Health and Wellness in Native American Communities will focus on supporting capacity building within AI/AN communities.	\$50,000 awarded to Phase I of learning collaborative project and \$35,000 to Phase II. First phase is completed. A draft of the paper was completed, and revisions are being made by the AI/AN UREP subcommittee. An additional \$15,000 has been allocated for the American Indian Conference.	The paper will capture the deliberative processes used, describe the development of trust and shared understanding, and define roles and responsibilities. The AI/AN UREP Subcommittee will act in an advisory capacity and quarterly reviews of progress of the project will be conducted.
African/African-American – Resource Mapping Project and brochures	\$50,000 awarded to Mapping Project with web capability and \$50,000 awarded to brochures. Completed draft of mapping project. Work is being completed on brochures.	The Mapping project will identify and increase the number of culturally-appropriate non-traditional resources in the African and African American communities. The brochures will be translated into the following African languages: Amharic, Amharic, Swahili, Ibo, Yoruba and Somali languages as well as culturally competent English. The brochures will be a means to provide culturally competent outreach and education to inform these ethnically diverse communities about stigma, mental health education and programs offered. The AAA UREP Subcommittee will act in an advisory capacity and quarterly reviews of progress of the project will be conducted.
Eastern-European/Middle Eastern – produce culturally competent materials	\$100,000 allocated to project. Identifying qualified and appropriate vendors. Work being completed on brochures.	The project will see if the outreach materials helped to educate the communities on mental illness and reduced the barriers to access by providing the information in the languages of the communities. The EE/ME UREP Subcommittee will act in an advisory capacity and quarterly reviews of progress of the project will be conducted.
Asian Pacific-Islander – Capacity Building Project for API Consumer	\$100,000 allocated for this vendor . Documentation has been submitted and work	Community outreach, multi-lingual and multi-cultural approaches to engage, educate and train a diverse group of API mental health

Leadership Council	will commence imminently.	consumers while involving existing API client coalitions. Through these efforts, the goal is to create a new countywide API Leadership Council that reflects the diverse needs of the target populations. The API UREP Subcommittee will act in an advisory capacity and quarterly reviews of progress of the project will be conducted.
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Strategies for 200% Poverty

	Implementation Status	Measuring/Monitoring/Results/Findings
<p>Innovation Plan –</p>	<p>Proposers' Conference was held on Tuesday February 15, 2011 for RFS 2: Community Designed Integrated Service Management (ISM) Model. Proposals are due by March 15, 2011. Nine (9) contracts will be awarded for the five (5) statements of work within this RFS.</p>	<p>Implementation of the nine contracts for the five UREP communities will begin on July 1, 2011.</p>
<p>1115 Waiver/Low-Income Health Plan</p>	<p>Multiple committees have been formed to work in partnership with DHS to develop an effective implementation plan. These Committees include Referral and Enrollment; Array of Services; Quality Assurance and Outcome Measures.</p>	<p>To be determined</p>
<p>Project 50</p>	<p>Project 50 is in its third year, which is program evaluation, and this is currently in process at the CEO. In total, 67 participants were housed, 14 incarcerated and 8 disenrolled.</p> <p>Mental health services provided include: Individual/group therapy; individual/group rehabilitation; psychotropic medication support/management; psychiatry services; crisis intervention; and targeted case management. During a 9 month period (January 2010 through September 2010): 1) Mental Health staff provided an average of 360 service contacts per month for Project 50 participants (an average of over 17 service contacts per work day) and 2) Mental Health staff provided an average of 337 hours of mental health services for Project 50 participants (an average of over 16 hours of mental health services per work day)</p>	<p>Project 50 is primarily measured by its housing retention rate of the most chronically vulnerable homeless individuals in Skid Row. Through the Project's collaboration with 24 government, community, and non-profit organizations, we are able to monitor multiple indicators, including:</p> <ul style="list-style-type: none"> - Service Utilization (health, mental health, substance abuse, and housing case management – as Project 50 utilizes Shelter Plus Care Certificates, the housing provider coordinates monthly service utilization data to meet the requirements of the program) - Successful Benefit Establishment - Incidences of incarcerations, emergency room visits, and inpatient hospitalizations <p>These measures outline Project 50's efforts to reduce recidivism of our participant's utilization of costly services. Through these measures, Project 50 is able to show cost-avoidance for the County. Monitoring efforts include monthly participant tracking logs that track the status of each participant and an overall project status report that was</p>

		presented to the Board of Supervisors after the first year. In addition, the County Executive Office is in the process of completing a full cost analysis of Project 50 at this time.
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WET Plan

	Implementation Status	Measuring/Monitoring/Results/Findings
County of Los Angeles Oversight Committee	The Oversight Committee has been effective for over one year, and has played a crucial role in the development of the WET Plan and its implementation in LA County.	We will continue to utilize the Oversight Committee to provide “a voice” of advocacy for cultural and linguistic competency.
Recovery-Oriented Supervision Trainings	This RFS will be released in early – mid July 2010. Contracts will hopefully be signed in Winter 2010.	<p>Although this strategy does not reduce disparities by recruiting additional staff who meet the needs outlined in Part II of Criterion 3, it will ensure that the individuals working with consumers do so in a more culturally competent manner. As clients are treated in a more culturally competent manner, they will be more inclined to continue working towards their mental health recovery.</p> <p>Cultural competency will have to be a key area of measurement in the outcome tools that will be developed once the curriculum has been finalized.</p>
Interpreter Training Program	We provided four Interpreter Trainings for staff used as interpreters and four trainings for Providers who use interpreters in FY 09-10.	<p>Although this strategy does not reduce disparities by recruiting additional staff who meet the needs outlined in Part II of Criterion 3, it will ensure that the individuals working with consumers do so in a more culturally and linguistically competent manner.</p> <p>Cultural competency will have to be a key area of measurement in the outcome tools that will be developed once the curriculum has been finalized.</p>
Training for Community Partners	This strategy is still being defined and developed.	Although this strategy does not reduce disparities by recruiting additional staff who meet the needs outlined in Part II of Criterion 3, it will ensure that the individuals working with consumers do so in a more culturally competent manner.

		Cultural competency will have to be a key area of measurement in the outcome tools that will be developed once the programs have been defined and developed.
Expanded Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	This will be contracted out. The RFS should be released in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported. Each individual recruited to the public mental health workforce who match the disparities outlined in Section II of Criterion 3 will effectively reduce the disparity.
Expanded Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System	This will be contracted out. The RFS should be released in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported. Each individual recruited to the public mental health workforce who match the disparities outlined in Section II of Criterion 3 will effectively reduce the disparity.
Expanded Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System	This will be contracted out. The RFS should be released in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported. Each individual recruited to the public mental health workforce who match the disparities outlined in Section II of Criterion 3 will effectively reduce the disparity.
Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System	This strategy is on hold due to the economic climate and lack of vacancies in the public mental health system.	The mechanism to measure and monitor the effect of this program will be developed once the program is going to be utilized. The disparities identified in Section II of Criterion 3 will be used to develop this strategy.
Tuition Reimbursement Program	This is expected to begin in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported.
Associate and Bachelor Degree 20/20 and/or 10/30 Program	This is expected to begin in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported.
Stipend Programs for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians	This has been funded by WET for three years.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce have been tracked and reported. Please see Criterion 6 for more information.

Loan Forgiveness Program	This is expected to begin in FY 2010 – 2011.	The demographics (including ethnicity, age and languages spoken) of each participant and their subsequent employment in the public mental health workforce will be tracked and reported.
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PEI Plan

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>1. The <u>School Mental Health Project</u> will initiate (1) School Threat Assessment Response Teams (START) comprised of law enforcement offices and DMH clinicians working with school personnel and (2) a school mental health PEI demonstration project in service area 6.</p>	<p>To date the Department has initiated the START program, beginning with three training workshops. Currently under review is the Request for Services (RFS) for the School Mental Health Prevention And Early Intervention Demonstration Pilot in service area 6, one of the most at-risk community areas with a sizable African/African American and Latino populations.</p>	<p>Demographic information on the individuals served will be collected. Outcomes have been identified for the demonstration project, and outcome measures will be used to collect information on the effectiveness impact of the program.</p>
<p>2. The <u>Stigma and Discrimination Reduction Project</u> will provide outreach and education to the broader community utilizing staff that have lived experience in mental illness through a three-fold plan: (1) family supports and education strategies; (2) client-focused strategies; and (3) community advocacy strategies.</p>	<p>To date the Department has developed two RFSs for these three strategies, and the confirmation of the winning bidder for Family Focused Strategies for Reducing Mental Health Stigma and Discrimination RFS is pending.</p>	<p>Demographic information on the individuals served will be collected. Outcomes have been identified for the RFSs, and outcome measures will be used to collect information on the effectiveness impact of the programs.</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>3. The <u>Suicide Prevention Project</u> will provide</p> <p>(1) a program targeting at-risk Latina youth and their families</p> <p>(2) a suicide hotline transformation and expansion of suicide prevention services</p> <p>(3) information and education through web-based training of school personnel</p> <p>(4) suicide prevention specialize teams</p> <p>(5) an integrated care model to bring mental health services to primary care agencies.</p>	<p>(1) Latina Youth Program has expanded to include male as well as female youth – ages 14 – 25 years of age, who were identified as being “at risk” for suicide.</p> <p>(2) The Suicide Hotline has been transformation was completed and expanded to include a 24/7 Spanish Speaking Hotline effective Dec 2009. Hotline has handled 37065 calls to date and Spanish Speaking Hotline has handled 408 calls to date.</p> <p>(3) A web-based Suicide Prevention training program has been developed and will be launched January 2011.</p> <p>(4) A Suicide Prevention Specialist Team (SPST) became operational July 2010. Team includes 3 Spanish-speaking and 1 Korean-speaking members.</p> <p>(5) Integrated care model to be launched sometime in 2011</p> <p>The health care partners 60+ program will be implemented through the Early Start Improving Mood—Promoting Access To Collaborative Treatment (IMPACT) RFS bidding process under review.</p>	<p>(1) During FY 09/10, 25 youth were served; and during FY 10/11, 17 youth have been served to date. All have been Latino.</p> <p>(2) In FY 09/10 Suicide Hotline handled 26,089 calls; 108 calls were handled by the Spanish Speaking Hotline. During the 1st Quarter of FY 10/11 the Suicide Hotline handled 10,976 calls and the Spanish Speaking Hotline handled 300 calls.</p> <p>(3) NA</p> <p>(4) For the 1st Quarter of FY 10/11 SPST has provided training o 1461 staff and community members; including 144 African Americans, 302 Latino, 169 Asian-Pacific Islanders, 686 Other/Not identified, and 160 White.</p> <p>(5) NA</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>4. The <u>School-based Services Project</u> will (1) build resiliency and increase protective factors among children, youth and their families; (2) identify as early as possible children and youth who have risk factors for mental illness; and (3) provide on-site services to address non-academic problems that impede successful school progress.</p>	<p>To date the Department has implemented four programs:</p> <p>(a.) Aggression Replacement Training (ART), designed for use with all ethnic groups, between the ages of 12-17.</p> <p>(b.) Cognitive Behavioral Intervention for Trauma in School (CBITS), designed for use with ethnic minorities and immigrants, between the ages of 10-14. Support for use with Latinos, African-Americans, and Native Americans.</p> <p>(c.) Multidimensional Family Therapy (MDFT), designed for use with all ethnic groups, between the ages of 11-18.</p> <p>(d.) Strengthening Families (SF), designed for use with all ethnic groups, between the ages of 3-16.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>
<p>5. The <u>Family Education and Support Project</u> will build competencies, capacity and resiliency in parents, family members and other caregivers in raising their children by teaching a variety of strategies.</p>	<p>To date the Department has implemented four programs:</p> <p>(a.) Caring for Our Families (CFOF), designed for Cambodian and Korean immigrant and refugee families, between the ages of 5-11.</p> <p>(b.) Incredible Years (IY), designed for use with all ethnic groups, between the ages of 3-12.</p> <p>(c.) Managing and Adapting Practice (MAP)</p> <p>(d.) Positive Parenting Program (Triple P), designed for use with all ethnic groups, between the ages of 0-18.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>6. The <u>At-risk Family Services Project</u> will (1) provide training and assistance to families whose children are at risk for placement in foster care, group homes, psychiatric hospitals, and other out of home placements; (2) build skills for families with difficult, out of control or substance abusing children who may face the juvenile justice involvement; and (3) provide support to families whose environment and history renders them vulnerable to forces that lead to destructive behavior and the disintegration of the family.</p>	<p>To date the Department has implemented seven programs:</p> <p>(a.) Brief Strategic Family Therapy (BSFT), designed for use with all ethnic groups, between the ages of 10-18. Strong support for use with Latinos.</p> <p>(b.) Child-Parent Psychotherapy (CPP), designed for use with all ethnic groups, between the ages of 0-7. Strong support for use with Latinos.</p> <p>(c.) Incredible Years (IY), designed for use with all ethnic groups, between the ages of 3-12. Some support for use with African Americans, Asians, and Latinos.</p> <p>(d.) MAP is designed to improve the quality, efficiency, and outcomes of children's mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols.</p> <p>(e.) Parent-Child Interaction Therapy (PCIT), designed for use with all ethnic groups, between the ages of 3-6. Adapted for use with Latinos.</p> <p>(f.) Triple P, designed for use with all ethnic groups, between the ages of 0-18.</p> <p>(g.) UCLA Ties Transition Model, designed for use with all ethnic groups, between the ages of 0-8.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>7. The <u>Trauma Recovery Services Project</u> will (1) provide short-term crisis debriefing, grief, and crisis counseling to clients, family members and staff who have been affected by a traumatic event; and (2) provide more intensive services to trauma-exposed youth, adults, and older adults to decrease the negative impact and behaviors resulting from the traumatic events.</p>	<p>To date the Department has implemented eight programs:</p> <p>(a.) Child-Parent Psychotherapy (CPP), designed for use with all ethnic groups, between the ages of 0-7. Strong support for use with Latinos.</p> <p>(b.) Crisis Oriented Recovery Services (CORS), designed for use with all ethnic groups of all ages.</p> <p>(c.) MAP is designed to improve the quality, efficiency, and outcomes of children’s mental health services by giving administrators and practitioners easy access to the most current scientific information and by providing user-friendly monitoring tools and clinical protocols. (d.) PCIT, designed for use with all ethnic groups, between the ages of 3-6. Adapted for use with Latinos.</p> <p>(e.) Prolonged Exposure Therapy for Posttraumatic Stress Disorder (PE-PTSD), designed for use with all ethnic groups, between the ages of 18-65.</p> <p>(f.) Seeking Safety (SS), designed for use with all ethnic groups, between the ages of 15-55.</p> <p>(g.) System Navigators for Veterans, designed for veterans and their families of all ethnic groups, ages 16 and up.</p> <p>(h.) Trauma Focused Cognitive Behavioral Therapy (TF-CBT), designed for use with all ethnic groups, between the ages of 3-18.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
8. The <u>Primary Care and Behavioral Health Project</u> will develop mental health services within primary care clinics in order to increase primary care providers' capacity to offer effective mental health guidance and early intervention through the implementation of screening, assessment, education, consultation, and referral.	To date, the Department has implemented two programs: (a.) IY, designed for use with all ethnic groups, between the ages of 3-12. (b.) Triple P Positive Parenting Program, designed for use with all ethnic groups, between the ages of 0-18.	The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.
9. The <u>Early Support and Care for Transition-Age Youth Project</u> will (1) to build resiliency, increase protective factors, and promote positive social behavior among TAY; (2) address depressive disorders among the TAY, especially those from dysfunctional backgrounds; and (3) identify, support, treat, and minimize the impact for youth who may be in the early stages of a serious mental illness.	To date the Department has implemented five programs: (a.) ART, designed for use with all ethnic groups, between the ages of 12-17. (b.) Early Detection and Intervention for the Prevention of Psychosis (EDIPP), designed for use with all ethnic groups, between the ages of 12-25. (c.) Interpersonal Psychotherapy for Depression (IPT), designed for use with all ethnic groups, between the ages of 12-18. (d.) MDFT, designed for use with all ethnic groups, between the ages of 11-18. (e.) Seeking Safety (SS), designed for use with all ethnic groups, between the ages of 15-55.	The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>10. The <u>Juvenile Justice Services Project</u> will (1) build resiliency and protective factors among children and youth who are exposed to risk factors that leave them vulnerable to becoming involved in the juvenile justice system; (2) promote coping and life skills to youths in the juvenile justice system to minimize recidivism; and (3) identify mental health issues as early as possible and provide early intervention services to youth involved in the juvenile justice system.</p>	<p>To date the Department has implemented eight programs:</p> <p>(a.) ART, designed for use with all ethnic groups, between the ages of 12-17.</p> <p>(b.) CBITS, designed for use with ethnic minorities and immigrants, between the ages of 10-14.</p> <p>(c.) Functional Family Therapy (FFT), designed for use with all ethnic groups, between the ages of 11-18.</p> <p>(d.) Loving Intervention for Family Enrichment (LIFE), designed for Latino families with monolingual (Spanish) parents, between the ages of 10-17.</p> <p>(e.) MDFT, designed for use with all ethnic groups, between the ages of 11-18.</p> <p>(f.) Multisystemic Therapy (MST), designed for use with all ethnic groups, between the ages of 11-18.</p> <p>(g.) PE-PTSD, designed for use with all ethnic groups, between the ages of 18-65.</p> <p>(h.) TF-CBT, designed for use with all ethnic groups, between the ages of 3-18.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>
<p>11. The <u>Early Care and Support Project for Older Adults</u> will (1) establish the means to identify and link older adults who need mental health treatment but are reluctant, are hidden or unknown, and/or unaware of their situation; (2) prevent and alleviate depressive disorders among the elderly; and (3) provide brief mental health treatment for individuals.</p>	<p>To date the Department has implemented CORS, designed for use with all ethnic groups of all ages.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>

PEI Plan Strategies		
	Implementation Status	Measuring/Monitoring/Results/Findings
<p>12. The <u>Improving Access for Underserved Populations Project</u> will (1) build resiliency and increase protective factors among monolingual and limited English-speaking immigrants and underserved cultural populations, lesbian/gay/bisexual/transgender/questioning (LGBTQ) individuals, deaf/hard of hearing individuals, blind/visually impaired individuals and their families; (2) identify as early as possible individuals who are a risk for emotional and mental problems; and (3) provide culturally and linguistically appropriate early mental health intervention services. The programs will provide outreach and education as well as promote mental wellness through universal and selective prevention strategies.</p>	<p>To date the Department has implemented three programs: (a.) GLBT CHAMPS: Comprehensive HIV & At-Risk Mental Health Services, designed for use with African-Americans, between the ages of 15-25. (b.) PE-PTSD, designed for use with all ethnic groups, between the ages of 18-65. (c.) TF-CBT, designed for use with all ethnic groups, between the ages of 3-18.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>
<p>13. The <u>American Indian Project</u> will (1) build resiliency and increase protective factors among children, youth and their families; (2) address stressful forces in children/youth lives, teaching coping skills, and divert suicide attempts; and (3) identify as early as possible children and youth who have risk factors for mental illness.</p>	<p>The Department has not yet implemented the two programs selected for this project.</p>	<p>The demographics (including ethnicity, age and languages spoken) of each participant and improvements in their mental health will be tracked and reported through the outcome measures and the IS.</p>

C. Identify county technical assistance needs.

The following are the technical assistance needs we have identified:

- Need guidance on how to implement evidence-based practices that are difficult to implement with populations that may not take well to certain components. Need more staff in order to meet the challenges of delivering culturally and linguistically competent services. In addition, outreach is a time-intensive activity.
- Need guidance in how to measure cultural competency and the impacts and value of outreach and engagement.
- Online training is desirable in order to accommodate people's time more efficiently, especially given the size of Los Angeles County.
- Need more resources to translate documents into the multitude of languages spoken in Los Angeles County

Criterion 3 Attachments:

Attachment 1: O&E Team Orientation PowerPoint

CRITERION 4
CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE
COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

- I. **The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.**

The county shall include the following in the CCPR

- A. **Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).**

The Cultural Competence Committee (CCC), which was originally a subcommittee of the Quality Improvement Council (QIC), was elevated to its own governing body within the Planning Division in May 2010. The overarching goal of the CCC is to increase cultural awareness and sensitivity in the Department's response to the needs of diverse underserved and cultural populations. The specific roles and functions of the CCC are based on the commitment to furthering The Department's progress in the provision of culturally and linguistically competent services. In general terms, the CCC serves as an advisory group for the infusion of cultural competency in diverse aspects of LACDMH operations and service delivery. It also functions as a vehicle for the achievement of the Cultural Competency Unit goals, such as translation of LACDMH forms into the threshold languages and completion of the cultural competency organizational assessment (for more details, please see Criterion 4 Section II, A.).

At the present time, the CCC is comprised of 25 members including LACDMH staff, contracted providers, consumers and family members. Great care is taken to assure that full perspectives are given a place at the table. Within the current CCC membership, there are eight ethnic groups and eleven languages represented. In addition to linguistic, racial/ bi-racial and ethnic diversity, the CCC enjoys representation from other cultural perspectives such as faith-based, age, physical disability and LBGTQ. Additionally, we consider the inclusion of the perspectives of key LACDMH programs, Service Areas and position (front line, administrative and management) to be essential to the internal balance of the CCC and the impact we hope to make in the current system of care.

The organizational structure of the CCC consists of two co-chairs who organize and lead the group. The co-chairs work closely with the Ethnic Services Manager and UREP Leadership Team in communicating the focus of the CCC activities, projects and recommendations on diverse aspects of LACDMH operations. Co-chairs are elected by majority vote for a one-year term that runs from February to January of the following year with the possibility of re-election. There are no term limits for membership in the CCC. The meetings are held monthly and are open to everyone.

CCC members share a professional and personal commitment to disseminating the voice of cultural competency throughout our system of care. As CCC members, each acts as a cultural competency ambassador in his or her specific unit or program. Many involved feel passionately about the values the CCC promotes. The CCC chose the following logo because it conveys the message of working together toward the goal of embracing cultural diversity by focusing on human experience and points of interaction:



These are just some of the comments made by members about being part of the CCC:

- “My hope as a member of the CCC is to promote cross-cultural understanding among DMH staff both because it is essential in serving the diverse population that makes up our county communities, and because it enhances the working environment of DMH with its culturally diverse workforce. When the department provides opportunities to learn about cultures other than one’s own it enriches the staff professionally and personally.”
- “I joined the CCC when I found out that it existed because of my passion for issues of diversity and cultural proficiency. Our culture, whatever it may be, influences who we are, and therefore is such an important part of us. The CCC is a group of individuals dedicated to bringing awareness to the important role culture plays in the lives of therapists and clients alike; in fact, in all of our lives. Not only embracing, but celebrating diversity is what the CCC is about. I love being a part of this very important and innovative group!”
- “[Being part of the CCC] gives me the opportunity to learn other cultures and help to then teach what I have learned. To be a vessel in helping others understand that we were all born human and if we can understand that, then we can understand that we’re all equal, we just have different and unique gifts.”
- “I like the idea of going to meetings, what takes place is not more idle talk, but that actually leads to system changes that have real and valued effect in the lives of the people we serve.”

- “I enjoy being part of the CCC and working with a group of people who similarly value culture and diversity. It is stimulating because we are really productive when we meet and we work on more than just one aspect of cultural competency. Also, this is the one meeting where the primary focus is on culture, no matter if we are discussing training needs, budget, or service delivery and accessibility. The committee is also very diverse as well and each member contributes so much of his or her own experiences. I really enjoy being part of this committee!”

Please see Criterion 4, Attachment 1 for CCC Roles & Responsibilities.

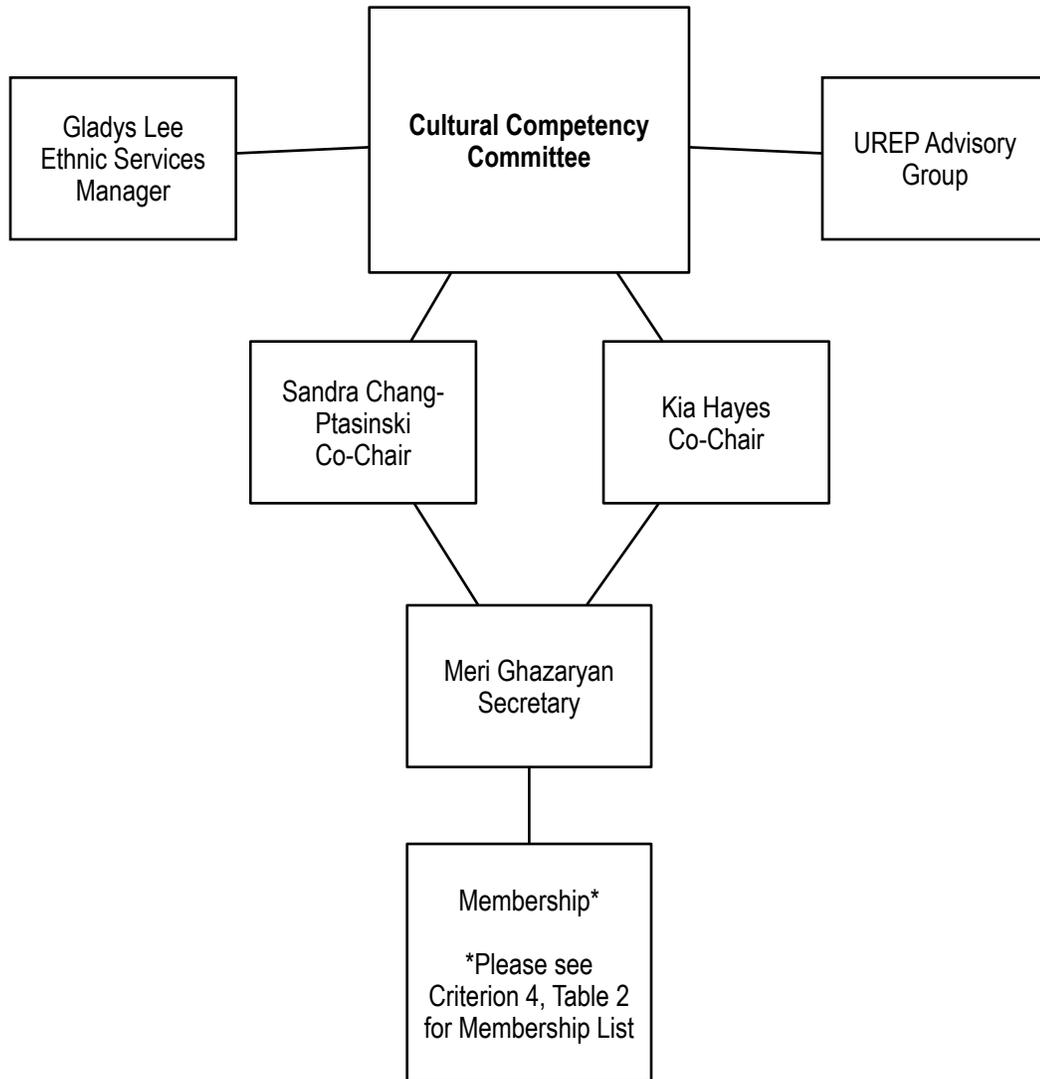
B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

To the extent feasible, the ethnic and demographic representation of the CCC reflects the ethnic diversity of Los Angeles County clients and population as defined in Criterion 4, Section I, A. above. The CCC is comprised of representatives of the LACDMH’s programs, management and line staff, consumers and family, providers, community partners, contractors, and other members from ethnic, racial, and cultural groups. LACDMH is committed to making sure that the CCC reflects the diversity within our organization and community. Please see the CCC Roles & Responsibilities (Criterion 4, Attachment 1). Tables 3 and 4 below display demographical information on the CCC membership and UREP Leadership Advisory Group.

C. Organizational Chart

Please refer to Criterion 4, Table 1 below for the Cultural Competency Committee Organizational Chart.

Criterion 4, Table 1
Cultural Competency Committee Organizational Chart



D. Committee membership roster listing member affiliation if any.

**Criterion 4, Table 2
CULTURAL COMPETENCY COMMITTEE MEMBER LIST**

	Name	Agency	Email	Phone #	Self -Identified Membership Affiliation
					1. Client 2. Family Member/Caregiver 3. DMH Staff 4. DMH Contract Provider 5. DMH Directly-Operated Provider 6. Community Member/Partner 7. Ethnic/Racial/Cultural Group 8. Other (Please Specify)
1	Sandra Chang-Ptasinski	Planning/CC	schang@dmh.lacounty.gov	213 251-6815	3, 7 (biracial)
2	Kia Hayes	Planning/CC	khayes@dmh.lacounty.gov	213 251-6875	3, 7 (African-American)
3	Meri Ghazaryan	Planning/CC	mghazaryan@dmh.lacounty.gov	213 251-6808	3, 7 (White)
4	Kumar Menon	Public & Gvm't Relations	kmenon@dmh.lacounty.gov	213 639-6757	3
5	Keren Goldberg	Public & Gvm't Relations	kgoldberg@dmh.lacounty.gov	213 351-5297	3
6	Albert Thompson	Office of Consumer Affairs		213 251-6522	1
7	Naga Kasarabada	ACCESS	nkasarabada@dmh.lacounty.gov	562 651-5027	3
8	Sylvia Guerrero	Patient Rights	sguerrero@dmh.lacounty.gov	213 738-4124	3, 6

9	Ann Lee	Geo Init SA 8	alee@dmh.lacounty.gov	562 435-3027	3
10	Adrienne Hament	DMH CDD	ahament@dmh.lacounty.gov	213 738-4392	3
11	Martin Jones	AVMH SA 1	mjones@dmh.lacounty.gov	661 723-4260	3, 7 (African American), 7 (visually impaired), 8 (Apostolic/Pentecostal Minister)
12	James Randall	DMH	jrandall@dmh.lacounty.gov	818 708-4511	2, 3
13	Anahid Assatourian	SA 4	aassatourian@dmh.lacounty.gov	213 738-3423	3
14	Diane Guillory	Stand & QA	dguillory@dmh.lacounty.gov	213 738-3777	3, 7 (African-American)
15	Leticia Ximenez	DMH EOB/SA 4	lximenez@dmh.lacounty.gov	213 738-6193	3, 7 (Mexican-American)
16	Rose Lopez	Pacific Clinics	Rlopez@pacificclinics.org	626 744-5230 ext. 215	4
17	Kimberly Spears	SA6 QIC Chair	kspears@dmh.lacounty.gov	323 290-5824	3, 5
18	Patricia Lopez-White	Training Division	Plopezwhite@dmh.lacounty.gov	213 251-6873	3, 7 (Mexican-American)
19	Karen Sprague	Pacific Clinics	Ksprague@pacificclinics.org		2, 4
20	Krista Scholton	WET	kscholton@dmh.lacounty.gov	213 738-2126	3
21	Kelli Blanchfield	Older Adults Admin	kblanchfield@dmh.lacounty.gov	213 804-6474	3
22	Ruby Quintana	SA 4 Admin	rquintana@dmh.lacounty.gov	213 345-6645	3
23	John Sheehe	COD System wide coordinator	jsheehe@dmh.lacounty.gov	213 351-7705	DMH and representative for LGBTQ individuals
24	Ilda Aharonian	DMH SA 3 Program Admin	iaharonian@dmh.lacounty.gov	213 739-5441	2, 3, 7 (Latino/Mexican- American)

**Criterion 4, Table 3
CULTURAL COMPETENCY COMMITTEE DEMOGRAPHICS**

Member Name	Gender	Organization					Position			Groups Represented			Language Spoken
		DMH	Contractor	CBO	Other	SA	Management	Administration	Front Line	Consumer	Family Member	Ethnicity	
Kumar Menon	M	X				4	X					East Indian	English & Malayalam
Patricia Lopez White	F	X						X				Mexican American	Filipino, Chinese, Spanish
Meri Ghazaryan	F	X						X				Armenian	English, Armenian
Diane Guillory	F	X						X			X	X	English
Sandra Chang Ptasinski	F	X					X					Latino/Chinese	Spanish
Anahid Assatourian	F	X							X				Armenian, Farsi, English
Ann Lee	F	X				8		X				Asian	English
Nagalakshmi Kasarabada	F	X					X					Asian Indian	Telugu, Hindi
John Sheehe	M	X					X					LGBTQ	English
Kelli Blanchfield	F	X				CW			X			White	English
Ruby M. Quintana	F	X							X			Latina	English/Spanish
Krista Scholton	F	X					X						English
Jim Randall	M	X							X		X	White	English
Ilda Aharonian	F	X				3		X				Latino	English & Spanish
Sylvia Guerrero	F	X							X	X	X	Mexican American	Spanish
Martin Jones	M	X				1	X					African	English

												American	
Kimberly Spears	F	X				6		X				African American	English
Rose Lopez	F		X			3 & 4	X				X	Latino	English
Leticia Ximénez	F	X				4		X				Mexican	Fluent English & Spanish, and Some French
Adrienne Hament	F	X					X					Filipino	Tagalog, Spanish
Kia Hayes	F	X						X				African American	English
Keren Goldberg	F	X					X					X	English & Spanish
TOTAL		21	1	0	0	10	9	8	5				
%		95%	5%	0%	0%	45%	41%	36%	23%				

**Criterion 4, Table 4
UREP LEADERSHIP ADVISORY GROUP**

Member Name	Gender	Organization					Position			Groups Represented			Language Spoken
		DMH	Contractor	CBO	Other	SA	Manage-ment	Admin-istrative	Front Line	Consumer	Family Member	Ethnicity	
Mariko Kahn	F		X	X		2, 5, 8	X					Chinese & Japanese	English, some Spanish and some German
Katty Callender	F	X				CW	X					Latina	English, Spanish
Katrin Aslanian-Vartan	F	X						X				Armenian	Armenian, English
Scott Hanada	M	X				CW	X					API	English
Angela Savoian	F				Volunteer				X		X	Armenian	Armenian, English
Yolanda Whittington	F	X					X					African American	English
Ed Viramontes	M		X				X					Hispanic	Spanish
Ernie Smith	M				Retired		X					African American	English
Mastaneh Moghadam	M		X				X					Iranian	Farsi, English
Mark Parra	M	X				CW		X				American Indian	English, Spanish, American Sign Language
Daniel Dickerson	M			x					X			American Indian/Alaskan Native	English
TOTAL		5	3	2	2		7	2	2				
%		45%	27%	18%	18%		64%	18%	18%				

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System. The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities

- 1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county.**
- 2. Provides reports to Quality Assurance/Quality Improvement Program in the county.**
- 3. Participates in overall planning and implementation of services at the county.**
- 4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director.**
- 5. Participates in and reviews county MHPA planning process.**
- 6. Participates in and reviews county MHPA stakeholder process.**
- 7. Participates in and reviews county MHPA plans for all MHPA components.**
- 8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs).**
- 9. Participates in revised CCPR (2010) development.**

The CCC has become a formal and centralized mechanism that supports the exploration and expansion of cultural competency within our Department. As such, the Committee serves as an advisory group for the infusion of cultural competency in diverse aspects of LACDMH program planning, implementation and service delivery. All roles, functions and activities of the CCC are based on its commitment to furthering The Department's progress in the provision of culturally and linguistically competent services.

With LACDMH being the largest mental health system in the nation, the challenges for the CCC and Cultural Competency Unit to review "all services/programs and cultural competence issues" grow in direct proportion to LACDMH's size and diversity of programs. Participation in the CCC is 100% voluntary for our members, and we have been productive with the time we spend together in our monthly meetings as it has yielded tangible results in our collaborative work with several Departmental units.

The attendance and content of all CCC meetings are documented in meeting minutes. The minutes show the trajectory of the Committee, identification and progression of projects, and group decisions and recommendations made by the CCC to diverse LACDMH programs. The CCC activities can be categorized into six general levels of involvement/practices/procedures:

The first level of involvement of CCC members is evident in targeted program and service review. For example, the Committee provided feedback to the Data Geographical Information Systems Unit on the Provider Directory on essential areas of information to include in the directory such as language spoken by staff, work hours, location and a link to public transportation. The CCC has collaborated with the Patients Rights Office by reviewing the most recent version of the "Change of Provider Request Form" by recommending that the new form includes items that inquire whether the change of provider is being requested for cultural competency issues. The CCC has also provided input into the update of the Training Division's Instructor-led Training Evaluation Form. Hence, items that assess the participants' evaluation of cultural competency content in the training have been added, such as: 1) The training attended "provided information that was culturally competent" and (2) "Curriculum addresses diversity and cultural competency". Also noteworthy are the CCC review of the 2008 LACDMH Cultural Competency Organizational Assessment to identify future directions and priorities, and the CCC's identification, prioritization and recommendation for LACDMH forms to be translated into the threshold languages.

Another level of CCC's work is focused on MHSA. Members of the CCC have participated in LACDMH MHSA planning process as part of the duties they perform within their particular work units. CCC members have actively participated in multiple MHSA meetings and workgroups, thereby joining other Departmental Programs in advocating for the voice of underserved populations to be heard in the Stakeholder's process, delegate meetings and MHSA Planning meetings. Specific examples include: CCC representation in the UREP Subcommittees and their system capacity projects; and the Outreach and Engagement Team as mental health promoters, service liaisons and educators. The CCC has also reviewed and provided recommendations and feedback on the WET and Innovation MHSA Plans.

The third area of strong CCC concentration has been the implementation of the LACDMH Cultural Competency Plan Requirements and participation in the 2010 System Review and CAEQRO audits. For the CCPR, the CCC reviewed the entire protocol/ guidelines and made recommendations on content to be included; brainstormed on programs to be featured; provided information on some LACDMH programs including utilization data, language capability data, cultural competency procedures and practices; provided personal and professional demographics and work activities for inclusion in the Criterion 4 of the CCPR. Likewise, the CCC reviewed the State protocol for the 2010 System Review to identify cultural competency related questions and provided recommendations on materials to be featured in both the 2010 System Review and CAEQRO audits

Another level of involvement for CCC members and the Cultural Competency Unit revolves around collaborations with the Quality Improvement Division. For example, update reports are provided at every QIC monthly meeting on current CCC projects and points of discussion. It is also at the QIC meetings that the schedule for upcoming CCC meetings is announced. Service Area-based QIC

subcommittee chairs attend the CCC monthly meetings in order to collaborate with the CCC and advance cultural competency communication and information flowing through out the system.

The fifth area of CCC involvement for Committee members and the CC Unit is with consumer groups and consumer-run activities such as self-help groups. Although the degree of engagement has been on an as-needed-basis, efforts have been made to honor consumer groups' requests for in-services and mentorship. Some of the topics for in-services requested in the past include: the Wellness Recovery Action Plan (WRAP), conflict resolution, specific mental health conditions, UREP, and the LAC-DMH Self-help and Recovery Libraries (presented in Criterion 8 of the CCPR).

Finally, the CCC maintains close communication with the Ethnic Services Manager (ESM) for purposes of reporting State requirements, transmission of recommendations to the Executive Management Team, and current status of CCC projects. The ESM serves as a link between the Committee and the Executive Management Team which includes our mental health director. By sharing all plans and recommendations developed by the CCC with the Ethnic Services Manager, we ensure representation of CCC matters before the Executive Management Team for their review, guidance and approval.

In addition to all of the CCC activities described above, members of the CCC are also involved in a plethora of meetings and taskforces in which they actively represent both cultural competency and the Committee. The following table captures sample group affiliations of CCC members and a brief description on how members represent cultural competency in these Departmental efforts.

Additional group affiliation and activities of CCC members

Activities/ Group Affiliations	Cultural Competency Representation
Outreach & Engagement Team	Development of O & E activities or underserved populations
NAMI	On-going collaboration between LACDMH and NAMI events
Under-represented Ethnic Populations (UREP) Team	Advocacy for mental health services access by underserved populations, development and implementation of capacity building projects for each of the five UREP Subcommittees
Innovation Team	Development of projects to serve UREP with a model that is defined by the community and promotes integration of formal and non-traditional service providers

Northeast LA Faith-Based	Discuss mental health services accessibility by faith-based organizations and areas of unmet need
DCFS Community Meeting	Discuss mental health services needs in Boyle Heights and El Sereno area
DMH Clergy Advisory Committee	Discuss mental health services accessibility with faith communities
Patients Rights	Address issues regarding client's right to request cultural appropriate services at the clinic
DMH Web Governance Council	Ensure the DMH approach to publishing content online addresses needs of various cultural groups
Stakeholder Process	Advocate for inclusion of ethnic and other cultural groups in MHSA processes
Service Area based Quality Improvement Council (QIC)	Address cultural competency issues and CCC activities, roles and responsibilities
Training Division Policy & Procedure Meetings	<ul style="list-style-type: none"> • Training evaluations reviewed and modified to incorporate two CC items (1) "Provided information that was culturally competent" (2) "Curriculum addresses diversity and cultural competency" (July 22, 2009) • The group reviewed the presenters' guidelines on the integration of Cultural Competence in the curriculum of LACDMH trainings offered (June 22, 2010) • The group reviewed Protocol and Procedures and made revisions to the Cultural Competence Section (July 13, 2010)
Gangs, Youth Trauma, Domestic/Family Violence, & Field Safety	Development of a one-day experimental workshop on gangs, youth trauma, domestic and family violence. Part of the curriculum will include guest speakers from Homeboy Industries who will describe his/her experience with domestic and family violence. Cross cultural differences and how these factors affect diagnoses and treatment will also be discussed.
Integrated COD screening assessment and TX forms trainings	Participation in discussions pertinent to drug use as influenced by race, gender and or sexual orientation in clinic staff trainings on integration of COD services.
Crystal Meth Taskforce	Ongoing interdepartmental and community discussion of the need for demographics on the use of meth by gender and sexual orientation.

B. Provide evidence that the Cultural Competence Committee participates in the above review process

The CCC 's participation in the review process covered in Criterion 4, Section A above is well documented in the meetings minutes and CCC Annual Report 2009-2010. Please refer to the CCC Annual Report 2009-2010 (Criterion 4, Attachment 3) for detailed information and evidence that the CCC ensures the integration of cultural competency as a critical part of policy and strategy in the planning and delivery of mental health services to children, transitional age youth, adults, and older adults. Please refer to the CCC Minutes & Agendas (Criterion 4, Attachment 2) for dates and minutes of specific topics and discussions of cultural competency items.

C. Annual Report of the Cultural Competence Committee's activities

1. Detailed discussion of the goals and objectives of the committee

a. Were the goals and objectives met?

- **yes, explain why the county considers them successful**
- **no, what are the next steps?**

2. Reviews and recommendations to county programs and services

3. Goals of cultural competence plans

4. Human resources report

5. County organizational assessment

6. Training plans

7. Other county activities, as necessary

The CCC's Annual Report 2009-2010 (included as Criterion 4, Attachment 3) organizes the CCC activities under the following 10 strategies:

1. Increase the CCC's role in enhancing cultural diversity within LACDMH
2. Participate in targeted planning and implementation of services at the county
3. Develop cultural competency policies and procedures to guide cultural competency projects and practices
4. Increase the system wide knowledge of LACDMH cultural competency policies as well as relevant State and Federal regulations
5. Serve as advisory group for the completion and implementation of the LACDMH CCPR as well as Medi-Cal System Review and CAEQRO audit
6. Identify LACDMH forms and other key written documents to be translated into the threshold languages
7. Gather and review data on racial, ethnic and cultural populations currently served and seeking to receive LACDMH services
8. Collaborate with the Training Division regarding cultural competency trainings
9. Collaborate with the Quality Improvement and Quality Assurance Divisions

10. Maintain close communication and consultation with the Ethnic Services Manager

Each of these objectives has been met to the extent described in the CCC Annual Report 2009-2010. As previously stated, the CCC is a very young committee and has only been operating under its own governing body since May 2010. The range of reported CCC activities under the 10 strategies continues as the plan for the current calendar year. Nonetheless, it is important for the CCC to keep a realistic appraisal and perspective on what can be accomplished given the considerable size of our Department, its abundance of programs, and the exponential number of projects that get generated for review of cultural competency.

At present, the CCC is working on establishing a more visible role within LACDMH and will be launching a new project titled "CC: Did you know?" CCC members will be writing a column on cultural competency for the Department's electronic news as an on-going method for disseminating information on diverse aspects of culture, CCC projects and practical information relevant to cultural competency. It is our hope that the creation of a space for cultural competency in the electronic Departmental news will become tool to increase awareness and sensitivity in the Department's response to the needs of diverse underserved and other cultural populations within our system of care.

Please refer to Criterion 4, Attachment 3: the CCC Annual Report 2009-2010 for additional information on specific CCC activities

Criterion 4 Attachments

Attachment 1: CCC Roles & Responsibilities

Attachment 2: CCC Minutes & Agendas

Attachment 3: CCC Annual Report 2009-2010

CRITERION 5
CULTURALLY COMPETENT TRAINING ACTIVITIES

- I. **The county system shall require all staff and stakeholders to receive annual cultural competence training.**

The county shall include the following in the CCPR:

- A. **The county shall develop a three-year training plan for required cultural competence training that includes the following:**

1. **The projected number of staff who need the required cultural competence training. This number shall be unduplicated.**

The Training Division is responsible for offering frequent trainings in Cultural Competence to ensure availability to all DMH employees and stakeholders.

2. **Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.**

According to DMH Policy/Procedure (609.5), all DMH employees shall complete “a foundation course in cultural diversity as provided/recommended by DMH.” “Subsequent to the initial foundation course, a cultural diversity course shall be taken every three years.” The cultural diversity foundation course is a mandatory four-hour class (See Criterion 5, Attachment 1). The Training Division has now begun to schedule this foundation course on a monthly basis. This should continue until all DMH staff have completed the course.

Upon verification that all DMH staff have completed the cultural diversity foundation course, Training Division will subsequently schedule the course for new employees during the New Employee Orientation.

DMH employees will be able to meet the requirement for taking a cultural diversity course every three years following completion of the initial foundation. This requirement can be satisfied by the employee’s participation in at minimum, a four hour training or workshop that is focused solely on culturally or linguistically diverse populations. It can also be satisfied by attendance at appropriate conference workshops of the same focus and duration.

The Training Division will continue to work with the Cultural Competency Committee to ensure trainings are in compliance with the State requirements. The Training Division will also ensure that an adequate number of appropriate trainings are offered to DMH employees and contract providers so that minimum requirements can readily be met and maintained.

3. How cultural competence has been embedded into all trainings.

The Training Division has developed Cultural Competence guidelines (See Criterion 5, Attachment 2) which are distributed to all presenters who will be conducting trainings or conference workshops in order to ensure that cultural competence is integrated into their presentations. Trainers will be expected to understand the Training Division's cultural competence goals and how to incorporate cultural competence into their respective curricula.

The Training Evaluation Form will ask participants if the presenter included cultural competence factors in the training.

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

A. Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function (If available, include if they are clients and/or family members):

- 1. Administration/Management**
- 2. Direct Services, Counties**
- 3. Direct Services, Legal Entities**
- 4. Support Services**
- 5. Community Members/General Public**
- 6. Community Event**
- 7. Interpreters**
- 8. Mental Health Board and Commissions**
- 9. Community-based Organizations/Agency Board of Directors**

See Criterion 5, Attachment 3 for the list of Cultural Competence staff trainings for FY 09-10.

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

- 1. Cultural Formulation**
- 2. Multicultural Knowledge**
- 3. Cultural Sensitivity**
- 4. Cultural Awareness**
- 5. Social/Cultural Diversity (Diverse groups, LGBTQ, SES, Elderly, Disabilities, etc.).**
- 6. Mental Health Interpreter Training**
- 7. Training staff in the use of mental health interpreters**
- 8. Training in the Use of Interpreters in the Mental Health Setting**

See Criterion 5, Attachment 3 for the list of Cultural Competence staff trainings for FY 09-10.

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

A. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities

The Cultural Competence staff trainings have addressed some of the identified disparities. The listed cultural competence staff trainings increase awareness by addressing barriers and inequalities that might affect the quality of mental health care for Los Angeles County clients and consumers. These disparities are (but are not limited to): stigma; lack of knowledge of mental health services; lack of suitability of mental health services; poverty; unemployment; disrupted families; race/ethnicity; primary language not English/linguistic Isolation; and physical disabilities. There were 26 trainings which focused on intervening with Latino clients and their families. There were five trainings on Asian American mental health concerns. There were 16 trainings on improving access to mental health services. There were 12 trainings on improving interpreter services in mental health settings. There were ten trainings which addressed stigma and discrimination. There were three trainings which focused on physical disabilities.

The Training Division will continue to work with the Cultural Competency Committee to increase the development and number of trainings that address identified disparities.

The Training and Quality Improvement Divisions will collaborate with the Planning Division to conduct longitudinal surveys on the relevance and effectiveness of cultural competence trainings.

2. Results of pre/post tests (Counties are encouraged to have a pre/post test for all trainings)

Due to changes in requirements by the various professional boards for continuing education approval, the Training Division no longer uses pre/post tests for instructor-led trainings and/or conferences.

3. Summary report of evaluations

See Criterion 5, Attachment 4 for evaluation summaries of trainings. Although participants are requested to complete evaluations of all trainings they attend, summaries of the evaluations are not made for all trainings and conference workshops due to limited resources.

4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.

The Training Division is currently involved in developing a committee to examine and improve the evaluation process in order to determine whether or not employees report using the information/skills they have acquired in trainings/conference workshops.

The Training Division is not in an appropriate position to monitor all DMH staff advancement regarding progression of skill learning. It seems that each program manager would be better placed to determine and ensure that their respective employees are using the skills learned. Supervisors are able to monitor and track their supervisees' training by using the Learning Management System, also known as the Learning Net. In 2008 the County of Los Angeles implemented the Learning Net to search, view, and register for trainings, receive confirmation, and obtain transcripts. Supervisors are also able to document employees' attendance in trainings and skills learned in the annual Performance Evaluation (PE).

5. County methodology/protocol for following up and ensuring staffs are utilizing the skills learned.

As previously noted, the Training Division is currently involved in developing a project to examine and improve the evaluation process to determine whether or not employees report using the information/skills they receive during trainings. Additionally, it is primarily the responsibility of the respective on-site supervisor/manager to ensure that this is occurring. The Training Division will continue to be responsible for monitoring the quality of Cultural Competence trainings.

IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

The county shall include the following in the CCPR:

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

See Criterion 5, Attachment 5 for the list of trainings that include a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities for FY 09-10.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

- 1. Family focused treatment**
- 2. Navigating multiple agency services**

3. Resiliency

The Training Division will consider inclusion of these areas in future trainings

Criterion 5 Attachments

Attachment 1 - Cultural Diversity Foundation Course Handouts

Attachment 2 - Cultural Competence Guidelines for Presenters

Attachment 3 - List of Cultural Competence Staff Trainings for FY 09-10

Attachment 4 - Evaluation Summaries of Trainings

Attachment 5 - List of Trainings that Include Client's Personal Experiences

CRITERION 6

COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

- I. **Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations**
The county shall include the following in the CCPR:

- A. **Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.**

As part of the required WET Plan, a Workforce Needs Assessment for the County of Los Angeles public mental health system's workforce was performed in the second half of FY 2007-2008. The Assessment identified the various job classifications within DMH and its contracted agencies. All classifications were grouped into one of five major categories. At the time of assessment, the public mental health system workforce consisted of 12,873.5 FTE staff members. The five major categories and the percentage of authorized FTEs were:

Unlicensed Mental Health Direct Service Staff	26.71%
Licensed Mental Health Direct Service Staff	33.18%
Other Health Care Staff	2.52%
Managerial and Supervisory	13.61%
Support staff	23.98%

In addition to staffing classification, the bilingual capability of the workforce was assessed. At the time of assessment, the public mental health workforce had 4,616 individuals who were bilingual. The percentage of staff for each language was:

Arabic	0.43%
Armenian	1.39%
Cambodian	1.30%
Cantonese	2.08%
Farsi	1.93%
Korean	1.67%
Mandarin	1.19%
Other	7.34%
Other Chinese	1.86%
Russian	0.95%
Spanish	75.58%
Tagalog	3.14%
Vietnamese	1.13%

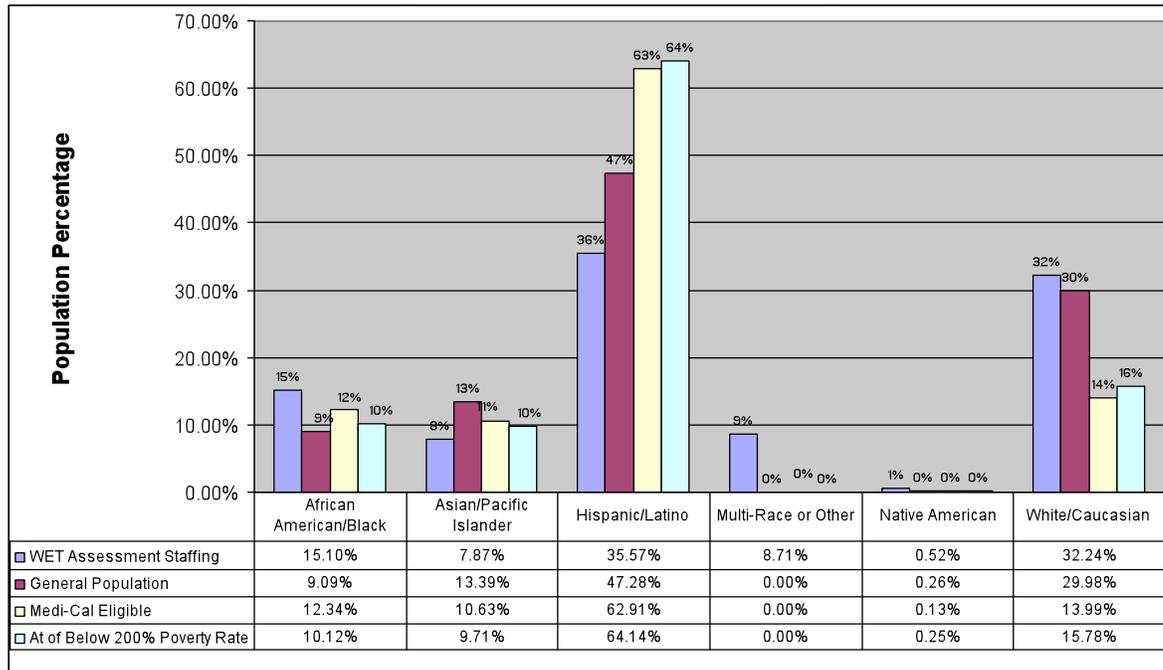
All staff members of the public mental health system are required to be fluent in English.

See attached copy of WET Plan Workforce Needs Assessment (Criterion 6, Attachment 1) for detailed information related to both job classification and language capabilities.

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data.

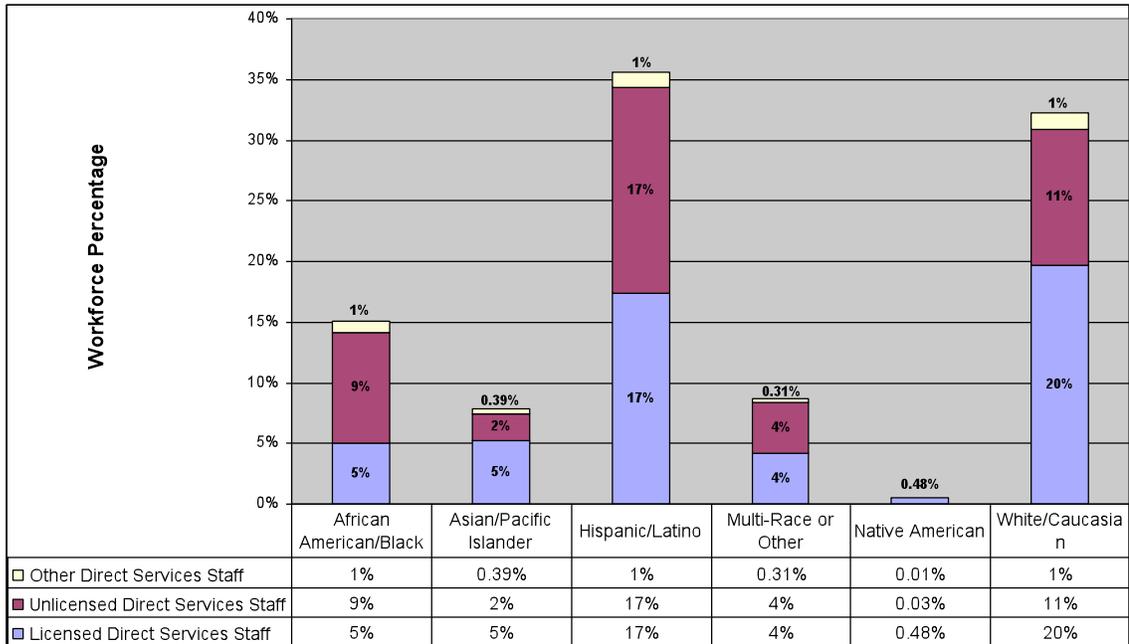
As required by State DMH, our County Workforce Assessment detailed public mental health workforce data including both linguistic capabilities and racial composition. Given the parameters, comparisons are limited to these particular aspects of the data. The following three tables compare the available data amongst the populations. Keep in mind that none of the following tables account for rates of prevalence or penetration.

Table 1 compares the ethnic distribution of: 1) the mental health workforce as assessed in the WET Plan; 2) the general population; 3) the Medi-Cal eligible population; and 4) those living at or below the 200% Poverty Rate.



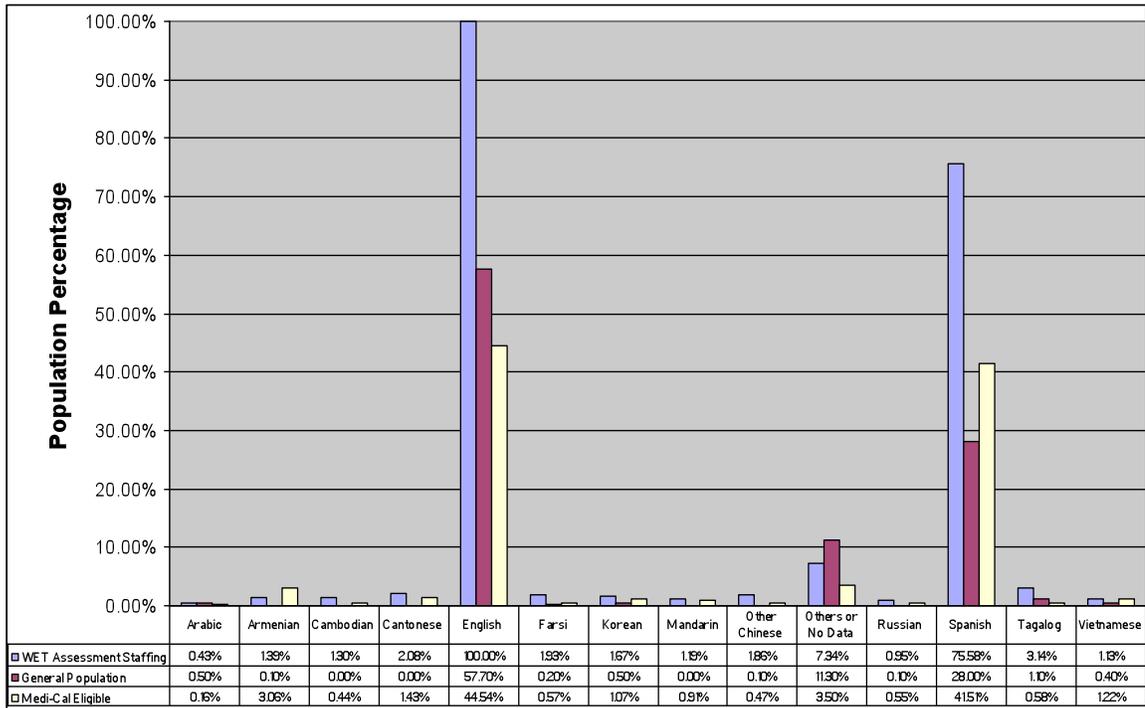
Findings: Given the client ethnicity disparity, data reflects a need to recruit additional Asian/Pacific Islander and Hispanic/Latino staff into the public mental health system.

Table 2 details workforce’s ethnic distribution of direct service staff only, as assessed in the WET Plan, and their direct service role.



Findings: Hispanic/Latino and White/Caucasian encompass two thirds of the direct service staff. Native Americans are the smallest identifiable ethnic group, representing approximately 0.5% of the direct service workforce.

Table 3 compares the 13 threshold language capabilities of: 1)the mental health workforce, as assessed in the WET Plan; 2) the general population; and 3) Medi-Cal eligible population. Linguistic capabilities data was unavailable for those living at or below the 200% Poverty Rate.



Findings: Data reflects a need to recruit additional Arabic, Armenian, and Vietnamese speaking staff.

C. Report the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.

At this point, the WET Plan has funded five Programs that were identified for initial implementation. Since the approval of the WET Plan, the majority of the Programs have yet to be implemented due to the lengthy Request for Services (RFS) process. The importance of linguistic and cultural competency are foremost in the development and implementation of WET. We understand that extensive discussions with WET contracted agencies as well as ongoing monitoring of the programs are essential measures we are undertaking to meet the mandates. While ensuring that cultural responsiveness is embedded in WET funded trainings and programs, other attempts to enhance these priorities specifically target the recruitment of individuals from underserved and ethnic communities as another avenue for meeting these mandates (i.e., WET Program #13 – High School Through University Mental Health Pathways; Program #14 Market Research and Advertising Strategies for Recruitment of Professionals in the Public Mental Health System). Lastly, we are cognizant of the expansiveness

of our County's diversity concerns and understand the need for Workforce Education and Training Staff to increase their participation and serve in committees where linguistic and cultural competency issues are primary, thus keeping us in touch with community needs which enhance/create a responsive public mental health workforce.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

Five programs were funded during FY 08-09. Since data is not available for FY 09-10, only FY 08-09 data will be presented.

1. Intensive Mental Health Rehabilitation Specialists

Consists of 12 to 16-week training for consumers, family members and other individuals, interested in employment within the public mental health system who have received a Bachelor level degree or have "life experience." This program provides didactic and experiential field placement components relevant to recovery oriented treatment.

The FY 2008-09 trainings graduated 169 individuals, with 73% of those either working or actively interviewing in the public mental health system. Demographic data reflects that participants included: 54% consumers; 33% family members; 87% ethnic minorities; and 39% speak a language other than English.

Enrolled participant's self-identified ethnicity is:

African American	30%
Asian/Pacific Islander	8%
Caucasian	13%
Latino/Latina	37%
Other	12%

Please Note: Participants in this training program are not guaranteed a paid position in the public mental health system, but their completion does make them eligible to apply for employment in the public mental health system. Unfortunately, the current economy has limited the number of available positions.

2. MSW/MFT Stipends

The MSW/MFT Stipend Programs provides up to \$18,500 for 2nd year MSW/MFT students who are committed to employment in a hard to fill area of Los Angeles County. Priority is given to those that are bilingual and/or represent underserved/unserved communities. Students enter a contractual obligation to work for one year in an area of Los Angeles County that has been designated as Hard-To-Fill by DMH's Executive Management Team.

Those unable to secure employment to fulfill their commitment obligation are required to refund the stipend award.

During FY 2008-09, 52 MSW stipends were awarded (two were subsequently returned by the awardees), with 98% of the awardees possessing bilingual capabilities and 71% actively employed. During the same period, 72 MFT stipends were awarded, with 78% possessing bilingual capabilities and 86% actively employed.

In addition to English, the following languages were spoken by the stipend awardees.

	MSW	MFT
English Only	1.9%	22%
American Sign Language	0.0%	1%
Armenian	9.6%	1%
Farsi	1.9%	10%
Japanese	0.0%	3%
Korean	5.8%	6%
Mandarin	0.0%	1%
Spanish	80.8%	56%

Please Note: Participants in this training program are not guaranteed a paid position in the public mental health system, but their completion does make them eligible to apply for employment in the public mental health system. Unfortunately, the current economy has limited the number of available positions.

3. Peer Support Training Program

The Peer Support Training Programs is a training targeted to consumers interested in employment within the public mental health system in a Peer Advocate role. This accelerated training is completed in 15 days, and the curriculum consists of such topics as group facilitations, active listening, advocacy and basic work skills. Participants will be certified to apply for Peer Advocate positions upon successful completion of the course.

During FY 08-09, this training was attended by 60 participants. 57 participants self-identified ethnicity is:

African American	42%
Asian/Pacific Islander	5%
Caucasian	16%
Latino/Latina	28%

Other 9%

The bilingual capabilities of all 60 participants is:

English Only	70.0%
Arabic	1.7%
Spanish	25.0%
Spanish, Sign Language	1.7%
Tagalog, Ilocano	1.7%

Please Note: Participants in this training program are not guaranteed a paid position in the public mental health system, but their completion does make them eligible to apply for employment in the public mental health system. Unfortunately, the current economy has limited the number of available positions.

4. College Faculty Immersion to MHSA

This immersion training is designed for undergraduate and graduate school staff that teach/instruct and student who are enrolled in the human service area of study or have an interest in working in the public mental health field. The College Faculty Immersion promotes the development of human services professionals who may potentially work or volunteer in a best-practices system of care. The training program does this by updating under-graduate and graduate school staff and students increasing their understanding of best practices, including evidence based practices and promising approaches utilized in the public mental health field.

During FY 2008-09 this training provided consultation to 18 educational institutes, varying from high school to Graduate Schools) in the Los Angeles Area. Those schools that benefited from this program were:

- Alliant International University
- American University of Health Services
- Antioch University
- Azusa Pacific University
- Cal State University Dominguez Hills
- Cal State University Fullerton
- Cal State University Long Beach
- Cal State University Los Angeles
- Cal State University Northridge

Cerritos College
Huntington Park High School
Loyola Marymount
Narbonne High School
Pepperdine University
San Diego State University
University of California, Irvine
University of California, Los Angeles
University of Southern California

5. Public Mental Health Staff Immersion to MHSA

This three-day training is designed to enhance the knowledge of the public mental health workforce by immersing them in the tenets of MHSA and providing lessons on how to integrate MHSA into their work with consumers and their families.

During FY 08-09, 109 staff members of the public mental health workforce were trained.

E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

Several programs have been implemented with initial funding provided in FY 2007-2008. Reflecting on these programs and looking forward to implementation of the next phase of WET, we learned that data collection is important to the success or understanding of modification of a program. Pre/post evaluations, the tracking of participants after training and acquiring demographic information are being refined with every training completed. Outcome measures are developed based on what we think is critical and are solicited on an on-going basis, to ensure correct data is indeed collected. Still, databases are setup for all funded WET Program to the best of our knowledge and ability. In addition to obtaining objective information, we have learned that witnessing firsthand the benefits of WET funded programs is likewise important. Having WET staff attend the graduation for the Intensive Mental Health Recovery Specialist Program enables us to “own” WET Programs making our work that much more meaningful.

In addition, we have learned repeatedly that we need to continuously outreach individuals from the unserved/underserved communities. One such community is the Asian Pacific Islanders. In reviewing the data, they represent 7.87% of the workforce, while at the same time representing 13.25% of the total population and 10.6% of the Medi-Cal enrolled population. Focus groups such as those conducted for Parent Advocates/Parent Partners indicated the challenges faced over the years. Collaboration with the under-represented ethnic population (UREP) API group in Los Angeles County is needed to identify other ways of recruiting API personnel into our workforce.

F. Identify county technical assistance needs.

Our Legal Entities Survey revealed that the legal entities would like some assistance in obtaining testing and certification in medical or therapeutic terminology (both written and oral) for bilingual staff.

**CRITERION 7
LANGUAGE CAPACITY**

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.

LACDMH is striving to meet the language capacity needs of our diverse communities by developing bilingual staff capacity for the following thirteen threshold languages: Arabic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. “Threshold language” means a language identified on the Medi-Cal Eligibility Data System as the primary language of 3,000 beneficiaries or 5% of the beneficiary population, whichever is lower, in an identified geographic area, per Title 9, CCR, Section 1810.410.

Because of the size of Los Angeles, LACDMH has determined threshold language profiles for each of our eight Service Areas, which are as follows:

Threshold Languages by Service Area

Service Area 1	English, Spanish
Service Area 2	English, Spanish, Korean, Tagalog, Armenian, Farsi
Service Area 3	English, Spanish, Cantonese, Mandarin, Other Chinese, Vietnamese
Service Area 4	English, Spanish, Cantonese, Korean, Tagalog, Armenian, Russian
Service Area 5	English, Spanish, Farsi
Service Area 6	English, Spanish
Service Area 7	English, Spanish
Service Area 8	English, Spanish, Cambodian
Countywide	Arabic

Funded WET Program efforts to increase the bilingual capacity have included:

- *Intensive Mental Health Recovery Specialists* – a 12-16 week training for consumers, family members and individuals interested in employment within the public mental health system. This program provides didactic and experiential components relevant to recovery-oriented treatment.
- *MSW/MFT Stipends* – which provides up to \$18,500 for 2nd year MSW/MFT students who are committed to employment in a hard-to-fill area of Los Angeles County. Priority is given to those that are bilingual and/or

represent underserved/unserved communities. During FY 2008-09, 52 MSW stipends were awarded, with 98% of the awardees possessing bilingual capabilities and 71% actively employed. During the same period, 72 MFT stipends were awarded, with 78% possessing bilingual capabilities and 86% actively employed.

- *Peer Support Training Program* – a 15-day training targeted to consumers interested in employment within the public mental health system in a Peer Advocate role. The curriculum topics include: recovery oriented tenets, communication/listening skills, overview of the peer model, conflict resolution, and job readiness and managing workplace stress. During FY 08-09, this training was attended by 60 participants.

In addition, the MHSA Mental Health Loan Assumption Program will be jointly offered by LACDMH and the State Department of Mental Health. This loan assumption program is for mental health professionals in the public mental health system (DMH and its community-based contracted programs) to provide awardees up to \$10,000 for repayment of educational loans. A limited number of awards are available for the County of Los Angeles public mental health workforce. This program requires that eligible applicants work in a “hard-to-fill/retain” position, as defined by the LACDMH. This program is included in the WET Plan but has not yet been implemented. Please refer to Criterion 7, Attachment 1 for the “hard-to-fill/retain” criteria and application established for the County of Los Angeles public mental health workforce.

2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations

The WET Plan workforce survey undertaken for the plan was exhaustive with more than 64% response rate by legal entities. It is anticipated that for the next tri-annual Cultural Competence Plan, a workforce survey will be conducted. Since the approval in April 2009 of the WET Plan, there have been no additional updates to determine current workforce language capacity.

3. Total annual dedicated resources for interpreter services.

While there is no dedicated budget for interpreter services within LACDMH, interpreter service funding is embedded in all programs including but not limited to: MHSA programs, ACCESS center, trainings, etc. Please refer to Criterion 1, Table 4 for specific budget line items for interpreter services. This budget is by no means inclusive of all the funds that are dedicated to interpreter services and activities, but it can provide a general idea of funding designated for interpreter services that are not otherwise embedded into program/agency budgets.

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The county shall include the following in the CCPR:

A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

- 1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.**

LACDMH currently meets clients' language needs through a 24-hour, toll-free language line service called the ACCESS Center. Two policies are the primary evidence of our efforts to meet language needs:

- DMH Policy No 202.21 Language Interpreters Section 3.2.1 states, "Directly operated and contract programs will have access to telephone interpretation services 24 hours a day, 7 days a week, via ACCESS Center at 800-854-7771". (Criterion 7, Attachment 2)

Currently, DMH providers contact the ACCESS Center for interpretation needs. The ACCESS Center provides guidance and technical assistance at the time of contact. Although the ACCESS Center does not have the mobile capability to deploy staff to clinics for face-to-face interpretation, they assist providers by giving information about the telephone interpretation services so that providers may use them.

LACDMH's webpage showcases a direct link to the Multi-Linguistic Mental Health Service Provider Directory. This directory is a tremendous resource for all directly-operated and contract providers to do system-wide searches for providers who have diverse cultural and/or linguistic areas of expertise. By clicking on the <http://dmh.lacounty.gov> link to the Directory, providers can direct their search by language, city, Service Area and treatment specialty based on age group. Once the target language is searched for, the directory will list providers who have that linguistic capability. Once a provider is selected, the directory presents specific information such as the staff's position and work hours.

- DMH Policy No 202.17 Hearing Impaired Mental Health Access Section 2.3 states, "Access to interpretation services is managed by contacting LACDMH, ACCESS Center" and Section 2.4 states, "Sign language interpretation/translation services are available 24 hours a day, 7 days a week, via the DMH agreement with Accommodating Ideas, Interpreter Unlimited, and Life Signs." (Criterion 7, Attachment 3)

For equitable service on all deaf/hearing impaired consumers and providers requesting American Sign Language (ASL) Interpretation services for their clients, the ACCESS Center provides emergency and non-emergency services. Directly Operated/Contract facilities requesting ASL service are forwarded to the ACCESS Center ASL Liaison.

Emergency Requests are handled when a response is needed by ACCESS within one hour from the time of the request of the caller for an ASL Interpreter.

2. Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.

Los Angeles County encompasses over 4,000 square miles of service area, including sparsely-populated geographies which are considerable distances from public health and mental health services as well as densely-populated areas with historically underserved populations. LACDMH is committed to providing services broadly and equitably, including offering psychiatric services at remote sites and in facilities for which hiring has been historically difficult. Telepsychiatry extends LACDMH's functionality to meet the MHS Information Technology goal of modernizing and transforming clinical and administrative information systems to improve quality of care, operational efficiency and cost effectiveness.

At present, two telepsychiatry pilot projects have been implemented at underserved rural locations of the county. Three Psychiatrists, two of them with Spanish/English bilingual capabilities, are providing telepsychiatry services to clients in three remote locations: Antelope Valley Mental Health Center, Palmdale Mental Health Center and Catalina Island. As part of its ongoing efforts to address service disparities LACDMH proposes to expand its existing single-provider, point-to-point telepsychiatry pilot program to a system of networked facilities allowing numerous psychiatrists to provide services to clients at a minimum of eight (8) remote or underserved facilities. Initially identified sites include Palmdale or Antelope Valley Mental Health Centers, urban areas and other underserved portions of the County.

3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.

LACDMH's 24-hour phone line is implemented through the ACCESS Center which abides by the Protocols for State Compliance. All staff must identify themselves by first name, the program as Los Angeles County-Department of Mental Health ACCESS Center, and offer interpreter services. If ACCESS employees cannot assist callers because of a language barrier, they then contact the Language Line to assist in providing service to the caller. The protocol is provided in detail as Criterion 7, Attachment 4 – ACCESS Center Program Protocol 2010.

4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

At the present time, there is no formal systemic training on the use of the Language Line. Currently, DMH providers contact the ACCESS Center for interpretation needs. The ACCESS Center provides guidance and technical assistance at the time of contact by providers. Although the ACCESS Center does not have the mobile capability to deploy staff to clinics for face-to-face interpretation, they assist providers by providing information about the telephone interpretation services in order for providers to call in for interpretation services. Additionally, the ACCESS Center refers providers to the Multi-linguistic Mental Health Service Directory to locate DMH staff who speak the language needed, their academic discipline, work location and work hours.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

LACDMH provides a poster in all the threshold languages to all its providers stating that beneficiaries have “the right to receive mental health services in the language of your choice. Language assistance services are free of charge”. The LACDMH provided the poster to all its directly operated and contract providers to be posted in visible areas. Please note the poster will be made available during the visit.

The “Guide to Medi-Cal Mental Health Services” (Criterion 7, Attachment 5, English) is available in the threshold languages and on CD in the threshold languages for those beneficiaries that are visually impaired. The “Guide to Medi-Cal Mental Health Services”, informs the beneficiaries that the Los Angeles County MHP can provide materials in the threshold languages. The Guide also provides two (2) phone numbers to call 800-854-7771 and 213-738-4949, if they have trouble understanding the Guide and/or want to find out about other ways they can access this information. The Guide can be downloaded from the LACDMH website at www.dmh.lacounty.gov. The Guide in English is attached as Criterion 7, Attachment 5; and the Guide in the threshold languages and on CD will be made available during the site review

C. Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services

For the calendar year 2009, the ACCESS Center served a total of 9,332 clients who needed assistance with translation. For calendar year 2010, January to December the ACCESS Center served a total of 7,199 clients. The vast majority of those calls were for Spanish-speaking clients, and approximately half of those calls were handled by ACCESS Spanish-speaking staff rather than the language line. Please refer to Criterion 7, Tables 1 and 2, Emergency Outreach Bureau (EOB) ACCESS Center Language Line Report 2009 & 2010 for the specific breakdown of languages that the ACCESS Center has provided with translation assistance.

Criterion 7, Table 1
Emergency Outreach Bureau ACCESS Center -- Language Line Report 2009

Language	Jan	Feb	March	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Total
AMHARIC						2		1	1				4
ARABIC							3	1		1			5
ARMENIAN	2	6		1	1	8	1	5		4	1	5	34
BENGALI													0
BURMESE												1	1
CAMBODIAN	2	1		1					2				6
CANTONESE	3	3	4	3	2	3		3	5	7	13	2	48
FARSI		1	2	5		5			2	2	2	2	21
FRENCH													0
GERMAN													0
HEBREW	1												1
HINDI					1				1	3			5
HUNGARIAN													0
ITALIAN												1	1
JAPANESE		4		1					1				6
KOREAN	8	8	5	5	13	6	7	6	3	6	8	4	79
LAOTIAN													0
MANDARIN	3	5	8	1		3	4	4	2	6	1	2	39
OROMO							2						2
POLISH			1				2						3
PORTUGUESE	1												1
PUNJABI					2							2	4
ROMANIAN													0
RUSSIAN		1						1			3	3	8
SPANISH	428	394	442	447	384	402	408	452	440	465	385	293	4940
SPANISH ACCESS *	359	280	297	413	336	362	341	350	316	414	334	253	4055
TAGALOG		12	4	4	1	4	2	3	3	1		1	35
THAI													0
TURKISH							2						2
URDU			1										1
VIETNAMESE	4	1		5	1	5	1	3	2	6	1	2	31
Total	811	716	764	886	741	800	773	829	778	915	748	571	9,332

* ACCESS Center Spanish speaking employee assisted in the translation.

Criterion 7, Table 2
Emergency Outreach Bureau ACCESS Center -- Language Line Report 2010

LANGUAGE	Jan 2010	Feb 2010	Mar 2010	Apr 2010	May 2010	June 2010	July 2010	Aug 2010	Sept 2010	Oct 2010	Nov 2010	Dec 2010	TOTAL
AMHARIC													0
ARABIC	1	2			4	3	1			1		1	13
ARMENIAN	2	2	2	2	2	1	3	5	1	9	5	2	36
BENGALI			2			1							3
BULGARIAN										1			1
BURMESE	3												3
CAMBODIAN			2	2	1								5
CANTONESE		1	2	1		2		6	1	2	2	2	19
FARSI	4	3	2	3	4	5	2	3		2	2	1	31
FRENCH				1									1
GERMAN					2								2
HEBREW													0
HINDI													0
HUNGARIAN													0
ITALIAN			1										1
JAPANESE		1	1	3			1		1				7
KOREAN	9	6	2	5	3	10	7	5	11	1		2	61
KHMER											4	1	5
LAOTIAN													0
MANDARIN	4	4	9	1	3	4	8	11	6	8		1	59
OROMO													0
POLISH													0
PORTUGUESE									1				1
PUNJABI										2			2
ROMANIAN							1						1
RUSSIAN	2	2		2		2	1	1	2	2		1	15
SERBIAN	3			2									5
SPANISH	373	369	457	434	360	387	374	362	335	402	343	351	4547
SPANISH ACCESS CTR *	354	430	438	405	374	365	433	377	312	465	366	325	4644
TAGALOG	3	6	3		1	2	1			7	1	2	26
THAI							1	4		1			6

TURKISH														0
URDU						1								1
VIETNAMESE	2	2	1	3	4	1	2	1	3	2	1	1		23
TOTAL	760	828	922	864	758	784	835	775	673	905	724	690		9,518

* ACCESS Center Spanish speaking employee assisted in the translation

1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

According to the survey we conducted of our legal entities, here is sample of lessons learned by our legal entities regarding accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff (the full 2010 Cultural Competency Plan Legal Entity Survey Report is available as Criterion 1, Attachment 2):

- API clients will not go to agencies if the staff are not bilingual.
- Being bilingual does not automatically make someone culturally competent.
- Front office and intake staff being bilingual provides excellent customer service.
- Services need to be in locations that are comfortable and convenient for the client.
- Need better way to account for the value of interpretive services by being able to bill for it especially if it is necessary in order to deliver services.
- Need more resources and documents in threshold languages
- Need valid surveys in participant’s language to measure outcomes. One of the challenges in using the telephone interpreter services is the need to insure high quality services via the telephone. In a recent test call study conducted by LACDMH Quality Improvement Division, the general satisfaction reported by Spanish-speaking callers was lower than that reported by English-speaking callers. Spanish-speaking callers found that literal translation does not their need for sensitivity. Collaboration with the LACDMH Training Division is needed in order to develop training curriculum and implement the training for the telephone language interpreters.
- Technical assistance is required from the State on standards for telephone interpreter services which address the quality of services.

D. Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

Below are some of the challenges and lessons we have learned:

- Many bilingual staff are happy to do translation work as a way to give back to their communities, but sometimes they can feel burdened by the responsibility of being the staff person who knows a certain language. This is particularly

- true in cases where the job responsibilities were not originally designed for translation/interpreter services, but the person has these responsibilities simply because they know the language.
- Proper training is very important.
 - There needs to be supervision in buddying up/shadowing types of situations.
 - Staff feel supported if they have other staff around them who are bilingual and understand the client population.

E. Identify county technical assistance needs.

Our Legal Entities Survey revealed the following technical assistance needs:

- Need more resources and documents in threshold languages
- Need more translation assistance
- Need access to funding for translation of resources and documents
- Need testing/certification in medical/therapeutic terminology, both written and spoken for staff
- Need to develop network of agencies and collaborative relationships to deal with issues together
- Need more staff

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

The county shall include the following in the CCPR:

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

As stated earlier, our ACCESS Center toll-free line and the attached call logs demonstrate the availability of interpreter or bilingual staff. Also mentioned earlier, the MHP provides a poster in all the threshold languages to all its providers making availability of interpreter services known. In addition, the “Guide to Medi-Cal Mental Health Services” informs beneficiaries that the Los Angeles County MHP can provide materials in the threshold languages.

LACDMH maintains an active list of employees who are certified bilingual in a plethora of languages. Criterion 7, Attachment 6, LACDMH Staff Language Proficiency Report shows threshold language and bi-lingual staff capability by Employee number, Job Title, and Pay Location.

As stated in Criterion 4, the Cultural Competence Committee has been maintaining the Multi-Linguistic Mental Health Service Provider Directory (MLSD) which lists the names, locations, hours, age groups served, and language services provided. The Directory provides a list of staff available, including their work hours, to offer services in their respective language and culture. The services are categorized by psychiatric inpatient hospital, targeted case

management and other specialty mental health services that are developed to meet the specific linguistic needs of each service area. The Directory is updated when there is a change on staffing to keep it current. The Directory can be accessed on-line from the LACDMH website at <http://dmh.lacounty.gov>. A memo dated 12/13/2010, (Criterion 7, Attachment 7) requests that providers send their staffing changes to DMH to update the Directory on a regular basis.

B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

The attachments for this criterion combined provide the documented evidence that these services are offered and used. In addition, the following table from our Legal Entities Survey shows that **almost all** legal entities provide translators, interpreters or multi-cultural staff to assist non-English speaking consumers and/or provide training to all staff to increase their awareness of cultural competency:

	Yes	No
1. Have statements and documents that reflect that all services should be culturally competent?	73.56%	26.44%
2. Fund new initiatives that may better serve the culturally-specific needs of our staff and consumers and reduce disparities?	38.55%	61.45%
3. Recognize or compensates staff with a cultural skill, such as a second language, if they use that skill for work that is over and above their specific job duties?	52.33%	47.67%
4. Include a section on cultural competence in performance reviews?	47.62%	52.38%
5. Provide translators, interpreters, or multi-cultural staff to assist non-English speaking Consumers?	94.05%	5.95%
6. Have promotional and educational materials that are culturally sensitive and accessible to all consumer target groups?	75.00%	25.00%
7. Gather information about the demographics of the targeted consumer group?	79.76%	20.24%
8. Plan, develop and implement culturally appropriate service delivery models?	77.11%	22.89%
9. Evaluates the effectiveness of culturally-specific services?	51.81%	48.19%
10. Provide training to all staff to increase their awareness of cultural competency?	86.05%	13.95%

C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

Given the real-life limitations of hiring and retaining staff who speak the specific threshold languages in each Service Area, LACDMH utilizes the following resources:

1. List of employees who are certified bilingual in a plethora of languages. Please refer to the Staff Language Proficiency (HR) report, which shows threshold language and bi-lingual staff capability by Employee number, Job Title, and Pay Location. (Criterion 7, Attachment 6, DMH Staff Language Proficiency Report)
2. ACCESS Center – Please refer to the EOB ACCESS call logs, Criterion 7, Table 1 & Table 2. DMH Policy No 202.21, Language Interpreters, Section 3 states directly operated and contract programs will have access to telephone interpretation services 24 hours a day, 7 days a week, via ACCESS Center at 800-854-7771. Also, directly operated and contract programs will maintain an internal roster of staff proficient in non-English languages. (Criterion 7, Attachment 8 provides samples of providers' language capability rosters).
3. Tracking of linguistic capabilities of all DMH providers -- The Cultural Competency Unit / Ethnic Services Manager sends out a memo to all 540 providers requesting prompt response in tracking of the linguistic and cultural capacities of the staff working in the direct and contract providers' clinics. The data received on each language capability log summarizing the linguistic and cultural capacities of each provider is entered into the Multi-Linguistic Mental Health Service Providers Directory. This directory, available via the Department's Intranet, allows all directly-operated and contracted providers to do searches by staff's language, service location and areas of mental health specialty such as age groups, cultural groups, and treatment modalities. The services are categorized as psychiatric inpatient hospital, targeted case management and other specialty mental health services that are developed to meet the specific linguistic needs of each Service Area. The ultimate purpose of the directory is to serve as resource for making appropriate cultural and/or linguistic referrals to the different ethnic individuals and/or communities seeking mental health services throughout Los Angeles County. The Directory is updated when there is a change on providers' staffing. The Directory can be accessed on-line from the LACDMH website at <http://dmh.lacounty.gov>. Criterion 7, Attachment 7: Memo dated 12/13/2010 requests that providers send their Staff Language Capacities Log and Sample Staff Language Capacities Log from providers across the eight Service Areas.
4. Tracking of language needs and emerging languages in the system of care – The Cultural Competency Unit also works with all DMH directly operated and contracted providers in tracking Initial Requests and Referral Log for Language and Culture-Specific Mental Health Services. This log allows The Department to collect data on language-specific service requests, each provider's capacity to serve clients seeking services in the specific language requested or whether clients were referred to a provider with the requested linguistic capability. Additionally, the log also collects information

on clients' cultural needs, whether the ACCESS CENTER or other telephone interpretation service had to be utilized to serve clients at time of initial contact and the information of the agencies where clients were referred to match their linguistic and cultural needs. This log is due to the Cultural Competency Unit by the fifth of each month. Each log is entered in the data system in order to track language needs of the communities served and language-specific case disposition as to whether clients requesting services in languages other than English were referred in or out to other mental health providers.

See Criterion 7, Attachment 9: Memo dated 12/13/2010, requests that providers send their Initial Requests and Referral Log for Language and Culture-Specific Mental Health Services.

5. As LACDMH contracts with more than 1,000 providers, the services offered by contracted providers are a critical aspect of our language capacity. We conducted a survey for our legal entity providers in the fall of 2010 (Criterion 1, Attachment 2) to help us understand how our contract providers (or "legal entity staff") are meeting the communities' cultural competency needs. The response rate was 85%.

D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

DMH Policy No 602.1, The Bilingual Bonus Policy, Section 3 & 4 states employees must possess a valid Language Proficiency Certificate issued as a result of the County's Bilingual Proficiency Examination procedure, which tests for proficiency to either speak, read and/or write the language. DMH may administer examinations and establish eligible registers (or certification lists) for some positions with foreign language skills as a requirement. Candidates will be tested for bilingual proficiency as part of the examination process and, if successful, issued a Language Proficiency Certificate. (Please see Criterion 7, Attachment 10)

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system at all points of contact.

The county shall include the following in the CCPR:

- A. Policies, procedures, and practices the county uses that include the capability to refer and otherwise link clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.**

The Initial Requests and Referrals Log for Language and Culture Specific Mental Health Services (Criterion 7, Attachment 10) was developed by the Cultural Competency Unit to assist the providers with tracking the linguistic and cultural needs of individuals requesting mental health services.

In addition, the MHP provides a "Multi-Linguistic Mental Health Service Providers Directory" (MLSD) that lists the names, locations, hours, age groups served, and language services provided. The Directory provides a list of staff available, including their work hours, to offer services in their respective language and culture. The services are categorized by psychiatric inpatient hospital, targeted case management and other specialty mental health services that are developed to meet the specific linguistic needs of each service area. The Directory is updated when there is a change on staffing to keep it current. The Directory can be accessed on-line from the LACDMH website at <http://dmh.lacounty.gov>. The "Multi-Linguistic Mental Health Service Providers Directory" also maintains its listings for languages not included in the thirteen threshold languages.

B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Each program uses a "whatever we can" approach to communicate with consumers and families in their non-threshold language. Below is the procedure we use:

1. Identify and document the State required information, including the consumer's preferred language and/or cultural need, in the "Referral Log for Language and Culture specific Mental Health Services" or other equivalent log.
2. Assign the case to the program staff that best meets the consumer's language and/or cultural needs.
3. If there are no program staff that can speak the consumer's preferred language and/or meet his/her cultural need, we see if there is another program in the Service Area that can.
4. If there are no other Service Area program staff that can meet the need, we then contact Human Resources to see if there are staff within the Department who can assist.
5. If Human Resources cannot identify appropriate staff, we contact the referring entity (which is often part of the consumer's community) or a community group
6. If there are no interpreters available for the language that is preferred by the consumer, the attending staff can call ACCESS Center at (800) 854- 7771 that has linguistic capabilities via a telephone service provider 24 hours a day/7 days a week. Attending staff from the program document the procedure in the "Referral Log for Language and Culture-specific Mental Health Services" or other equivalent log. ACCESS Center has linguistic capabilities via a telephone service provider 24 hours a day/ 7 days a week.
7. As a last resort we use family and friends.
8. When a referral is made, the referring staff must document the receiving agency where the consumer was referred to in the "Referral Log for

Language and Culture specific Mental Health Services" or other equivalent log.

9. The receiving agency must provide the referring staff with verification of the completed referral and document in the "Referral Log for Language and Culture specific Mental Health Services" or other equivalent log.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

1. Prohibiting the expectation that family members provide interpreter services

DMH Policy No 202.21, Language Interpreters, Section 4 states that in accordance with Title VI (Civil Rights Act) requirements, the expectation that family members provide interpreter services is prohibited. (Criterion 7, Attachment 2)

2. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services

DMH Policy No 202.21, Language Interpreters, Section 4 states that in accordance with Title VI (Civil Rights Act) requirements, the expectation that family members provide interpreter services is prohibited. If a consumer insists on using a family member or friend as an interpreter, they may do so only after being informed of the availability of free interpreter services. (Criterion 7, Attachment 2)

3. Minor children should not be used as interpreters

DMH Policy No 202.21, Language Interpreters, Section 4 states that it is strongly recommended that minor children not be used as interpreters. (Criterion 7, Attachment 2)

V. Required translated documents, forms, signage, and client informing materials
The county shall have the following available for review during the compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. Member service handbook or brochure
2. General correspondence
3. Beneficiary problem, resolution, grievance, and fair hearing materials.
4. Beneficiary satisfaction surveys
5. Informed Consent for Medication form
6. Confidentiality and Release of Information form
7. Service orientation for clients
8. Mental health education materials
9. Evidence of appropriately distributed and utilized translated materials.

The Cultural Competency Committee (CCC) and the Cultural Competency (CC) Unit have determined that translations are a high priority. The CCC has compiled a list of key documents to be translated. The list was then compared to the list created by the Forms Committee and expanded. The CCC in collaboration with the CC Unit has also proposed expanding the unit to formalize the translation policy to standardize the translation of forms into the LACDMH threshold languages and to coordinate translation needs. Please refer to the Criterion 7, Table 3 for a list of materials available in threshold languages and Criterion 7, Table 4 for the CCC List of Forms to be Translated by Priority. Additional samples of materials from our directly operated and contracted agencies that have been translated into threshold languages will be available during the site review.

From our Legal Entities Survey, the legal entities provided a listing of more than 100 examples of documents, forms, fliers and brochures that are translated into non-English languages. They tended to fall into two main categories:

- Direct Consumer/Client Treatment (such as Confidentiality/Privacy/HIPAA/ Release Forms, Billing/Termination of Treatment/No show/Patient Discharge/Change of Provider Forms: Therapy Contract/Referral/Medication Forms: Benefits/Medical/Workers Comp/Intake Forms; and Complaint/Grievances-Appeals/Consent/Patient Rights Forms/Consumer Acknowledgement Forms and Documents)
- Agency and Mental Health System (such as Agency services and orientation materials and Local Mental Health Plan/Handbooks/Protocol manuals)

If asked, 75% of the legal entities that responded to this survey could make hard copy examples available.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

According to DMH Policy No 104.8, The Clinical Records Guidelines Policy, Section 4, interventions to accommodate the needs of the visually impaired and hearing impaired, as well as those with limited English proficiency, must be documented. Also, when the client's primary language is not English, there is to be documentation to show that services were offered in the client's primary language and/or that interpretive services were offered. Furthermore, when cultural or linguistic issues are present, they must be documented along with the actions to link the client to culturally and/or linguistically specific services. Please see Criterion 7, Attachment 11 for a copy of the policy.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

The Consumer Satisfaction Surveys from the California State Department of Mental Health (DMH) is available in only some of the threshold languages. A letter from the California State DMH, dated October 22, 2008 (Criterion 7, Attachment 12), states that the California State DMH website has the form translated into Spanish, Chinese, Hmong, Russian, Tagalog, and Vietnamese. The letter further states that the form will be translated into Armenian, Arabic, Cambodian, Farsi, and Korean. We will release these surveys as they become available.

Some of the FSP programs conducted consumer satisfaction surveys. For example, the child FSP program gathered consumers' overall satisfaction with services including: "FSP services have helped my child," "able to receive services in their preferred language," "able to say when & where services were delivered," "aware that treatment team is available 24/7," "FSP treatment team is supportive of their needs," and "linked to community services & supports."

Criterion 7, Attachment 13: FSP Child Consumer Satisfaction Survey CY 2009

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

LACDMH believes that all services and programs provided by the County must reach out to underserved populations, including persons with limited English proficiency.

To this end, the Planning, Outreach and Engagement (POE) Division has a list of vendors organized by language expertise. When translation projects are identified, the vendors are provided a document that specifies all requirements and expectations. These specifications/requirements for vendors range from years of experience in translations and languages of expertise to how to format the document. Vendors interested in entering the bidding process for a translation project must explain and submit documentation as evidence of them meeting the requirements.

Sample requirements asked of translation vendors include:

1. Minimum of five (5) years experience of translation and cross-cultural linguistic adaptation of forms in:
 - Arabic
 - Armenian
 - Cambodian
 - Cantonese
 - Farsi
 - Korean
 - Mandarin
 - Russian
 - Spanish
 - Tagalog

➤ Vietnamese

- 2) Strong familiarity with the cultural and linguistic background of the communities who speak the languages listed above.
- 3) The translated documents must not be a word for word rendition of the original document, but rather a meaning for meaning transfer in which the end result is not just an accurate translation, but naturally sounding target language.
- 4) In the final translated document, syntax, grammar, spelling and terminology must be correct, and cultural elements must be taken into account.
- 5) Indicate mechanism use in ensuring accuracy of translated materials in terms of both language and culture.
- 6) Translated documents must be at a 6th grade reading level. Indicate mechanism use in ensuring required reading level.
- 7) Must have strong familiarity with the mental health system, including terminology and concepts used by the Department of Mental Health.

Criterion 7, Attachment 14: Specifications for Translation Projects

Currently, DMH follows an informal translation procedure as follows:

1. DMH Programs seeking translation of DMH documents contact the Planning, Outreach and Engagement Division (POE).
2. POE provides step-by-step technical assistance to LACDMH programs for preparation of materials to be translated
3. POE gathers information from the requesting Program to determine type of materials to be translated, relevance of materials to LACDMH, purpose of translations and how translations will benefit LACDMH's commitment to providing culturally and linguistically appropriate services, and languages in which materials are to be translated.
4. POE provides a list of vendors who specialize in translations by language of specialty upon request
5. Copies of materials to be translated are gathered and submitted to POE District Chief, who is also LACDMH's Ethnic Services Manager, for approval.

6. Once a translation project is approved, "Special Request Forms" describing and justifying the project are completed and submitted the Procurement Unit for processing. Copies of materials to be translated are attached.
7. POE and requesting Program discuss due date(s) for translations to be completed.
8. POE submits the translation project to vendors to get estimated cost of the translations.
9. Once POE has a projected cost for the project, the selection of vendors is decided in accordance to DMH policy as follows:
 - When the cost of translations is below \$1,500.00, only one bid from a vendor is required.
 - When the project is above \$1,500.00, a minimum of three bids are required before a vendor is chosen for the project.
 - If the project is over \$5,000.00, Planning Division secures one bid and requests the bidding process be carried out by the Internal Services Department (ISD). Once ISD finish the bidding process and they choose the vendor, then the translation project can be initiated by the selected vendor.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade).

Please refer to answer D. above

The Cultural Competency Unit, housed within POE, is in the process of developing a translation policy using best practice methods. This translation policy will inform, organize and standardize all of The Department's translation efforts. This translation policy will come at a time when LACDMH is getting positioned to successfully roll out the three PEI Statewide Projects, Suicide Prevention, Anti-stigma and Reduction, and School Violence Reduction and the EBPs in the approved PEI Plan. with materials translated into the threshold languages in order to effectively serve the diverse ethnic communities with culturally and linguistically competent outreach materials. While LACDMH has used an informed mechanism for translation, it is time to develop a translation policy using best practice methods. Once developed, the translation policy will guide the sizeable undertaking of PEI's translation of Evidence-Based Practices and Community-Defined Evidence materials into the various threshold languages.

Deliverables for the LACDMH Translation Policy and Procedures include a protocol for translation which includes request forms for translations, bidding processes, and translation procedures. Key elements of the policy may include but not be limited to:

- Field testing
- 6th grade reading level for translated documents

- Best practices for health care translation of materials into diverse languages
- Incorporate Federal and State statutes to set LACDMH standards and procedures for translations

Criterion 7 Attachments:

Attachment 1: MHSA Mental Health Loan Assumption Program

Attachment 2: DMH P&P 202.21 Language Interpreters

Attachment 3: DMH P&P 202.17 Hearing Impaired Mental Health Access

Attachment 4: ACCESS Center Program Protocol 2010

Attachment 5: Guide to Medi-Cal Mental Health Services - English

Attachment 6: DMH Staff Language Proficiency Report

Attachment 7: MSLD Memo

Attachment 8: Sample Providers' Language Capability Forms

Attachment 9: Initial Requests & Referrals Log for Language & Culture Specific Mental Health

Attachment 10: DMH P&P 602.1 Bilingual Bonus

Attachment 11: DMH P&P 104.8 Clinical Records Guidelines

Attachment 12: Letter from the California State DMH, dated October 22, 2008, regarding Consumer Satisfaction Surveys in threshold languages

Attachment 13: FSP Child Consumer Satisfaction Survey, CY 2009

Attachment 14: Specifications for Translation Projects

CRITERION 8
ADAPTATION OF SERVICES

I. Client driven/operated recovery and programs

The county shall include the following in the CCPR:

A. List and describe the county's/ agency's client-driven/operated recovery and wellness programs.

LACDMH has made many efforts to support consumers as part of the workforce, which has grown from a few dozen ten years ago to more than 200. LACDMH programs employ more than 60 individuals in peer support positions. Since 2003, more than 600 people who identify themselves as clients or former clients have been trained in Los Angeles County to work in mental health services settings. A major advancement is the employment of consumer-disclosed individuals in management and executive roles. While this change has not kept pace with need it has notably highlighted the new vision of consumers at every level of the mental health workforce.

Wellness Centers

Thanks to MHSA-funded initiatives, LACDMH has significantly expanded and developed client-driven Wellness Centers to focus on wellness and recovery in each of the eight service areas and to serve thousands of diverse individuals on a yearly basis. At present, LACDMH has implemented 48 Wellness Centers. The countywide average number of clients served per month at our 48 Wellness Centers is 293 clients, but some of our larger Wellness programs serve upwards of 1,182 clients per month. Each of the 48 Wellness Centers operated by the county DMH and its contract providers is mandated to employ consumers or former clients with lived experience in its program structure providing peer services.

Our Wellness Centers provide psychiatric services, case management, healthy living activities, peer-led groups, self-help groups, peer support services, supports for clients with co-occurring disorders, linkage and referral and community outreach and collaboration. They also include medication support, prescription management and basic health screenings for blood pressure, diabetes, cholesterol and body mass index among others.

The Wellness Center programs have peer services incorporated as a key element and have achieved significant success in integrating this new service component with physical health supports and select psychiatric services. While the number of peer staff in these programs has yet to reach the stated ideal (constrained largely by the availability of training and career development opportunities) the reach and visibility of clients in recovery at these sites is significantly shifting the dynamic for people in need who seek services. Many now are welcomed into Wellness Centers by people who are themselves former clients. Many Wellness Centers programs have further empowered their own

clients by providing opportunities for individuals to work as volunteers at the program site. At one Wellness Center, more than 40 individuals are registered volunteers, the majority of which are Spanish-speaking members of the local Latino community.

Please see Criterion 8, Attachment 1 for a list of Wellness Centers

Drop-in Centers

LACDMH's Drop-In Centers provide temporary safety and basic supports for seriously emotionally disturbed and severely and persistently mentally ill transitional age youth (TAY) who are living on the streets or in unstable living situations. Drop-In Centers provide "low demand, high tolerance" environments in which TAY can make new friends; participate in social activities; and access computers, books, music and games. When the youth are ready, staff persons can connect them to the services and supports they need in order to work toward stability and recovery. Drop-In center services include the following: showers, meals, clothing, computer and Internet access, DVD and games, social activities, peer support groups, linkage to mental health and case management services, linkage to substance abuse treatment, educational services, employment assistance, and housing assistance, among others.

Since they began in March 2008, Drop-In Centers have served a total of 4,405 unduplicated clients. Of the clients that reported ethnicity, 33% were African-American, 25% Latino, 22% White, 3% Native American, 1% Asian and 16% multiracial or other. In terms of gender, of the clients that reported their gender, 64% were male, 29% female 6% transgender male to female and 1%, transgender female to male.

Client-Run Programs

Also through the MHSA Community Services and Supports plan, LACDMH has funded 12 Client-Run Centers which are designed to be entirely staffed by consumers. These contracted programs provide recovery, wellness, personal care planning and supportive services in a peer model in every service area of the county. The client-run programs provide all the same services as the Wellness Centers except for psychiatric services, medication support and prescription management. These sites provide support groups, meeting space and a welcoming environment to hundreds of people daily.

As community-based programs, these programs connect to their local communities and represent the cultural character of their local areas. These programs have created new opportunities for clients, providers and families to challenge stigma and raise awareness of recovery. Although most of these programs operate under broader provider agencies, their innovation and recovery focus has helped foster a growing acceptance of client-provided services and supports.

In FY 2009-2010, the Client-run Centers served 12,258 clients which included Caucasian, Latino, African, African American, American Indian, Asian/ Pacific

Islander, Middle Eastern, Eastern European, European and LGBTQ. The Department anticipates this number doubling in FY 2010-11.

Other Adaptations

Self-help Groups for Latino Spanish Monolingual Consumers and Community Members

The Planning Division has continued the sponsorship and technical assistance of self-help groups, originally implemented by the Latino Access Program (LAP) in 2005. LAP created the self-help group project to develop a bridge between mental health programs and the Latino community. Support groups represent a “more accessible” environment to the Latino community due to the stigma associated with mental health and the mental health system. The groups provide a safe environment where participants can learn about mental health, share their questions and concerns about mental illness and to gradually develop trust toward the mental health system.

These groups are currently operating in Service Areas 4 and 6 at Northeast Wellness Center, West Central Mental Health Center and Augustus Hawkins Mental Health Center. It is estimated that these groups combined are serving between 25-35 Latino Spanish monolingual consumers and community members on a weekly basis. Some of the consumers utilize the self-help groups as an adjunct to the psychotherapy and psychiatric services they receive. For others, the self-help groups function as an on-going source of support once mental health treatment has concluded. Yet, others have joined the self-help groups as their initial step in seeking mental health services. Some of the original self-help groups have taken on a more focused purpose and become other types of self-help groups such as Wellness Recovery Action Plan (WRAP) groups, men’s self-help groups, and arts and crafts groups.

These groups will be transferred to the Adults System of Care (ASOC) which is implementing a larger self-help component. In addition to running self-help groups, the ASOC Self-Help Group Project also involves on-going training and mentoring to group leaders. The project includes the following four components:

1. Training. Training on how to start, coordinate and maintain support groups and on leadership skills provided to all new leaders and co-leaders.
2. Curricula development. Curricula have been developed for three types of support groups: guides for consumers, family members and community participants. Each curriculum has 18-30 topics that provide an essential guide to group leaders. Each curriculum is revised regularly.
3. Implementation of support groups. Currently there are 13 active support groups through the county of Los Angeles. Support groups are held weekly at various sites including churches, schools, and community centers. At least 52 sessions take place each month.
4. Ongoing mentoring. Monthly meetings are held on the first Monday of each month at DMH headquarters for all leaders and co-leaders of the support groups. Guest speakers are invited to each meeting in order to provide valuable information on various DMH programs and resources. In

addition, case presentations are conducted to identify best referral resources and support the transition of group participants to mental health services and/or other resources.

During the year of 2010, we conducted 15 support groups in Spanish (eight community support groups, four family members support groups and three Consumers support groups). The average number of attendees were 15 persons per group. Due to the voluntary participation in the group meetings, some attendees attended less than six meetings, others more than 20, and the most attended between 10-18 meetings. For instance, during the year of 2010 we have almost 950 people in the Support Groups in Spanish Project. In addition, group leaders attend half-day monthly meetings where they receive on-going coaching and training.

Self-help and Recovery Libraries

The Self-help and Recovery Library Project is another type of adaptation of services at LACDMH. The Planning Division has implemented a total of eight Self-help and Recovery Libraries located in each Service Area. Several of these libraries are operated by peer advocates and registered volunteers. Dedicated to wellness, recovery, self-help, and a variety of mental health education, each of the Self-help Libraries serves as an enrichment resource where consumers, family members, and the community as a whole, can obtain quality and specialized educational information.

The Self-help and Recovery Library mission statement states: “The Self-help/Recovery Library’s main goal is to educate, inspire, inform and transform communities and the mental health system by:

- Developing an educational resource on wellness, self-help and mental health that will provide accurate and relevant information to diverse communities in order to increase their knowledge and sensitivity, and reduce the stigma associated with mental illness.
- Promoting the use of educational materials on wellness, recovery and mental health to make these available to consumers, family members, caretakers, clinicians, providers and the interested general public.

The resources features in the libraries have been organized into the following themes:

1. Wellness—Factual information on mental health, physical health education, nutrition and exercise
2. Recovery/resilience—Self-help support, vocational, educational, Wellness Recovery Action Plan (WRAP)
3. Hope—Anti-stigma, inspirational and personal stories

A unique aspect of the Self-help Library Project was also to equip parent advocates from each Service Area with resources for them to utilize in their daily work with diverse communities. These resources include factual, practical,

concise information relevant to parenting issues, learning disabilities, navigating the school system and Social Security benefits among others.

The development of the Self-help Library Project was accomplished through the Library Taskforce, formed with representation from diverse LACDMH programs and consumer driven organizations such as: Adult Systems of Care – MHSA Implementation Unit, Advocacy and Empowerment Division, Office of the Medical Director, Planning Division, Training Division, National Alliance for the Mentally Ill (NAMI) – Los Angeles County and Project Return Peer Support Network and SHARE! The Self Help and Recovery Exchange. The library taskforce played an instrumental role in identifying materials for the Self-help Libraries, including resources printed in different languages.

At present, all service areas have Self-help Libraries in full operation, several of them located at Wellness Centers. In addition to utilization by individual consumers and family members, the libraries have become a resource for self-help groups to select reading materials and/or topics for discussion during group sessions. Below are the locations and schedules of the Self-help Libraries:

SA	Location/Phone	Weekly Schedule	Contact
1	Palmdale/AntelopeValley Wellness Center 349 /A, East Avenue K-6 Lancaster, CA 93535 (661) 723-4260	Mon. 10:00 am to 12:00 pm Tues. 2:00 pm to 4:00 pm Thur. 10:00 am to 12:00 pm Fri. 8:00 am to 4:00 pm	Mr. Daryl Riley
2	San Fernando Mental Health Center 10605 Balboa Blvd. Granada Hills, CA. 91344 (818) 832-2400	Mon. 3:00 pm to 6:00 pm Tues. 4:00 pm to 6:00 pm Wed. 3:00 pm to 6:00 pm Thur. 4:00 pm to 6:00 pm Fri. 3:00 pm to 6:00 pm	Mr. Hugh Hayes
3	Arcadia Wellness Center 301 E. Foothill blvd. Arcadia, CA. 91006 (626) 471-6500	Mon. 8:00 am to 4:30 pm Tues. 8:00 am to 4:30 pm Wed. 8:00 am to 4:30 pm Thur. 8:30 am to 4:30 pm Fri. 8:30 am to 4:30 pm	Mr. Makan Emadi
4	Northeast Wellness Center	Mon. 1:00 pm to 3:00 pm	Ms. Mary González-Veleta

	5564 N. Figueroa St. Los Angeles, CA. 90042 (323) 341-5100	Tues. 9:00 am to 11:00 am Wed. 1:00 pm to 3:00 pm Thur. 1:00 pm to 3:00 pm Fri. 9:00 pm to 11:00 pm	
5	Edelman Wellness Center 11303 Washington Blvd. 2nd floor Los Angeles, CA. 90066 (310) 482-3200	Mon. 8:00 am to 5:00 pm Tues. 8:00 am to 5:00 pm Wed. 12:00 pm to 6:00 pm Thur. 8:00 am to 5:00 pm Fri. 8:00 am to 5:00 pm	Mr. Sherwood Brown
6	West Central Mental Health Center 4741 Stocker St. 2 nd floor Los Angeles, CA. 90008 (323) 298-3686	Mon. 9:00 am to 4:30 pm Tues. 9:00 am to 4:30 pm Wed. 9:00 am to 4:30 pm Thurs. 9:00 am to 4:30 pm Fri. 9:00 am to 4:30 pm	Stephanie Stewart, M.D.
7	Rio Hondo Mental Health Center 17707 S. Studebaker Road Cerritos, CA. 90703 (562) 402-0688	Mon. 10:30 am to 2:30 pm Tues. 10:30 am to 2:30 pm Wed. 10:30 am to 2:30 pm Thur. 10:30 am to 2:30 pm Fri. 10:30 am to 2:30 pm	Mrs. Juanita Gonzales
8	Harbor-UCLA Wellness Center 21730 S. Vermont Ave. Suite 210 Torrance, CA. 90502 (310) 781-3403	Mon. 12:00 am to 3:00 pm Tues. 12:00 am to 3:00 pm Wed. 10:00 am to 1:00 pm Fri. 12:00 am to 3:00 pm	Mr. Jeffrey Adams

The following quotes are expressing the benefits people gained from visiting the self-help libraries:

- “The wellness center, through the Self-Help Library Project, is promoting self-advocacy and clients are thrilled about it.”
- “People have been checking out the library books to educate themselves about their mental health issues.”

- “Clients are excited to educate themselves about different life issues. Staff is having the opportunity to recommend a book as homework to compliment the therapeutic process.
- “So far, Clients like it because they have a dedicated room for reading which makes for a relaxed and welcoming environment.”
- “Consumers are really interested in reading.”
- “The library has given consumers the opportunity of knowing more about their mental issues and getting together through our brown bag and book discussion club at lunch time on daily basis.”
- “Consumers are saying they are happy knowing more about their mental health and having their families involved in the process as family members read books to consumers.”

Please see Criterion 8, Attachment 2 for the Self-help Library Project PowerPoint and a list of Self-help Library Resources.

1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.

Wellness Centers

The following Wellness Centers offer services that are racially, ethnically, culturally, and linguistically aligned with the community seeking services. Services are provided in various languages on an individual and group basis, including psychiatric services. The Wellness Centers also collaborate with local faith-based organizations as well as participate in various community events attended by consumers of different ethnic backgrounds:

- Northeast Wellness Center (Hispanic/Spanish)
- Verdugo Mental Health Care (Armenian/Farsi)
- Pacific Clinics Asian Pacific Family Center (API/Chinese/Vietnamese/Tagalog)
- Santa Clarita MHC (Armenian/Russian)
- Special Services for Groups Asian Pacific Counseling and Treatment Centers (API/Chinese/Vietnamese/Tagalog)
- The One in Long Beach, Inc (LGBTQI population)
- California Hispanic Commission on Alcohol and Drug Abuse (Hispanic/Spanish)
- Rio Hondo MHC (Hispanic population/Spanish; Asian Indian population/Telegu)
- Coastal API (API/Chinese/Vietnamese/Tagalog/Other Asian languages)
- Long Beach API (API/Chinese/Vietnamese/Tagalog/Other Asian languages)
- Enki La Puente/Commerce (Hispanic/Spanish)

Client-Run Centers:

The following is the list of Client-Run Centers:

- CA Hispanic Commission (Hispanic/Caucasian/African American/American Indian)
- Mental Health America – Palmdale (Hispanic)
- Mental Health America – Huntington Park (Hispanic)
- Pacific Clinics El Camino (Hispanic/African American/Asian/Pacific Islander)
- San Fernando Valley Community Mental Health Center (Caucasian/Hispanic/African American/Asian/Pacific Islander/Middle Eastern/Eastern Indian)
- SHARE! Culver City (Caucasian/Hispanic/Asian/Pacific Islander/Middle Eastern)
- SHARE! Downtown (American Indian/Hispanic)
- Special Services for Groups – BACUP (Asian/Pacific Islander/African American/Caucasian/Hispanic/African/Middle Eastern)
- Step Up On Second (Asian/Pacific Islander/African American/Caucasian/Hispanic)
- The Center Long Beach, Inc (LGBTQI/African American/Hispanic/Asian/Pacific Islander/Caucasian)
- Topanga West (Hispanic/African American/Caucasian/LGBTQI/Asian/Pacific Islander/European)
- Westside Center for Independent Living (Caucasian/African American/Asian/Pacific Islander/Hispanic).

2. Briefly describe, from the list in ‘A’ above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

Wellness Centers:

Because all of the programs above are racially, ethnically, culturally and/or linguistically specific, we have chosen to highlight in detail two of programs that serve the Asian Pacific Islander and Latino communities:

Coastal Asian Pacific Islander Mental Health Center – The Coastal Asian Pacific Islander Mental Health Center is co-located in the Asian Center with the Los Angeles Department of Community and Senior Services and several API community organizations including the Indo-Chinese Youth Community Council, Center for the Pacific Asian Family and the Tongan Service Center. The Asian Center is located in the Gardena area of Los Angeles County. The Gardena area consists of a large number of second and third generation Japanese and first generation Koreans. Due to the language skills of the staff and the availability of services for uninsured individuals, the clinic also serves numerous Vietnamese and Chinese clients from the San Gabriel and Long Beach areas, as well as Korean clients from the Koreatown area.

All of the clinic’s API clients are able to receive the same continuum of mental health services available in other DMH clinics, but provided in a linguistically appropriate and culturally sensitive manner. API clients who come to the clinic feel more welcomed and hopeful by seeing staff and other consumers who share similar cultural backgrounds. Almost all of the clinic’s staff, both clinical and clerical, speak

at least one Asian language. Many also share the same immigrant and cultural experiences as the clients. This allows the clinic to provide all of its services in all the State identified API threshold languages. Services offered at Coastal Asian Mental Health Center include:

- Adult and Child Therapy Services in all of the API threshold languages identified by the State
- Linguistically appropriate and culturally sensitive Mental Health Evaluation and Consultation – all service providers and support staff, with only a couple of exceptions, speak at least one Asian language and either immigrated from Asia or are first generation
- Crisis Intervention
- Medication Evaluation and Treatment –includes services by one of the County’s very few Vietnamese/Cambodian speaking psychiatrist.
- Targeted Case Management, including referrals to mental health providers and community resources within the various API communities
- Field Clinical Capable Services (FCCS) with field based mental health services provided in the local API communities by bilingual staff
- Full Service Partnership (FSP) with 24/7 coverage by bilingual staff
- API culture based Recovery and Wellness Groups
- Life Skills Support Group for Cal-WORKS clients
- API Multi-Family Focused Group with language interpretation
- Korean Parents’ Support Group (conducted in Korean)
- Friendship Group to help API clients develop skills for appropriate relationships within their own culture, as well as across cultures
- Communication Skills Group to help API clients develop effective communication skills utilizing their primary Asian language and English
- Community Living Program (CLP) which assists immigrant API, non-English speaking clients integrate into American society including both in-clinic and community-based activities – tai chi, cooking, and visits to local Asian communities as well as non-API related locations
- Transitional Youth Wellness Activities
- Annual API cultural celebrations with ethnic foods and activities for Lunar New Year, May is Mental Health Month/API Heritage Month, Moon Festival and Year End Celebration
- Cal-WORKS and GAIN/ GROW Program
- Dual Diagnosis Assessment and Treatment
- Community Outreach and Education to API community organizations, programs and mental health providers

Please see Criterion 8, Attachment 3: Coastal Wellness Center Brochure

Northeast Wellness Center – The Northeast Mental Health is located near East Los Angeles and serves a largely Spanish-speaking community. To best serve this population and promote wellness and recovery, Northeast Wellness Center works actively with the community to establish itself and support its clients and family members. Northeast does this by working with local businesses and faith-based groups. They are known throughout the community, and local church leaders work

on-site to support clients, offering services in both English and Spanish. Northeast and its consumers support the community directly by fundraising for local schools and causes. This past year, they participated in a community “March for Peace” to help educate the Spanish-speaking community on mental health issues, and they developed plays in Spanish titled “Como las olas del mar/Like the Ocean Waves” “Quinceañera y madre/ Fifteen Years Old and a Mother”, and “Una familia como otras/ A Family Like Any Other” which shows how families can support loved ones with mental health problems. Fliers about the plays are attached as Criterion 8, Attachment 4.

Programs offered at Northeast include:

- Orientation to Wellness
- Positive Visions
- The University of Life
- Don Quixote Books
- The East Los Angeles Skills Center
- Community Connections
- The Go-Getters
- Advocacy, Support and Linkages to Community Resources
- Angels On Call
- Short-Term Therapy, Case Management, Physical Education, and Medication Support
- The Substance Abuse Program
- The Family Support and Education Group
- Tai Chi group
- Anger management in Spanish
- Bilingual Chat n Fun Craft group
- Woman to Woman in Spanish
- Bilingual Healing through Art
- Spanish Family Support group
- WRAP in Spanish

Criterion 8, Attachment 5: Northeast Wellness Center Brochure

Client-Run Centers:

The following are highlights of three of the twelve Client-Run Centers that serve large ethnic/cultural populations:

The Center Long Beach – The Center provides services to support inform and connect the lesbian, gay, bisexual and transgender communities through programs of information and education, health and well-being, cultural and social justice. They advocate for the inclusion of all individuals into a free and just community, without judgment or restriction due to sexual orientation or gender expression. Having served the community for over 30 years, The Center continues to provide information support, and assistance to over 21, 000 people very year. They have staff who speak Spanish, Mandarin, Cantonese, French and American Sign Language.

Programs and Services offered at The Center include:

- Youth Drop In (MYTE) – provides a safe, welcoming space for youth ages 13-17 to drop in after school and socialize. Games, educational opportunities, mentoring, and support are offered.
- LGBT Community Library - thousands of books available on loan to community
- 24 Hour Hate Crimes Hotline – operated and maintained by The Center in conjunction with the City of Long Beach.
- Information and Education
 - Community help desk for referrals
 - Housing and roommate postings, job postings and employment assistance
 - LGBT library
- Health and Well Being
 - Health Education & Prevention Programs
 - Health Education Action Team: individual risk reduction counseling
 - MPower Long Beach: risk reduction LGBT social network
- Youth Services
 - MYTE Program (Empowering Youth Through Empowerment)
- Social and Support Programs
 - Gay and Lesbian AA
 - Women of 40-plus
 - She Chat
 - Bisexual Chat
 - Men Over 40
 - Living with HIV/AIDS Support Group
 - Healthy LGBTQ Relationships Workshops
 - Transgender Support Group
 - Men's Rap Group
 - Coming Out Support Group
 - Intimate Recovery Men's AA
 - Overeaters Anonymous
 - Native American LGBT/Two Spirit Support Group
 - Sign On
 - Committee of Patients Advocacy and Support Group
 - Women of Color Support Group
 - Social and Cultural Activities
- Social Justice
 - Hate Crimes Hotline (in cooperation with the LB Police Department)
 - Diversity training and community outreach on LGBT issues

San Fernando Valley Community Mental Health Center – The Client-Run Center serves adult mental health consumers (aged 18 – 64) in the San Fernando Valley, Santa Clarita Valley and Burbank areas. With the addition of Community Services and Supports (CSS) funds under the Mental Health Services Act (MHSA), the Center added this component to complement those consumers who are in later stages of mental health recovery and no longer require professional mental health treatment services to remain engaged in recovery.

The SFVCMHC, Inc. Client-Run Center provides peer support, self-help, mental health advocacy, recreation and social activities for consumers in Service Area 2 who are well grounded in their mental health recovery and can benefit from ongoing peer support to remain involved in their recovery process. The Client-Run Center has served a wide variety of ethnic populations which include Hispanic, Caucasian, African America, Middle Eastern, Eastern Indians, and Asian. The program provides:

- Guidance in developing a WRAP (Wellness Recovery Action Plan)
- Peer support and self-help activities
- Dual Recovery Anonymous
- Schizophrenia Anonymous
- Rational Recovery
- Procovery
- Open topic discussion groups
- Social and recreational activities
- Recovery Specialists
- Wellness Trainer
- Information and Referral Specialist
- Warm Line
- Independent Living Coach
- Mental Health Advocate
- Hobby Clubs to develop talents and meaningful personal roles

SHARE! – The Self-Help and Recovery Exchange helps people in Los Angeles pursue personal growth and change. SHARE! empowers people to change their own lives and provides them a loving, safe, non-judgmental place where they can find community, information and support. SHARE! offers many workshops/meetings at both Culver City and Downtown locations, including Spanish, Japanese, and Korean meetings. SHARE! Culver City offers over 90 meetings per week and serves about 3,500 clients per month, and the Downtown location offers more than 40 meetings weekly and serves about 1,500 clients monthly. SHARE! operates self-help centers that provide meeting space for self-help support groups of all kinds ranging from anger management, depression, self-esteem, communications and relationships, incest survivors, alcoholics, drug addicts, smoking, reaching goals, etc.

SHARE provides many services including:

- Self-help Support Group Clearinghouse for Los Angeles County
- SHARE! Self-Help Centers
- Collaborative Housing
- Volunteer-to-Job Program
- Technical assistance
- Workshops/Meetings in different topics everyday

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider.

The LACDMH 2010 Provider Directory – “Locations of Publicly Funded Mental Health Providers in the County of Los Angeles” – is a complete listing for Psychiatric Inpatient and Outpatient Short Doyle/Medi-Cal Facilities, Fee-For-Service Psychiatric Inpatient Facilities, Community Outreach, Forensic, Residential and Specialized Foster Care Services providers. The Provider Directory includes provider addresses, provider numbers, phone numbers, hours of operation, provider types, age groups served, languages spoken and Specialty Mental Health Services (SMHS) by provider location. The Provider Directory also includes provider profiles for each Service Area with map locations for each provider. Providers are listed alphabetically by name and the primary mode of service. The Provider Directory may be accessed at <http://dmh.lacounty.gov/providerlocatorDMH.html>

As mentioned previously in Criterion 7, we also developed and maintain a “Multi-Linguistic Mental Health Service Providers Directory” (MLSD) that lists the names, locations, hours, age groups served, and language services provided. The Directory provides a list of staff available, including their work hours, to offer services in their respective language and culture. The services are categorized by psychiatric inpatient hospital, targeted case management and other specialty mental health services that are developed to meet the specific linguistic needs of each service area. The Directory is updated when there is a change on staffing to keep it current. The Directory can be accessed on-line from the LACDMH website at <http://dmh.lacounty.gov>. Please refer to Criterion 7, Attachment 6.

B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

As mentioned previously in Criterion 7, LACDMH offers a “Guide to Medi-Cal Mental Health Services” which is available in the threshold languages and on CD in the threshold languages for those beneficiaries that are visually impaired. The “Guide to Medi-Cal Mental Health Services”, informs the beneficiaries that the Los Angeles County Mental Health Plan can provide materials in the threshold languages. The Guide also provides two (2) phone numbers to call (800-854-7771 and 213-738-4949) if they have trouble understanding the Guide and/or want to find out about other ways they can access this information. The Guide can be downloaded from the LACDMH website at www.dmh.lacounty.gov. (Criterion 7, Attachment 7, English) The Guide in English is attached and the Guide in the threshold languages and on CD will be made available during the site review.

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

In addition to the “Guide to Medi-Cal Mental Health Services” and the 2010 Provider Directory “Locations of Publicly Funded Mental Health Providers in the County of Los Angeles,” the Patients Right Office has published a Mental Health Client Resource Directory that is available online at: <http://dmh.lacounty.gov/ResourcesForConsumers/Forms/Documents/ResourceDirectory061709.pdf>. This Resource Directory is to assist mental health clients from all over Los Angeles County to know where to go to find help. The Resource Directory includes locations, hours, and telephone numbers by service type. The listings include: Outpatient/Wellness Centers, Support Groups, Inpatient Psychiatric Hospitals, Mental Health Care Alternatives, Services for Physically Disabled and Client Empowerment Organizations, just to name a few.

D. Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

- 1. Location, transportation, hours of operation, or other relevant areas**
- 2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds**
- 3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings.**

The DMH Legal Entity Agreement Contract (please refer to Criterion 1, materials available for site review) stipulates in the preamble that the County of Los Angeles and their partners work together to achieve the following Customer Service and Satisfaction Standards:

- Personal Service Delivery – The service delivery team, staff and volunteers, will treat customers and each other with courtesy, dignity, and respect.
- Service Access – Service providers will work proactively to facilitate customer access to services.
- Service Environment – Service providers will deliver services in a clean, safe, and welcoming environment, which supports the effective delivery of services.

LACDMH makes every effort to consider factors such as location, hours of operation, accessibility, transportation, and reduction of stigma when deciding on adaptations of services. Our Wellness Centers, Client-Run programs and Self-Help Libraries are well-distributed geographically throughout the county in order to ensure equal access. For more detailed information, please see Criterion 8, Attachment 8, the LACDMH 2010 Provider Directory, which provides links to public transportation, directions and maps.

III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

- A. Evidence of how a contractor’s ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.**

The preamble of the DMH Legal Entity Agreement Contract contains two specific categories – Nondiscrimination in Services and Nondiscrimination in Employment. The contract also stipulates that the legal entities will face immediate termination by County if they fail to comply with these provisions. (Please refer to Criterion 1, materials available for site review)

The Contractor’s Negotiation Package Contract (please refer to Criterion 1, materials available for site review) requires legal entities to define the Cultural/Linguistic Capability: “Define your program’s capability to respond to the cultural and linguistic needs of the target population. Address in-service training provided to increase staff awareness and sensitivity to ethnic and cultural minorities.” The Contractor’s Negotiation Package also requires legal entities to list staff with threshold language capability by position.

The Request for Services (RFS) includes language in the preamble to address cultural and linguistic needs in the following manner: “The County has also established the following values and goals for guiding this effort to integrate the health and human services delivery system: County agencies and their partners work together seamlessly to demonstrate substantial progress towards making the system more strength-based, family-focused, culturally-competent, accessible, user-friendly, responsive, cohesive, efficient, professional, and accountable.” In addition, the RFS states that personal service delivery must be responsive to cultural and linguistic needs.

IV. Quality Assurance

The county shall include the following in the CCPR:

- A. List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.**

The LACDMH Quality Improvement (QI) Work Plan Beneficiary Satisfaction goals and activities are related to two components. The first component is completed in collaboration with the State DMH, POQI Unit, to obtain consumers/families perception of satisfaction. The second component is completed in collaboration with the LACDMH Patients’ Rights Office for Beneficiary Complaints, Grievances, and Appeals. Please refer to the QI Work Plan Evaluation for CY 2009 for further detail.

Table 1: My Staff Were Sensitive to Cultural/ Ethnic Background by Age Group

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	95.0%	95.5%
YSS	82.9%	84.6%
Adult	85.2%	84.6%
Older Adult	90.5%	91.2%
All Age Groups	88.4%	89.0%

Table 1 shows an overall positive response rate at 89% for the survey question: “Staff was sensitive to my cultural/ethnic background”.

Table 2: The Location of Services was Convenient (parking, public transportation, distance, etc.)

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	91.9%	93.4%
YSS	80.6%	82.9%
Adult	82.9%	84.7%
Older Adult	86.7%	90.0%
All Age Groups	85.5%	87.8%

Table 3: Services were Available at Times that were Convenient

Age Group	Percent Strongly Agree/Agree	
	CY 2008	May 2009
YSS-F	79.8%	94.0%
YSS	93.6%	81.8%
Adult	88.6%	89.7%
Older Adult	91.8%	93.4%
All Age Groups	89.0%	89.7%

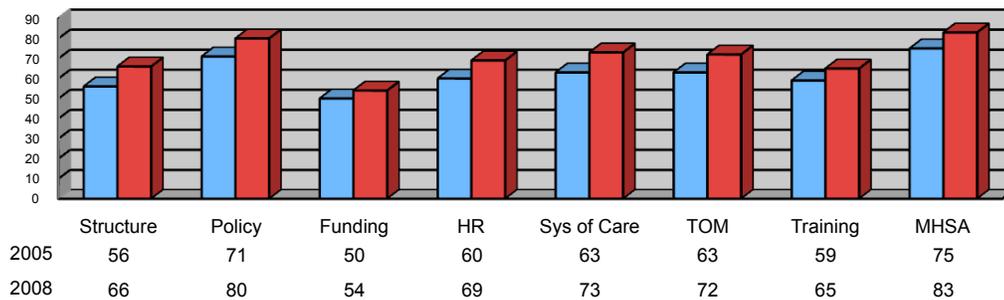
Please see Criterion 8, Attachment 9 for the full results from the Quality Improvement Work Plan Evaluation for CY 2009.

B. Staff Satisfaction: A description of methods used to measure staff experience or opinion regarding the organization’s ability to value cultural diversity in its workforce and culturally and linguistically competent services

As reported in the QI Work Plan Evaluation Report, LACDMH conducted a longitudinal study entitled Cultural Competency Organizational Assessment in

2002, 2005 and 2008 (please refer to Criterion 1, materials available for site review). The purpose of the study was to assess organizational cultural competency within the LACDMH System of Care. The 2008 Organizational Assessment contained seven focus areas. They are: Structure, Policy, Funding, Human Resources, System of Care, Treatment Outcome Measurement, Training and MHSAs. The assessment received 3,443 responses from LACDMH directly operated and contracted agencies. The chart below shows an overall improvement across all focus areas.

Chart 1. Mean percent favorableness by focus area – 2005 and 2008



The overall pattern of the 2008 organizational cultural competency assessment survey results reflects a positive improvement from the 2005 findings. This pattern can be depicted in several ways. First, for the 2008 assessment, twenty-eight (28) or sixty-one percent (61%), of the questions had favorable ratings above the seventy percent cut-off score (Metric 1). Eighteen (18) questions or thirty-nine percent (39%) had ratings below the cut-off score. This compares positively with the 2005 scores where these percentages were reversed. In 2005, 39% had favorable ratings, and 61% were unfavorable.

Second, there is a clear upward shift in the percent favorable responses across all eight focus areas. This shift is evident when comparing the percentile scores for virtually every question between 2005 and 2008. Thirty-nine questions (85%) show an upward shift in percent favorableness, whereas seven questions (15%) do not. None of the questions show a downward shift.

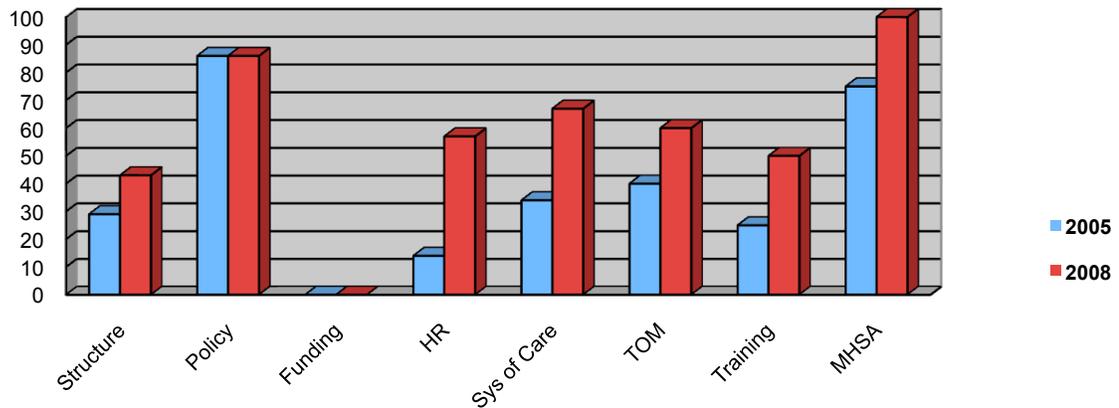
Third, an overall measure of improvement can be computed for each focus area by calculating the mean favorableness score for all of the questions within a focus area. This score provides an aggregate measure of favorableness for each focus area and enables a comparison between 2005 and 2008. A measurable improvement is observed in each focus area between 2005 and 2008.

Beyond Chart 1 as a graphic depiction of improvement across all focus areas, Chart 1 also indicates that from the point of view of an overall measurement, four of the focus areas are above the seventy percent threshold in 2008 whereas four

of the focus areas are not. Policy, System of Care, Treatment Outcome Measurement, and MHSA exceed the threshold. Structure, funding, HR and Training fall below the seventy percent threshold value. This reflects both achievements and areas for further assessment and improvement.

Finally, there is a significant positive improvement across six of the eight focus areas. This shift is graphically depicted in Chart 2.

Chart 2. Improvement as a function of the shift in the percentage of favorable focus area scores between 2005 and 2008



The percentage improvement in each of the eight focus areas between 2005 and 2008 is as follows:

Focus Area	Percent Improvement	Measure of Improvement
• Human Resources	300%	From 14% favorable response to 57%
• Training	100%	From 25% favorable response to 50%
• System of Care	97%	From 34% favorable response to 67%
• Treatment Outcome Measurement	50%	From 40% favorable response to 60%
• Structure	48%	From 29% favorable response to 43%
• MHSA	33%	From 75% favorable response to 100%
• Policy	0%	Held steady at 86% favorable response
• Funding	0%	Held steady at 0% favorable response

Regarding the MHSa domain results, four survey questions are used to assess the system's practices of these concepts from the Mental Health Services Act. The percent favorable responses for the four MHSa questions in the survey range from a low of 80% favorable to a high of 85% . Overall, the percent favorable responses for all four MHSa questions fall above the seventy percent cut-off score. Results indicate that the respondents perceive their organizations (LACDMH directly operated and legal entity contracted agencies) are focused on reducing or eliminating symptoms, and assisting consumers in the development of productive lives, problem-solving skills, and hope.

MHSa is the only Focus Area where one hundred (100) percent of the questions fall above the seventy (70) percent cut-off score. This suggests that when the system makes a clear and sound commitment to a course of action and backs it up with resources, communication strategies and behavioral reinforcement, it can turn a very large ship in a new strategic direction.

Please see Criterion 8, Attachment 10 - Cultural Competency Organizational Assessment Report, 2008

C. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

The MHP provides the "Grievance & Appeal Procedures" brochure in the threshold languages. (Criterion 8, Attachment 11) The "Grievance & Appeal Procedures" brochure states:

- This pamphlet and related materials are available in alternative format.
- Persons requesting materials in an alternate format may contact the Patient Rights Office at 800-700-9996 or 213-738-4888. Persons with speech or hearing impairments are contacted through California Relay Services (800) 735-2929.
- You have the right to free language assistance services.

In addition, the "Beneficiary/Client Grievance or Appeal and Authorization Form" is available in the threshold languages. (Criterion 8, Attachment 12) Beneficiaries who contact the toll-free telephone number that is available 24-hours a day, seven (7) days a week, at 800-854-7771, will be informed that verbal and oral interpretation, including sign language, of their rights, benefits and treatments is available in their preferred language. If beneficiaries contact 213-738-4949, a Patient Rights Advocate will assist the beneficiary with interpretation, translation or other alternative formats that are appropriate to the beneficiary. Alternative formats may include reading the material with the beneficiary with limited reading proficiency and translate the information so the information is easily understood.

LACDMH Policy & Procedure No, 202.29 (Attachment 13) entitled Beneficiary Problem Resolution Process details how “to ensure that Medi-Cal beneficiary’s grievances with DMH specialty Mental Health Services are addressed in a sensitive, timely, appropriate, and culturally competency manner.”

The Patients’ Rights Office (PRO) prepared and submitted to the State the LACDMH Annual Beneficiary Grievance/Appeal/State Fair Hearing Report (Criterion 8, Attachment 14) for Fiscal Year 2008/2009 consistent with LAC DMH Policy and Procedure 202.29. (Attachment 13)

The Problem Resolution Process is also detailed in the Medi-Cal Mental Health Services handbook available to all beneficiaries from their provider or the Patients’ Rights Office. The handbook is available in all threshold languages. Alternate formats for the handbook include large print version or audio CD’s for those with limited reading proficiency.

Criterion 8 Attachments:

Attachment 1: List of Wellness Centers

Attachment 2: Self-help Library Project PowerPoint and List of Self-help Library Resources

Attachment 3: Coastal Wellness Center Brochure

Attachment 4: Fliers for Plays

Attachment 5: Northeast Wellness Center Brochure

Attachment 6: Multi-Linguistic Mental Health Service Providers Directory

Attachment 7: “Guide to Medi-Cal Mental Health Services”

Attachment 8: LACDMH 2010 Provider Directory

Attachment 9: QI Work Plan Evaluation for CY 2009

Attachment 10: Cultural Competency Organizational Assessment Report ,2008

Attachment 11: The “Grievance & Appeal Procedures” brochure

Attachment 12: Beneficiary/Client Grievance or Appeal and Authorization Form

Attachment 13: DMH Policy and Procedure 202.29

Attachment 14: LACDMH Annual Beneficiary Grievance/Appeal/State Fair Hearing Report