LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 1

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Director

August 2023

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

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT
EXECUTIVE SUMMARY

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

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

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

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

The 2023 Cultural Competence Plan Update Report is based on data and programmatic information for Fiscal Year 21-22.

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Commitment to Cultural Competence

August 2023

Criterion 1: Commitment to Cultural Competence

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

I. Commitment to Cultural Competence Policy and Procedures

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

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

TYPE	INFRASTRUCTURE DOCUMENTS

Strategic Plan, Overarching Policies, and Practice Parameters	• LACDMH Strategic Plan 2020-2030
	• Policies and Procedures (P&Ps)
	  ○ Policy No. 200.09 – Culturally and Linguistically Inclusive Services
	  ○ Policy No. 200.03 – Language Translation and Interpreter Services
	  ○ Policy No. 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community
	• Parameters for General Considerations (GC)
	  ○ GC -1 – Recovery Model and Clinical Care
	• Parameters for Clinical Programs (ClinP)

TYPE	INFRASTRUCTURE DOCUMENTS
	○ ClinP-8 – Culturally Sensitive Services ○ ClinP-9 – Referral to Self-Help Groups ○ ClinP-10 – Wellness Centers ○ ClinP-11 – Lifestyle Counseling or Healthy Living Programs ○ ClinP-13 – Department of Mental Health Peer Advocates ○ ClinP-15 – Assessment and Integration of Spiritual Interests of Clients in Their Wellness and Recovery ○ ClinP-16 – Family Engagement and Inclusion for Adults ○ ClinP-18 – Co-Occurring Developmental Disabilities • Parameters for Medication Use (Med) ○ Med-6 – Psychoactive Medications for Individuals with Co-Occurring Substance Use and Mental Health Conditions ○ Med-8 – Psychotropic Medication in Children and Adolescents ○ Med-9 – Review of Psychotropic Medication Authorization Forms for Youth in State Custody ○ Med-10 – Medication Assisted Treatment in Individuals with Co-Occurring Substance Use Disorders • Parameters for Psychotherapy (Psych) ○ Psych-5 – Psychotherapy with Children, Adolescents, and Their Families ○ Psych-6 – Family Therapy Techniques with Families of Adult Children • Parameters for Special Considerations (SC) ○ SC-2 – Sexual and Gender Diversity ○ SC-6 – Older Adults ○ SC-7 – Assessment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-8 – Treatment for Co-Occurring Cognitive Impairment with Mental Health ○ SC-9 – Access to Care After Discharge from Psychiatric Hospitals and Juvenile Justice Programs
	• Policy No. 200.05 – Request for Change of Provider • Policy No. 200.08 – Access to Care for Veterans and Their Families • Policy No. 200.09 – Culturally and Linguistically Inclusive Services • Policy No. 201.02 – Nondiscrimination of Beneficiaries • Policy No. 305.01 – Mental Health Disorders and Co-Occurring Substance

TYPE	INFRASTRUCTURE DOCUMENTS
	• Policy No. 310.01 – HIV and AIDS Clinical Documentation and Confidentiality • Policy No. 311.01 – Integration of Clients' Spiritual Interests in Mental Health Services • Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services
Human Resource Training and Recruitment Policies	• Code of Organizational Conduct, Ethics, and Compliance • Los Angeles County Policy of Equity (CPOE) • Just Culture • Implicit Bias and Cultural Competence • Gender Bias

See attachment 1 for additional details.
*

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

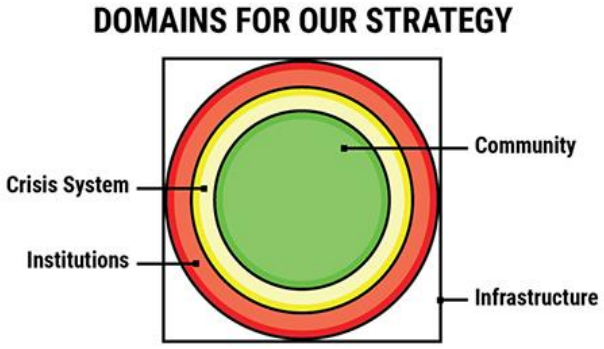
Consistent with the Cultural Competence Plan Requirements (CCPR) and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS), LACDMH recognizes and values the racial, ethnic, cultural, and linguistic diversity of its communities. The vision of the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

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

- **Client driven** – where we engage consumers, families, communities, and our grassroots stakeholders as full collaborators in transformation, from care delivery to systems redesign.

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

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



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

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

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

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

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

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

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
Values and Principles		Equitable and culturally competent – where consumers, family members and communities are cared for equitably and services are delivered with cultural humility, respect, and competence.	Anti-Racism, Diversity, and Inclusion- where services are delivered with sensitivity and understanding to the impact of collective racism against Black and other communities of color.		1
Community Domain	**Prevention Services** Goal 1A:	The navigation, coordination, and follow-up across our system must be improved to ensure that individuals of all ages, families and communities get the resources they want and need (Strategy 1A.3)… and every strategy will be viewed through the lens of culture to ensure we are providing outreach and engagement that takes into consideration individuals' *cultural backgrounds and linguistic needs.*		CR 1, CR 3 and CR 8	1, 9,13, and 15
	<u>Early Identification and Engagement</u> Strategy 1A.2		Invest in community access platforms as ideal entry points to resources; use homes, clinics, parks, libraries, schools, places of worship, community centers and other gathering points in local communities to provide access to mental health information for children, youth, families, and individuals in comfortable, affirming, and safe settings.	CR 2 and CR 3	12, 13, and 15

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Social Support Goal 1B Strategy 1B.2		Train up the ecosystem of community access platforms to identify needs and coordinate resources to meet them; provide training to ensure those who work at community-based access points are more knowledgeable about culture, social determinants of health, and the impact of racism on mental health issues. This understanding will improve ability to recognize community members (including children and youth) who may be in need, and to improve engagement and linkage to appropriate resources. Expand local community resources for preventing and mitigating stressors; invest in and expand access to more programs that promote effective coping skills, parenting classes and support for children and teachers, and school-wide interventions to promote a positive mental health climate that values diversity, equity, and inclusion. **Support and expand accessible social environments**	CR 3, CR 4, and CR 8	3 and 4 9, 10, 12, 13, and 15 11, 12, and 13

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Strategy 1B.3	Emphasize a whole-person approach to assessment: o Integrate individuals' comprehensive needs including behavioral health, physical health, and social support during assessments through the lens of their *culture and native language.* o For children, include developmental and educational needs.	Collaborate with community leaders and organizations to create Anti-Racist, welcoming, and empowering environments. Help individuals to develop and pursue hobbies and interests. Increase opportunities for individual connection to purpose by facilitating educational and employment opportunities for those in treatment, re-entry, or recovery.		9 and 10
	Outpatient Mental Health Care Goal 1C:	During the assessment process, culture and native language must be considered to understand an individual's comprehensive needs, including behavioral health, physical health, and social support.			11, 12, and 13
	Strategy 1C.1: Assessment and Care Planning	And finally, we will find ways to make sure treatment plans are completed in a timely manner and continuously updated; that high-quality, value-based care is delivered consistently across communities that are age appropriate and in a culturally competent manner. Services will be designed to do everything possible to guard against crisis, isolation, hospitalization, homelessness, prolonged or repeated involvement in the child welfare system and justice involvement.	Evaluate the system of care to ensure understanding of racism and its impact upon at-risk children, youth and families engaged with systems of care, including the Departments of Children and Family Services and Probation and Aging and Disability.		1, 2, 3, 9, and 11
	Strategy 1C.3: Outpatient Care	*Conduct culturally and linguistically specific outreach to* engage underserved communities in understanding what			9, 10, and 11

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		outpatient services are available to them and how to access care. ○ Expand outpatient clinic hours into the evenings and weekends in order to more effectively engage communities and provide services to enhance accessibility. ○ Support communities in advocating for equity of resources and services			9, 10, and 11
Crisis System Domain	Goal 2: Intensive Care Strategy 2.1: Real-Time Crisis Response	Build a real-time, robust, well-coordinated, recovery-oriented, and client- and family-centered crisis response network. ○ Integrate high-quality crisis response services into every community and staff then with well-trained, *culturally competent,* and caring first responders who work to resolve crises safely for both youth and adults and make every attempt to avoid the need for hospitalization.	Despite the best efforts of crisis responders and the inpatient and residential treatment network, there are some individuals who continue to experience intensive needs over a longer period, resulting in frequent hospitalization and intensive care. For this population we must examine the role of historical racism and the disconnect between services and client needs.	CR 3, CR 5, CR 6, and CR 8	1, 2, 4, 9, 10, 11, and 12 1, 2, 3, 4, 9, 10, 11, and 13
Institutions Domain	Goal 3: Re-entry initiatives		Goals 1 and 2 of this Strategic Plan propose significant investment and fundamental equitable and just changes to the system of care in LA County that, when fully realized, will dramatically reduce the number	CR 2, CR 7 and CR 8	1, 2, 3, 4, 9, 10, 11, 12, 13, and 15

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Strategy 3.1 Identifying and Connecting with the Deeply Isolated	Deploy tactics for reaching out to and engaging individuals who are isolated. Assist individuals to return to the community and facilitate opportunities for education, employment, and meaningful connection, which is key to stability and successful re-entry. ○ Train staff to understand the associated stigmas attached to co-occurring disorders and inter-generational trauma within the cultures represented. ○ Train front-line and clinical staff in *cultural humility and sensitivity* in order to better demonstrate empathy for increased cultural competency	of adults and youth with a serious emotional disturbance and mental illness, who when impacted by racism, poverty and inequity fall out of their community and into the institutions of deep isolation, the streets, prolonged or repeated child welfare or justice involvement Unfortunately, implementing these interventions will take time during which we must seek to empower and uplift those already living in, or likely to enter, the institutions. Evaluate systemic issues that are impacting disproportionality and promotion of equity within DMH that may be contributing to or enabling isolation. Identify co-occurring disorders that may be further isolating individuals. Train staff to understand the associated stigmas attached to co-occurring disorders, impact of racism, and inter-generational trauma within the cultures represented.	CR 1, CR 7 and CR 8	
Infrastructure Domain	Organizational support Goal 4			CR 1, CR 7 and CR 8	1, 2, 3, 4, 5, 6, 7, 8, 9, 10,

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
Infrastructure Domain	Strategy 4.2: Process	Process consumer grievances, complaints and appeals through the lens of cultural humility and service competency to understand diverse communities that inform the background and mental health needs of individuals. o Ensure equity in the reviews to help address racial and ethnic disproportionality in access to and delivery/quality of care.	Overhaul processes for recruiting and hiring new staff to increase equity, and promote diversity in the DMH workforce, enable quicker program development to more competitively attract talented hires.		11, 12, 13, and 14
	Strategy 4.3: Outcomes	Improve training and professional development to increase the skills and capabilities of departmental staff. o Create a true learning organization by building the capacity for staff to manage projects and improve the quality of programs and services. o Infuse cultural competency training in every new employee orientation. o Conduct regular and frequent staff trainings to increase their cultural competency, with a focus on staff who directly engage with clients in outpatient and inpatient settings.	Optimize DMH's services from the ground up with the values of Equity, Anti-Racism, Social Justice, Just Culture and continuous quality improvement.	CR 5, CR 6, and CR 8	
		Collect and utilize data to analyze service utilization by communities of color to address disparities and inequities in the system of care. o Conduct cultural competence assessments to better understand the demographic characteristics of communities. o Work to improve data collection to track and specify the cultural composition of DMH consumers beyond broad ethnic category labels,		CR 1, 2, 3, and 7	

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
		e.g., “Latino,” in order to provide enhanced culturally specific services and valid, relevant outcomes. Translate key documents for DMH consumers into the top 13 threshold languages spoken in L.A. County to capture the elements of culture and equity in service delivery o Ensure critical documents like consent for services, treatment plans and assessments are widely *available in clients’ preferred language and capture culturally specific details* that will help enhance the delivery of care.		CR 1, 3, and 7	
Addendum B	What We Heard Goal Goals 1A – Prevention Services	Our prevention services in LA County must improve culturally competent outreach and engagement efforts to those experiencing mental health stressors and increase empowering equitable linkage assistance to needed resources. Stigma and lack of awareness remains a problem throughout the County. Individuals, families, and communities often have difficulty recognizing early signs of mental health challenges. People who work in communities often lack the cultural awareness and training that would help them to recognize and engage individuals in need.		CR 1, CR 6, and CR 7	1, 2, 3, 4, 9, 11, 12, 13 and 15

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal IB - Social Support		Black and other diverse communities of color are disproportionally impacted by multi-generational trauma, poverty, and violence. Many family members are stressed and feel they lack the resources required to help their loved ones. Further, many individuals with mental illness find it difficult to maintain their relationships with others and become isolated. Communities of color often lack venues where individuals can safely interact with others free of violence and stigma. In such environments, there are often not enough opportunities. Employment and education are only a small part of DMH programming, and few consumers experience improvement in these key life domains.		
	1C – Outpatient Mental Health Care	Even when individuals can access the care they need, they rarely experience being active members of the care team. Many individuals and their families find DMH clinics to be unwelcoming or stigmatizing. And there are not enough clinic staff with the appropriate language skills and cultural competence to adequately serve LA County's diverse communities.			
	Goal 3 – Re-entry Initiatives		Now, these individuals occupy LA County's institutions at		

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal 4 – Organizational Support		alarming rates. These include not only the institutions of long-term involuntary psychiatric care but also the insidious institutions of chronic homelessness, criminal justice system involvement and isolation. Black, Latino, Indigenous, and other communities of color occupy these institutions at alarming rates. Whether closed- or open-air, these institutions cut off individuals living with serious mental illness from community. Without community, people cannot flourish and move towards recovery. Our organization was designed and built in a different era to address a different paradigm of need in LA County. Back then, the system was designed with little to no sensitivity to race matters and understanding of the impact of social determinants of health. In order to successfully implement this Strategic Plan, we need an overhaul.		
Addendum C	Active Tactics Goal 1A – Prevention Services - *Active Tactics*	Expanding the Promotores de Salud Mental (Spanish Speaking) and the Mental Health Promoters (Multicultural and Multilingual) Programs: These programs provide specialized mental health prevention services in the community by	The WhyWeRise Campaign (including the We Rise events): A movement to break through barriers, increase diverse voices and defy old assumptions about mental health and the many related	CR 8	1, 2, 3, 5, 7, 8, 10, 12, 13, and 15

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
	Goal 4 – Organizational Support – Active Tactics	trained community residents familiar with the language and culture.	social conditions that compound problems and hurt our communities. School-Based Community Access Platforms (SBCAPs): Provide programming and training for students, their families, and the school's workforce to address issues related to violence, racism, trauma and to facilitate healthy dynamics in schools and communities. Increase cultural and language-specific media resources and campaigns to address racism, diversity, and inclusion. Anti-Racism, Diversity, and Inclusion (ARDI) Division and ARDI Staff Advisory Council: DMH has formed the ARDI Division, which will address internal issues related to creation of an anti-racist, transparent, and empowering work environment. The ARDI Staff Advisory Council will represent an important bridge between staff and management. The external component of the ARDI Division will improve outcomes to maximize resources and increase community participation.		

Sections	Goal/Strategy/ Appendix	Cultural Competence Related Content	Anti-Racism and Equity Related Content	CCPR Criterion (CR) 1-8*	CLAS Standard**
Addendum D	**Goal 1A - Prevention Services** Goal 1B – Social Support Goal 1C – Outpatient Mental Health Care		Increase prevention initiatives focused on anti-racism and diversity to promote pride and resilience in Black, Latino, Indigenous and other communities of color. Increased number of culturally competent services available. Increased opportunities for clients and staff to engage in anti-racism and empowering activities. Increased equity and access of services to underserved cultural communities. Increased number of DMH-funded facilities that are welcoming, linguistically, and culturally relevant for the communities they serve.		1, 2, 9, 10, 11, 12, 13, and 15

* Specifications for the CCPR, Criterion 1 - 8

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

**CLAS Standards

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

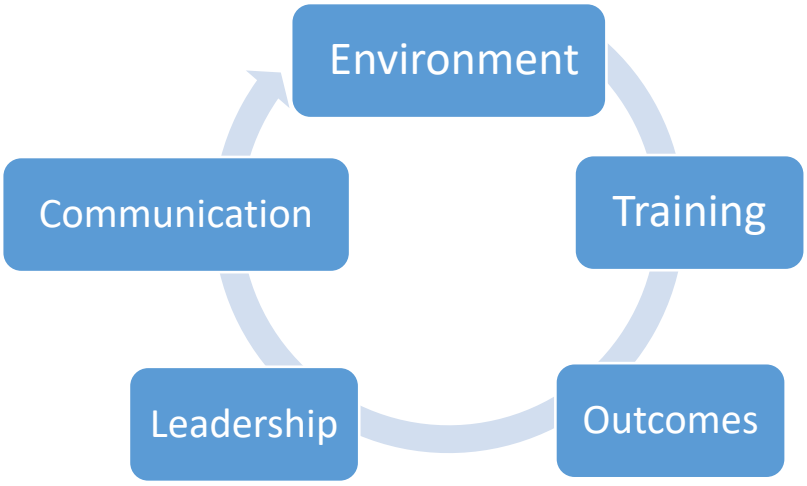
Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

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

1. ARDI Division

The framework of the Division is composed of the five domains illustrated below. Each domain contributes to the Department's overall readiness, responsiveness, and inclusion for sustainable progress in equity and racial justice for the workforce and the communities served. Each domain has an internal and external focus with strategic goals and deliverables.



The ARDI General Internal Focus Goals include:

- Promote an anti-racist work environment
- Increase transparency and inclusion in executive decision making
- Define clear pathways and career advancement for culturally diverse staff inclusive of LGBTQIA2-S and Black, Indigenous, and People of Color (BIPOC)
- Create safe spaces to explore impact of racism and oppression at work
- Reduce incidents of work-related racism and inequities
- Provide staff trainings to address impact of systemic oppression, racism, and inequities

The ARDI General External Focus Goals include:

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

Throughout Calendar Year (CY) 2022, the ARDI Division continued solidifying its position and functions in the system of care, utilizing the Cultural Competency Unit as the main driving source to initiate activity across five anchoring domains. The ARDI Division components include:

- Cultural Competency Unit (inclusive of the LGBTQIA2-S Specialist position)
- United Mental Health Promoters Program (UMHP)
- Spanish Support Groups
- Speakers Bureau (SB)
- Language Assistance Services (LAS)
- ARDI Data Team

Below is a brief summary of the ARDI Division's domain-specific goals followed by sample accomplishments for CY 2022.

1) Environment

A. Internal – to create a work environment that moves toward more inclusive, transparent, and anti-racist awareness.
   - The ARDI Division launched culture-specific events emphasizing ARDI principles through collaboration with stakeholder groups such as the Cultural Competency Committee (CCC), Faith-Based Advocacy Council (FBAC), Underserved Cultural Communities subcommittees (UsCC), and the Speakers Bureau. Events were openly available to DMH employees. The first event focused on commemorating Pride Month and the second on National Minority Mental Health Awareness Month.
   - The Division enhanced the voice and visibility of the LGBTQIA2-S staff workgroup and LGBTQIA2-S Specialist activities. The workgroup provided detailed LGBTQIA2-S training recommendations for LACDMH's workforce and were directly involved in the planning of Pride Month event.
   - The ARDI-CCU held Cultural Competence Plan in-services with key DMH programs and gave flexibility to programs to report on strategies and activities that were most meaningful to their functions.

B. External environment – to focus on anti-racism services and service delivery.
   - The planning for the 2022 ARDI Division culture-specific events was done in collaboration with the stakeholder groups mentioned above, inclusive of bringing their representatives into the planning process as well as participation in panel presentations and keynote deliveries.
   - Implementation of the LGBTQIA2-S Champion Network comprised of DMH administrative and clinical staff that bring into practice the meaningful experience, knowledge, and training in affirming clinical practice with LGBTQIA2-S communities. The LGBTQIA2-S Champion Network, in collaboration with the DMH ARDI Division, promotes responsive and sustainable system change to ensure that DMH is an affirming and inclusive institution for consumers and employees of all genders and sexualities. Additionally, the Champion Network operates as a public-facing entity in order to increase visibility of and access to affirming services for LGBTQIA2-S community members. Furthermore, the Champion Network serves as an

internal-facing community of DMH employees who can provide consultation, resources, and other support to County staff who may have questions, concerns, or related learning needs related to best practice with LGBTQIA2-S communities.

2) Training

A. Internal – to develop, implement, and evaluate curriculum designed to provide employees the information and necessary psychological safety to explore issues of anti-Black and other forms of racism, oppression, inequities, and institutional barriers in the workplace, which impede or hinder advancement and equitable treatment.

- The ARDI Division initiated an analysis of all existing training offered during CY 2022 and past years to identify training topics related to anti-racism, diversity and inclusion. Each of the training topics offered were reviewed by the ARDI administrative team to determine their proximity to ARDI themes. Discussions of topics included consideration of its cultural focus and target audience.
- The ARDI-CCU completed the inventory of trainings provided by the Training Unit and key DMH programs within the system and community at large. This analysis was incorporated into the divisional ARDI training analysis and included in the annual Cultural Competence Plan as prescribed by the requirements.
- The Division developed a training framework based on ARDI principles with the goal of addressing racism, oppression, inequities, and institutional barriers in clinical service delivery interactions within the culturally diverse programs in which they work.

B. External – to develop, implement, and evaluate curriculum, workshops, and groups designed with input, feedback, and participation from the underserved and diverse communities that are the focus and intention of service.

- The LACDMH Speakers Bureau responded to requests from community-based organizations, the community at large, and DMH programs on an extensive variety of clinical topics. The most common themes included: children and youth mental health, LGBTQ+ mental health, racial/ethnic group-specific mental health, seniors and aging, COVID-19, domestic violence, the experience of homelessness, mood disorders, suicide prevention, and crisis management.
- The UMHP engaged various underserved communities in learning through various psychoeducational workshops delivered in multiple languages and with a well-developed culture-specific lens.

3) Outcomes

A. Internal – to identify outcome measures to evaluate impact of staff trainings offered through the ARDI Division.

B. External – to evaluate outcome measures of programs, trainings, and services to improve relevance and impact on intended populations.

- Development of ARDI Division's Language Assistance Services
- Interpreter Services Satisfaction Surveys for consumers and staff utilizing these services
- Scheduling of ASL clinical appointments
- Translation and Interpreter services

- Divisional reports: annual Cultural Competence Plan, Speakers Bureau outcomes and annual Multicultural Community Conference
- Annual Speakers Bureau Multicultural Community Conference
- UMHP workforce enhancement: an estimated 154 Promoter interviews were conducted in CY 2022, 44 Promoters onboarded, and after attrition (32 resigned) 113 were retained at the end of CY 2022.

4) Leadership

A. Internal - to advocate and support BIPOC and other diverse staff members to identify advancement and leadership opportunities within LACDMH.

- ARDI advocacy in the service of stakeholder groups (e.g., FBAC and CCC) parity to receive funding for capacity-building projects as part of Stakeholder Process revamping

B. External - to work with culturally and linguistically diverse communities, inclusive of BIPOC and LGBTQIA2-S, to identify and develop community leadership that is reflective and representative of the communities served.

- Provision of Support for the ARDI Division's public facing teams
  - UMHP
  - Spanish Support Groups
  - Speakers Bureau
  - LGBTQIA2-S Specialist projects
- Participation of DMH executive management in ARDI Division events

5) Communication

A. Internal communication - to nurture and support an employment environment that fosters clear and open communication, offering accessible channels for two-way communication to collect and integrate the input and participation of its diverse and valued workforce into LACDMH planning.

- Divisional reports and strategic presentations in various departmental venues. Reports include annual Cultural Competence Plan, Speakers Bureau services utilization data, and UMHP activities data.
- CCC's integration of and collaboration with various stakeholder groups in meetings and agendas.
- ARDI Division presentations at New Employee Orientation which include a dialogue segment to gather staff input on divisional domains and activities.

B. External Communication - to communicate with underserved and diverse communities in an accessible, linguistically, and culturally competent manner intended to educate, orient and connect individuals and families to departmental services and resources.

- Continued presence of the CCC's Cultural Traditions and Connections Newsletter Column in LACDMH's "Connecting Our Community" newsletter.
- Annual Speakers Bureau Multicultural Community Conference and fulfillment of community requests throughout the year, which involve delivery in multiple threshold languages and specialized cultural and clinical focus.
- Annual Spanish Support Groups' "May is Mental Health Awareness Month" Community Event.

- Multicultural and multilinguistic UMHP activities in all Service Areas

2. Stakeholder Process and Engagement

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

YourDMH

The purpose of this collaborative and inclusive approach is to develop shared goals of hope, recovery, and wellbeing. Strategically, YourDMH constituents play an active role in identifying funding priorities for services provided under the Mental Health Services Act (MHSA). The main goal of YourDMH is to engage communities in dialogue and decision-making pertinent to departmental priorities, service delivery models, funding allocations, target populations for various programs and projects, and outcomes. These dialogues produce essential feedback and guidance for the Department to focus on community-driven stakeholder priorities and develop action plans for enhanced service provision with shared goals of hope, recovery, and wellbeing. *See Attachment 3: "YourDMH Get Involved flyer"*

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

During FY 21-22, many important adjustments were made to ensure services to consumers during the COVID-19 pandemic. These adjustments were informed by YourDMH in alignment with the LACDMH strategic plan. Specifically:

- Increased use of technology, including telehealth and telepsychiatry, virtual groups and celebrations to ensure regular phone check in with clients and/or their families
- Implementation of a peer/volunteer run warm line for those seeking to reach out by phone to stay connected
- Video clinical team meetings, case conferencing, and clinical supervision to ensure best clinical practice and team cohesion
- WebEx court hearings when possible for clients involved in the justice system
- Continued street outreach to clients experiencing homelessness
- Resuming outreach and engagement teams with increased COVID-19 safety measures.

Cultural Competency Committee (CCC)

The CCC serves as an advisory group for the infusion of cultural competence in LACDMHs operations. The CCC membership includes the cultural and lived experience perspectives of consumers, family members, peers, advocates, Directly

Operated (DO) providers, Contracted providers, and community-based organizations. The Committee considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining its mission. The CCC is led by two Co-Chairs who are community representatives and elected annually by the membership. In the absence of funds to implement projects, the CCC focuses on providing cultural competence-related input for various LACDMH initiatives. The Committee collaborates with the ARDI Division-Cultural Competency Unit's projects. Examples of CY 2022 collaborative projects with a systemwide impact:

- Development of the LACDMH Diversity and Multicultural Calendar which has been posted in the departmental website for public access
- Commemoration of Black History Month in February, Asian Pacific Islander (API) American Heritage Month in May, National Minority Mental Health Month & Juneteenth in June, and Native American Heritage Month in November, which rounded the expertise of speakers from different cultural backgrounds and walks of life, lived and shared experience with mental illness, and stakeholder groups to increase knowledge and sensitivity of consumers, family members, peers, community based organizations, client-based organizations, and departmental staff from clinical and administrative programs.

Underserved Cultural Communities (UsCC) subcommittees

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

The seven UsCC subcommittees include:

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

Every Fiscal Year, each UsCC subcommittee is allotted one-time funding totaling $200,000 to focus on Community Services and Support (CSS)-based capacity-building projects. The membership from each subcommittee generates conceptual ideas for capacity building projects. The UsCC projects are voted on via a participatory and consensus-based approach within each subcommittee. Overall, the UsCC capacity building projects aim to increase knowledge about mental illness,

increase access to mental health resources, and decrease stigma related to mental illness in the targeted UsCC communities. These projects are not intended for the delivery of mental health services but to increase access to care consistent with the language and cultural needs and demographics of those communities for unserved, underserved, and inappropriately served populations who are uninsured/uninsurable.

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

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

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

3. *Public Information Office*

LACDMH's Public Information Office (PIO) is responsible for managing and facilitating the department's communication activities, including:

- Interview, photography, filming, and audio recording requests
- Social media
- Announcements to the LACDMH mailing list
- Maintaining the department's public event calendar

- Public service announcements (PSAs)
- Organizational branding
- Event promotion
- Graphic design and layout
- Marketing campaigns
- Communication partnerships and collaborations

During FY 21-22, PIO continued to create and disseminate communication materials related to our COVID-19 response and recovery efforts. This includes physical materials (flyers, brochures), website content, and social media postings highlighting departmental well-being services and resources available to the community at large as well as specific groups (e.g., first responders, persons who lost a loved one to COVID-19, school communities, BIPOC and/or LGBTQIA2-S community members). These materials primarily focused on promoting personal, familial, and community wellbeing with an emphasis on addressing mental health issues related to COVID-19. PIO works closely with L.A. County partners such as CEO's Countywide Communications, L.A. County Office of Emergency Management, and the Department of Public Health to share and disseminate messages to L.A. County's diverse audiences. Activities also include producing and translating departmental materials into threshold languages, addressing social justice issues in LACDMH's communications, and promoting services/resources offered by DMH specialized programs that work directly with diverse populations such as LACDMH's Speakers Bureau and United Mental Health Promoters)

4. *WERISE*

LACDMH launched another WERISE campaign in May 2022 to commemorate May is Mental Health Month. The framework of the campaign was comprised of "hyperlocal" community-centered events throughout Los Angeles County, which took place throughout the month of May. The 2022 WERISE effort delivered approximately a dozen events customized to meet the needs of a culturally and linguistically diverse audience. The campaign evaluation was conducted by the RAND Corporation via two samples of Los Angeles County participants inclusive of 382 youth (ages 14–15, 16–17, 18–21, and 22–25) and 868 adults (ages 26–34, 35–44, 45–59, and 60+). Participants represented diverse racial and ethnic backgrounds, including Black, API, AI/NA, Multi-Racial, Latino, and White.

The 2022 WERISE campaign was facilitated by Cause Communications. A summary report generated by Cause Communication specified that more than 22 community-based organizations served as lead partners for the event, representing all five supervisorial districts. The main focus of the campaign was to destigmatize mental health by enhancing community capacity, community connection, and individual well-being. Furthermore, recognizing that many young people access information on social media, WERISE utilized these platforms to connect youth with WERISE events and community resources.

Key Findings

- Youth and adults exposed to WERISE outreach were more likely to be aware of mental health resources and said they were better able to heal from the stress of the pandemic and racial injustice than unexposed same-age residents.
- They were also more likely to report mobilization to address mental health challenges and barriers to receiving mental health treatment.
- Adults who were exposed felt better able to recognize the symptoms of mental health challenges and better able to provide support to those experiencing them. *See attachment 4 for additional details.*

5. Speakers Bureau

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

6. Faith-Based Advocacy Council (FBAC)

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

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

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

7. LACDMH COVID-19 Webpage

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

1) COVID-19 Mental Health, including materials that address mental health and well-being needs and concerns:
   - Maintaining Health and Stability During COVID-19
   - Staying Connected During Physical Distancing
   - Alleviating Fear and Anxiety During Essential Trips in Public
   - Understanding the Mental Health and Emotional Aspects of COVID-19
   - Coping with the Loss of a Loved One
   - Your Wellbeing on Your Terms brochure
2) Additional COVID-19 materials specific to coping strategies for families, parents, and children; healthcare providers; workers; peer support; and the community at large.
3) Online practical information such as the LACDMH Help Line, Headspace app, iPrevail, suicide prevention, back to school, veterans, grief and loss, first responders, LGBTQ+, anti-racism, public safety, and holiday season resources.

8. Outreach and Engagement (O&E) Teams

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

9. Cultural Competence Trainings

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

- Age groups (Children, TAY, Adults and Older Adults)
- Cultural competence and cultural humility
- Deaf and hard-of-hearing population
- Evidence-Based Practices
- Forensic population

- Gender identity
- Persons experiencing homelessness
- Implicit Bias
- Intellectual and physical disabilities
- Language interpreter series
- Peer support
- Race and ethnicity
- Racism
- Sexual orientation
- Spirituality
- Substance use and co-morbidity
- Trauma-informed services
- Veterans

B. **LACDMH Programs and activities focused on elements of cultural diversity**

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

1. Assisted Outpatient Treatment Program (AOT)

Assisted Outpatient Treatment (AOT), also known as Laura's Law, was initiated following the 2001 killing of Laura Wilcox by an individual suffering from severe mental illness. Former Assemblywoman Hellen Thomson authored Assembly Bill 1421, thereby establishing Assisted Outpatient Treatment Demonstration Project Act of 2002 (WIC 5345 et seq). As of 2022, AOT serves persons with serious mental illness, history of treatment inconsistency, substantial risk for deterioration, relapse, or detention, all of which could result in grave disability or serious harm to self or others.

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

CalWORKs and GROW Mental Health Supportive Services programs are funded by the Department of Public Social Services (DPSS). CalWORKs and GROW recipients are eligible to receive Specialized Mental Health Supportive Services as part of their Welfare-to-Work (WtW) plan to assist them in removing mental health barriers to employment and moving toward self-sufficiency. There are 52 LACDMH CalWORKs Providers and 17 GROW Providers countywide, including Directly Operated and Contracted agencies. Program recipients are screened by DPSS and referred to a CalWORKs Provider or GROW clinical assessor for a mandatory clinical assessment. During the assessment process, CalWORKs and GROW recipients are assessed for mental health barriers to employment and, if a need is identified, are referred to a CalWORKs or GROW Provider for mental health treatment.

3. Child Welfare Division

LACDMH Child Welfare Division services include the following:

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

4. Community Ambassador Network (CAN)

The CAN program is designed to hire, train, and certify community members as "lay" mental health workers in the neighborhoods where they reside. In this capacity, the Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community members with resources relevant to their needs. All the Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical, and spiritual wellbeing of underserved communities. During FY 21-22, the teams continued to reach out to underserved populations regarding the COVID-19 pandemic, providing accurate information regarding testing, vaccinations, updates on the multiple variants, door to door provision of PPE, as well as PPE distribution at outreach events, food delivery to infected families, etc. The CAN Program prioritizes support of communities who self-identify as Black, Asian, Indigenous and individuals of Color, all of which have been disproportionately impacted by systemic racism and inequality. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in the most disenfranchised communities.

5. Crisis Residential Treatment Programs (CRTP)

CRTP are short-term, intensive residential programs that provide recovery-oriented, intensive, and supportive services to individuals ages 18 years and older in a safe and therapeutic home-like setting. CRTPs provide services 24 hours per day, seven (7) days per week (24/7). CRTPs have a maximum bed capacity of 16 individuals per site. While the average length of stay in CRTPs is 10-14 days, an individual's maximum stay shall not exceed 30 days. CRTPs serve as an alternative to hospitalization, reduce the psychiatric inpatient days of individuals, and may serve as a resource for individuals who might otherwise be incarcerated without the appropriate community services.

6. Enriched Residential Care Program (ERC)

The ERC program was established to facilitate the placement of consumers who require intensive care and supervision at licensed residential facilities. Approved consumer participants receive the financial support necessary to obtain and maintain

stable housing including funds for rent, personal, and incidental expenses. The program enables LACDMH to subsidize the rent for consumers who live in Board and Care (B&C) homes and have no income or provide additional funding beyond the Supplemental Security Income (SSI) rate for B&C's to admit individuals with serious mental illness. These unlocked facilities are licensed through the State and provide 24-hour care and supervision, medication management, three meals per day and assistance with activities of daily living. Per the LA County Board of Supervisors directives, this program also supports efforts to preserve the stock of this valuable housing resource as many licensed residential care facilities across the County have closed due to underfunding, causing housing instability for highly vulnerable individuals for whom it may be challenging to find new housing without these resources.

7. Full Service Partnerships (FSP)

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

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

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

9. Health Neighborhoods (HN)

Implemented by LACDMH in partnership with the Department of Public Health (DPH) and Department of Health Services (DHS), HNs increase health equity and access to quality services through integrated care and community collaboration. The mission of the Health Neighborhoods is to form a coalition of community partners working to build thriving communities in underserved areas through prevention, improved coordination, and strong support networks. Health Neighborhoods bring together health, mental health, and substance use treatment providers to establish and enhance collaborative relationships and promote the integration of whole-person care. Participating service providers are linked to an extensive network of governmental and community supports

including, but not limited to: County and city agencies, educational institutions, housing services, faith-based groups, vocational supports, advocacy and non-profit organizations, prevention programs, social services, etc. These providers come together with vital input from the community to enhance the health and wellbeing of neighborhood residents.

10. Homeless Outreach and Mobile Engagement (HOME)

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

11. Housing and Supportive Services Program (HSSP)

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

12. Law Enforcement Teams

This co-response/mutual aid model pairs a DMH clinician with a law enforcement officer. The primary mission is to respond to 911 or patrol officer requests for assistance on calls involving persons who are mentally ill, experiencing homelessness, or high-risk.

13. LGBTQIA2-S Clinical Consultation Team

The overall vision of the LGBTQIA2-S Clinical Consultation Team is to engage mental health providers in collective capacity-building related to affirming service delivery for LGBTQIA2-S community members. While there is a standing membership of approximately 30 providers across LA County who attend regularly, these meetings are open to anyone who could benefit from didactic education and/or clinical consultation. Members are invited to bring questions or concerns that are related to a specific case or client, clinical procedure (e.g., referral letters for gender affirming treatment), and/or programmatic initiatives promoting a welcoming environment (e.g., expanding restroom access, updating intake forms). All individuals in attendance are encouraged to participate in the discussion in order to learn from and alongside each other.

14. Linkage programs

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

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

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

- The Mental Health Court Linkage Program operates with two MHSA-funded sub-programs: The Court Liaison and Community Reintegration Programs. The Court Liaison Program is a problem-solving collaboration between the Department and the Los Angeles County Superior Court. This program has mental health clinicians co-located at courts countywide and serves adults who have mental health conditions, co-occurring disorders, and who are involved with the criminal justice system.
    - *The Men's Community Re-Entry Program (MCRP)* is a mental health forensic program that is based on evidenced models to increase prosocial methods of living and reduce maladaptive behaviors. The mission of MCRP is to reduce recidivism and facilitate community reintegration by treating mental health symptoms and modify poor decision-making behaviors that impair a client's ability to meet his needs. The focus population consists of justice-involved men 18 to 65 years of age who present with high criminogenic risk factors and moderate acuity of mental illness. The clients must commit to program participation for a minimum of one year and maximum 18-24 months.
    - *The Women's Community Reintegration Program (WCRP)* aims to assist women who have been incarcerated to reintegrate and become successful members of their communities. The program is field-based and aims to reduce recidivism by addressing criminogenic risk factors and promoting mental health. WCRP is Community Health Worker driven along with field psychiatry. WCRP Teams are mostly comprised of Community Health Workers with mental health and incarceration lived experience.

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

15. Maternal Mental Health (MMH) Program

This program provides specialized mental health services tailored to address the unique experiences accompanying pregnancy and parenthood. MMH Program is designed to support families who may be currently pregnant, plan to become pregnant, or are post-partum, typically up to a year after the child's birth. Services are tailored to meet specific aspects of cultural competence identified as key for the participant's recovery. Examples of LACDMH programs who provide MMH services

include: Roybal Family Mental Health's Young Mothers and Babies Full-Service Partnership (FSP) Program, SA 7's Perinatal and Early Childhood Mental Health Champions Task Force, Augustus F. Hawkins Family Mental Health Center, MMH - Antelope Valley Mental Health Center & Outreach and Engagement SA 1, and MMH in SA 4.

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

This program supports mental health prevention services and activities that reduce risk factors associated with the onset of serious mental illness of MHLA participants. The target population is traditionally underserved individuals who are low income and uninsured. The services are provided at MHLA-contracted Community Partner Clinics. LACDMH is utilizing MHSA funding to support mental health prevention services and/or activities focused on prolonged engagement to help build protective factors and reduce/manage risk factors associated with the onset of serious mental illness of low income MHLA participants.

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

Service Extenders are volunteers who have been specially trained to provide highly sensitive and culturally appropriate supportive services to Older Adults. They work with the treatment team and may provide added support and advocacy as part of the multi-disciplinary team. Service Extenders may assist in providing friendly visits to isolated Older Adults, assisting in community reintegration, and providing hope and support in the recovery process. Service Extenders may be peers who are recovering from a mental illness, family members who have experience with an Older Adult loved one with a mental illness, or other qualified individuals interested in providing services as a part of an interdisciplinary team and receiving supervision from professional clinical staff.

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

These Drop-In Centers are an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who live on the streets or in unstable living situations. Services include basic supports (i.e., showers, meals, clothing, vouchers, etc.) as well as linkage and referrals to help the youth work towards stability and recovery. Seeking Safety (SS) groups are offered to address risk factors including trauma, alcohol/drug use, rejection from peers/family, and interpersonal conflict/stress. Drop-In Centers engage and outreach to TAY that are unserved and underserved and provide an environment in which TAY can find temporary safety and basic support. Additionally, the Drop-In Centers serve TAY who may be exposed to traumatic events or co-occurring disorders in their communities.

19. Preventing Homelessness and Promoting Health

Prevent Homelessness Promote Health, $(PH)^2$, is a DMH Countywide field-based program that provides assessment, crisis intervention, short term intervention and linkage to ongoing mental health services and other supportive services. Persons who have experienced homelessness, who are at risk of returning to homelessness

due to untreated serious and persistent mental illness are referred by Intensive Case Manager Service (ICMS) providers with the intent of ameliorating stabilizing symptoms and ensuring they are not at risk of losing their housing. PH^2 uses an interdisciplinary approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), Department of Mental Health (DMH) and other community service providers to address risk factors threatening the stability of permanent supportive housing (PSH). All services are provided in the community where the individual lives to promote access to care. $(PH)^2$ conducts triage, risk assessment, crisis evaluation and response, coordination of supportive services, brief clinical interventions, and linkage to appropriate level of ongoing mental health services to achieve long-term housing stability and prevent recidivism to homelessness.

20. Prevention and Early Intervention (Older Adults)

This effort includes the Anti-Stigma & Discrimination (ASD) team that presents the Mental Wellness Series for Older Adults. This series is a community education program providing psycho-educational presentations related to mental wellness and well-being in various languages. The program was designed specifically for Older Adults and Older Adult care providers. The program's aim is to increase awareness of mental wellness for Older Adults throughout Los Angeles County, particularly among underserved and underrepresented communities.

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

The Promotores de Salud Mental and the United Mental Health Promoters (UMHP) Program strives to reduce the stigma associated with mental illness among underserved cultural and linguistic communities in Los Angeles County (LAC) by increasing awareness about mental health issues, removing barriers, and improving timely access to culturally and linguistically appropriate care and resources. The Promotores de Salud Mental Program was a pilot program initiated in 2010-11 within the Latino, Spanish-speaking community. The United Mental Health Promoters Program, which started in November 2020, is the multi-cultural expansion of the original program. The unified programs merge a community leadership/peer-to-peer approach with support, guidance, and training from DMH-licensed clinicians. In addition, Senior and Supervising Community Health Workers who once served as Promotores and/or peer advocates provide mentorship and share knowledge and lived experiences to support Mental Health Promoters in their professional development and service delivery.

22. Psychiatric Mobile Response Teams (PMRT)

PMRT consists of DMH clinicians and community health workers designated per Welfare and Institutions Code 5150/5585 to perform evaluations for involuntary detention of individuals determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter as a result of a mental disorder.

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

START is a collaborative program with educational institutions and law enforcement designed to prevent school violence by identifying students at risk and providing an immediate comprehensive response and case management.

24. Spanish Support Groups & Latino Community Outreach information

The mission of the Spanish Support Groups (SSG) is to create a safe space where participants feel comfortable to share common life experiences and provide each other with encouragement, ideas for coping, information about available resources, and emotional support. The structure of the groups and their culturally sensitive recovery activities allow participants to engage in personal exploration, emotional expression, and problem solving. Support groups and art activities serve as vehicles to create a sense of community, develop companionship, discover hidden artistic talents, and reduce stigma associated to mental illness. SSG increase access to mental health services and contribute to reducing disparities by engaging and training mental health consumers who are linguistically and culturally diverse. In this sense, we highlight the life experience as consumers or family members and the path of recovery of most of the support group facilitators, who, together with the numerous trainings received and accumulated wisdom, are experts and peers.

25. Transition Age Youth (TAY) Navigation Team

The TAY Navigation Team is a field-based team comprised of Clinicians, Medical Case Workers (serving in the role of Housing Specialists), a Substance Use Counselor, and a Community Health Worker who work with TAY, ages 16-25, countywide. Each Service Area has one clinician and one housing specialist assigned. The team assists youth, often unhoused, through the various human services systems to link to mental health, housing, and other essential services. The staff also provide clinical consultations to county departments and organizations while outreaching and engaging TAY who are referred.

26. Telemental Health Program (TMH)

The goal of the TMH program is to provide psychiatric services to the areas of Los Angeles County that need psychiatrists. It provides the services in outpatient clinics across all eight Service Areas and prioritizes geographical areas that are the hardest to reach. The overall goal of the TMH program is to use technology to improve access to care, treatment adherence and outcomes as well as consumer satisfaction. The TMH Program provides psychiatric medication evaluation and management (E+M) services, also called Medication Support Services by Medi-Cal, for DMH clinics throughout the county of Los Angeles.

27. Therapeutic Transportation Teams (TTT)

The TTT is a pilot program that expands the mental health care system's current reach and impact by integrating LA County mental health experts into the emergency response for calls that come to the 911 system or go directly to the LA City Police

Department or LA City Fire Department. The pilot program has embedded a team of LA County mental health experts 24 hours a day, seven days a week, in five LA City Fire stations across the County to co-respond or take the lead on incoming emergency calls related to, or presumed to involve, an individual experiencing a mental health crisis.

28. Urgent Care Centers (UCC)

UCC serve to divert individuals from County and private hospital emergency departments and avoidable engagement with law enforcement and incarceration. This is accomplished through the development of an individualized plan for each individual served, focused on recovery and wellness principles that will promote successful reintegration into the community. UCC partners with the network of County-operated and contracted mental health providers, as it is common for consumers to initiate their services at the UCC and continue with their established provider after services are provided. .

29. Veteran Peer Access Network (VPAN)

VPAN services are led by veterans for veterans. VPAN helps Veterans and Military Family Members navigate often complicated systems so that they receive the services deserved. VPAN is the first-ever community-driven support network serving veterans and their families in the U.S. The Veteran Peer Access Network connects County departments, non-profits, the U.S. Dept. of Veterans Affair (VA) and LA City programs. The network embodies the #YouMatter ideal – that veterans deserve hope, well-being, and a greater quality of life as valued members of the LA County community. VPAN puts trained Veteran Peers on the ground in Los Angeles County communities to assist in connecting Veterans to the services they need as they transition out of the military and into LA County.

30. Wellness Outreach Workers (WOW) Program

LACDMH's WOW volunteers have lived experience and provide peer support in our Directly Operated sites. They work with treatment teams to assist clients on their path to wellbeing and recovery. The purpose of the WOW program is to promote ongoing peer support to vulnerable adult consumers to facilitate community reintegration and educate consumers, family members, and community members about mental health care through culturally sensitive treatment options.

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

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

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

- Capital Facilities/Technology Needs (CFTN)

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

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

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

Examples of how the ESM accomplished these functions during CY 2022:

- Developing and/or a revising departmental policies and procedures (P&P) related to cultural and linguistic competence
- Serving as main advisor and writer of policies pertinent to cultural competence
    - P&P 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community (Revision completed)
    - P&P 200.09 – Culturally and Linguistically Inclusive Services (Revision completed)
- Leading the development of annual LACDMH Cultural Competence Plan (CCP) Reports and submission to External Quality Review Organization (EQRO) and California Department of Health Care Services' (DHCS)
- Serving as departmental lead for cultural competence during the triennial Medi-Cal Reviews and the annual EQRO Site Reviews
- Developing reports for the Los Angeles County Board of Supervisors in response to specific Board Motions addressing mental health disparities
- Developing and providing trainings on cultural competence, cultural humility, and implicit bias, at various departmental venues and the community at large
- Providing oversight for the conduction of the cultural competence organizational assessments, informing executive management of outcomes, and addressing knowledge gaps in the workforce
- Implementing initiatives that advance the Department's commitment to Anti-Racism, Diversity and Inclusion (ARDI) work via strategic cultural and linguistic competence within the system of care, inclusive of planning and implementation of the LACDMH ARDI Division

- Participation in cross-departmental workgroup with DPH and DHS to address improvement to existing Language Assistance Services Master Agreement (LASMA). This includes the on-going analysis of vendor performance and conveyance of recommendations to update the existing master agreement
- Overseeing the coordination, delivery, and reporting of Language Assistance Services via hired vendors for threshold language interpreters, American Sign Language (ASL) and closed captioning services for consumers, family member and the community at large to participate in departmental stakeholder groups
- Overseeing the coordination, delivery, and reporting of ASL interpreter services for clinical sites operated by Directly Operated and Legal Entity/Contracted providers
- Development of an online American Sign Language Service Satisfaction Survey (ASL SSS) that gathers feedback from clinic requestors and the deaf and hard of hearing individuals utilizing ASL services by hired vendors
- Serving as co-director for the LACDMH Speakers Bureau and overseeing the processing of requests for trainings and presentations received from the community at large and the system of care
- Co-directing the planning and delivery of the annual Speakers Bureau Multicultural Community Conference. During CY 2022, the ESM visited all stakeholder groups to solicit potential workshop topics to ensure the conference would address the needs of underserved communities
- Reviewing service utilization data and actively participating in local mental health planning projects that respond to the needs of the county's culturally diverse populations in collaboration with sister Health Departments
- Promoting knowledge and participation in state cultural competence projects with ESMs from other counties in Southern California
- Providing administrative oversight of the Cultural Competency Committee (CCC) activities
- Oversight and writing of articles on various informative topics for the CCC's Cultural Traditions and Connections Column featured in LACDMH's Connecting Our Community newsletter. The ESM's article contributions include:
  - Cultural Traditions & Connections Project
  - Join LACDMH's Cultural Competency Committee (co-author)
  - LACDMH's Speakers Bureau celebrates its second anniversary
  - What works for me and my mental health (co-author)
  - My struggles as an immigrant (Spanish translation)
- Providing technical assistance and training to diverse LACDMH programs regarding cultural competence in general, CCPR compliance, and procedures for language translation and interpreter services
- Participating in the Department's Quality Improvement Council meetings as a standing member to provide updates related to the ARDI-CCU as well as presentations on the CCC projects and activities
- Representing the ARDI-CCU in various departmental committees such as the Faith-Based Advisory Council, UsCC subcommittees, and Service Area Leadership Team meetings

- Collaborating with LACDMH executive management, LACDMH programs/Units management and stakeholder groups to increase the accessibility of mental health services to underserved communities
- Collaborating with the Southern Region ESMs and representing LACDMH in the County Behavioral Health Directors Association of California Cultural Competency, Equity and Social Justice Committee
- Serving as the Cultural Competence Lead for the Labor Management Transformation Council (LMTC) which operates under the leadership of the three Health Department directors and Labor Unions. This included responsibilities as the LMTC Cultural Intelligence Workgroup with member representation from the Health Departments and Labor Unions.

The most salient CY 2022 activities of the ARDI Division-CCU directly under the oversight of the ESM include the following:

1. Development of the annual Cultural Competence (CC) Plan Report, a systemwide report on LACDMH's progress and updates regarding cultural and linguistic competence. The overall goal of the CC Plan is to move all Counties toward more culturally and linguistically competent services and reduce racial/ethnic/cultural and linguistic mental health disparities among unserved, underserved and inappropriately served populations. The ARDI-CCU coordinated and strategically worked with approximately 60 sources of information and provided technical assistance to LACDMH programs being featured in the report in their process of compiling data and information for the report. The Unit writes the CC Plan report utilizing the information gathered in accordance with the CCPR areas of focus.

2. Development and implementation of the second annual LACDMH Speakers Bureau (SB) Multicultural Community Conference, offering over 70 workshops in seven languages.

3. Language Assistance Services for Stakeholder Group Meetings
   During CY 2022, the ARDI Division-CCU coordinated language assistance services for 23 specific stakeholder groups. Most of these efforts required monthly coordination with language interpreter vendors and departmental units. Several of these meetings involved multiple languages and/or a combination of more than one type of accommodation based on requests received from the community. Most language assistance requests involved American Sign Language, closed captioning in real time, and interpreter services for L.A. County threshold languages.

4. Coordination of ASL interpreter services for clinical appointments at Directly Operated sites.

5. Development and implementation of consumer satisfaction forms for Language Assistance Services pertinent to stakeholder group meeting participation and ASL interpreter facilitation of clinical appointments for deaf and hard of hearing consumers and family members.

6. Completion of State-level reporting pertinent to ASL services and outcomes

7. Review of LACDMH's Policies and Procedures (P&P) 200.02 and 200.09 pertinent to delivery of cultural and linguistic competent services

   The ESM was called upon to review departmental policies pertinent to cultural competence based on the Cultural Competence Plan Requirements (CCPR) and CLAS Standards. The ESM incorporates cultural and linguistic competence content and vets policy revisions with the Cultural Competency Committee.

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

   The Workgroup delivered a formal presentation of the CQ educational campaign materials to the LMTC executive group which included the three health department directors and representatives from the Labor Unions. The same presentation was delivered to equity leads from the three departments to determine ways of incorporating the developed materials into their operations. The CQ Workgroup products include toolkits, screensavers, a universal poster addressing the four themes specified below:

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

9. Cultural Competence Trainings and Community Presentations pertinent to cultural competence, cultural humility, implicit bias and ARDI Division Framework delivered at New Employee Orientation (NEO)

   The ARDI Division-CCU continued training new employees on cultural competence and cultural humility during NEO. This introductory training serves the purpose of introducing new employees to the functions of the unit, the CLAS Standards, the CCPR, County of Los Angeles demographics and threshold languages, and the Department's strategies to reduce mental health disparities.

10. External Quality Review Organization (EQRO) Review

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

11. CCC Administrative Oversight

    The ARDI Division-CCU continued providing technical assistance and administrative oversight conducive to the attainment of the Committee's goals and objectives. The

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

12. Cultural Traditions and Connections Column

This project is rooted in the Cultural Competency Committee's (CCC) "Share Your Culture" activity, which engaged community members, consumers, family members, peers, and staff in sharing about their cultural background at the time in-person meetings were the norm. In response to the COVID-19 pandemic, the ARDI Division-CCU in collaboration with the CCC created the on-line Cultural Traditions and Connections Column as a safe space to share, learn, celebrate, and connect our collective cultural experiences. The column is featured in LACDMH's monthly *"Connecting Our Communities Newsletter."* The content for the column features writers from the community as well as LACDMH staff who passionately share about different aspects of their cultural background and lived experience. The total number of contributions to the column included 24 articles and one poem.

The titles of published articles during of the CY 2022 include:

- Cultural Traditions & Connections Project
- Join LACDMH's Cultural Competency Committee
- Lunar New Year's Traditions
- Chinese New Year* (My Cantonese Traditions) (*also known as Spring Festival)
- Capitol Crawl to Access for All
- Celebrating Sexual and Gender Diversity in March
- Native American Gatherings
- Leaving Behind a Good Example / Dejando un Buen Ejemplo
- Never Mind
- Wondering How (I Could Be Me)
- A True Love Story and Redemption / Una Historia de Amor y Redención
- LACDMH's Speakers Bureau Celebrates its Second Anniversary
- Armenian History Month
- My Multicultural Experience
- The 11th Global Accessibility Awareness Day (GAAD) is Coming
- What Works for Me and My Mental Health
- Thoughts on COVID
- About Pride Month
- A Brief History of Our LGBTQIA2S Pride Flag
- My Struggles as an Immigrant
- The Evolution of Juneteenth
- Untitled Poem

- Food for Thought
- National Recovery Month: Locked Up from Employment
- Thanksgiving from the Lived Experience of an Indian

IV. Budgetary Allocations for Cultural Competence Activities, FY 21-22

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

Cultural Competence-related trainings

- $66,000 for Specialized Foster Care trainings
- $11,600 for juvenile justice trainings
- $28,317.50 for culture-specific trainings focusing on underserved populations
- $17,245 for interpreter trainings

Language Assistance Services

- $147,385 for language interpreter services, which allow consumers, family members and the community at large to participate in various departmental meetings and conferences
- $43,565 for language translation services provided for consumer, family members and community at large participation in stakeholder meetings
- $107,597 for Closed Captioning in Real Time (CART) services
- $139,646 for ASL services
- $210,504.16 for countywide translation services

MHSA Plan-Specific projected budget allocations

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

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

TABLE 5: SUMMARY OF MHSA PLAN BUDGETARY ALLOCATIONS AND EXPENDITURES, FY 21-22

Programs	Funding
CSS Programs 1. Full Service Partnerships 2. Outpatient Care Services (formerly known as Recovery, Resilience and Integration) 3. Alternative Crisis Services 4. Planning Outreach & Engagement 5. Linkage Services 6. Housing Services	 $95,397 $182,950 $132.1 million $6,178 $34,545 $40,593
Total CSS Program Expenditures	**$132.5 million**
PEI Programs 1. Total Gross Expenditures - Suicide Prevention 2. Total Gross Expenditures - Stigma Discrimination Reduction Program 3. Total Gross Expenditures - Prevention 4. Total Gross Expenditures - Early Intervention 5. Call Center Modernization	 $5.6 million $7 million $63 million $28.4 million 3.5 million
Total PEI Program Expenditures	**$107.5 million**
Total Gross Expenditures INN Programs	**$36.1 million**
Total Gross Expenditures WET Programs	**$63.0 million**
Total Gross Expenditures Capital Facilities/Technology Needs	**$27.6 million**

* Data Source: MHSA Annual Update Report FY 23-24.

CLAS Standards Implementation: Progress at a Glance

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

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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
1. Promote effective, equitable, understandable, and respectful quality of care and services	1 - 8	• Departmental mission and vision statements, strategic plan, P&P, providers manual, and parameters that guide clinical care • Implementation of the Anti-Racism, Diversity and Inclusion (ARDI) Division with inclusion of the CCU, Promotores and UMHP program, Speakers Bureau and Spanish Self-Help Group • Implementation of tri-departmental workgroups targeting cultural related service needs, such as cultural and linguistic responsiveness, homelessness, jail diversion, vulnerable youth, and co-occurring disorders • Comprehensive budget allocations for cultural competence activities • Culture and language specific outreach and engagement • Tracking of penetration rates, retention rates and mental health disparities • Collaborative efforts between the ARDI Division-CCU and the Quality Improvement Unit
2. Governance and leadership promoting CLAS	1, 4, 5, and 6	• Well-established Stakeholder Engagement Process • Departmental Strategic Plan • Policies and procedures that guide culturally and linguistically competent service provision • Review and discussions regarding the CLAS standards with departmental leadership, SA QIC, and CCC
3. Diverse governance, leadership, and workforce	1, 6, and 7	• Culturally diverse stakeholder process • Utilization of demographical and consumer utilization data in program planning, service delivery, and outcome evaluation • Presence of committees that advocate for the needs of cultural and linguistically underserved populations • Efforts to recruit culturally and linguistically competent staff who represent the communities and cultural groups served • Development of paid employment opportunities for peers and persons with lived experience

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• Hiring of a LGBTQIA2-S Services Specialist • Expansion of the Mental Health Promoters Program from a Latino focus to other cultural and language groups, known as the "United Mental Health Promoters Program" • Implementation of the Community Ambassador Program • LGBTQIA2-S Consultation Team with representation of staff from all Service Areas • Speakers Bureau members represent multiple cultural backgrounds, language of expertise, specialized DMH programs and collectively offer 200 areas of clinical expertise
4. Train governance, leadership, and workforce in CLAS	1 and 5	• Accessible cultural competence trainings • Opportunities for Program Managers to request cultural competence trainings needed by their respective staff • Inclusion of the CLAS standards in the cultural competence trainings provided at NEO • Trainings for language interpreters and for the use of language interpreters in mental health settings • Trainings specifically designed for peers and persons with lived experience
5. Communication and language assistance	5 and 7	• Established P&Ps for bilingual certification, language translation and interpretation services, interpreter services for the Deaf and Hard of Hearing community, and culturally and linguistically inclusive services • LACDMH 24/7 Help Line • On-line Provider Directories translated into threshold languages • Translation of consent forms that require consumer signage in the threshold languages • The ARDI Division-CCU's countywide coordination of language assistance services for consumers, family members, and community members to participate in stakeholder meetings and departmental events • Usage of posters at provider sites which inform the public of the availability of free of cost language assistance services

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

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

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
13. Partnerships with community	1, 3, and 4	• Media campaigns to increase access to mental health services and decrease stigma in partnership with community-based organizations • Presence of various stakeholder committees such as “YourDMH”, CCC, UsCC subcommittees, Faith-Based Advocacy Council • Provision of stipends and scholarships for consumers and family members to attend stakeholder meetings and conferences • Collaborations with agencies that specialize in services to Veterans • Implementation of Health Neighborhoods and other innovation programs based on partnerships with community-based organizations • Partnerships and collaborations with the faith-based communities • Partnerships and collaborations with other county departments for specialized programs such as Whole Person Care
14. Conflict and grievance resolution processes	8	• Development of online Patient’s Rights Office apps • Monitoring of consumer and family satisfaction with services received • Monitoring of beneficiary requests for change of provider • Monitoring the quality of services provided by the LACDMH 24/7 Help Line and the Language Interpreter Services Master Agreement’s vendors • Monitoring of grievances, appeals and request for State Fair Hearings
15. Progress in implementing and sustaining the CLAS standards	1	• The Cultural Competence Plan is accessible by LACDMH clinical and administrative programs, the Executive Management Team, and various stakeholders such as the CCC, UsCC subcommittees, and SA QICs. Additionally, it is posted in the departmental Cultural Competency Unit webpage • On-going stakeholder process and other committee meetings with community members, many of which are held monthly • Cultural Competence Organizational Assessment

CLAS Standard	CCPR Criterion	Examples of CLAS Standards Implementation in Departmental Practices
		• CLAS Standard inclusion in CCU's trainings and presentations such as New Employee Orientation and annual Cultural Competence Plan report • Implementation of Town Halls for DMH employees and/or for the community with multiple Language Assistance Services

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Criterion 1 Appendix

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

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

3. YourDMH Get Involved flyer

YourDMH Get Involved Flyer_upda

4. Link to WhyWeRise Report

RAND Report WeRise 2022.pdf

CauseComms-2022-WR-Final-Report-15

5. Link to MHSA report, FY 23-24
   1143711_MHSAAnnualUpdateFY23-24Adopted6-6-23.pdf (lacounty.gov)

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 2

Updated Assessment of Services Needs

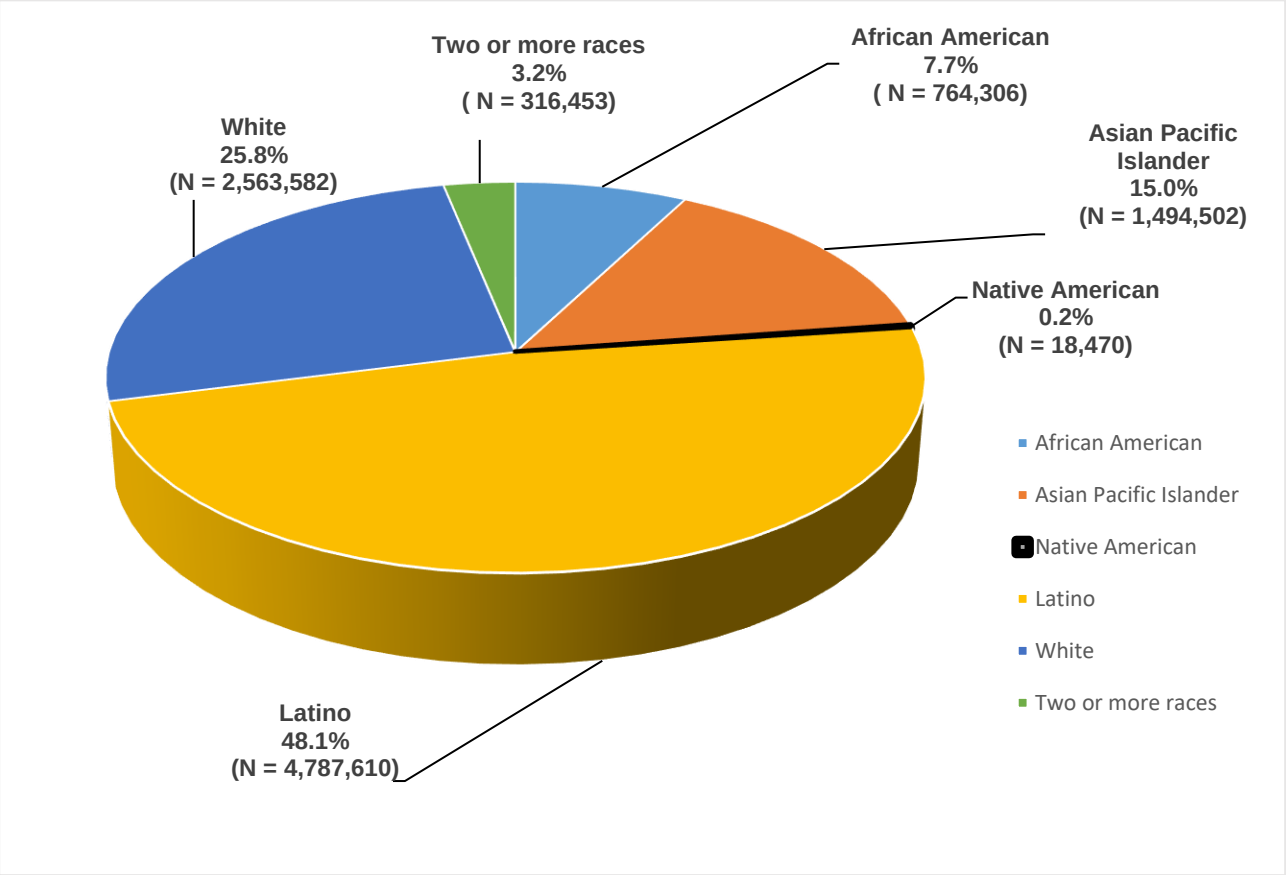
August 2023

Criterion 2: Updated Assessment of Services Needs

I. General Population: County Total Population

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

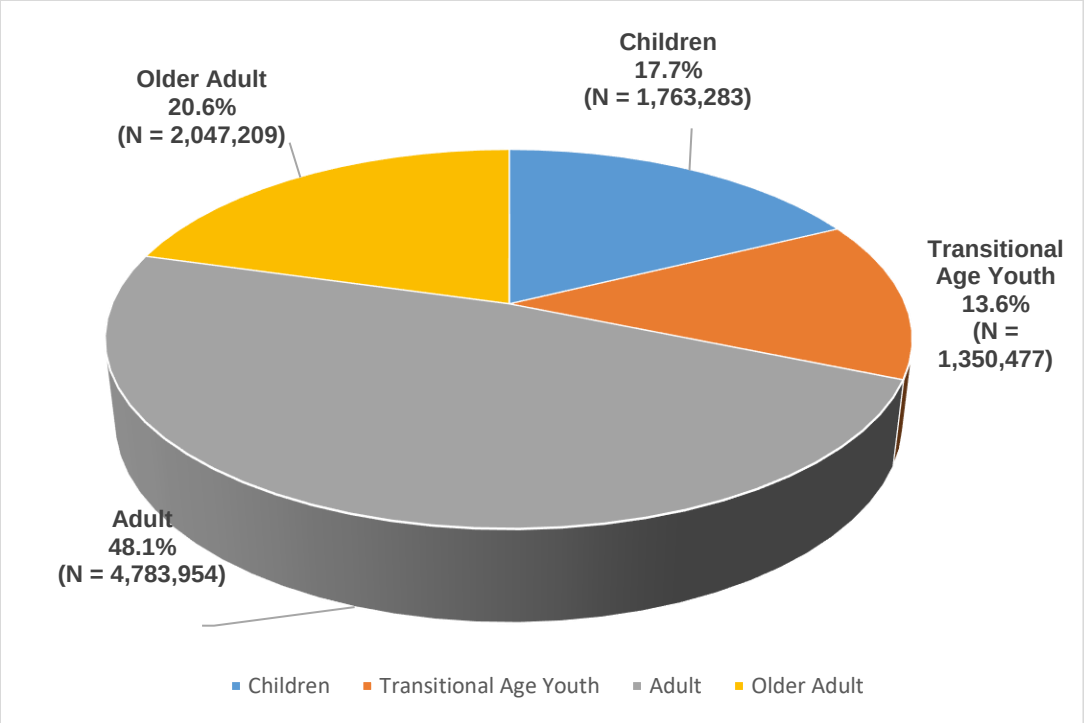
FIGURE 1: POPULATION BY RACE/ETHNICITY
CY 2021 (N = 9,944,923)



Data Source: ACS, US Census, Bureau and Hedderson Demographic Services, 2022.

Figure 1 shows population by race/ethnicity. Latinos are the largest group at 48.1%, followed by Whites at 25.8%, Asian/Pacific Islanders (API) at 15.0%, African Americans at 7.7%, persons with Two or More Races at 3.2%, and Native Americans at 0.2%.

FIGURE 2: POPULATION BY AGE GROUP
CY 2020 (N = 9,944,923)



Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Figure 2 shows population by age group. Adults make up the largest group at 48.1%, followed by Children at 17.7%, Older Adults at 20.6%, and Transition Age Youth (TAY) at 13.6%.

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TABLE 1: POPULATION BY RACE/ETHNICITY AND SERVICE AREA
CY 2021

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	Two or More Races	White	Total
SA 1	62,170	16,555	218,727	1,446	15,429	102,230	416,557
Percent	14.9%	4.0%	52.5%	**0.35%**	3.7%	24.5%	100.0%
SA 2	79,048	258,577	864,098	3,473	78,121	908,431	2,191,748
Percent	3.6%	11.8%	39.4%	0.16%	3.6%	41.4%	100.0%
SA 3	53,888	543,330	801,531	2,897	42,174	301,502	1,745,322
Percent	**3.1%**	**31.1%**	45.9%	0.17%	2.4%	17.3%	100.0%
SA 4	61,193	187,659	516,141	2,265	36,845	302,874	1,106,977
Percent	5.5%	17.0%	46.6%	0.20%	3.3%	27.4%	100.0%
SA 5	33,007	91,407	104,392	952	38,254	391,061	659,073
Percent	5.0%	13.9%	**15.8%**	**0.14%**	**5.8%**	**59.3%**	100.0%
SA 6	230,894	24,074	700,784	1,487	19,038	32,402	1,008,679
Percent	**22.9%**	**2.4%**	69.5%	0.15%	1.9%	**3.2%**	100.0%
SA 7	38,494	128,101	948,045	2,775	20,320	137,959	1,275,694
Percent	3.0%	10.0%	**74.3%**	0.22%	**1.6%**	10.8%	100.0%
SA 8	205,612	244,799	633,892	3,175	66,272	387,123	1,540,873
Percent	13.3%	16.0%	41.1%	0.21%	4.3%	25.1%	100.0%
Total	764,306	1,494,502	4,787,610	18,470	316,453	2,563,582	9,944,923
Percent	7.7%	15.0%	48.1%	0.19%	3.2%	25.8%	100.0%

Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Differences by Race/Ethnicity

The highest percentage of African Americans was in SA 6 (22.9%) compared to SA 7 (3.0%) with the lowest percentage.

The highest percentage of Asian/Pacific Islanders was in SA 3 (31.1%) compared to SA 6 (2.4%) with the lowest percentage.

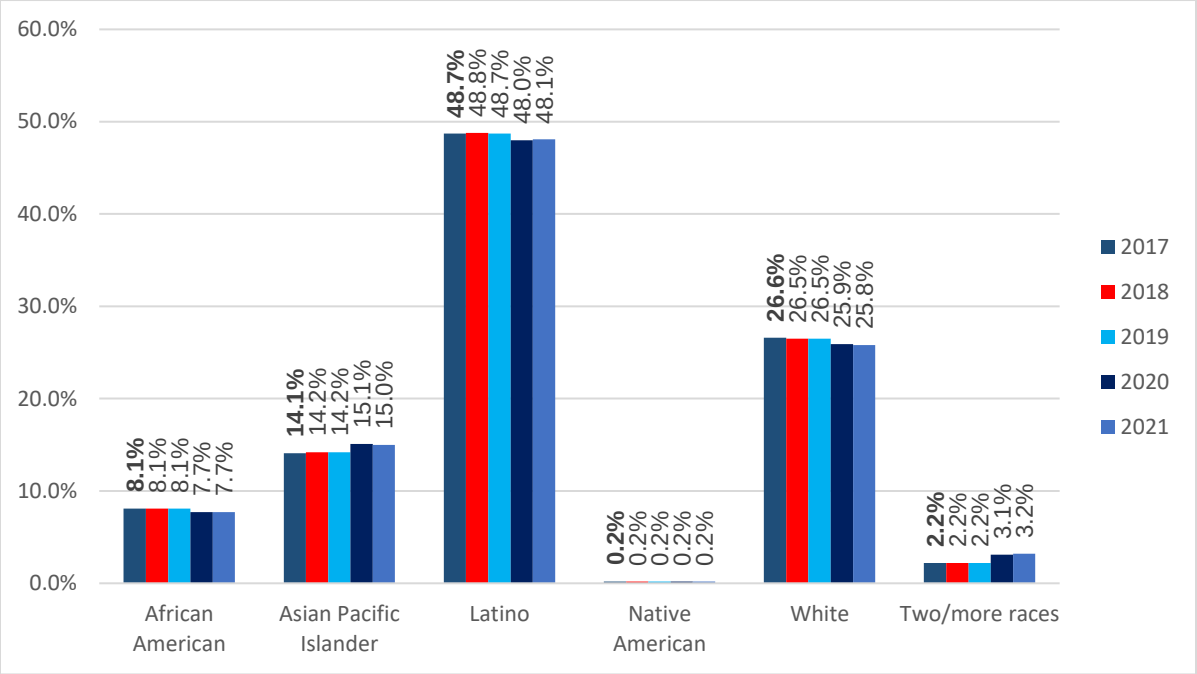
The highest percentage of Latinos was in SA 7 (74.3%) compared to SA 5 (15.8%) with the lowest percentage.

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

The highest percentage of Whites was in SA 5 (59.3%) compared to SA 6 (3.2%) with the lowest percentage.

The highest percentage of Two or More Races was in SA 5 (5.8%) compared to SA 7 (1.6%) with the lowest percentage.

FIGURE 3: POPULATION PERCENTAGE CHANGE BY RACE/ETHNICITY CY 2017 – 2021



Note: The "Two or More Races" ethnic group was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

The percentage of African Americans (AA) in the County has decreased by 0.4 percentage points (PP) over the past five years. AA represented 8.1% of the total population in CY 2017 and 7.7% of the population in CY 2021.

The percentage of Asian Pacific Islanders (API) in Los Angeles County has increased by 0.9 PP over the past five years. API represented 14.1% of the total population in CY 2017 and represented 15.0% in CY 2021.

The percentage of Latinos in Los Angeles County has decreased by 0.6 PP over the past five years. Latinos represented 48.7% of the total population in CY 2017 and represented 48.1% in CY 2021.

The percentage of Native Americans (NA) in Los Angeles County has remained the same over the past five years. NA represented 0.2% of the total population in CY 2017` and in CY 2021.

The percentage of Whites in Los Angeles County has decreased by 0.8 PP over the past five years. Whites represented 26.6% of the total population in CY 2017 and represented 25.8% in CY 2021.

The percentage of Two or More Races in Los Angeles County has increased 1.0 PP over the past five years. Two or More Races category represent 2.2% of total population in CY 2017 and represented 3.2% in CY 2021.

TABLE 2: POPULATION BY AGE GROUP AND SERVICE AREA
CY 2021

Service Area (SA)	Age Group						
	0-18	**19-20**	**21-25**	**26-59**	**60-64**	**65+**	**Total**
SA1	115,315	13,134	35,303	181,215	25,060	46,530	416,557
Percent	**27.7%**	3.2%	8.5%	**43.5%**	6.0%	11.2%	100.0%
SA2	462,597	54,801	142,976	1,050,856	148,155	332,363	2,191,748
Percent	21.1%	2.5%	6.5%	47.9%	**6.8%**	15.2%	100.0%
SA3	362,533	49,538	121,717	807,081	116,616	287,837	1,745,322
Percent	20.8%	2.8%	7.0%	46.2%	6.7%	16.5%	100.0%
SA4	183,630	23,998	61,072	618,582	64,214	155,481	1,106,977
Percent	16.6%	**2.2%**	**5.5%**	**55.9%**	5.8%	14.0%	100.0%
SA5	104,898	24,710	41,012	334,066	41,633	112,754	659,073
Percent	**15.9%**	**3.7%**	6.2%	50.7%	6.3%	**17.1%**	100.0%
SA6	270,032	36,855	86,442	468,018	49,894	97,438	1,008,679
Percent	26.8%	**3.7%**	**8.6%**	46.4%	**4.9%**	**9.7%**	100.0%
SA7	302,987	37,876	98,357	596,961	71,290	168,223	1,275,694
Percent	23.8%	3.0%	7.7%	46.8%	5.6%	13.2%	100.0%
SA8	337,679	41,326	104,972	727,175	101,359	228,362	1,540,873
Percent	21.9%	2.7%	6.8%	47.2%	6.6%	14.8%	100.0%
Total	2,139,671	282,238	691,851	4,783,954	618,221	1,428,988	9,944,923
Percent	21.5%	2.8%	7.0%	48.1%	6.2%	14.4%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Service 2022.

Differences by Age Group

The highest percentage of individuals between 0 and 18 years old was in SA 1 (27.7%) compared to SA 5 (15.9%) with the lowest percentage.

The highest percentage of individuals between 19 and 20 years old was in SA 5 and SA 6 (3.7%) compared to SA 4 (2.2%) with the lowest percentage.

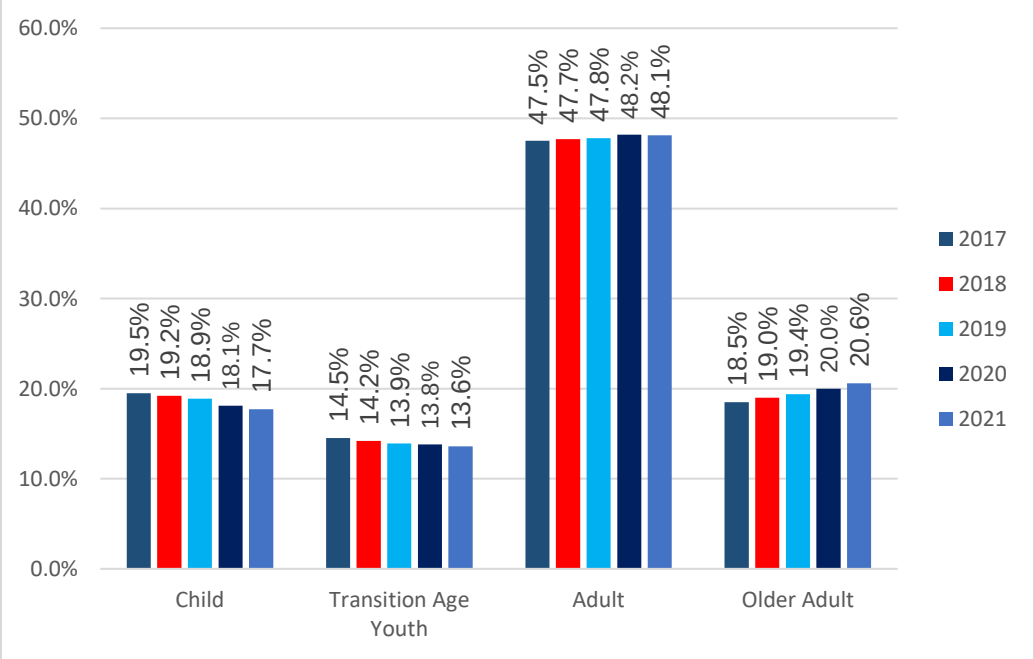
The highest percentage of individuals between 21 and 25 years old was in SA 6 (8.6%) compared to SA 4 (5.5%) with the lowest percentage.

The highest percentage of individuals between 26 and 59 years old was in SA 4 (55.9%) compared to SA 1 (43.5%) with the lowest percentage.

The highest percentage of individuals between 60 and 64 years old was in SA 2 (6.8%) compared to SA 6 (4.9%) with the lowest percentage.

The highest percentage of individuals 65+ years old was in SA 5 (17.1%) compared to SA 6 (9.7%) with the lowest percentage.

FIGURE 4: POPULATION PERCENTAGE (PP) CHANGE BY AGE GROUP CY 2017 – 2021



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

The percentage of Children in the County has decreased by 1.8 PP over the past five years. Children represented 19.5% of the total population in CY 2017 and 17.7% in CY 2021.

The percentage of Transition Age Youth (TAY) in the County has decreased by 0.9 PP over the past five years. TAY represented 14.5% of the total population in CY 2017 and 13.6% in CY 2021.

The percentage of Adults in the County increased by 0.6 PP over the past five years. Adults represented 47.5% of the total population in CY 2017 and 48.1% in CY 2021.

The percentage of Older Adults in the County has increased by 2.1 PP over the past five years. Older Adults represented 18.5% of the total population in CY 2017 and 20.6% in CY 2021.

TABLE 3: POPULATION BY GENDER AND SERVICE AREA
CY 2021

Service Area (SA)	Male	Female	Total
SA1	205,882	210,675	416,557
Percent	49.4%	50.6%	100.0%
SA2	1,085,478	1,106,270	2,191,748
Percent	49.5%	50.5%	100.0%
SA3	850,645	894,677	1,745,322
Percent	48.7%	51.3%	100.0%
SA4	572,730	534,247	1,106,977
Percent	**51.7%**	**48.3%**	100.0%
SA5	319,252	339,821	659,073
Percent	**48.4%**	**51.6%**	100.0%
SA6	493,940	514,739	1,008,679
Percent	49.0%	51.0%	100.0%
SA7	627,055	648,639	1,275,694
Percent	49.2%	50.8%	100.0%
SA8	754,163	786,710	1,540,873
Percent	48.9%	51.1%	100.0%
Total	4,909,145	5,035,778	9,944,923
Percent	49.4%	50.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Difference by Gender

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

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

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

TABLE 4: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY RACE/ETHNICITY AND SERVICE AREA - CY 2021

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	16,701	2,711	54,998	405	17,348	3,462	95,625
Percent	17.5%	2.8%	57.5%	**0.42%**	18.1%	3.6%	100.0%
SA 2	10,918	32,373	162,742	335	103,220	7,626	317,214
Percent	3.4%	10.2%	51.3%	0.11%	32.5%	2.4%	100.0%
SA 3	6,248	70,652	131,165	208	26,508	2,900	237,681
Percent	2.6%	**29.7%**	55.2%	0.09%	11.2%	1.2%	100.0%
SA 4	13,030	43,046	139,422	729	43,821	6,515	246,563
Percent	5.3%	17.5%	56.5%	0.30%	17.8%	2.6%	100.0%
SA 5	3,472	11,040	13,305	44	37,499	3,542	68,902
Percent	5.0%	16.0%	**19.3%**	**0.06%**	**54.4%**	**5.1%**	100.0%
SA 6	65,138	8,370	219,491	657	5,861	5,639	305,156
Percent	**21.3%**	**2.7%**	71.9%	0.22%	**1.9%**	1.8%	100.0%
SA 7	4,395	11,370.0	174,275	268	10,532	1,026	201,866
Percent	**2.2%**	5.6%	**86.3%**	0.13%	5.2%	**0.5%**	100.0%
SA 8	40,898	31,926	131,465	582	32,921	7,492	245,284
Percent	16.7%	13.0%	53.6%	0.24%	13.4%	3.1%	100.0%
Total	160,800	211,488	1,026,863	3,228	277,710	38,202	1,718,291
Percent	9.4%	12.3%	59.8%	0.19%	16.2%	2.2%	100.0%

Note: Some totals/percentages may not total 100% due to rounding. Bold values represent the highest and lowest percentages within each racial/ethnic group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Differences by Race/Ethnicity

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

The highest percentage of Asian/Pacific Islanders (API) living at or below 138% FPL was in SA 3 (29.7%) compared to SA 6 (2.7%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 12.3% self-identified as API.

The highest percentage of Latinos living at or below 138% FPL was in SA 7 (86.3%) compared to SA 5 (19.3%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 59.8% self-identified as Latino.

The highest percentage of Native Americans (NA) living at or below 138% FPL was in SA 1 (0.42%) compared to SA 5 (0.06%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 0.2% self-identified as NA.

The highest percentage of Whites living at or below 138% FPL was in SA 5 (54.4%) compared to SA 6 (1.9%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 16.2% self-identified as White.

The highest percentage of Two or More Races living at or below 138% FPL was in SA 5 (5.1%) compared to SA 7 (0.5%) with the lowest percentage. Of the County's total population living at or below 138% FPL, 2.2% self-identified as having Two or More Races.

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TABLE 5: ESTIMATED POPULATION LIVING AT OR BELOW 138% FPL BY AGE GROUP AND SERVICE AREA - CY 2021

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	36,857	2,720	7,291	35,305	4,399	9,053	95,625
Percent	**38.5%**	2.8%	7.6%	**36.9%**	4.6%	9.5%	100.0%
SA2	89,995	7,855	20,855	139,735	16,624	42,150	317,214
Percent	28.4%	2.5%	6.6%	44.1%	**5.2%**	13.3%	100.0%
SA3	67,776	6,271	16,500	97,960	11,962	37,212	237,681
Percent	28.5%	2.6%	6.9%	41.2%	5.0%	**15.7%**	100.0%
SA4	61,497	5,223	13,896	118,949	11,581	35,417	246,563
Percent	24.9%	**2.1%**	**5.6%**	48.2%	4.7%	14.4%	100.0%
SA5	11,246	2,194	7,322	34,444	3,354	10,342	68,902
Percent	**16.3%**	**3.2%**	**10.6%**	**50.0%**	4.9%	15.0%	100.0%
SA6	116,909	9,595	24,385	117,977	12,004	24,286	305,156
Percent	38.3%	3.1%	8.0%	38.7%	**3.9%**	**8.0%**	100.0%
SA7	72,279	5,437	14,147	80,214	8,447	21,342	201,866
Percent	35.8%	2.7%	7.0%	39.7%	4.2%	10.6%	100.0%
SA8	78,331	6,448	16,741	102,719	12,019	29,026	245,284
Percent	31.9%	2.6%	6.8%	41.9%	4.9%	11.8%	100.0%
Total	534,890	45,743	121,137	727,303	80,390	208,828	1,718,291
Percent	31.1%	2.7%	7.0%	42.3%	4.7%	12.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each age group and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

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Differences by Age Group

The highest percentage of individuals between 0 and 18 years old estimated to be living at or below 138% FPL was in SA 1 (38.5%) compared to SA 5 (16.3%) with the lowest percentage. Overall, SA 6 had the highest number of individuals between 0 - 18 years living at or below 138% FPL (116,909).

The highest percentage of individuals between 19 and 20 years old estimated to be living at or below 138% FPL was in SA 5 (3.2%) compared to SA 4 (2.1%) with the lowest percentage. Overall, SA 6 had the highest number of individuals between 19-20 years living at or below 138% FPL (9,595).

The highest percentage of individuals between 21 and 25 years old estimated to be living at or below 138% FPL was in SA 5 (10.6%) compared to SA 4 (5.6%) with the lowest percentage. Overall, SA 6 had the highest number of individuals between 21-25 years living at or below 138% FPL (24,385).

The highest percentage of individuals between 26 and 59 years old estimated to be living at or below 138% FPL was in SA 5 (50.0%) compared to SA 1 (36.9%) with the lowest percentage. Overall, SA 2 had the highest number of individuals between 25-59 years living at or below 138% FPL (139,735).

The highest percentage of individuals between 60 and 64 years old estimated to be living at or below 138% FPL was in SA 2 (5.2%) compared to SA 6 (3.9%) with the lowest percentage. Overall, SA 2 had the highest number of individuals between 60-64 years living at or below 138% FPL (16,624)

The highest percentage of individuals 65 years old and older estimated to be living at or below 138% FPL was in SA 3 (15.7%) compared to SA 6 (8.0%) with the lowest percentage. Overall, SA 2 had the highest number of individuals ages 65 and older living at or below 138% FPL (42,150).

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TABLE 6: ESTIMATED POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER AND SERVICE AREA CY 2021

Service Area (SA)	Male	Female	Total
SA1	43,353	52,272	95,625
Percent	45.3%	54.7%	100.0%
SA2	143,783	173,431	317,214
Percent	45.3%	54.7%	100.0%
SA3	106,171	131,510	237,681
Percent	44.7%	55.3%	100.0%
SA4	115,475	131,088	246,563
Percent	**46.8%**	**53.2%**	100.0%
SA5	30,602	38,300	68,902
Percent	**44.4%**	**55.6%**	100.0%
SA6	138,192	166,964	305,156
Percent	45.3%	54.7%	100.0%
SA7	89,958	111,908	201,866
Percent	44.6%	55.4%	100.0%
SA8	110,171	135,113	245,284
Percent	44.9%	55.1%	100.0%
Total	777,705	940,586	1,718,291
Percent	45.3%	54.7%	100.0%

Note: Bold values represent highest and lowest percentages within each gender and across all SAs. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Differences by Gender

Overall, the data shows that 54.7% of individuals living at or below 138% FPL are female compared to 45.3% being male.

The highest percentage of Males estimated to be living at or below 138% FPL was in SA 4 (46.8%) compared to SA 5 (44.4%) with the lowest percentage.

The highest percentage of Females estimated to be living at or below 138% FPL was in SA 5 (55.6%) compared to SA 4 (53.2%) with the lowest percentage.

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

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

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

Table 7 shows the estimated population living at or below 138% Federal Poverty Level (FPL) and primary language.

A percentage of 97.0% (N = 1,667,815) of the population living at or below 138% FPL (N = 1,718,291) spoke a LACDMH threshold language.

- Spanish and English are the highest (87.6%) reported threshold languages among estimated population living at or below 138% Federal Poverty Level (FPL) in all the SAs.
- Spanish was the highest (N= 874,826 or 52.5%) reported non-English threshold language among estimated population living at or below 138% Federal Poverty Level (FPL) compared to other non-English threshold languages (N= 206,314 or 12.3%)
- SA 7 has the highest number of Spanish speakers (71.7%) compared to SA 5 (16.7%) with the lowest number of individuals living at or below 138% FPL.

Note:
Threshold languages by Service Area (SA) could not be determined. Medi-Cal threshold language data by SA is not available.

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TABLE 8: ESTIMATED PREVALENCE OF SEVERE EMOTIONAL DISTURBANCE (SED) AND SERIOUS MENTAL ILLNESS (SMI) AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY AND SERVICE AREA
CY 2021

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Two or More Races	Total
SA 1	3,240	502	8,800	70	4,198	526	17,336
Percent	18.7%	**2.9%**	50.8%	0.41%	24.2%	**3.0%**	100.0%
SA 2	2,118	5,989	26,039	58	24,979	1,159	60,342
Percent	3.5%	9.9%	43.2%	0.10%	41.4%	1.9%	100.0%
SA 3	1,212	13,071	20,986	36	6,415	441	42,161
Percent	2.9%	**31.0%**	49.8%	0.09%	15.2%	1.0%	100.0%
SA 4	2,528	7,964	22,308	127	10,605	990	44,521
Percent	5.7%	17.9%	50.1%	**0.28%**	23.8%	2.2%	100.0%
SA 5	674	2,042	2,129	8	9,075	538	14,466
Percent	4.7%	14.1%	**14.7%**	**0.05%**	**62.7%**	3.7%	100.0%
SA 6	12,637	1,548	35,119	114	1,418	857	51,694
Percent	**24.4%**	3.0%	**67.9%**	0.22%	**2.7%**	1.7%	100.0%
SA 7	853	2,103	27,884	47	10,532	156	41,575
Percent	**2.1%**	5.1%	67.1%	0.11%	25.3%	**0.4%**	100.0%
SA 8	7,934	5,906	21,034	101	7,967	1,139	44,082
Percent	18.0%	13.4%	47.7%	0.23%	18.1%	2.6%	100.0%
Total	31,195	39,125	164,298	562	67,206	5,807	308,193
Percent	10.1%	12.7%	53.3%	0.18%	21.8%	1.9%	100.0%

Note: Bold values represent the highest and lowest percentages within each Ethnic Group and across the Service Areas. Estimated prevalence rates of mental illness by Ethnicity for Los Angeles County are provided by the California Health Interview Survey (CHIS) for the population living at or below 138% FPL, CY 2020 and CY 2021. Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2022.

Differences by Race/Ethnicity

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

The highest rate of prevalence of SED and SMI among individuals who identified as African American (AA) was in SA 6 (24.4%) compared to SA 7 (2.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals who identified as Asian/Pacific Islander (API) was in SA 3 (31.0%) compared to SA 1 (2.9%) with the lowest percentage.

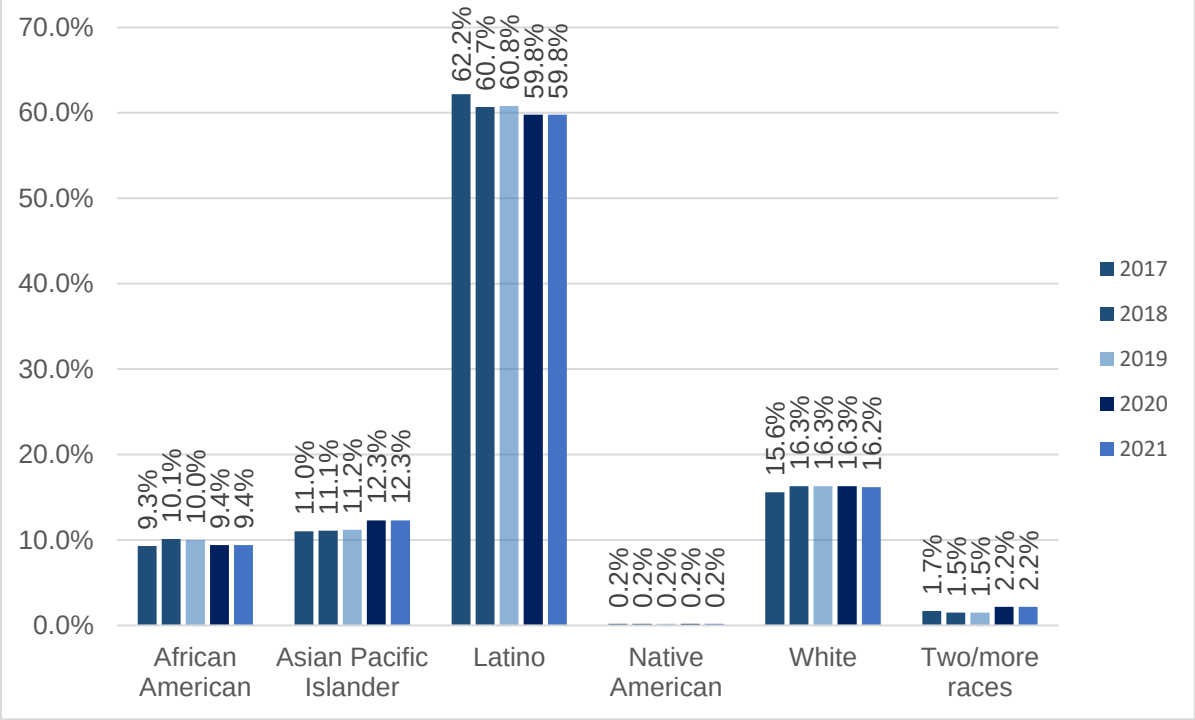
The highest rate of prevalence of SED and SMI among individuals who identified as Latino was in SA 6 (67.9%) compared to SA 5 (14.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals who identified as Native American (NA) was in SA 4 (0.28%) compared to SA 5 (0.05%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals who identified as White was in SA 5 (62.7%) compared to SA 6 (2.7%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among individuals who identified as Two or More Races was in SA 1 (3.0%) compared to SA 7 (0.4%) with the lowest percentage.

FIGURE 5: ESTIMATED PERCENTAGE CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY
CY 2017–2021



Note: The "Two or More Races" category was added in CY 2016. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

The percentage of African Americans living at or below 138% FPL has increased by 0.1% from 9.3% in CY 2017 to 9.4% in CY 2021.

The percentage of Asian/Pacific Islanders (API) living at or below 138% FPL has increased by 1.3% from 11.0% in CY 2017 to 12.3% in CY 2021.

The percentage of Latinos living at or below 138% FPL has decreased by 2.4% from 62.2% in CY 2016 to 59.8% in CY 2021.

The percentage of Native Americans living at or below 138% FPL has remained unchanged at 0.2% from CY 2017 to CY 2021.

The percentage of Whites living at or below 138% FPL has increased by 0.6% from 15.6% in CY 2017 to 16.2% in CY 2021.

The percentage of category Two or More Races living at or below 138% FPL increased by 0.5 from 1.7% in CY 2017 to 2.2% in CY 2021.

TABLE 9: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP AND SERVICE AREA CY 2021

Service Area (SA)	Age Group						
	0-18	19-20	21-25	26-59	60-64	65+	Total
SA1	9,878	615	2,195	5,613	515	824	19,639
Percent	50.3%	3.1%	11.2%	28.6%	2.6%	4.2%	100.0%
SA2	24,119	1,775	6,277	2,643	1,945	3,836	40,595
Percent	**59.4%**	4.4%	15.5%	6.5%	**4.8%**	9.4%	100.0%
SA3	18,164	1,417	4,967	1,902	1,400	3,386	31,236
Percent	58.2%	**4.5%**	15.9%	**6.1%**	4.5%	10.8%	100.0%
SA4	16,481	1,180	4,183	1,841	1,355	3,223	28,264
Percent	58.3%	4.2%	14.8%	6.5%	**4.8%**	**11.4%**	100.0%
SA5	3,014	496	2,204	5,477	392	941	12,524
Percent	**24.1%**	4.0%	**17.6%**	**43.7%**	3.1%	7.5%	100.0%
SA6	31,332	2,168	7,340	18,758	1,404	2,210	63,213
Percent	49.6%	3.4%	11.6%	29.7%	**2.2%**	**3.5%**	100.0%
SA7	19,371	1,229	4,258	12,754	988	1,942	40,542
Percent	47.8%	**3.0%**	**10.5%**	31.5%	2.4%	4.8%	100.0%
SA8	20,993	1,457	5,039	16,332	1,406	2,641	47,869
Percent	43.9%	**3.0%**	**10.5%**	34.1%	2.9%	5.5%	100.0%
Total	143,351	10,338	36,462	115,641	9,406	19,003	334,201
Percent	42.9%	3.1%	10.9%	34.6%	2.8%	5.7%	100.0%

Note: Bold values represent the highest and lowest percentage within each age group and across all SAs. Estimated prevalence rates of mental illness for Los Angeles County are provided by the CHIS for the population living at or below 138% FPL, CY 2020 and 2021. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

Differences by Age Group

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

The highest rate of prevalence of SED and SMI in Age Group 0-18 was in SA 2 (59.4%) compared to SA 5 (24.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 19-20 was in SA 3 and SA 3 (4.5%) compared to SA 7 and SA 8 (3.0%) with the lowest percentage.

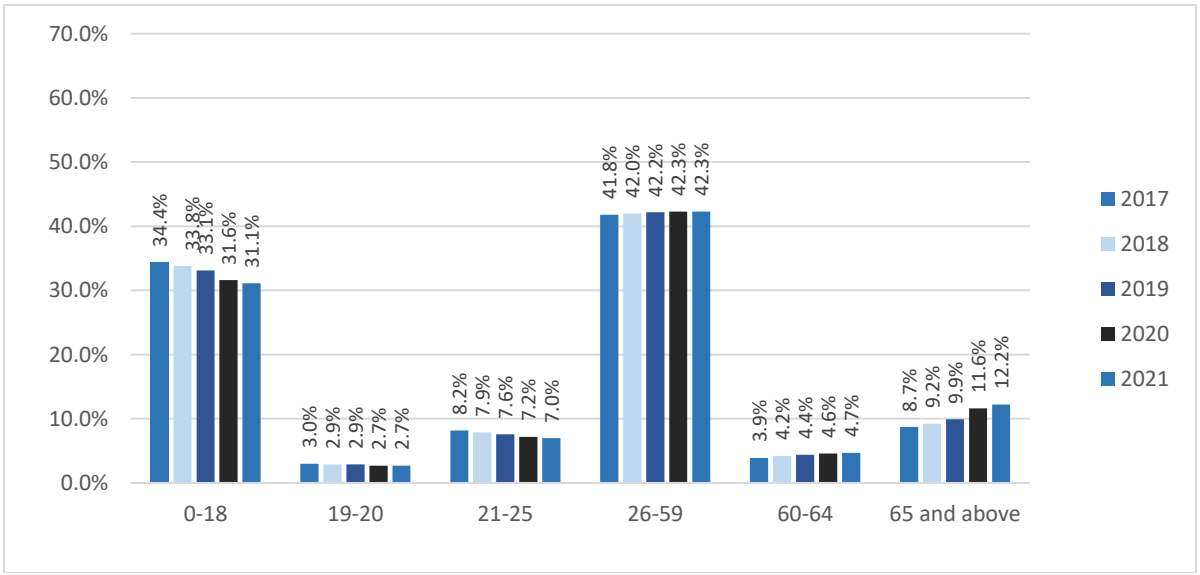
The highest rate of prevalence of SED and SMI in Age Group 21-25 was in SA 5 (17.6%) compared to SA 7 and SA 8 (10.5%) the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 26-59 was in SA 5 (43.7%) compared to SA 3 (6.1%) with the lowest percentage.

The highest rate of prevalence of SED and SMI in Age Group 60-64 was in SA 2 and SA 4 (4.8%) compared to SA 6 (2.2%).

The highest rate of prevalence of SED and SMI in Age Group 65 and older was in SA 4 (11.4%) compared to SA 6 (3.5%) with the lowest percentage.

FIGURE 6: ESTIMATED PERCENTAGE CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP CY 2017–2021



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2022.

The percentage of individuals between 0 and 18 years old and estimated to be living at or below 138% FPL decreased by 3.3 PP from 34.4% in CY 2017 to 31.1% in CY 2021.

The percentage of individuals between 19 and 20 years old and estimated to be living at or below 138% FPL decreased by 0.3 PP from 3.0% in CY 2017 and to 2.7% in CY 2021.

The percentage of individuals between 21 and 25 years old and estimated to be living at or below 138% FPL decreased by 1.2 PP from 8.2% in CY 2017 to 7.0% in CY 2021.

The percentage of individuals between 26 and 59 years old and estimated to be living at or below 138% FPL increased by 0.5 PP from 41.8% in CY 2017 to 42.3% in CY 2021.

The percentage of individuals between 60 and 64 years old and estimated to be living at or below 138% FPL increased by 0.8 PP from 3.9% in CY 2017 to 4.7% in CY 2021.

The percentage of individuals 65 years old and older and estimated to be living at or below 138% FPL increased by 3.5 PP from 8.7% in CY 2017 to 12.2% in CY 2021.

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TABLE 10: ESTIMATED PREVALENCE OF SED AND SMI AMONG POPULATION LIVING AT OR BELOW 138% FPL BY GENDER AND SERVICE AREA - CY 2021

Service Area (SA)	Male	Female	Total
SA1	6,590	9,932	16,521
Percent	39.9%	60.1%	100.0%
SA2	21,855	32,952	54,807
Percent	39.9%	60.1%	100.0%
SA3	16,138	24,987	41,125
Percent	39.2%	60.8%	100.0%
SA4	17,552	24,907	42,459
Percent	**41.3%**	**58.7%**	100.0%
SA5	4,652	7277	11,929
Percent	**39.0%**	**61.0%**	100.0%
SA6	21,005	31,723	52,728
Percent	39.8%	60.2%	100.0%
SA7	13,674	21,263	34,936
Percent	39.1%	60.9%	100.0%
SA8	16,746	25,671	42,417
Percent	39.5%	60.5%	100.0%
Total	118,211	178,711	296,923
Percent	39.8%	60.2%	100.0%

Note: Bold values represent the highest and lowest percentages within each gender and across all SAs. Estimated prevalence of mental illness for Los Angeles County are provided by CHIS for the population living at or below 138% FPL, CY 2020 and CY 2021. Data Source: ACS, US Census Bureau and Hedderson Demographic Services, 2022.

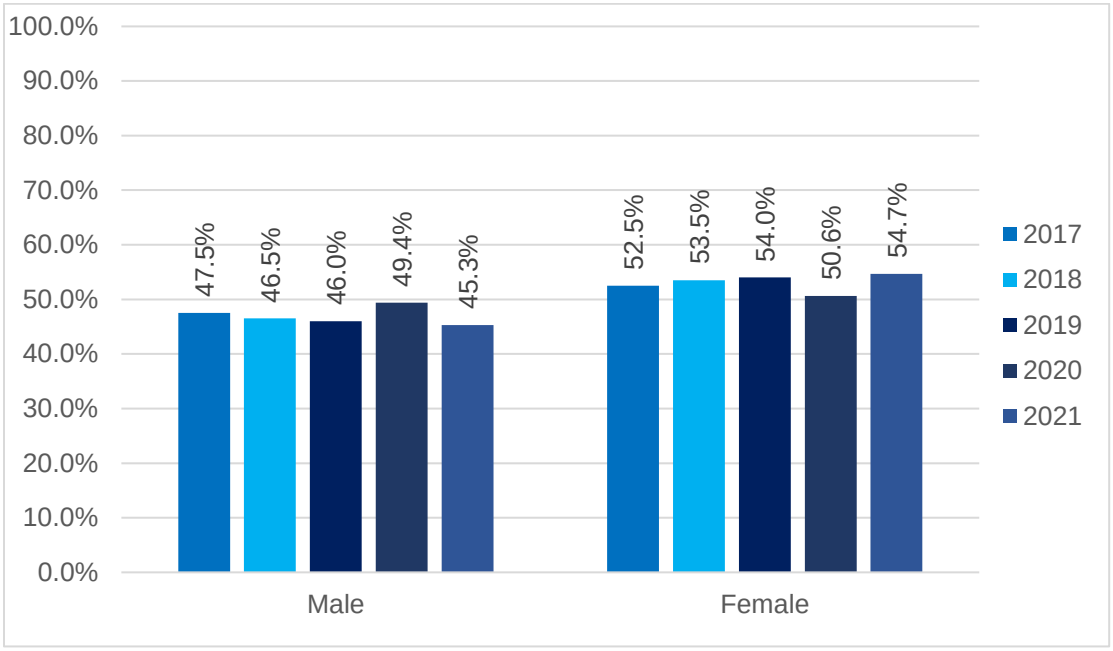
Differences by Gender

Table 10 compares the prevalence of SED and SMI for population living at or below 138% FPL for Males and Females. Overall, the estimated prevalence for SED and SMI was higher for females (60.2%) than for males (39.8%).

The highest rate of prevalence of SED and SMI among Males was in SA 4 (41.3%) compared to SA 5 (39.0%) with the lowest percentage.

The highest rate of prevalence of SED and SMI among Females was in SA 5 (61.0%) compared to SA 4 (58.7%) with the lowest percentage.

FIGURE 7: ESTIMATED PERCENTAGE CHANGE AMONG POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER CY 2017–2021



Data Source: American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, 2022.

The percentage of Males living at or below 138% FPL decreased by 2.2% PP from 47.5% in CY 2017 to 45.3% in CY 2021.

The percentage of Females living at or below 138% FPL increased by 2.2% from 52.5% in CY 2017 to 54.7% in CY 2021.

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II. Medi-Cal Population Service Needs

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

Table 11: Population Enrolled in Medi-Cal by Race/Ethnicity, CY 2022

CY 2022	Black/ AA	API	Latino	AI/AN	White	Not Reported	Total
January to December Average	427,352	406,389	2,544,367	6,005	557,995	501,172	4,443,279
Percentage	9.6%	9.1%	57.3%	0.1%	12.6%	11.3%	100.0%

Note: Race/ethnicity categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, downloaded March 2023 Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Race/Ethnicity

Table 11 presents the Los Angeles County Medi-Cal enrolled population by racial categories averaged across monthly estimates for CY 2022. The Latino group was the race/ethnicity with the highest Medi-Cal enrollment (57.3%), followed by the White group (12.6%), Black/African American (AA) group (9.6%), API group (9.1%), and American Indian/Alaska Native (AI/AN) group (0.1%). A sizeable proportion (11.3%) did not report a specific race/ethnicity.

Table 12: Population Enrolled in Medi-Cal by Age Group, CY 2022

CY 2022	Age Group				
	0-18	19-44	45-64	65+	Total
January to December	1,350,605	1,655,495	947,825	489,354	4,443,279
Percentage	30.4%	37.3%	21.3%	11.0%	100.0%

Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Age Group, and Sex. Downloaded March 2023. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Age Group

Table 12 presents the Medi-Cal enrolled population by age group. The age group with the highest percentage of Medi-Cal enrollees are individuals ages 19 to 44 (37.3%),

followed by youth ages 0 to 18 (30.4%), adults ages 45 to 64 (21.3%), and adults ages 65 and older (11.0%).

Table 13: Population Enrolled in Medi-Cal by Gender, CY 2022

CY 2022	Gender		
	Male	Female	Total
January to December Average	2,077,547	2,365,732	4,443,279
Percentage	46.8%	53.2%	100.0%

Note: Gender categories as defined by State. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Age Group, and Sex. Downloaded March 2023. Due to rounding, some estimated totals and percentages may not total 100%.

Differences by Gender

Table 13 presents the monthly Medi-Cal enrolled population by gender. Females had a higher representation across twelve months (53.2%), followed by Males (46.8%).

TABLE 14: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY RACE/ETHNICITY
CY 2022

CY 2022	Black/ AA	API	Latino	AI/AN	White	Not Reported	Total
January to December Average	75,214	87,780	424,909	1,093	145,079	91,213	825,288
Percentage	9.1%	10.6%	51.5%	0.1%	17.6%	11.1%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2020 and CY 2021. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded March 2023. Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Race/Ethnicity

Table 14 compares the prevalence of estimated SED and SMI among Medi-Cal enrolled population by race/ethnicity. The Latino group is the race/ethnicity with the highest

estimated SED/SMI (51.5%), followed by the White group (17.6%), API group (10.6%), Black/African American (AA) group (9.1%), American Indian/Alaska Native (AI/AN) group (0.1%) and ethnic group not reported (11.1%).

TABLE 15: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY AGE GROUP
CY 2022

CY 2022	Age Group				
	0-18	19-44	45-64	65+	Total
January to December Average	333,600	342,687	149,756	56,765	882,808
Percentage	37.8%	38.8%	17.0%	6.4%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2020 and CY 2021. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded March 2023. Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Age Group

Table 15 compares the prevalence of estimated SED and SMI among Medi-Cal enrolled population by age group. The 19-44 age group had the highest estimated SED/SMI (38.8%), followed by the 0-18 age group (37.8%), 45-64 age group (17.0%). The 65 and above age group had the least estimated SED/SMI (6.4%).

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TABLE 16: ESTIMATED PREVALENCE OF SED AND SMI AMONG MEDI-CAL ENROLLED POPULATION BY GENDER
CY 2022

CY 2022	Gender		
	Male	Female	Total
January to December Average	363,571	444,758	808,328
Percentage	45.0%	55.0%	100.0%

Note: Estimated prevalence rates of mental illness by race/ethnicity for Los Angeles County are provided by the CHIS for the population living at or below 100% FPL and are pooled estimates for CY 2020 and CY 2021. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Race/Ethnicity, and Age Group, and Sex. Downloaded March 2023. Due to rounding, some estimated numbers and percentages may not add up correctly.

Differences by Gender

Table 16 compares the prevalence of SED and SMI Medi-Cal enrolled population by gender. Female had the highest estimated SED/SMI (55.0%), followed by male (45.0%).

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TABLE 17: PRIMARY LANGUAGE OF POPULATION ENROLLED IN MEDI-CAL CY 2022

Language	January to October Average	Average %
English	2,563,437	59.3%
Spanish	1,448,952	33.5%
Armenian	82,783	1.9%
Mandarin	51,443	1.2%
Cantonese	43,750	1.0%
Korean	35,905	0.8%
Vietnamese	30,106	0.7%
Farsi	15,423	0.4%
Russian	18,019	0.4%
Tagalog	9,541	0.2%
Cambodian	8,687	0.2%
Arabic	6,092	0.1%
Other Non-English	5,262	0.1%
Other Chinese	2,347	0.1%
American Sign Language (ASL)	1,001	0.2%
Total	4,321,746	100.0%

Note: The totals were suppressed for the Mien and Unknown categories, which may affect the overall total. "Threshold language" means a language that has been identified as the primary language, as indicated on the State MEDS File, of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. "Other Chinese" no longer meets the definition of a threshold language. The "Other non-English" category met the criteria of a threshold language and was included in this table. Data Source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County, Month of Eligibility, Primary Language. Downloaded March 2023.

Table 17 presents the Medi-Cal enrolled population by primary language. The primary language with the highest percentage of Medi-Cal enrollees was English (59.3%), followed by Spanish (33.5%), Armenian (1.9%), Mandarin (1.2%), Cantonese (1.0%), Korean (0.8%), Vietnamese (0.7%), Farsi (0.4%), Russian (0.4%), Tagalog (0.2%), Cambodian (0.2%), ASL (0.2%), Arabic (0.1%), Other Non-English (0.1%) and Other Chinese (0.1%). The remaining languages represented under 0.1%.

Consumers Served in Outpatient Programs

TABLE 18: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA FY 21–22

Service Area (SA)	African American	Asian/Pacific Islander	Latino	Native American	White	Two or More Races	Unreported	Total
SA 1	3,772	104	2,842	50	2,374	501	1,158	10,801
Percent	34.9%	1.0%	26.3%	0.46%	22.0%	**4.6%**	**10.7%**	100.0%
SA 2	3,575	991	10,930	101	7,379	910	5,851	29,737
Percent	12.0%	3.3%	36.8%	**0.34%**	24.8%	3.1%	19.7%	100.0%
SA 3	2,742	2,606	8,097	114	3,798	1,069	10,766	29,192
Percent	9.4%	**8.9%**	27.7%	0.39%	13.0%	3.7%	**36.9%**	100.0%
SA 4	6,304	1,757	12,231	206	4,708	721	4,992	30,919
Percent	20.4%	5.7%	39.6%	0.67%	15.2%	2.3%	16.1%	100.0%
SA 5	2,097	270	1,894	49	2,733	327	1,708	9,078
Percent	23.1%	3.0%	**20.9%**	0.54%	**30.1%**	3.6%	18.8%	100.0%
SA 6	10,500	205	8,846	254	1,166	448	4,091	25,510
Percent	**41.2%**	**0.8%**	34.7%	**1.00%**	**4.6%**	**1.8%**	16.0%	100.0%
SA 7	1,185	458	9,145	176	1,968	673	5,731	19,336
Percent	**6.1%**	2.4%	**47.3%**	0.91%	10.2%	3.5%	29.6%	100.0%
SA 8	7,949	1,741	10,255	115	4,703	1,087	5,546	31,396
Percent	25.3%	5.5%	32.7%	0.37%	15.0%	3.5%	17.7%	100.0%
Total	26,386	5,994	45,003	827	20,503	3,756	26,593	129,062
Percent	20.4%	4.6%	34.9%	0.64%	15.9%	2.9%	20.6%	100.0%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes Null (N=80,943), Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, June 2023.

Differences by Race/Ethnicity

Table 18 presents the unduplicated count of consumers served in outpatient programs by Race/Ethnicity and SA.

The highest percentage of African American consumers served in outpatient programs was in SA 6 (41.2%) as compared to SA 7 (6.1%) with the lowest percentage.

The highest percentage of Asian Pacific Islander consumers served in outpatient programs was in SA 3 (8.9%) as compared to SA 6 (0.8%) with the lowest percentage.

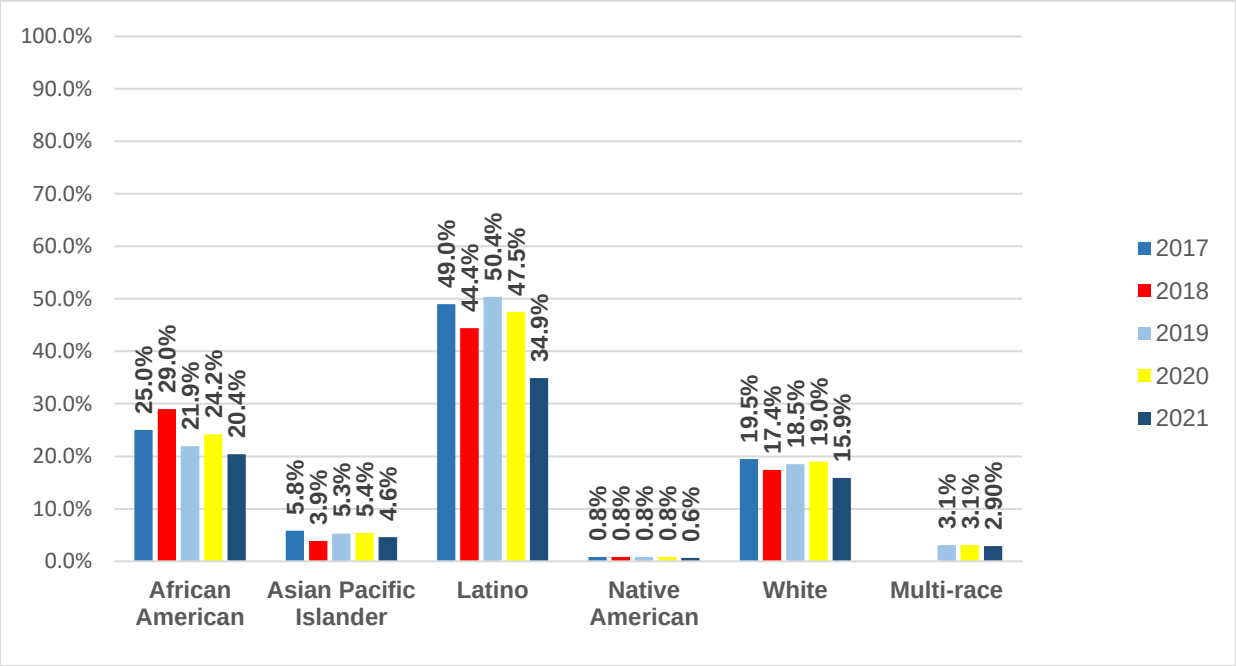
The highest percentage of Latino consumers served in outpatient programs was in SA 7 (47.3%) as compared to SA 5 (20.9%) with the lowest percentage. Stop

The highest percentage of Native American consumers served in outpatient programs was in SA 6 (1.0%) as compared to SA 2 (0.3%) with the lowest percentage.

The highest percentage of White consumers served in outpatient programs was in SA 5 (30.1%) as compared to SA 6 (4.6%) with the lowest percentage.

The highest percentage of Two or More Races served in outpatient programs was in SA 1 (4.6%) as compared to SA 6 (1.8%) with the lowest percentage.

FIGURE 8: PERCENTAGE CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY FY 17–18 TO FY 21–22



Data Source: LACDMH, IS-IBHIS, June 2023

The percentage of African Americans (AA) served in outpatient programs decreased by 4.6% from 25.0% to 20.4% between FY 17-18 and FY 21-22.

The percentage of Asian/Pacific Islanders (API) served in outpatient programs decreased by 1.2% from 5.8% to 4.6% between FY 17-18 and FY 21-22.

The percentage of Latinos served in outpatient programs decreased by 14.1% from 49.0% to 34.9% between FY 17-18 and FY 21-22.

The percentage of Native Americans (NA) served in outpatient programs decreased by 0.2% from 0.8% to 0.6% from FY 17-18 and FY 21-22.

The percentage of Whites served in outpatient programs increased by 3.6% from 19.5% to 15.9% between FY 17-18 and FY 21-22.

The percentage of Two or More Races served in outpatient programs increased by 2.9% from 0.03% to 2.9% between FY 19-20 and FY 21-22.

TABLE 19: CONSUMERS SERVED IN OUTPATIENT FACILITIES BY AGE GROUP AND SERVICE AREA FY 21–22

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA1	6,065	3,283	7,046	1,355	17,749
Percent	34.2%	18.5%	39.7%	7.6%	100.0%
SA2	12,105	10,118	21,246	5,264	48,733
Percent	24.8%	20.8%	43.6%	10.8%	100.0%
SA3	15,627	12,172	15,739	3,885	47,423
Percent	33.0%	**25.7%**	33.2%	8.2%	100.0%
SA4	12,958	8,959	20,514	6,038	48,469
Percent	26.7%	18.5%	42.3%	12.5%	100.0%
SA5	2,769	2,253	6,701	2,222	13,945
Percent	**19.9%**	**16.2%**	**48.1%**	**15.9%**	100.0%
SA6	13,531	7,919	14,867	3,712	40,029
Percent	33.8%	19.8%	37.1%	9.3%	100.0%
SA7	11,537	7,841	10,284	2,155	31,817
Percent	**36.3%**	24.6%	**32.3%**	**6.8%**	100.0%
SA8	14,995	10,332	20,181	4,833	50,341
Percent	29.8%	20.5%	40.1%	9.6%	100.0%
Total	57,623	40,996	86,714	24,672	210,005
Percent	27.4%	19.5%	41.3%	11.7%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, June 2023.

Differences by Age Group

Table 19 shows the unduplicated count of consumers served in outpatient programs by age group and SA.

The highest percentage of Children (0-15 years old) served was in SA 7 (36.3%) compared to SA 5 (19.9%) with the lowest percentage.

The highest percentage of TAY (16-25 years old) served was in SA 3 (25.7%) when compared to SA 5 (16.2%) with the lowest percentage.

The highest percentage of Adults (26-59 years old) served was in SA 5 (48.1%) compared to SA 7 (32.3%) with the lowest percentage.

The highest percentage of Older Adults (60+ years old) was in SA 5 (15.9%) compared to SA 7 (6.8%) with the lowest percentage.

TABLE 20: CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 21-22

Service Area (SA)	Gender					
	Male	Female	Transgender (M to F)	Transgender (F to M)	Unknown	Total
SA1	7,863	9,844	22	15	5	17,749
Percent	**44.3%**	**55.5%**	0.12%	**0.08%**	0.03%	100.0%
SA2	23,278	25,367	37	39	12	48,733
Percent	47.8%	52.1%	0.08%	**0.08%**	0.02%	100.0%
SA3	22,146	25,210	22	38	7	47,423
Percent	46.7%	53.2%	0.05%	**0.08%**	**0.01%**	100.0%
SA4	24,510	23,815	82	49	13	48,469
Percent	**50.6%**	**49.1%**	**0.17%**	0.10%	0.03%	100.0%
SA5	6,833	7,075	11	20	6	13,945
Percent	49.0%	50.7%	0.08%	0.14%	**0.04%**	100.0%
SA6	18,461	21,505	16	36	11	40,029
Percent	46.1%	53.7%	0.04%	0.09%	0.03%	100.0%
SA7	14,317	17,458	8	30	4	31,817
Percent	45.0%	54.9%	**0.03%**	0.09%	**0.01%**	100.0%
SA8	23,130	27,050	58	85	18	50,341
Percent	45.9%	53.7%	0.12%	**0.17%**	**0.04%**	100.0%
Total	97,554	112,014	183	201	53	210,005
Percent	46.5%	53.3%	0.09%	0.10%	0.03%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Data Source: LACDMH-IS-IBHIS, June 2023.

Differences by Gender

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

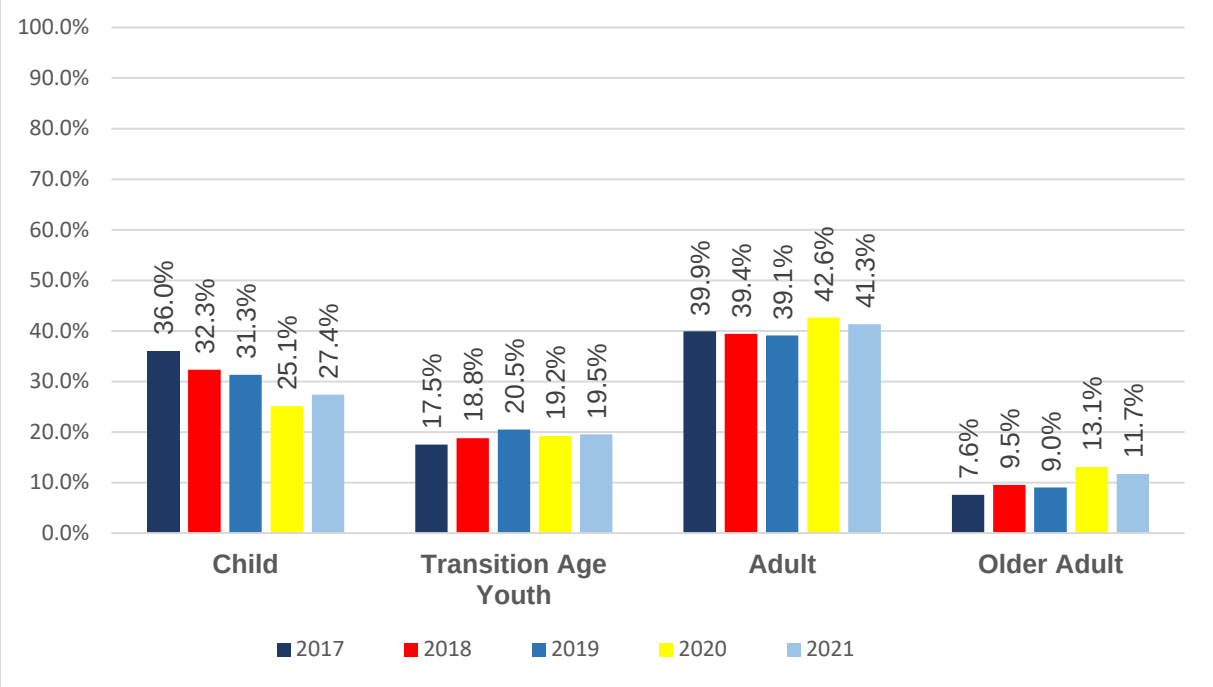
The highest percentage of Males served in outpatient programs was in SA 4 (50.6%) compared to SA 1 (44.3%) with the lowest percentage.

The highest percentage of Females served in outpatient programs was in SA 1 (55.5%) compared to SA 4 (49.1%) with the lowest percentage.

The highest percentage of Transgender (M to F) persons served in outpatient programs was in SA 4 (0.2%) compared to SA 7 (0.03%) with the lowest percentage.

The highest percentage of Transgender (F to M) persons served in outpatient programs was in SA 8 (0.17%) compared to SA 1, SA 2 and SA 3 (0.08%) with the lowest percentage.

FIGURE 9: PERCENTAGE CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP FY 17–18 TO FY 21–22



Data Source: LACDMH, IS-IBHIS, June 2023

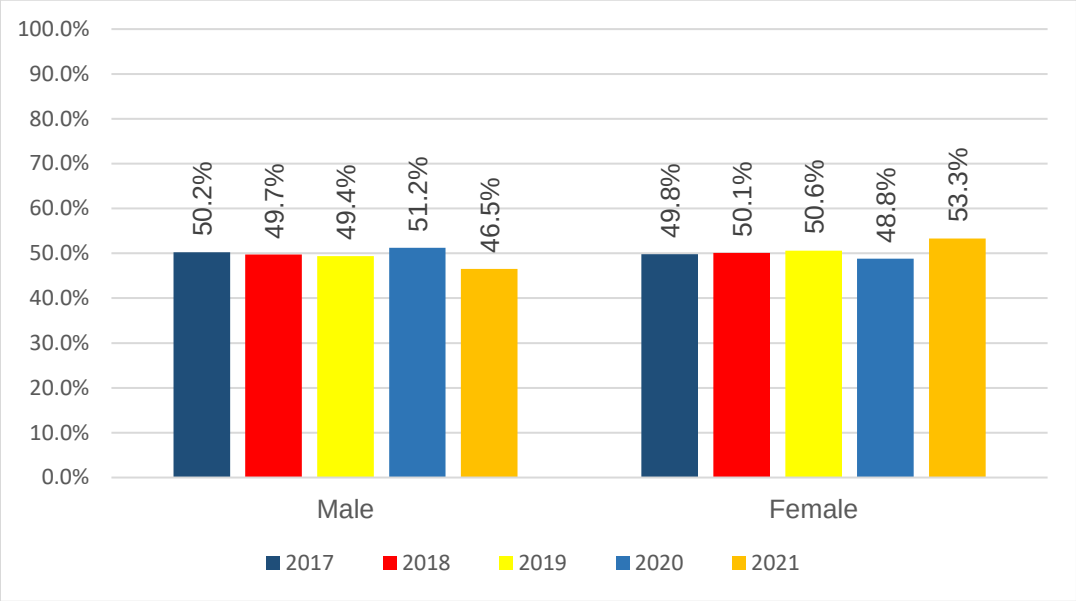
The percentage of Children served in outpatient programs decreased by 8.6% from 36.0% to 27.4% between FY 17-18 and FY 21-22.

The percentage of TAY served in outpatient programs increased by 2.0% from 17.5% to 19.5% between FY 17-18 and FY 21-22.

The percentage of Adults served in outpatient programs increased by 1.4% from 39.9% to 41.3% between FY 17-18 and FY 21-22.

The percentage of Older Adults served in outpatient programs increased by 4.1% from 7.6% to 11.7% between FY 17-18 and FY 21-22

FIGURE 10: PERCENTAGE CHANGE IN CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY GENDER FY 17–18 TO FY 21–22



Data Source: LACDMH, IS-IBHIS, June 2023.

The percentage of Males in outpatient programs decreased by 3.7% from 50.2% to 46.5% between FY 17-18 and FY 21-22.

The percentage of Females served in outpatient programs increased by 3.5% from 49.8% to 53.3% between FY 17-18 and FY 21-22.

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TABLE 21: PRIMARY LANGUAGE OF CONSUMERS SERVED IN OUTPATIENT PROGRAMS BY SERVICE AREA AND THRESHOLD LANGUAGE FY 21–22

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other Non-English	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	7	13			16,040	12		2		3	4	1,124	6		17,211
Percent	0.04%	0.08%	0.00%	0.00%	**93.20%**	0.07%	0.00%	0.01%	0.00%	0.02%	0.02%	**6.53%**	0.03%	0.00%	100.00%
SA 2	68	951	30	16	38,724	572	82	18	16	17	100	5,379	75	56	46,104
Percent	0.1%	2.1%	0.1%	0.0%	84.0%	1.2%	0.2%	0.0%	0.0%	0.0%	0.2%	11.7%	0.2%	0.1%	100.0%
SA 3	30	73	129	662	36,544	17	79	693	80	14	7	6,131	36	463	44,958
Percent	0.1%	0.2%	0.3%	1.5%	81.3%	0.0%	0.2%	1.5%	0.2%	0.0%	0.0%	13.6%	0.1%	1.0%	100.0%
SA 4	26	345	53	108	37,077	51	649	84	16	8	216	7,495	68	42	46,238
Percent	0.1%	0.7%	0.1%	0.2%	80.2%	0.1%	1.4%	0.2%	0.0%	0.0%	0.5%	16.2%	0.1%	0.1%	100.0%
SA 5	13	14	2	7	12,051	139	10	7	2	2	41	881	8	7	13,184
Percent	0.1%	0.1%	0.0%	0.1%	91.4%	1.1%	0.1%	0.1%	0.0%	0.0%	0.3%	6.7%	0.1%	0.1%	100.0%
SA 6	3	23		6	32,641	9	20	4	1	1	5	6,065	9	10	38,797
Percent	0.01%	0.06%	0.00%	0.02%	84.13%	0.02%	0.05%	0.01%	0.00%	0.00%	0.01%	15.63%	0.02%	0.03%	100.00%
SA 7	16	3	25	7	24,810	2	45	31	11	2		6,301	24	10	31,287
Percent	0.05%	0.01%	0.08%	0.02%	**79.30%**	0.01%	0.14%	0.10%	0.04%	0.01%	0.00%	**20.14%**	0.08%	0.03%	100.00%
SA 8	23	40	572	22	41,217	21	87	36	12	9	17	5,813	76	130	48,075
Percent	0.05%	0.08%	1.19%	0.05%	85.73%	0.04%	0.18%	0.07%	0.02%	0.02%	0.04%	12.09%	0.16%	0.27%	100.00%
Total	155	1,196	746	535	163,835	693	780	562	103	40	332	29,229	245	543	198,994
Percent	0.1%	0.6%	0.4%	0.3%	82.3%	0.3%	0.4%	0.3%	0.1%	0.0%	0.2%	14.7%	0.1%	0.3%	100.0%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. Table excludes Unknown address (N = 7,328). A total of consumers served in Outpatient Programs specified another non-threshold primary language show in in Table 23. Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, June 2023.

Table 21 shows the primary language of consumers served in outpatient programs.

English was the highest reported primary language among consumers served in outpatient programs, in all SAs. A total of 163,835 (82.3%) English-speaking consumers were served followed by 29,229 (14.7%) Spanish-speaking consumers. The remaining 5,930 (3.0%) consumers served spoke other threshold languages beyond English and Spanish. A total 35,159 (17.6%) of the consumers served reported a primary language other than English.

- SA 1 (93.2%) had the highest percentage of English-speaking consumers, as compared to SA 7 (79.3%) which had the lowest percentage.
- Spanish was the highest reported non-English threshold language for consumers served in all SAs.
- The SA with the highest percentage of consumers served reporting Spanish as their primary language was in SA 7 (20.1%) and the lowest percentage was in SA 1 (6.5%).

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B. **Needs Assessment/Analysis of Disparities**

A demographic profile of Los Angeles County is presented in the next section. This includes total population and population living at or below 138% FPL distribution by race/ethnicity, age group and gender in CY 2021 and consumers served in FY 21-22. The needs assessment section further analyzes the demographic distribution of the outpatient consumers served in the County Service Areas for FY 21-22 and compares it with population enrolled in Medi-Cal estimated with SED and SMI to assess the unmet need for mental health services in the County.

Disparity by Race/Ethnicity

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

	African American	Asian/Pacific Islander	Latino	Native American	White	Unreported	Total
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	75,214	87,780	424,909	1,093	145,079	91,213	825,288
Outpatient Consumers Served	26,386	5,994	45,003	827	20,503	26,593	125,306
Total Disparity	-48,828	-81,786	-379,906	-266	-124,576	-64,620	-699,982

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on March, 2022.

Table 22 shows unmet need among ethnic groups at the County level.

Among African Americans (AA), there was an estimated unmet service need for 48,828 Medi-Cal Enrolled AA individuals. The number of unduplicated consumers served was 26,386 while the estimated Medi-Cal Enrolled Population with SED and SMI was 75,214.

Among Asian/Pacific Islanders, there was an estimated unmet service need for 81,786 Medi-Cal Enrolled Asian/Pacific Islander individuals. The number of unduplicated consumers served was 5,994 while the estimated Medi-Cal Enrolled Population with SED and SMI was 87,780.

Among Latinos, there was an estimated unmet service need for 379,906 Medi-Cal Enrolled Latino individuals. The number of unduplicated consumers served was 45,003 while the estimated Medi-Cal Enrolled Population with SED and SMI was 424,909.

Among Native Americans, there was an estimated unmet service need for 266 Medi-Cal Enrolled Native American individuals as the number of unduplicated consumers served was 827 while the estimated Medi-Cal Enrolled Population with SED and SMI was 1,093.

Among Whites, there was an estimated unmet service need for 124,576 Medi-Cal Enrolled White individuals. The number of unduplicated consumers served was 20,503 while the estimated Medi-Cal Enrolled Population with SED and SMI was 145,079.

Among Unreported ethnicities, there was an estimated unmet service need for 64,620 Medi-Cal Enrolled Unreported ethnicity individuals. The number of unduplicated consumers served was 26,593 while the estimated Medi-Cal Enrolled Population with SED and SMI was 91,213.

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Disparity by Language

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

Language	Medi-Cal Enrolled Population Estimated with SED and SMI[1]	Outpatient Consumers Served	Total Disparity
English	466,545	163,835	-302,710
Spanish	263,709	29,229	-234,480
Armenian	15,066	1,196	-13,870
Mandarin	9,363	562	-8,801
Cantonese	7,962	535	-7,427
Korean	6,535	780	-5,755
Vietnamese	5,479	543	-4,936
Farsi	2,807	693	-2,114
Russian	3,280	332	-2,948
Tagalog	1,736	245	-1,491
Cambodian	1,581	745	-836
Arabic	1,109	155	-954
Other Non-English	958	40	-918
Other Chinese	427	103	-324
American Sign Language (ASL)	182	70	-112
Total	**786,740**	**199,063**	**- 587,677**

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded on March 2023.

Table 23 shows that among the Outpatient consumers in Los Angeles County.

The language with the highest unmet need was English with an estimated 302,710 (unduplicated) English-speaking individuals in need of services. The least disparity was ASL with an estimated 112 (unduplicated) individuals in need of services. Overall, at the County level, there was an estimated unmet service need based on language for 587,677 Medi-Cal Enrolled individuals as the number of unduplicated consumers served was 199,063 while the estimated Medi-Cal Enrolled Population with SED and SMI was 786,740.

Disparity by Age Group

TABLE 24: NEEDS ASSESSMENT OF MEDI-CAL ENROLLED BY AGE GROUP ESTIMATED WITH SED AND SMI FY 21–22

	Age Group				
CY 2021	**0-18**	**19-44**	**45-64**	**65+**	**Total**
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	333,600	342,687	149,756	56,765	882,808
Outpatient Consumers Served	78,055	73514	46265	12,171	210,005
Total Disparity	-255,545	-269,173	-103,491	-44,594	-672,803

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded March,2023

Table 24 shows that among the Outpatient consumers in Los Angeles County.

The age group with the highest unmet need is 0-18 with an estimated 255,545 (unduplicated) individuals in need of services. The age group with the least unmet need 65 and above with an estimated 44,594 (unduplicated) individuals in need of services. Overall, at the county level, there was an estimated unmet service need for 672,803 Medi-Cal Enrolled individuals as the number of unduplicated consumers served across age groups was 210,005 while the estimated Medi-Cal Enrolled Population with SED and SMI was 822,808.

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Disparity by Gender

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

CY 2021	Male	Female	Total
Medi-Cal Enrolled Population Estimated with SED and SMI[1]	363,571	444,758	808,328
Outpatient Consumers Served	97,554	112,014	209,568
Total Disparity	-266,017	-332,744	598,760

Note: [1]SED=Serious Emotional Disturbance (Children), SMI=Serious Mental Illness (Adults). A negative number indicates that the estimated need for mental health services has not been met. Zero indicates "no disparity". A "+" number in parentheses indicates the number of individuals receiving services beyond the estimated need of services. Data source: California Health and Human Services Agency Open Data Portal, Medi-Cal Certified Eligibles Tables by County. Downloaded March,2023

Table 25 shows unmet need among gender at the county level.

Among males there was an estimated unmet service need for 266,017 Medi-Cal Enrolled males individuals as the number of unduplicated consumers served was 97,554 while the estimated Medi-Cal Enrolled Population with SED and SMI was 363,571.

Among females there was an estimated unmet service need for 332,744 Medi-Cal Enrolled females individuals as the number of unduplicated consumers served was 112,014 while the estimated Medi-Cal Enrolled Population with SED and SMI was 332,744.

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

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

TABLE 26: ESTIMATED COUNTYWIDE TOTAL POPULATION BY RACE/ETHNICITY TREND FOR CY 2019, CY 2020, AND CY 2021

Race/Ethnicity	Countywide Estimated Total Population					
	2019		2020		2021	
	N	%	N	%	N	%
African American	835,191	8.1%	773,282	7.7%	764,306	7.7%
Asian /Pacific Islander	1,457,731	14.2%	1,507,702	15.1%	1,494,502	15.0%
Latino	4,993,673	48.7%	4,803,963	48.0%	4,787,610	48.1%
Native American	23,720	0.2%	18,602	0.2%	18,470	0.2%
White	2,719,729	26.5%	2,594,341	25.9%	2,563,582	25.8%
Two or More Races	230,193	2.2%	314,524	3.1%	316,453	3.2%
Total	10,260,237	100.0%	10,012,414	100.0%	9,944,923	100.0%

Table 26 presents the estimated countywide total population by Race/Ethnicity Group for CY 2019, CY 2020, and CY 2021.

The African American population decreased by 70,885 between CY 2019 and CY 2021, from 835,191 to 764,306 (percentage decreased 0.4 from 8.1% to 7.7% of the total population.) The African American population decreased by 8,976 between CY 2020 and CY 2021, from 773,282 to 764,306 (percentage remained the same at 7.7% of the total population).

The Asian/Pacific Islander population increased by 36,771 between CY 2019 and CY 2021, from 1,457,731 to 1,494,502 (percentage increased by 0.9% from 14.2% to 15.1% of the total population.) The Asian/Pacific Islander population decreased by 13,200 between CY 2020 and CY 2021, from 1,507,702 to 1,494,502 (percentage decreased by 0.1 from 15.1% to 15.0% of the total population).

The Latino population decreased by 206,063 between CY 2019 and CY 2021, from 4,993,673 to 4,787,610 (percentage decreased by 0.6% 48.7% to 48.1% of the total population.) The Latino population decreased by 16,353 between CY 2020 and CY 2021, from 4,803,963 to 4,787,610 (percentage increased by 0.1% from 48.0% to 48.1% of the total population.)

The Native American population decreased by 5,250 between CY 2019 and CY 2021, from 23,720 to 18,470 (percentage remained at 0.2% of the total population.) The Native

American population decreased by 132 from 18,602 to 18,470 between CY 2020 and CY 2021 (percentage remained the same at 0.2% of the total population.)

The White population decreased by 156,147 between CY 2019 and CY 2021, from 2,719,729 to 2,563,582 (percentage decreased by 0.7% from 26.5% to 25.8% of the total population.) The White population decreased by 30,759 between CY 2020 and CY 2021, from 2,594,341 to 2,563,582 (percentage decreased by 0.1% from 25.9% to 25.8% of the total population.)

The Two or More Races population increased by 86,260 from CY 2019 and CY 2021 from 230,193 to 316,453 (percentage increased by 1.0% from 2.2% to 3.2% of the total population). The Two or More Races population increased by 84,331 (0.9) from CY 2019 and CY 2020 from 314,524 to 316,453 (percentage increased by 0.1 from 3.1% to 3.2% of the total population.)

TABLE 27: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY RACE/ETHNICITY TREND FOR CY 2019, CY 2020, AND CY 2021

Race/Ethnicity	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2019		2020		2021	
	N	%	N	%	N	%
African American	213,465	10.0%	179,112	9.4%	160,800	9.4%
Asian/Pacific Islander	238,106	11.2%	234,816	12.3%	211,488	12.3%
Latino	1,297,085	60.8%	1,143,924	59.8%	1,026,863	59.8%
Native American	5,038	0.2%	3,249	0.2%	3,228	0.2%
White	348,173	16.3%	311,293	16.3%	277,710	16.2%
Two or More Races	32,374	1.5%	41,705	2.2%	38,202	2.2%
Total	2,134,242	100.0%	1,914,099	100.0%	1,718,291	100.0%

Table 27 presents the estimated total population living at or below 138% FPL by Race/Ethnicity Group for CY 2019, CY 2020, and CY 2021.

The African American population living at or below 138% FPL decreased by 52,665 between CY 2019 and CY 2021, from 213,465 to 160,800 (percentage decreased by 0.6% from 10.0% to 9.4% of the total 138% FPL population). The African American population decreased by 18,312 between CY 2020 and CY 2021, from 179,112 to 160,800 (percentage remained the same at 9.4 of the total 138% FPL population.)

The Asian/Pacific Islander population living at or below 138% FPL decreased by 26,618 between CY 2019 and CY 2021, from 238,106 to 211,488 (percentage increased by 1.1% from 11.2% to 12.3% of the total 138% FPL population). The Asian/Pacific Islander population decreased by 23,328 between CY 2020 and CY 2021, from 234,816 to 211,488 (percentage remained the same at 12.3% of the total 138% FPL population).

The Latino population living at or below 138% FPL decreased by 270,222 between CY 2019 and CY 2021, from 1,297,085 to 1,026,863 (percentage decreased by 1.0% from 60.8% to 59.8% of the total 138% FPL population). The Latino population decreased by 117,061 between CY 2020 and CY 2021, from 1,143,924 to 1,026,863 (percentage remained the same at 59.8% of the total 138% FPL population).

The Native American population living at or below 138% FPL decreased by 1,810 between CY 2019 and CY 2021, from 5,038 to 3,228 (percentage remained the same at 0.2% of the total 138% FPL population). The Native American population decreased by 21 between CY 2020 and CY 2021, from 3,249 to 3,228 (percentage remained at 0.2% of the total 138% FPL population).

The White population living at or below 138% FPL decreased by 70,463 between CY 2019 and CY 2021, from 348,173 to 277,710 (percentage decreased by 0.1 from 16.3% to 16.2% of the total 138% FPL population.) The White population decreased by 33,583 between CY 2020 and CY 2021, from 311,293 to 277,710 (percentage decreased by 0.1 from 16.3% to 16.2% of the total 138% FPL population).

The Two or More Races population increased by 5,828 from CY 2019 and CY 2021 from 32,374 to 38,202 (percentage increased by 0.7 from 1.5% to 2.2% of the total population). The Two or More Races population decreased by 3,503 from CY 2020 and CY 2021 from 41,705 to 38,202 (percentage remained the same at 2.2% of the total population).

TABLE 28: ESTIMATED COUNTYWIDE TOTAL POPULATION BY AGE GROUP TREND FOR CY 2019, CY 2020, AND CY 2021

Age Group	Countywide Estimated Total Population					
	2019		2020		2021	
	N	%	N	%	N	%
0-18	2,329,975	22.7%	2,187,956	21.9%	2,139,671	21.5%
19-20	300,201	2.9%	292,488	2.9%	282,238	2.8%
21-25	732,995	7.1%	704,679	7.0%	691,851	7.0%
26-59	4,904,764	47.8%	4,823,661	48.2%	4,783,954	48.1%
60-64	618,685	6.0%	613,885	6.1%	618,221	6.2%
65 and older	1,373,617	13.4%	1,389,745	13.9%	1,428,988	14.4%
Total	10,260,237	100.0%	10,012,414	100.0%	9,944,923	100.0%

Table 28 presents the estimated countywide total population by Age Group for CY 2019, CY 2020, and CY 2021.

The Age Group 0-18 decreased by 190,304 between CY 2019 and CY 2021, from 2,329,975 to 2,139,671 (percentage decreased by 1.2 from 22.7% to 21.5%). The Age

Group 0-18 decreased by 48,285 between CY 2020 and CY 2021, from 2,187,956 to 2,139,671 (percentage decreased by 0.4% from 21.9% to 21.53%).

The Age Group 19-20 decreased by 17,963 between CY 2019 and CY 2021, from 300,201 to 282,238 (percentage decreased by 0.1% from 2.9% to 2.8%). The Age Group 19-20 decreased by 10,250 between CY 2020 and CY 2021, from 292,488 to 282,238 (percentage decreased by 0.1% from 2.9% to 2.8%).

The Age Group 21-25 decreased by 41,144 between CY 2019 and CY 2021, from 732,995 to 691,851 (percentage decreased by 0.1% from 7.1% to 7.0%). The Age Group 21-25 decreased by 12,828 between CY 2020 and CY 2021, from 704,679 to 691,851 (percentage remained the same at 7.0%).

The Age Group 26-59 increased by 120,810 between CY 2019 and CY 2021, from 4,904,764 to 4,783,954 (percentage increased by 0.3% from 47.8% to 48.1%). The Age Group 26-59 decreased by 39,707 between CY 2020 and CY 2021, from 4,823,661 to 4,783,954 (percentage decreased by 0.1% from 48.2% to 48.1%).

The Age Group 60-64 increased by 464 between CY 2019 and CY 2021, from 618,685 to 618,665 (percentage increased by 0.2% from 6.0% to 6.2%). The Age Group 60-64 population increased by 4,780 between CY 2020 and CY 2021, from 613,885 to 618,221 (percentage increased by 0.1% from 6.1% to 6.2%).

The Age Group 65 and older increased by 55,371 between CY 2019 and CY 2021, from 1,373,617 to 1,428,988 (percentage increased by 1.0% from 13.4% to 14.4%). The Age Group 65 and older increased by 39,243 between CY 2020 and CY 2021, from 1,389,745 to 1,428,988 (percentage increased by 0.5% from 13.9% to 14.4%).

TABLE 29: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY AGE GROUP TREND FOR CY 2019, CY 2020, AND CY 2021

Age Group	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2019		2020		2021	
	N	%	N	%	N	%
0-18	707,071	33.1%	604,649	31.6%	534,890	31.1%
19-20	60,915	2.9%	52,629	2.7%	45,743	2.7%
21-25	162,265	7.6%	137,592	7.2%	121,137	7.0%
26-59	900,114	42.2%	809,591	42.3%	727,303	42.3%
60-64	93,028	4.4%	87,665	4.6%	80,390	4.7%
65 and above	210,849	9.9%	221,973	11.6%	208,828	12.2%
Total	2,134,242	100.0%	1,914,099	100.0%	1,718,291	100.0%

Table 29 presents the estimated total population living at or below 138% FPL by Age Group for CY 2019, CY 2020, and CY 2021.

The Age Group 0-18 living at or below 138% FPL decreased by 172,181 between CY 2019 and CY 2021, from 707,071 to 534,890 (percentage decreased by 2.0% from 33.1% to 31.1% of the total 138% FPL population). The Age Group 0-18 living at or below 138% FPL decreased by 69,759 between CY 2020 and CY 2021, from 604,649 to 534,890 (percentage decreased by 0.5% from 31.6% to 31.1%).

The Age Group 19-20 living at or below 138% FPL decreased by 15,172 between CY 2019 and CY 2021, from 60,915 to 45,743 (percentage decreased by 0.2% from 2.9% to 2.7% of the total 138% FPL population). The Age Group 19-20 living at or below 138% FPL decreased by 6,886 between CY 2020 and CY 2021, from 52,629 to 45,743 (percentage remained the same at 2.7%).

The Age Group 21-25 living at or below 138% FPL decreased by 41,128 between CY 2019 and CY 2021, from 162,265 to 121,137 (percentage decreased by 0.6% from 7.6% to 7.0% of the total 138% FPL population). The Age Group 21-25 living at or below 138% FPL decreased by 16,455 between CY 2020 and CY 2021, from 137,592 to 121,137 (percentage decreased by 0.2% from 7.2% to 7.0%).

The Age Group 26-59 living at or below 138% FPL decreased by 172,811 between CY 2019 and CY 2021, from 900,114 to 727,303 (percentage increased by 0.1% from 42.2% to 42.3% of the total 138% FPL population). The Age Group 26-59 living at or below 138% FPL decreased by 82,288 between CY 2020 and CY 2021, from 809,591 to 727,303 (percentage remained the same at 42.3%).

The Age Group 60-64 living at or below 138% FPL decreased by 12,638 between CY 2019 and CY 2021, from 93,028 to 80,390 (percentage increased by 0.3% from 4.4% to 4.7% of the total 138% FPL population.) The Age Group 60-64 living at or below 138% FPL decreased by 7,275 between CY 2020 and CY 2021, from 87,665 to 80,390 (percentage increased by 0.1% from to 4.6% to 4.7%).

The Age Group 65 and older living at or below 138% FPL decreased by 2,021 between CY 2019 and CY 2021, from 210,849 to 208,828 (percentage increased by 2.3% from 9.9% to 12.2% of the total 138% FPL population). The Age Group 65 and older living at or below 138% FPL decreased by 13,145 between CY 2020 and CY 2021, from 221,973 to 208,828 (percentage increased by 0.6% from 11.6% to 12.2%).

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TABLE 30: ESTIMATED COUNTYWIDE TOTAL POPULATION BY GENDER TREND FOR CY 2019, CY 2020, AND CY 2021

Gender	Countywide Estimated Total Population					
	2019		2020		2021	
	N	%	N	%	N	%
Male	5,060,057	49.3%	4,941,542	49.4%	4,909,145	49.4%
Female	5,200,180	50.7%	5,070,872	50.6%	5,035,778	50.6%
Total	10,260,237	100.0%	10,012,414	100.0%	9,944,923	100.0%

Table 30 presents the estimated countywide total population by gender for CY 2019, CY 2020, and CY 2021.

The Male population decreased by 150,912 between CY 2019 and CY 2021, from 5,060,057 to 4,909,145 (percentage increased by 0.1% from 49.3% to 49.4%). The Male population decreased by 32,397 between CY 2020 and CY 2021 from 4,941,542 to 4,909,145 (percentage remained the same at 49.4%).

The Female population decreased by 164,402 between CY 2019 and CY 2021, from 5,200,180 to 5,035,778 (percentage decreased by 0.1% from 50.7% to 50.6%). The Female population decreased by 35,094 between CY 2020 and CY 2021, from 5,070,872 to 5,035,778 (percentage remained the same at 50.6%).

TABLE 31: ESTIMATED COUNTYWIDE TOTAL POPULATION LIVING AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) BY GENDER TREND FOR CY 2019, CY 2020, AND CY 2021

Gender	Countywide Estimated Population at or Below 138% Federal Poverty Level (FPL)					
	2019		2020		2021	
	N	%	N	%	N	%
Male	981,510	46.0%	867,220	45.3%	777,705	45.3%
Female	1,152,732	54.0%	1,046,879	54.7%	940,586	54.7%
Total	2,134,242	100.0%	1,914,099	100.0%	1,718,291	100.0%

Table 31 presents the estimated total population living at or below 138% FPL by gender for CY 2019, CY 2020, and CY 2021.

The Male population living at or below 138% FPL decreased by 203,805 between CY 2019 and CY 2021, from 981,510 to 777,705 (percentage decreased by 0.7% from 46.0% to 45.3%). The Male population living at or below 138% FPL decreased by 89,515 between CY 2020 and CY 2021, from 867,220 to 777,705 (percentage remained the same at 45.3%).

The Female population living at or below 138% FPL decreased by 212,146 between CY 2019 and CY 2021, from 1,152,732 to 940,586 (percentage increased by 0.7% from 54.0% to 54.7%). The Female population living at or below 138% FPL decreased by 106,293 between CY 2020 and CY 2021, from 1,046,879 to 940,586 (percentage remained the same at 54.7%).

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

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

TABLE 32: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY RACE/ETHNICITY AND SERVICE AREA FY 21–22

Service Area (SA)	African American	Asian/ Pacific Islander	Latino	Native American	White	Multi-race	Unreported	Total
SA 1	2,849	91	2,244	44	1,953	405	785	8,371
Percent	34.0%	1.1%	26.8%	0.53%	23.3%	**4.8%**	**9.4%**	100.0%
SA 2	1,529	669	6,721	65	4,969	592	3,335	17,880
Percent	8.6%	3.7%	37.6%	0.36%	27.8%	3.3%	18.7%	100.0%
SA 3	1,366	1,859	4,881	75	2,267	676	6,280	17,404
Percent	7.8%	**10.7%**	28.0%	0.43%	13.0%	3.9%	**36.1%**	100.0%
SA 4	4,467	1,375	8,257	164	3,317	496	2,812	20,888
Percent	21.4%	6.6%	39.5%	0.79%	15.9%	2.4%	13.5%	100.0%
SA 5	1,435	184	1,290	41	2,222	237	1,092	6,501
Percent	22.1%	2.8%	**19.8%**	0.63%	**34.2%**	3.6%	16.8%	100.0%
SA 6	8,202	162	6,315	54	908	339	2,710	18,690
Percent	**43.9%**	**0.9%**	33.8%	**0.29%**	**4.9%**	**1.8%**	14.5%	100.0%
SA 7	790	353	5,979	138	1,423	424	3,379	12,486
Percent	**6.3%**	2.8%	**47.9%**	**1.11%**	11.4%	3.4%	27.1%	100.0%
SA8	5,226	1,482	6,866	87	3,388	726	3,132	20,907
Percent	25.0%	7.1%	32.8%	0.42%	16.2%	3.5%	15.0%	100.0%
Total	21,150	4,968	34,204	659	16,486	3,027	18,080	98,574
Percent	21.46%	5.04%	34.70%	0.67%	16.72%	3.07%	18.34%	100.00%

Note: Bold values represent the highest and lowest percentages within each ethnic group across Service Areas. Table excludes Null (N=56,594). Total reflects an unduplicated count of consumers served. Data Source: LACDMH-IS-IBHIS, June 2023.

Differences by Race/Ethnicity

The highest percentage of African American MHSA consumers served in outpatient programs was in SA 6 (43.9%) compared to SA 7 (6.3%) with the lowest percentage.

The highest percentage of Asian/Pacific Islander (API) MHSA consumers served in outpatient programs was in SA 3 (10.7%) compared to SA 6 (0.9%) with the lowest percentage.

The highest percentage of Latino MHSA consumers served in outpatient programs was in SA 7 (47.9%) compared to SA 5 (19.8%) with the lowest percentage.

The highest percentage of Native American MHSA consumers served in outpatient programs was in SA 7 (1.11%) compared to SA 6 (0.29%) with the lowest percentage.

The highest percentage of White MHSA consumers served in outpatient programs was in SA 5 (34.2%) compared to SA 6 (4.9%) with the lowest percentage.

The highest percentage of Two or more races MHSA consumers served in outpatient programs was in SA 1 (4.8%) compared to SA 6 (1.8%) with the lowest percentage.

The highest percentage of Unreported Ethnicity MHSA consumers served in outpatient programs was in SA 3 (36.1%) compared to SA 1 (9.4%) with the lowest percentage.

TABLE 33: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY AGE GROUP AND SERVICE AREA FY 21–22

Service Area (SA)	Age Group				
	0-15	16-25	26-59	60+	Total
SA 1	3,154	2,318	6,472	1,309	13,253
Percent	23.8%	17.5%	48.8%	9.9%	100.0%
SA 2	7,207	6,120	12,696	3,573	29,596
Percent	24.4%	20.7%	42.9%	12.1%	100.0%
SA 3	8,623	6,664	10,209	2,789	28,285
Percent	**30.5%**	23.6%	**36.1%**	9.9%	100.0%
SA 4	6,669	5,553	14,615	4,823	31,660
Percent	21.1%	17.5%	46.2%	15.2%	100.0%
SA 5	1,696	1,620	5,035	1,721	10,072
Percent	**16.8%**	**16.1%**	**50.0%**	**17.1%**	100.0%
SA 6	6,976	5,098	12,431	3,451	27,956
Percent	25.0%	18.2%	44.5%	12.3%	100.0%
SA 7	5,485	4,759	7,880	1,801	19,925
Percent	27.5%	**23.9%**	39.5%	**9.0%**	100.0%
SA 8	8,067	5,863	14,990	3,958	32,878
Percent	24.5%	17.8%	45.6%	12.0%	100.0%
Total	36,764	29,266	69,067	20,071	155,168
Percent	23.7%	18.9%	44.5%	12.9%	100.0%

Note: Bold values represent the highest and lowest percentage within each Age Group across Service Areas. Total reflects unduplicated count of consumers served. Data Source: LACDMH IS-IBHIS, June 2023.

Differences by Age Group

The highest percentage of Children MHSA consumers 0-15 years old was in SA 3 (30.5%) compared with SA 5 (16.8%) with the lowest percentage.

The highest percentage of TAY MHSA consumers 16-25 years old was in SA 7 (23.9%) compared with SA 5 (16.1%) with the lowest percentage.

The highest percentage of Adult MHSA consumers 26-59 years old was in SA 5 (50.0%) compared with SA 3 (36.1%) with the lowest percentage.

The highest percentage of Older Adult MHSA consumers 60 years old and over was in SA 5 (17.1%) compared with SA 7 (9.0%) with the lowest percentage.

TABLE 34: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY GENDER AND SERVICE AREA FY 21–22

Service Area (SA)	Male	Female	Trans (M to F)	Trans (F to M)	Unknown	Total
SA 1	5,603	7,619	16	13	2	13,253
Percent	**42.3%**	**57.5%**	0.12%	0.10%	0.02%	100.0%
SA 2	13,235	16,308	23	24	6	29,596
Percent	44.7%	55.1%	0.08%	0.08%	0.02%	100.0%
SA 3	12,944	15,303	13	22	3	28,285
Percent	45.8%	54.1%	0.05%	0.08%	**0.01%**	100.0%
SA 4	15,640	15,903	70	38	9	31,660
Percent	**49.4%**	**50.2%**	0.22%	0.12%	0.03%	100.0%
SA 5	4,810	5,234	9	15	4	10,072
Percent	47.8%	52.0%	0.09%	0.15%	**0.04%**	100.0%
SA 6	12,547	15,371	12	20	6	27,956
Percent	44.9%	55.0%	**0.04%**	**0.07%**	0.02%	100.0%
SA 7	8,743	11,153	8	18	3	19,925
Percent	43.9%	56.0%	**0.04%**	0.09%	0.02%	100.0%
SA 8	14,512	18,256	49	52	9	32,878
Percent	44.1%	55.5%	**0.15%**	**0.16%**	0.03%	100.0%
Total	70,114	84,688	167	163	36	155,168
Percent	45.2%	54.6%	0.11%	0.11%	0.02%	100.0%

Note: Bold values represent the highest and lowest percentages within each Gender and across Service Areas. Data Source: LACDMH-IS-IBHIS, June 2023.

Differences by Gender

The highest percentage of Male MHSA consumers served in outpatient programs was SA 4 (49.4%) compared with SA 1 (42.3%) with the lowest percentage.

The highest percentage of Female MHSA consumers served in outpatient programs was SA 1 (57.5%) compared with SA 4 (50.2%) with the lowest percentage.

The highest percentage of Trans Male to Female MHSA consumers served in outpatient programs was SA 8 (0.15%) compared with SA 4 (0.04%) with the lowest percentage.

The highest percentage of Trans Female to Male MHSA consumers served in outpatient programs was SA 8 (0.16%) compared with SA 6 (0.07%) with the lowest percentage.

The highest percentage of Unknown MHSA consumers served in outpatient programs was SA 5 (0.04%) compared with SA 3 (0.03%) with the lowest percentage.

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TABLE 35: MHSA CSS POPULATION SERVED IN OUTPATIENT PROGRAMS BY THRESHOLD LANGUAGE AND SERVICE AREA FY 21–22

Service Area (SA)	Arabic	Armenian	Cambodian	Cantonese	English	Farsi	Korean	Mandarin	Other Chinese	Other Non - English	Russian	Spanish	Tagalog	Vietnamese	Total
SA 1	7	13			11,866	11		2		3	4	878	4		12,788
Percent	0.05%	0.10%	0.00%	0.00%	**92.79%**	0.09%	0.00%	0.02%	0.00%	0.02%	0.03%	**6.87%**	0.03%	0.00%	100.00%
SA 2	56	693	22	4	23,560	515	49	5	11	9	82	3,603	68	34	28,198
Percent	0.20%	2.46%	0.08%	0.01%	83.55%	1.83%	0.17%	0.02%	0.04%	0.03%	0.29%	12.78%	0.24%	0.12%	100.00%
SA 3	23	39	79	499	21,212	7	54	502	60	10	2	3,984	31	304	26,806
Percent	0.09%	0.15%	0.29%	1.86%	79.13%	0.03%	0.20%	1.87%	0.22%	0.04%	0.01%	14.86%	0.12%	1.13%	100.00%
SA 4	20	299	50	79	24,535	47	543	54	12	6	77	4,832	59	41	30,654
Percent	0.07%	0.98%	0.16%	0.26%	80.04%	0.15%	1.77%	0.18%	0.04%	0.02%	0.25%	15.76%	0.19%	0.13%	100.00%
SA 5	10	10	2	2	8,885	121	7	1		2	40	623	47	3	15,360
Percent	0.07%	0.07%	0.01%	0.01%	57.85%	0.79%	0.05%	0.01%	0.00%	0.01%	0.26%	4.06%	0.31%	0.02%	100.00%
SA 6	2	23		2	22,869	6	12	4	1	1	4	4,374	7	7	66,412
Percent	0.00%	0.03%	0.00%	0.00%	**34.44%**	0.01%	0.02%	0.01%	0.00%	0.00%	0.01%	6.59%	0.01%	0.01%	100.00%
SA 7	14	3	19	6	15,648	2	36	26	10	2		3,769	22	10	19,567
Percent	0.07%	0.02%	0.10%	0.03%	79.97%	0.01%	0.18%	0.13%	0.05%	0.01%	0.00%	**19.26%**	0.11%	0.05%	100.00%
SA 8	16	34	562	15	26,934	17	77	26	9	8	7	4,051	71	124	31,951
Percent	0.05%	0.11%	1.76%	0.05%	84.30%	0.05%	0.24%	0.08%	0.03%	0.03%	0.02%	12.68%	0.22%	0.39%	100.00%
Total	131	942	692	423	123,654	638	657	444	81	32	182	21,434	222	398	149,930
Percent	0.09%	0.63%	0.46%	0.28%	82.47%	0.43%	0.44%	0.30%	0.05%	0.02%	0.12%	14.30%	0.15%	0.27%	100.00%

Note: "Threshold Language" means a language that has been identified as a primary language, as indicated on the MEDS file, from the 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area. A total of 3,198 consumers served in Outpatient Programs specified other non-threshold primary language. Another 2,040 consumers had primary languages that were "Unknown/Not reported". Arabic is a Countywide threshold language and does not meet the threshold language criteria at the SA level. Data Source: LACDMH-IS-IBHIS, June 2023.

Table 35 shows that Spanish and English are the most common languages in all of the Service Areas among the MHSA consumers.

English was the highest reported primary language among MHSA consumers served in outpatient programs and across all SAs. A total of 123,654 (82.5%) English-speaking MHSA consumers were served, followed by 21,434 (14.3%) Spanish-speaking consumers.

The remaining 4,842 (3.2%) consumers served spoke other threshold languages. A total 26,276 (17.5%) of the consumers served reported a primary language other than English.

SA 1 (92.8 %) had the highest percentage of English-speaking MHSA consumers, as compared to SA 6 (34.4%) which had the lowest percentage.

Spanish was the highest reported non-English threshold language for MHSA consumers served in all SAs. The SA with the highest percentage of MHSA Spanish-speaking consumers served reporting Spanish as their primary language was in SA 7 (19.3%) and the lowest percentage was in SA 5 (4.1%).

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Analysis of Disparities

FIGURE 11: ESTIMATED POPULATION BELOW OR AT 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2021

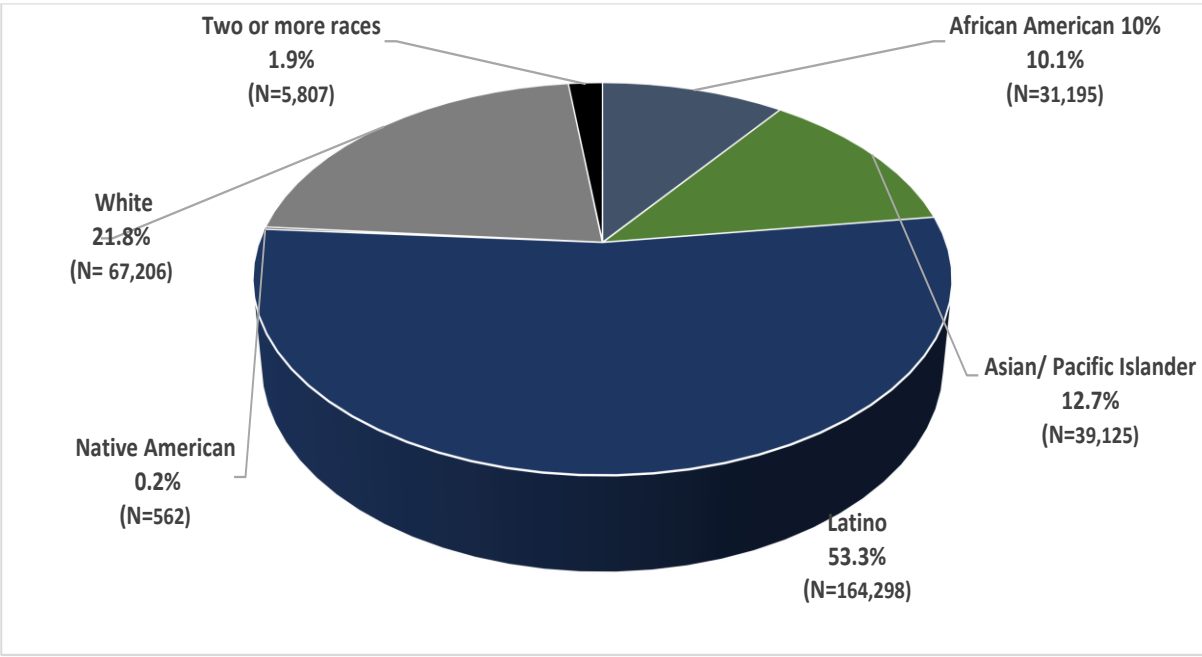

Figure 11 shows the estimated population below or at 138% FPL in need of services by Race/Ethnicity. This compares with the proportion of CSS Consumers by Race/Ethnicity in Figure 12.

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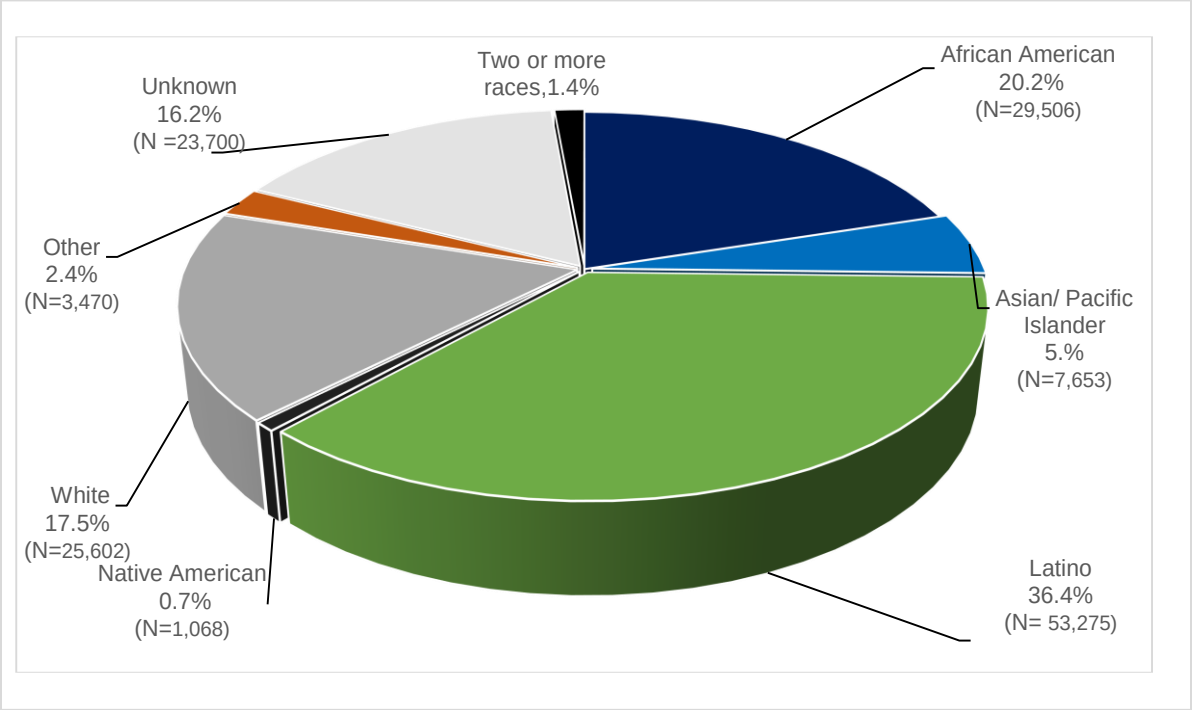
FIGURE 12: CSS CONSUMER POPULATION BY RACE/ETHNICITY FY 23-24



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary, FY 23-24.

Figure 12 shows the CSS enrolled population by Race/Ethnicity. Latinos are the largest group at 36.7%, followed by African Americans at 20.2%, Whites at 17.5%, Asian/Pacific Islanders at 5.2%, Other at 2.4%, Native Americans at 0.7% and Two or More Races at 1.4%. The Unknown/Not specified Race/Ethnicity category is at 16.2%.

Figures 11 and 12 indicate the following:

African Americans constitute 10.1% of the population in need of services at or below 138% FPL and 20.2% of the CSS consumers.

Asian/Pacific Islanders constitute 12.7% of the population in need of services at or below 138% FPL and 5.2% of the CSS consumers.

Latinos constitute 53.3% of the population in need of services at or below 138% FPL and 36.4% of the CSS consumers.

Native Americans constitute 0.2% of the population in need of services at or below 138% FPL and 0.7% of the CSS consumers.

Whites constitute 21.8% of the population in need of services at or below 138% FPL and 17.5% of the CSS consumers.

Two or more races constitute 1.9% of the population in need of services at or below 138% FPL and 1.4% of CSS consumers.

FIGURE 13: NEEDS ASSESSMENT SUMMARY FOR CSS PROGRAMS: PERCENTAGE COMPARISON OF POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES AND CONSUMERS SERVED BY RACE/ETHNICITY FY 21–22

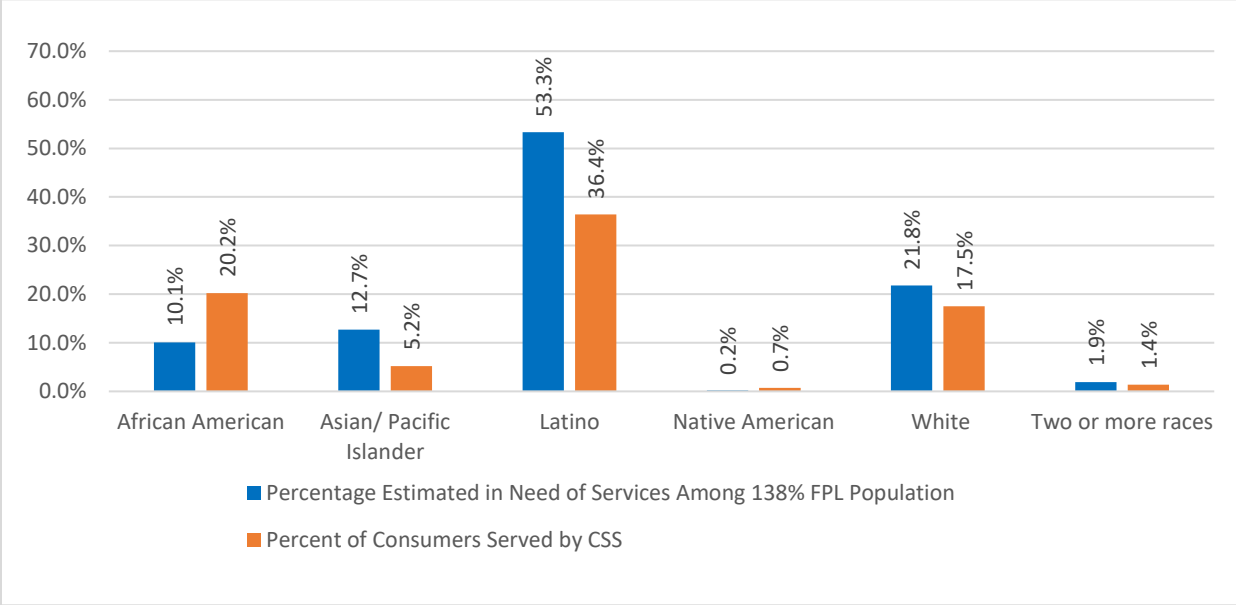


Figure 13 compares the information in Figures 11 and 12.

The percentage of African Americans receiving CSS services was 20.2% when compared with their population at or below 138% FPL in need of services at 10.1%.

The percentage of Asian/Pacific Islanders receiving CSS services was 5.2% when compared with their population at or below 138% FPL in need of services at 12.7%.

The percentage of Latinos receiving CSS services was 36.4% when compared to their population at or below 138% FPL in need of services at 53.3%.

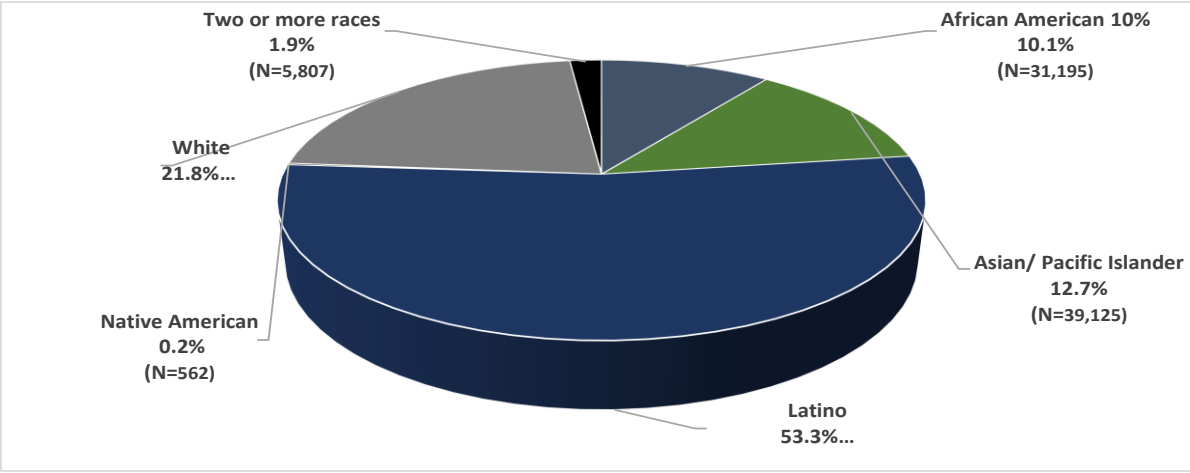
The percentage of Native Americans receiving CSS services was 0.7% when compared with their population of Native Americans at or below 138% FPL in need of services at 0.2%.

The percentage of Whites receiving CSS services was 17.5% when compared with their population at or below 138% FPL in need of services at 21.8%.

The percentage of Two or More Races receiving CSS services was 1.4% when compared with their population at or below 138%, FPL estimated in need of services at 1.9%.

Prevention and Early Intervention (PEI) Plan

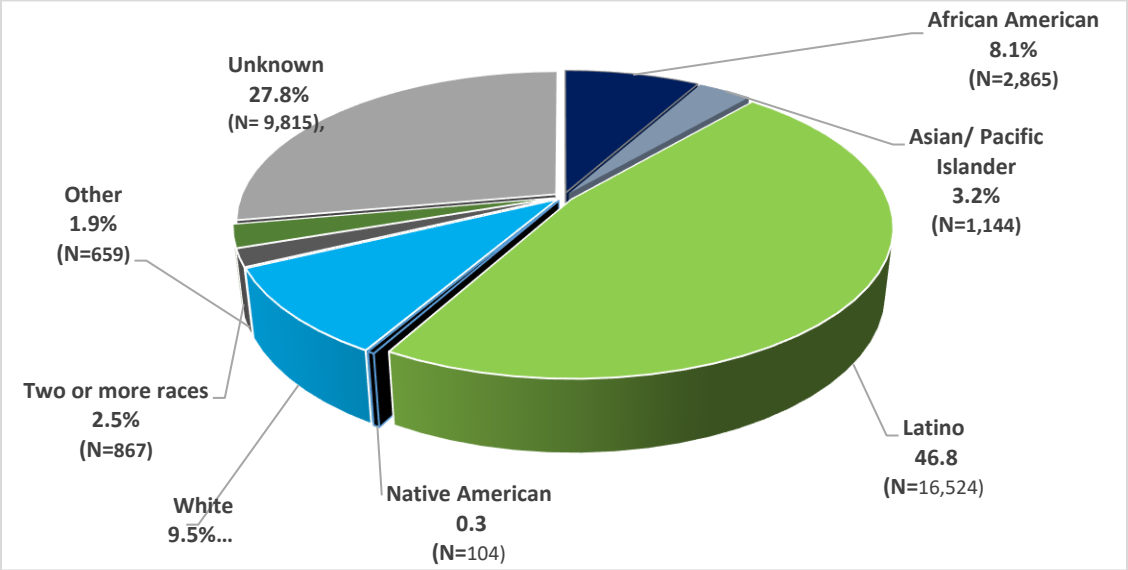
FIGURE 14: ESTIMATED POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) IN NEED OF SERVICES BY RACE/ETHNICITY CY 2021



Data Source: Estimated prevalence of mental illness by Race/Ethnicity for Los Angeles County is provided by the California Health Interview Survey (CHIS) 2020-2021 pooled.
Estimate for population living below 138% FPL provided by American Community Survey (ACS), US Census Bureau and Hedderson Demographic Services, March 2022.

Figure 14 shows the estimated population at or below or 138% FPL in need of services by Race/Ethnicity. It is presented here to be compared with the proportion of PEI Consumers by Race/Ethnicity in Figure 15.

FIGURE 15: PEI CONSUMER POPULATION BY RACE/ETHNICITY
FY 21-22



Data Source: County of Los Angeles - Department of Mental Health, Mental Health Services Act - Annual Update Summary FY 2022-23.

Figure 15 shows the PEI enrolled population by Race/Ethnicity. Latinos are the largest group at 46.8%, followed by Whites at 9.5%, African Americans at 8.1%, Asian/Pacific Islanders at 3.2%, and Native Americans at 0.3%.

Figures 14 and 15 indicate the following:

African Americans constitute 10.1% of the population in need of services at or below 138% FPL and 8.1% of the PEI consumers.

Asian/Pacific Islanders constitute 12.7% of the population in need of services at or below 138% FPL and 3.2% of the PEI consumers.

Latinos constitute 53.3% of the population in need of services at or below 138% FPL and 46.8% of the PEI consumers.

Native Americans constitute 0.2% of the population in need of services at or below 138% FPL and 0.3% of the PEI consumers.

Whites constitute 21.8% of the population in need of services at or below 138% FPL and 9.5% of the PEI consumers.

Two or more races constitute 1.9% of the population in need of services at or below 138% FPL and 2.5% of the PEI consumers.

FIGURE 16: NEEDS ASSESSMENT SUMMARY FOR PEI PROGRAM: PERCENTAGE COMPARISON OF THE POPULATION AT OR BELOW 138% FEDERAL POVERTY LEVEL (FPL) AND CONSUMERS SERVED BY RACE/ETHNICITY FY 21-22

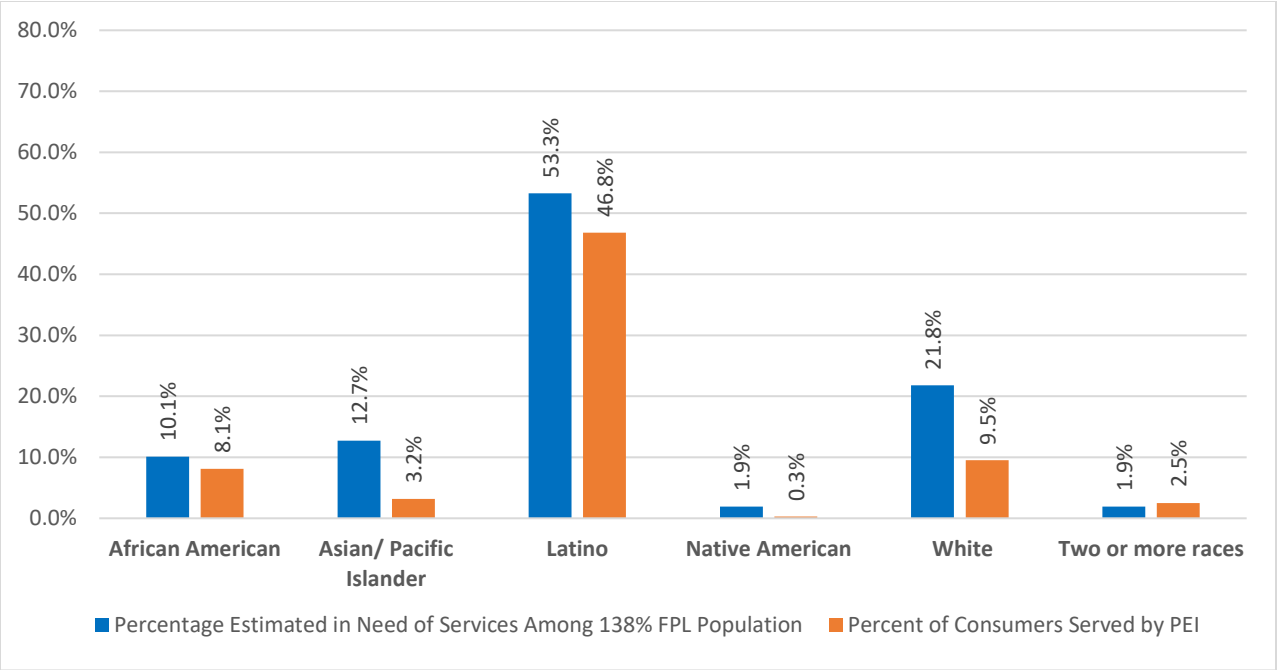


Figure 16 compares the information in Figures 14 and 15.

The percentage of African Americans receiving PEI services was 8.1% when compared with their population at or below 138% FPL in need of services at 10.1%.

The percentage of Asian/Pacific Islanders receiving PEI services was 3.2% when compared with their population at or below 138% FPL in need of services at 12.7%.

The percentage of Latinos receiving PEI services was the highest at 46.8% when compared to their population at or below 138% FPL in need of services at 53.3%.

The percentage of Native Americans receiving PEI services was 0.3% when compared with their population at or below 138% FPL in need of services at 1.9%.

The percentage of Whites receiving PEI services was 9.5% when compared with their population at or below 138% FPL in need of services at 21.8%.

The percentage of Two or More Races receiving PEI services was 2.5% when compared with their population at or below 138% FPL in need of services at 1.9%.

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 3

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

August 2023

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

Identified unserved/underserved target population (with disparities)

I. List of Target Populations with Disparities

Based on FY 21-22 data, the Los Angeles County Department of Mental Health (LACDMH) has identified the following target populations as having mental health countywide disparities.

Medi-Cal Enrolled Population

By ethnicity

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

By language

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

By age group

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

By gender

- Male

- Female

II. Identified disparities within the Cultural Competence Plan Requirements (CCPR) target populations

A. Community Services and Support (CSS) Plan

The CSS disparities are the same as Medi-Cal listed above due to overlap in the populations served in Los Angeles (LA) County.

By ethnicity

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

By language

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

By age group

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

By gender

- Male
- Female

B. Workforce, Education, and Training (WET)

By ethnicity

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

By age group

- Children
- Transition Age Youth (TAY)
- Adults
- Older Adults

By language

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

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

Underserved Cultural Populations

- Lesbian, Gay, Bisexual, Transgender, Questioning, Queer, Intersex, Asexual, and 2-Spirit (LGBTQIA2-S)
- Deaf/Hard of Hearing
- Blind/Visual Disabilities
- AI/AN

Individuals Experiencing Onset of Serious Psychiatric Illness

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

Children/Youth in Stressed Families

- Children ranging from birth to five years of age
- Young Children
- TAY

Trauma-exposed

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

Children/Youth at Risk for School Failure

- Young Children
- Children
- TAY

Children/Youth at Risk of or Experiencing Juvenile Justice

- Children
- TAY

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

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

1. Collaboration with faith-based and other trusted community entities/groups
2. Development and translation of public facing materials that address mental health education
3. Co-location of staff within other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)
4. Community education to increase mental health awareness and decrease stigma
5. Consultation to gatekeepers
6. Countywide Full Service Partnership (FSP) networks to increase cultural and linguistic access
7. Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery
8. Designation and tracking ethnic targets for FSP
9. Diversification of Evidence-Based Practices (EBPs) and Community-Defined Evidence Practices (CDEs)

10. Field-based services
11. Flexibility in FSP enrollment such as allowing “those living with family” to qualify as at-risk for homelessness
12. Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health
13. Implementation of capacity-building projects based on the specific needs of targeted groups which may be identified in collaboration with stakeholder groups such as the Cultural Competency Committee (CCC), the Underserved Cultural Communities (UsCC) subcommittees, Faith-Based Advocacy Committee (FBAC) and Service Area Leadership Teams (SALTs)
14. Implementation of new Departmental policies and procedures that improve the quality and timeliness of delivering mental health services
15. Implementation of new technologies to enhance the Department’s service delivery
16. Augmentation of mental health service accessibility to underserved populations
17. Coordination of language interpreter and Communication Access Realtime Translation (CART) services for consumer, family member, and community member participation in clinical appointments and stakeholder group meetings
18. Integrated Supportive Services
19. Interagency Collaboration
20. Investments in learning (e.g., Learning collaboratives and innovative models)
21. Multi-lingual/multi-cultural staff development and support
22. Outreach and Engagement (O&E) efforts
23. Integration of physical health, mental health, and substance use services
24. Programs that target specific ethnic and language groups
25. Provider communication and support
26. School-based services
27. Trainings/case consultation
28. Utilization of the community’s knowledge, feedback, and capacity to promote health and wellbeing
29. Utilization of the workforce’s responses to cultural competence organizational assessments, surveys, and focus groups to address knowledge gaps and support advancements in culturally responsive service delivery
30. Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness, and equity
31. Post COVID-19 interventions

    Examples of interventions reported by LACDMH programs:

    - The Assisted Outpatient Treatment Program (AOT) maintained 100% field-based services throughout the pandemic. Services were rendered in various languages, specifically English, Spanish, and Tagalog. The AOT’s support staff were available to provide services in Arabic, Armenian, Cantonese, French, German and Mandarin. Staff utilized Protective Personal Equipment (PPE) such as masks, gloves and hand sanitizer and had PPE available for clients upon request.

- Innovation (INN) 2 Provider Network services were offered online including exercise classes, art classes, story time for parents, and TAY support groups. All these activities addressed coping with isolation. In addition, the agencies hosted live events to support high risk communities in a variety of ways such as distributing backpack/school supplies, diaper drive-thru events, hot meal distribution and wellness activities.
- LACDMH partnered with DHS and DPH to educate all the Community Ambassador Network (CAN) staff on COVID-19. In turn the CAN conducted presentations in their communities in English and Spanish. Weekly updates issued by DPH were delivered to the communities served by the CAN.
- In response to the increased post COVID-19 need for Crisis Residential Treatment Program (CRTP) services, capacity was increased by adding more sites to serve TAY, adults, and older adults particularly from underserved communities where health insurance may be scarce. Since the inception of the program, there has been an increase in the number of CRTP contracts and beds. The number of CRTP beds has been increased by a total of 209.
- Enriched Residential Care Program (ERC) provided extensive technical assistance, training and supports to its operators amidst collaborative efforts with DHS, DPH, and Community Care Licensing such as This includes assistance with PPE access, COVID-19 testing and vaccines, weekly informative webinars, and COVID-19 surveys.
- During the pandemic, the Full-Service Partnership (FSP) program continued to provide services via telemental health and in the field with the use of PPE. The program ensured that clients and staff took the utmost precautions when interfacing in-person.
- Due to the COVID-19 pandemic, the Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Older Adult Program modified its service delivery model to prioritize field-based services for older adults most in need of in-person services. The program increased telemental health services. This practice ensured that the continuum of mental health services be provided to the culturally diverse and most vulnerable older adult community.
- Within Health Neighborhoods (HN), LACDMH staff provided regular updates regarding testing, vaccination, and emergency funeral assistance funds by FEMA.
- Homeless Outreach and Mobile Engagement (HOME) teams remained equipped with PPE for use by clients and staff. HOME teams collaborated with other Departments to access testing and vaccinations for persons experiencing homelessness.
- The Maternal Mental Health (MMH) programs enforced the protective mask policy during FY 21-22. PPE was provided to all staff and community members who request it. In addition, consumers were offered telemental health and telephone appointments in lieu of in-person contact.
- The Men's Community Re-Entry Program (MCRP) collaborated with the Sheriff's Department to conduct COVID-19 testing before releasing persons who were incarcerated into the community. MCRP conducted COVID-19

Symptom Screening Questionnaire at onset of enrollment and subsequent to client contact w to determine the possibility of COVID-19 infection LACDMH's Symptom Screening was also conducted for staff who called out due to illness/experiencing symptoms.

- Staff from My Health LA (MHLA) Behavioral Health Expansion Program followed all Public Health and LACDMH guidelines when working onsite and incorporated telework practices. Community Partner clinics contracted to provide MHLA also followed all Public Health's guidelines to keep staff and patients safe.
- At the Peer Resource Center (PRC), post-COVID-19 groups were held throughout the year using online, hybrid, and in-person modalities, in order to shift operations back to in-person contact.
- Prevent Homelessness Promote Health $(PH)^2$ program adhered to protocols, policies and procedures recommended by LACDMH regarding post-COVID-19 interventions. When staff reported incidences of COVID-19 exposure or symptoms, the appropriate screening was completed. Subsequent to this report being filed, instructions were provided to employees and follow-ups were done on a case-by-case basis.
- The Prevention & Early Intervention (Older Adults) Anti-Stigma & Discrimination (ASD) program offered in-person and virtual presentations during the COVID-19 pandemic. Community-based in-person outreach and educational events increased during FY 21-22, in comparison to the previous year. For example, several County-operated senior centers collaborated with the program to conduct a series of in-person presentations to increase COVID-19 awareness, promote wellness, and reduce isolation.
- Throughout FY 21-22, LACDMH's Public Information Office (PIO) continued to create and disseminate communication materials related to the Department's COVID-19 response and recovery efforts. This includes physical materials (flyers, brochures), website content, and social media postings highlighting wellbeing services, tools, and resources available to the community at large as well as specific groups. Materials primarily focused on personal wellbeing as well as the wellbeing of loved ones and communities.
- The Spanish Support Groups (SSG) and Latino and Latinx Community Outreach Program switched to virtual meetings. The administrative team worked closely with group facilitators and members to learn how to navigate new technology to participate in virtual meetings.
- TAY Drop-In Centers abided by all health mandates presented by DPH and implemented a hybrid model (online and in-person) at all sites to minimize any disruption in services.
- In July 2021, TAY Navigation Team added a COVID-19 vaccination screening question to their Gatekeeping Screening form, to ensure shelters had knowledge of the vaccination status of clients and how many still needed vaccines. The team returned to providing field-based in-person services in the Enhanced Emergency Shelters and Drop-In Centers in February 2022.
- The Training Unit offered several new trainings focusing on post-COVID-19 interventions. Examples of training topics included the following:

Understanding & Addressing Racial Trauma in a Post-COVID Society; Effective Techniques in Working with Individuals with Mild to Moderate Cognitive Disabilities; and Post-COVID Syndrome with Neuropsychiatric Symptoms: Epidemiology and Clinical Presentation.

- Urgent Care Centers (UCCs) increased their capacity for services through additional sites to address crisis stabilization for adolescents, adults, and older adults, particularly from underserved communities.
- The United Mental Health Promoter (UMHP) Program continued adapting workshops and approaches to respond to post-COVID community needs. The program maximized opportunities for in-person outreach events and workshops to combat isolation and loneliness following the acute phase of the pandemic. Workshop content was adapted to include healthy coping, resilience, and self-care components.
- Veteran Peer Access Network (VPAN) staff continued to provide field-based services post the pandemic. Similarly, the VPAN Support Line continued to operate to address the unique needs of veterans.
- In the Women's Community Re-Entry Program (WCRP), PPE was delivered on a biweekly basis and was easily accessible throughout the office. Staff wore masks, sanitized often, and remained 6-feet apart interacting with others.
- COVID-19 negatively impacted volunteer services provided by Wellness Outreach Workers (WOW) and older adult Service Extenders due to clinics reducing in-person services. This reduction resulted in fewer opportunities for volunteers to provide in-person support.

32. Examples of program-based equity practices, FY 21-22
    - Based on the nature and scope of the Assisted Outpatient Treatment (AOT) program, every client was assessed taking into consideration the whole person, including cultural background and the impact of the environment. AOT linked clients to an age-appropriate, bilingual and/or culturally sensitive providers who could best assist them.
    - The CalWORKs and GROW Programs promoted equity in service planning and delivery by ensuring mental health treatment services were provided countywide. Administrative staff worked closely with providers to ensure services were delivered in accordance with the program's goals and objectives. In addition, staff overseeing the mental health referral process and clinical capacity ensured that CalWORKs and GROW providers remained continuously available for new clients.
    - The Community Ambassador Network (CAN) program gathered feedback from participants and community partners to develop the necessary and desired service planning and delivery. Providers and LACDMH worked closely with the evaluation team to ensure that the measures being implemented were culturally and linguistically appropriate for each community. The learning and evaluation team strived to develop agendas which were equitable by using the Chief Executive Office (CEO) ARDI Equity Explorer data and qualitative approaches that incorporate community feedback.

- The Child Welfare Division (CWD) collaborated with other County partners to ensure access to mental health services for youth involved in the child welfare and probation systems throughout LA County. This included underserved regions, specifically, Service Area (SA) 6 (South Los Angeles) and SA 1 (Antelope Valley). The CWD implemented training, coaching, and monitoring activities to ensure and promote culturally relevant, trauma-informed, and linguistically responsive services for youth and their families.
- The Crisis Residential Treatment (CRTP) Program promoted equity in service planning, delivery, and evaluation by increasing accessibility to underserved populations, collaborating with community members who have lived experience, and establishing partnerships with community-based organizations and other County Departments. The program utilized the LACDMH Clinical Informatics Program Profile to monitor the cultural and linguistic needs of individuals seeking services.
- The Enriched Residential Care (ERC) program provided housing resources for some of the County's most vulnerable residents: persons with serious mental illness, co-occurring substance use, and physical health conditions. This program targeted underserved populations experiencing or at risk of becoming homelessness. ERC also promoted education and training opportunities for licensed residential staff ensure that would competently serve the populations referred to their care.
- Full Service Partnership (FSP) staff reviewed data to determine which communities were experiencing mental health disparities. FSP services were provided in all the County's threshold languages by hiring multilingual staff or by using interpreter/translator services. The FSP program increased its capacity in specific areas of the County and most underserved communities (i.e., Asian and Pacific Islander) They also developed FSP brochures in other languages to ensure clients could access information relevant to FSP services and how to access them.
- Equity and accessibility are at the core of the GENESIS Older Adult Program. Specialty mental health services were provided to homebound older adults who were unable to access them at traditional outpatient clinics. The program provided culturally and linguistically appropriate services in English, Spanish, Russian, Farsi, and Tagalog. For languages not represented by the program's culturally diverse staff, the Program collaborated with contracted and community agencies capable of providing the needed services.
- Health Neighborhoods recruited participants from all the Service Areas and providers specializing in physical health, mental health, public health, substance use, education, child welfare, faith-based, and trauma prevention services. Effective recruitment, engagement and multicultural participation help ensure that the voices of the SA communities are represented and heard through the delivery of programming, community events and provision of resources in threshold languages.
- The Homeless Outreach and Mobile Engagement **(**HOME) program promoted equity inherently by delivering "in vivo" mental health services to persons living on the streets. When the team identified consumers with mobility needs,

efforts were made to secure the equipment needed. The team also provided services via telemental health for psychotherapy, psychiatric appointments, and for court appearances. The HOME team is comprised of staff from a variety of racial/ethnic backgrounds and languages who provide services in a culturally and linguistically competent manner.

- Housing and Job Development Division (HJDD) administrative staff who comprised the Housing & Service Integration (HSI) team engaged with the other health departments to review an equity-related report released by the Los Angeles County Homeless Services Authority (LAHSA) in collaboration with the California policy lab. DMH and DHS continued efforts to actualize the recommendations included in the report. HSI staff also monitored the housing process of matching, moving, and housing retention to remove any barriers, biases and inequities.
- Law Enforcement Teams (LET) promoted equity by responding to all calls for services in the community irrespective of cultural or linguistic background at the request of Patrol or Officers to a 911 call. LET staff assisted and provided support in situations involving persons experiencing this and/or mental health issues.
- The Men's Community Re-entry Program (MCRP) continued its focus on removing barriers to mental health treatment such as cultural and racial discrimination; intellectual and physical disabilities; language deficits and comprehension; housing and transportation issues; poverty; unfair treatment due to justice system involvement; housing/employment denials due to mental illness or physical disability; social rejection; and educational challenges. Case managers advocated clients in situations where discrimination or maltreatment was identified during their interactions with housing, education, employment, financial assistance, and other systems.
- My Health LA (MHLA) Behavioral Health Expansion Project improved access to prevention services among historically underrepresented and underinsured community members who access health care from Community Partner (CP) agencies. The project required that participating agencies maximized efforts to provide medical services to adults who do not meet Medi-Cal eligibility, largely due to their immigration status.
- For Maternal Mental Health (MMH) services, special care was taken to develop partnerships with culture- specific community-based organizations that specialize in serving marginalized communities in LA County. The MMH bilingual and bicultural staff demonstrated their ability to overcome linguistic and cultural barriers to reach immigrant and first-generation consumers.
- The Older Adult (OA) Service Extenders (SE) Program. equitable services through partnerships and collaborations with mental health providers. To foster equity and accessibility, the SE program provided supportive services in English, Spanish, Mandarin, Cantonese, Tagalog, and Russian.
- The Prevent Homelessness and Promote Health or $(PH)^2$ program received referrals from all eight (8) SAs in LA County. Every referral was carefully reviewed to ensure it met the following program criteria: 1) risk of returning to the experience of homelessness, and 2) presence of an acute mental health

condition. The next step evolved assigning the referral to a culturally and linguistically appropriate clinician possessing the clinical area of expertise needed for relevant service delivery.

- The Public Information Office PIO worked closely with LACDMH's partners Such as the Chief Executive Office's Countywide Communications, LA County Office of Emergency Management, and DPH to share and disseminate messages to LA County's diverse audiences. Efforts included producing and translating departmental materials to other languages, addressing social justice issues involving the Anti-racism, Diversity & Inclusion initiative (ARDI) initiative in communications, and promoting services and resources offered by LACDMH ARDI Division Programs (e.g., Speakers Bureau and United Mental Health Promoters).
- The Service Area-based Peer Resource Centers (PRC) intentionally hired staff to reflect the community. For example, staff who have experience being homeless and come from diverse racial and cultural backgrounds.
- Psychiatric Mobile Response Teams (PMRT) responded to all crisis calls for service in culturally and linguistically diverse communities.
- The Prevention & Early Intervention (Older Adults) program established equitable partnerships with other County Departments and community organizations. Among them, low-income housing organizations, faith-based organizations, and community-based organizations. The program provided culturally and linguistically appropriate services. For instance, educational materials were carefully researched to ensure inclusion of culturally relevant information. These materials were made available in various threshold languages. Additionally, educational presentations focusing on well-being were delivered to underserved communities, thereby reducing mental health stigma.
- The School Threat Assessment Response Team (START) responded to all crisis calls for service in the community considering the cultural and linguistic background of clients.
- Spanish Support Groups (SSG) and Latino and Latinx Community Outreach Project increased access to less intense mental health interventions. When necessary, SSG peers accompanied community members to clinics and helped them get connected to different types of social services needed to increase their quality of life.
- TAY Drop-In Center services were provided in all Service Areas. All centers met the Americans with Disability (ADA) accessibility requirements and were easily accessible by local public transportation service.
- TAY Navigation Team strived to culturally match clients and staff, particularly for clients who were mono-lingual Spanish-speaking. Staff completion of LGBTQIA2-S trainings was emphasized along with the importance of assessing consumer's gender identity and expression. Promoting the practice of asking consumers about their preferences allowed the navigation team deliver equitable services.
- The Telemental Health Program provided medication support services to clinics that located in underserved regions of the county.

- The Training Unit provided training opportunities for staff to acquire the knowledge and skill sets important to the delivery of culturally relevant mental health services prior to, during and post COVID-19.
- The United Mental Health Promoters (UMHP) program provided an effective approach to offer culturally responsive, grass-roots mental health outreach, engagement, and education to communities that may mistrust governmental organizations, or otherwise be unable to access mental health resources. The program actively gathered community feedback regarding the effectiveness of workshops content adapted workshop content based on community needs.
- Urgent Care Centers (UCC) promoted equity through efforts to increase accessibility to underserved populations and collaborating with community members with lived experience, community-based partners, and other County Departments.
- The Veterans Peer Access Network (VPAN) strived to hire veterans or military family members from diverse cultural and linguistic backgrounds. VPAN Support Line Services were provided by veteran Disaster Services Workers, staff, and volunteers.
- The Women's Community Re-entry program (WCRP) recruited staff from diverse cultural backgrounds and linguistic capabilities. Staff were also trained on how to provide culturally competent services.
- The Wellness Outreach Workers (WOW) program provided services through volunteers representing various cultural and linguistic backgrounds, and who have mental health lived experience. The language capacity of the program included English, Spanish, Chinese, Khmer, Korean, Greek, and Russian. Furthermore, WOW volunteers facilitated community reintegration and educated consumers, family, and community members about mental health services.

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

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health Departments	13. Culture-Specific Capacity Building Projects	14. Policies & Procedures	15. New Technologies	16. Service Accessibility	17. Language Assistance Services	18. Integrated Supportive Services	19. Interagency Collaboration	20. Investments in Learning	21. Multi-Cultural Staff Development	22. Outreach and Engagement Activities	23. Integrated Services (Physical/ Mental Health & Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge & Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
1)	Assisted Outpatient Treatment Program				X	X	X		X		X	X		X		X	X	X		X		X	X	X	X			X	X			X
2)	CalWORKs/GROW		X							X	X		X																			
3)	Child Welfare Division		X	X	X			X			X				X					X		X				X						
4)	Community Ambassador Network		X		X						X			X			X			X	X	X	X		X	X	X		X	X	X	X
5)	Crisis Residential Treatment Program	X	X	X	X			X						X	X		X			X				X	X			X	X		X	X
6)	Enriched Residential Care Program				X											X				X						X		X	X			X
7)	Faith-Based Advocacy Council	X	X	X	X								X									X							X			
8)	Full Service Partnership	X	X			X	X		X		X	X					X	X	X	X		X	X	X		X		X	X			X
9)	GENESIS			X							X													X				X				X
10	Health Neighborhoods	X																		X		X	X			X		X	X		X	X
11	HOME Teams	X			X						X				X		X		X	X		X	X	X		X		X				X
12	Housing and Supportive Services				X						X								X	X				X		X		X			X	
13	Law Enforcement Teams	X		X	X						X						X	X		X		X	X					X				

	PROGRAM NAME	1. Faith-Based Collaboration	2. Development and Translation of public informing materials	3. Co-location of Services	4. Community Education	5. Consultation to Gatekeepers	6. FSP-Countywide Networks	7. Committees & Taskforces	8. FSP-Ethnic Targets	9. EBPs/CDEs for Ethnic Populations	10. Field-Based Services	11. FSP-Enrollment Flexibility	12. CC Enhancement Across Health Departments	13. Culture-Specific Capacity Building Projects	14. Policies & Procedures	15. New Technologies	16. Service Accessibility	17. Language Assistance Services	18. Integrated Supportive Services	19. Interagency Collaboration	20. Investments in Learning	21. Multi-Cultural Staff Development	22. Outreach and Engagement Activities	23. Integrated Services (Physical/ Mental Health & Substance Use)	24. Specific Ethnic/Language Groups	25. Provider Communication/Support	26. School-based services	27. Trainings/Case Consultation	28. Utilization of Community Knowledge & Feedback	29. Workforce Assessment	30. Health Department Collaboration	31. Post COVID-19 Interventions
14	My Health LA (MHLA)	X			X			X					X				X							X					X		X
15	Maternal Mental Health	X	X	X	X	X	X			X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X		X	X
16	Men's Community Re-Entry Program		X			X			X		X						X		X	X		X			X		X	X		X		X
17	Older Adult Service Extenders																					X										
18	Prevent Homelessness Promote Health					X	X				X						X	X	X	X		X	X	X								X
19	Prevention Early Intervention (Older Adults)-ASD	X			X						X																					
20	Promotores de Salud & UMHP	X	X		X	X		X			X		X				X					X	X		X		X	X	X			X
21	Psychiatric Mobile Response Team & Therapeutic Transportation Team	X		X	X						X						X	X		X		X	X					X				
22	Public Information Office	X	X		X								X							X				X					X			X
23	Spanish Support Groups	X																							X				X			X
24	School-Based Community Access Point (SBCAP)				X																		X			X	X					

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

The section below presents detailed information on LACDMH programs that provide specialized mental health services with a specific focus on elements of cultural diversity. The information provided for each featured program contains:

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

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

Note: The information being reported below fulfill the Cultural Competence Plan Requirements for the following two sections: lV. "Additional Strategies/ Objectives/Actions" and V. "Planning and Monitoring of Identified Strategies/Objectives/ Actions/Timeliness to Reduce Mental Health Disparities" of the CCPR structure for Criterion 3.

Assisted Outpatient Treatment Program (AOT)
AOT, also known as Laura's law, was initiated following the 2001 killing of Laura Wilcox by an individual suffering from severe mental illness. Former Assemblywoman Hellen Thomson authored Assembly Bill 1421 establishing the Assisted Outpatient Treatment Demonstration Project Act of 2002 (WIC 5345 et seq), which focuses on persons experiencing serious mental illness and who have a history of inconsistent participation in treatment; substantial risk for deterioration, and/or detention under WIC 5150. As of 2022, the program also identifies individuals who need services in order to prevent a relapse or deterioration likely to result in grave disability or serious harm to self or others.

Services Provided by the AOT includes:

- Extensive outreach and engagement for a minimum of 30 days
- Screening and assessment
- Linkage to outpatient psychiatric treatment, primarily Full Service Partnership (FSP) providers
- May petition for court-ordered psychiatric treatment
- Participation in court hearing and follow-up on court mandate

To provide the culturally competent and sensitive services, the AOT program assigns and hires staff who are bilingual in Arabic, Armenian, French, German, and Spanish. When OAT staff cannot provide services in a client's and/or family member's language, they utilize a professional interpreter service (Language Line) to meet their clients' linguistic needs. Services are field based to eliminate the barriers associated with accessing "traditional" mental health services that are clinic based. AOT consults with community partners such as emergency room social workers, law enforcement and Urgent Care Centers (UCC) to identify underserved clients within the community and determine how to best address the situation in a clinically and culturally appropriate manner.

AOT services are equitably rendered regardless of clients' gender, race, or creed. AOT takes every consideration possible regarding their clients' culture, environment, identity and needs. Assignments to FSP are made with consideration of clients' specific cultural and language needs as determined during outreach and engagement activities.

The AOT Program is multidisciplinary and counts with many cultural and language capabilities. During FY 21-22, the percentage of persons of color served by the program increased from 59% to 69%, which speaks to AOT's capacity to bridge the gap in access to services and the effectiveness of collaboration efforts to increase access to services. Services are delivered where clients are geographically (i.e., at home, parks, sidewalks). AOT staff approach engagement of clients with persistence and "relentlessness" to maximize the chances of clients' participation in mental health services. The ethos of AOT is that "no client is left behind" which shows the program's commitment to link all clients to necessary services. AOT has the ability to petition in mental health court that clients are recommended receive mental health treatment.

AOT'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Community education to increase mental health awareness and decrease stigma	Presentations and meetings with various community stakeholders such as National Alliance on Mental Illness (NAMI), Law Enforcement Agencies, Department of Health Services (DHS), Jails, Department of Child and Family services (DCFS) and Hospitals.	Ongoing	CC Plan reporting	Numbers of referrals submitted to the AOT program increased from 508 to 584 during this reporting period. All AOT staff have security clearance to screen clients in county jails.
• Consultation to gatekeepers	Consultation with Intensive Care Division's (ICD) AOT Liaison to support client's specific cultural and linguistic needs. Advocacy for continuity of care and stabilization during involuntary hospitalizations with ICD staff. Communication/consultation with Service Area (SA)	Ongoing	Weekly meetings conducted on Tuesday afternoons including ICD staff to discuss all AOT clients in ERS placements. Database tracking referrals and AOT beds.	ERS referrals increased from 10 to 15 clients despite strict COVID restrictions and wait times. Due to the implementation of Senate Bill 317, there was a 5% increase in referrals from Judges, Public

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	Navigators about specific client needs. Communication/Consultation with ICD for securing Enriched Residential Service (ERS) placement for clients. Consultation with hospital social workers for treatment and discharge planning. Consultation and collaboration with the Public Defender's (PD) office.		Clients mandated to be placed in outpatient ERS services have monthly follow ups to monitor their progress in placement.	Defenders (PD) and other qualifying court personnel.
• Countywide Full-Service Partnership (FSP) Networks to increase linguistic/cultural access	When available, the AOT staff assigned clients to a FSP provider based on cultural and linguistic needs. Client and/or family's linguistic needs were documented in Service Request Tracking System (SRTS) to ensure a bilingual staff is assigned or cultural considerations are addressed.	Ongoing	AOT staff attended initial meetings with clients and their newly assigned FSP provider to ensure they meet the cultural and linguistic needs documented in SRTS referral.	58 FSP and three (3) ERS clients graduated from the AOT program during this reporting period. 36 clients were petitioned to mandated services. 16 signed voluntary settlement agreements. In total 52 clients were monitored by the court for a minimum of six (6) months to ensure completion of outpatient treatment. 77 (45%) of clients were linked to FSP services.
• Designation and tracking ethnic targets for FSP	Ethnic demographics were entered into SRTS for FSP assignment.	Ongoing	AOT staff electronically tracked the demographical information of all	Percentage of People of Color linked to FSP services:

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			clients referred for services including language and ethnicity.	○ 24% African American/Black ○ 38% Latino ○ 7% Asian/Pacific Islander
• Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"	Flex funds are available to FSP providers to cover expenses such as rent for clients in order to keep them from experiencing homelessness.	Ongoing	AOT FSP providers submit the expenditures to AOT monthly approvals: AOT program manager reviews all claims to monitor how funds are being spent and ensure they are addressing clients' needs.	Approximately 60 % of the expenditure invoices approved from the AOT FSP contracted agencies were for rent.
• Implementation of new technologies to enhance the Department's service delivery	Outreach and engagement staff utilized their county issued cellphones to facilitate access to medication support services, enrollment into FSP, ERS etc. via tele-mental health.	Ongoing	CC Plan reporting	None
• Augmentation of mental health service accessibility to underserved populations	Field-based service eliminated the barriers to access to care. All AOT services were rendered to unserved/underserved populations.	Ongoing	All referrals to the AOT program were reviewed to assess and address accessibility issues. Cases were presented to the AOT committee to discuss issues and how to best address them.	Referrals for people of color increased from 59% to 69% during this year.
• Coordination of language interpreter and CART services	Hiring and assignment of bilingual staff to provide cultural and linguistically appropriate services. Utilization of Language Line during outreach and	Ongoing	None at this time	Qualitative data obtained from clients reflects the following outcomes: ○ Clients can express their

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	engagement when necessary. Request for interpreter services for court proceedings for client/family.			thoughts, feelings and needs in their preferred language. ○ Clients understand the program/court hearings. ○ Ongoing communication with clients and collaboration with the family during treatment.
• Interagency Collaboration	Ongoing collaboration and consultation with courts, hospitals, Law Enforcement, Public Defenders, County Council, UCCs and other community agencies.	Ongoing	None at this time	Due to the implementation of Senate Bill 317, there was a 5% increase in referrals from Judges, Public Defenders and other qualifying court personnel.
• Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Department wide trainings and Staff meetings	Ongoing	Increased understanding of clients' cultural norms and expectations.	100% of AOT staff attended at least one (1) training related to cultural competency. As a result of these trainings, AOT staff are better equipped to be culturally competent.
• Integration of physical health, mental health, and substance use services	AOT refers to specialized services such as eating disorder, substance abuse and specialty programs needed by clients. Some FSP providers have diversified their staffing by	Ongoing	Graduation of AOT clients from ERS or FSP level of care are monitored by the AOT coordinator.	During this time 43% of clients referred to AOT program had documented current substance use. 24% had past substance use.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	adding substance abuse counselors. FSP arranged for primary care visits.			
• Programs that target specific ethnic and language groups	AOT referred/utilized FSP that specialize in specific age, ethnic, and language groups.	Ongoing	Monitored the level of engagement and graduation from FSP services.	None at this time
• Provider communication and support	○ Quarterly provider meetings ○ Trainings on AOT services ○ Ongoing daily support via FSP coordinator	Ongoing	Submission of monthly and quarterly measures for all AOT clients which were entered into their database.	None at this time
• Trainings/case consultation	Same as above	Ongoing	○ Staff meetings ○ AOT committee meeting with Departmental partners ○ Monthly consultation meetings with local law enforcement agencies ○ Weekly individual supervision with teams	100% of AOT staff attended at least one training related to cultural competence.
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	AOT held quarterly oversight committee meetings which involved community, agency, and court stakeholders.	Ongoing	The program incorporated many of the committee's suggestions.	AOT developed client and family brochures to disseminate in the community. AOT broadened the number of FSP utilized by the program.

CONSUMERS SERVED BY AOT
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
Outreach and Engagement	135	1	40	0	217	8	130	25	408	163	3	0	0	0	0	0	0	0	574	0	2-Legally Blind 2-Mobility issues requiring walkers/ Wheelchair
Full-Service Partnership (FSP)	31	0	17	0	72	3	28	3	122	30	2	0	0	0	0	0	0	0	154	0	2-Legally Blind 2-Mobility issues requiring walkers/ Wheelchair
Enriched Residential Services	7	0	1	0	5	0	3	0	15	1	0	0	0	0	0	0	0	0	16	0	

Program/Project	Consumers' preferred languages	Languages represented by Program staff
Full-Service Partnership	Armenian, English, Cantonese, Mandarin, Spanish	Armenian, English, Cantonese, Mandarin, Spanish
Enriched Residential Services	English, Spanish	English, Spanish

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

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

There are 52 LACDMH CalWORKs Providers and 17 GROW Providers countywide, including Directly-Operated and Contracted agencies, who provide these Supportive Services. CalWORKs and GROW recipients are screened by DPSS and referred to a CalWORKs Provider or GROW clinical assessor for a mandatory clinical assessment. Within the assessment process, mental health barriers to employment are identified and clients are referred to a CalWORKs or GROW Provider for mental health treatment.

Mental health services for CalWORKs recipients include:

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

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

Mental health treatment services for GROW recipients include:

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

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

CalWORKs and GROW services at each clinic are required to reflect the specific cultural and linguistic needs of each Service Area (SA) and community in which the clinic is located. CalWORKs and GROW Mental Health Supportive Services are currently available in twenty (20) languages countywide, in addition to English. CalWORKs and GROW services are offered countywide via telemental health. Referrals are made with the intention of ensuring all clients have immediate access to care. This countywide referral process is not limited to SA boundaries and helps to ensure clients have access to services that are consistent with their cultural and linguistic needs.

CalWORKs and GROW Mental Health Supportive Services have been contributing to LACDMH's provision of culturally and linguistically competent services by delivering services which reflect the specific cultural and linguistic needs of each community they serve. CalWORKs Programs and GROW Administration maintains the responsibility of ensuring all agencies provide culturally competent mental health services for all CalWORKs and GROW participants.

Additionally, the CalWORKs and GROW providers conduct outreach and education activities within their SA and community to educate CalWORKs or GROW participants about the availability of mental health services to address mental health barriers to employment and increase self-sufficiency. These outreach activities occur at DPSS offices, community colleges, and other locations where CalWORKs or GROW participants receive other services.

CALWORKS AND GROW'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Development and translation of public informing materials that address mental health education	CalWORKs and GROW Programs' Administration participates in special projects in collaboration with DPSS to develop and translate public information material addressing mental health awareness and education. For example, bilingual CalWORKs and GROW Administration staff provided presentations on mental health awareness, recognizing mental health issues, and seeking	Bilingual staff provided interpretation/ translation services within the Department on an ongoing basis. Staff provided Job Club presentations and translations on an as-needed basis.	Presentations and interpretation services were coordinated by program staff for DPSS staff as well as CalWORKs participants.	Three (3) mental awareness trainings were conducted during this reporting period (FY 21-22) for DPSS staff. Training resources were provided in

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	professional help that was made available to CalWORKs recipients participating in Job Club. This was made available in English and Spanish. Bilingual CalWORKs and GROW Administration staff also provided translation/interpretation services for Department use.			English and Spanish for their participants.
• Evidence-Based Practices (EBP)/ Community-Defined Evidence Practices (CDE) for ethnic populations	Individual Placement and Support (IPS), an evidence-based practice that assists individuals with Severe and Persistent Mental Illness (SPMI) in obtaining and maintaining employment was utilized by LACDMH CalWORKs Directly-Operated and Contracted sites countywide to support all CalWORKs participants toward their employment goals.	Ongoing	CalWORKs Programs Administration collected and analyzed IPS data for all CalWORKs providers and creates reports based on findings. In addition, CalWORKs Programs Administration developed and conducted trainings for CalWORKs providers to ensure that all CalWORKs participants had access to IPS services.	Of the 52 CalWORKs providers throughout the County, 46 fully integrated IPS into treatment services delivery.
• Field-based services	CalWORKs providers countywide provided field-based services to all CalWORKs participants, as needed, in order to assist participants in staying engaged in treatment. In addition, employment specialists conduct IPS job	Ongoing	CalWORKs Programs Administration collected and monitored data on the frequency of job development activities for all CalWORKs providers and	Employment Specialists provided 65% of their time in the field providing community-based services.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	development activities in communities where CalWORKs participants reside and/or are seeking employment. Job development activities are not limited to SA boundaries and help ensure CalWORKs participants have access to employers and job opportunities that are consistent with employment, cultural and linguistic needs.		conducts job development trainings to ensure providers conduct job development activities in the field that are consistent with clients' specific employment, cultural and linguistic needs.	
• Collaborations to enhance the cultural and linguistic competence within and across Departments of Health Services, Mental Health, and Public Health	The CalWORKs and GROW Programs employ multilingual and multicultural case management and clinical staff to provide treatment services countywide. DPSS staff who make referrals to LACDMH Directly-Operated and Contracted clinics have continuously updated listings of all clinics and their language capabilities to ensure that participants are appropriately referred if a specific language need is identified.	Ongoing	CalWORKs Programs and GROW Administration monitors accessibility of culturally competent mental health services for CalWORKs and GROW participants.	A total of 1713 participants were referred by DPSS for mental health services during FY 21-22.

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CONSUMERS SERVED BY CALWORKS AND GROW
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify)	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
CalWORKs & GROW Mental Health Services	649	20	52	0	712	0	190	90	168	1545											

Program/Project	Consumers' preferred languages	Languages represented by Program staff
CalWORKs & GROW Mental Health Services	English, Spanish, Armenian, Cambodian, Russian, Vietnamese, Chinese, Korean, Tagalog, and Farsi	English, Spanish, Armenian, Cambodian, Russian, Vietnamese, Chinese, Korean, Tagalog, and Farsi

Child Welfare Division (CWD)

CWD was created as a direct result of the Katie A. lawsuit, which alleged that youth in contact with the County's child welfare system were not receiving timely mental health services. CWD provides oversight to ensure that youth who are in or at-risk of entering the child welfare system receive specialty mental health services in an individualized and timely manner.

Key programs of CWD include:

- Specialized Foster Care (SFC) Program Co-located
- Medical Hubs
- Wraparound Program
- Family Preservation (FP)
- Intensive Field Capable Clinical Services (IFCCS)
- Intensive Services Foster Care (ISFC)
- Multidisciplinary Assessment Teams (MAT)
- Community Treatment Facility (CTF)

- Qualified Individual (QI)
- Short Term Residential Therapeutic Program (STRTP)
- Specialized Linkages Services Unit (SLSU)

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

The CWD contributes to LACDMH's overall provision of culturally and linguistically competent services by focusing on the delivery of timely and appropriate specialty mental health services for all youth and families within the community, and those affected by the child welfare and probation systems. The delivery of services such as Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) is closely monitored, and data is analyzed to ensure that populations are provided with services to meet their specific needs. The multitude of trainings promote the practice of culturally competent services and the application of cultural humility and the Integrated Core Practice Model (ICPM).

Furthermore, the CWD's multiple projects and activities contribute to increasing access to mental health services and eliminating disparities by providing connection and informational materials to various referral portals, contractors, county departments, resource parents, and youth on the availability of Specialty Mental Health Services (SMHS) with the intent to reduce and eliminate disparities. Additionally, field-based services facilitate access to care for youth and families by rendering services at the home, school, and in the community and the preferred location selected by the youth and family.

In collaboration with County partners, the CWD works to ensure that there is access to mental health services for youth involved with the child welfare and probation systems in all regions of LA County. Through continuous coaching, case consultation, technical assistance, monitoring, and training, the CWD works to ensure that services delivered to youth and families are culturally relevant, trauma-informed, and meet the linguistic needs of all youth.

CWD'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Development and translation of public informing materials that address mental health education	Updated program specific brochures (Wraparound, IFCCS, MAT, QI, SFC, STRTPs) and previously developed informational materials (webinar/brochure/flyer) in English and Spanish to guide youth, parents, resource parents and families in accessing specialty mental health services, including Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS). Created a guide titled Making Healthy Choices: A guide on psychotropic medications for youth in foster care in English and Spanish.	Informational materials were shared with the Department of Children and Family Services (DCFS) and the Department of Health Services (DHS) partners for distribution to parents and resource parents and families in May 2022. CWD programs' brochures in English and Spanish were updated and made available on LACDMH CWD public facing website.	Informational materials were included in placement packets provided by DCFS for distribution to resource families. Specialty Mental Health Services recorded webinars were shared with DCFS, DHS and Foster and Kinship Care Education for on-demand access and distribution.	Informational material and brochures in English and Spanish are available on the following LACDMH CWD public facing website: https://dmh.lacounty.gov/our-services/child-welfare-division/
• Co-location with other county departments	Both Specialized Foster Care (SFC) and the Countywide Medical Hub programs are LACDMH co-located programs that serve children and youth entering the child welfare system. SFC is co-located with DCFS. The Medical Hubs are co-located with the Department of Health Services (DHS), DCFS, and Department of Public Health (DPH). Services provided for	Ongoing – Services are provided on-site/in person, field-based and via tele-mental health. During the COVID-19 pandemic, most specialty mental health services were provided via telemental health. However, the Department required that intensive field-based programs	Both SFC and Medical Hubs procedures are outlined in the guidelines.	For FY 21-22, SFC and the Medical Hubs received approximately 21,305 referrals.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	both programs included triage, assessment, crisis intervention, specialty mental health services as needed and linkage to ongoing treatment.	deliver services to high-risk youth in-person in their home, school, and/or community setting.		
• Community education to increase mental health awareness and decrease stigma	Updates were made to the previously developed training curriculum and webinars on Specialty Mental Health Services for Children and Youth intended for parents, resource parents, youth, and DCFS partners to help raise mental health awareness, decrease stigma, and increase access to mental health services. Booklet titled, Message to Parents and Caregivers: Types of Psychotropic Medications Used in Children and Adolescents, was created in English and Spanish and made available on LACDMH CWD public facing website.	Updated informational material, curriculum, and pre-recorded webinars to address changes made because of Cal-AIMS were shared with DCFS, Foster and Kinship Care Education programs. Booklet is available on LACDMH CWD public facing website.	Training curriculum and informational materials are reviewed and updated as needed, depending on policy changes.	Informational material is available on the following LACDMH CWD public facing website: https://dmh.lacounty.gov/our-services/child-welfare-division/cwd-trainings/ LACDMH and LACDMH Contracted Providers are alerted of the LACDMH public facing website monthly with the distribution of training announcements.
• Continuous engagement with committees, subcommittees and taskforces that address culturally and linguistically	CWD workforce engaged with committees that addressed culturally and linguistically competent service delivery including the Anti-Racism, Diversity, and Inclusion (ARDI) Staff Advisory Council.	CWD workforce participated in the ARDI Staff Advisory Council, whose mission is to build an intra-departmental community of LACDMH employees who are	A statement of work for a Leadership Transformational training series was developed. The series will concentrate on efforts to dismantle anti-	During FY 21-22 CWD workforce members participated in 14 ARDI Staff Advisory Council meetings.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
competent service delivery.		connected through a shared commitment to advancing racial equity and shaping LACDMH as an organization grounded in principles of anti-racism, diversity, and inclusion.	Black racism, along with other forms of intersectional oppression, through education and leadership accountability. Regular meetings with the LA County Chief Executive Office (CEO) ARDI Initiative were held to provide updates on the efforts LACDMH has made towards the ARDI initiative.	
• Field-based services	Specialty Mental Health Services (SMHS) were rendered through Specialized Foster Care, Wraparound, Intensive Field Capable Clinical Services, and Intensive Services Foster Care in the home and/or community.	As a result of the pandemic, specialty mental health services were provided in the field or via telemental health, as clinically indicated, and based on safety concerns. Intensive field-based programs continued to deliver services to high-risk youth in person in their home, school, and/or community setting.	The appropriateness of field-based vs. telemental health was monitored through consultation, staffing, and claims data on a case-by-case basis.	For FY 21-22, during the COVID-19 pandemic, approximately 25% of high-risk children and youth accepted in-person, mental health services.
• Implementation of new Departmental policies and	CWD established practice parameters and procedural guidelines for Specialized Foster	Ongoing – the Guidelines are revised as needed.	Each program is responsible for the quality and timelines of	

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
procedures that improve the quality and timeliness of delivering mental health services	Care (SFC), Multidisciplinary Assessment Teams (MAT), Intensive Services Foster Care (ISFC), Short Term Residential Therapeutic Programs (STRTPs), Medical Hubs, Family Preservation (FP), Wraparound, and Intensive Field Capable Clinical Services (IFCCS). Guidelines address responsiveness to referrals in accordance with LACDMH Access to Care Policy 302.07.		delivery of mental health services through monitoring, technical reviews, and coaching staff and contractors.	
• Implementation of new technologies to enhance the Department's service delivery.	SFC and the Medical Hubs worked in collaboration with LACDMH to implement VSee to enhance the provision of telemental health services during the COVID-19 pandemic. SFC began to utilize the Service Request Tracking System (SRTS) 2.0 which allowed staff to electronically transfer referrals to the provider network.	Ongoing – SFC and Medical Hub staff participated in VSee training and developed a workflow. An SFC workflow and guidelines were developed in conjunction with LACDMH's Quality Assurance Division.	For FY 21-22, all newly hired staff were required to participate in the training. Training for SRTS is being developed by LACDMH Quality Assurance Staff and LACDMH SFC staff.	70% of SFC clinical staff are using VSee to provide mental health services via telemental health. 90% of referrals to the provider network were made via SRTS 2.0.
• Interagency Collaboration	During FY 21-22, CWD continued to collaborate with the Office of Child Protection (OCP), Department of Children & Family Services (DCFS), Department of Health Services (DHS)	CWD staff participated in ongoing meetings with DCFS regarding: • Youth hospital discharge	Monthly meetings were tracked using sign-in sheets. Reports to LACDMH Deputy and Program Managers are	During FY 21-22, LACDMH Special Linkage Services Unit (SLSU) continued to participate in daily hospital discharge planning meetings

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	and Probation to focus on improving mental health services to youth and families. In collaboration with DCFS and community partners, informational materials (training, flyers, recorded webinar) were developed for the Family Urgent Response System (FURS).	planning meetings • Crisis response protocols for non-hospitalized youth in need of stabilization and ongoing treatment • Collaborated with DCFS and developed a training to DCFS staff and LACDMH staff on FURS • System of Care Meeting • LACDMH participated in various FURS committees and developed informational material that was distributed to various community partners and stakeholders	provided monthly on the various activities.	for DCFS involved youth. A total of 589 discharge planning teleconferences were completed. LACDMH and DCFS Joint Field Response Operations team met once per month to discuss non-hospitalized youth protocols. During FY 21-22 189 children and youth were served via FURS.
• Multi-lingual/multi-cultural staff development and support	A Spanish language training was developed and presented to support the linguistic skills and cultural competence of LACDMH staff and contractors who deliver services to Spanish-speaking clients. This training included the Trauma Informed Care in Spanish (Atención Informada Sobre el Trauma).	A Pre-Recorded, On-demand Webinar was developed for this training and made available on the LACDMH CWD Public Facing Site.	Sign in Sheets were collected to track the number of participants.	Two (2) trainings were delivered in Spanish during FY 21-22. A total of 57 participants completed these trainings.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Provider communication and support	Provider meetings were held monthly for Wraparound, Intensive Field Capable Clinical Services (IFCCS), Intensive Services Foster Care (ISFC), Short Term Residential Therapeutic Programs (STRTPs), Specialized Foster Care (SFC), and Medical Hubs. The agendas focused on updates to services rendered (such as Intensive Care Coordination, and In-Home Based Services); new programmatic policies and procedures; providing training and coaching information; and providing additional resources for providers to improve and/or enhance their service delivery. In addition, on-going Technical Assistance (TA) was provided to agencies to address service delivery concerns, engaging youth and families, and appropriate Safety Planning.	During FY 21-22 and on-going, program specific provider meetings were held via Microsoft TEAMS. LACDMH staff rotated into the offices to provide support as needed.	Attendance/ registration information was collected from the monthly provider meetings. The provision of Technical Assistance (TA) was tracked to review on-going progress and utilization.	For the programs listed, there were 41 Provider Meetings and 9 ISFC Round Table meetings in FY 21-22.
• Trainings/case consultation	CWD continued to deliver training and coaching support to LACDMH staff and contractors. Case consultations, coaching sessions, and trainings included topics to promote cultural competence, including cultural humility, self-	Individualized coaching sessions were offered to LACDMH staff and contractors upon request. Booster trainings on specific topics addressing cultural competency were developed to meet the specific	CWD maintains a database to track all training and coaching sessions offered to LACDMH staff and contractors.	Total number of Coaching Sessions delivered for FY 21-22 were: 311; Total Number of Booster Trainings were: 96. During FY 21-22, LACDMH and

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	reflection, privilege and oppression, and implicit bias. The following trainings were developed and/or acquired through outside vendors: • Fetal Alcohol Spectrum Disorder: Screening, Diagnosis and Interventions • Fetal Alcohol Spectrum Disorder for the Mental Health Professional • Core Practice Concepts in Working with LGBTQIA+ Youth • Trauma Informed Strategies for Working with Individuals with Intellectual Disabilities (ID)/ Developmental Disabilities (DD)/ Autism Spectrum Disorders (ASD) (Clinical Staff and Non-Clinical staff) • Grief and Loss: Supporting Children, Youth and Families • Effective Strategies for Family and Youth Engagement Outside vendor trainings were reviewed to ensure that the content of trainings addressed cultural humility as well as cultural disparities.	training needs of the LACDMH contractors. Training opportunities were available via virtual platforms to ensure continued access for all LACDMH staff and contractors. Trainings were offered via a virtual platform on a regular basis to LACDMH staff and contractors.		contracted provider staff were trained in the following: • 2,676 staff trained in Fetal Alcohol Spectrum Disorder • 1,515 staff trained in Fetal Alcohol Spectrum Disorder for the Mental Health Professional • 210 staff trained in Core Practice Concepts in Working with LGBTQIA+ Youth • 2,776 staff trained in Trauma Informed Strategies for Working with Individuals with ID/DD/ASD (Clinical Staff and Non-Clinical staff) • 1,218 staff trained in Grief and Loss: Supporting Children, Youth and Families • 247 staff trained in Effective Strategies for Family and Youth Engagement

CONSUMERS SERVED BY CWD
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not	Do not know	Decline to respond	
CWD	3,607	57	220		6,774	655	1,975	4,642	8,691	9,203	12	7		5							

Program/Project	Consumers' preferred languages	Languages represented by Program staff
Programs within the CWD	All of the threshold languages represented in the LA County community.	All of the threshold languages represented in the LA County community.

Community Ambassador Network (CAN)

The INN 2, Community Ambassador Network (CAN) Project is made up of nine (9) contract providers and ten (10) projects across the LA County, and two (2) projects are represented within each Supervisorial District. The CAN program was designed to hire, train, and certify community members as "lay" mental health workers in the neighborhoods where they reside. In this capacity, the Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community members with resources relevant to their needs. All the Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical, and spiritual wellbeing of underserved communities. During FY 21-22, the CAN teams continued to reach out to underserved populations regarding the COVID-19 pandemic, providing accurate information regarding testing, vaccinations, updates on the multiple variants, door to door provision of PowerPoint presentations (PPT), as well as PPT distribution at outreach events, food delivery to infected families, etc. The CAN Program prioritizes support of communities who self-identify as Black, Indigenous and People of Color as well as the LGBTQIA2-S, all of which have been

disproportionately impacted by systemic racism and inequality. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in the most disenfranchised communities.

By working collaboratively with lead agencies, the evaluation team was able to identify data collection approaches which are culturally and linguistically appropriate for each community and learning-centered to understand the individual needs of each community, along with the project. The evaluation team developed both qualitative and quantitative data collection approaches to hear voices and perspectives which are typically overlooked to document the experiences and impacts of the INN2 and CAN Project. Community capacity building is not a linear process, so reporting of data utilizes a storytelling approach to document the process, highlighting best practices and learnings and reflect on success beyond percentages and counts so it is meaningful to a diverse audience of readers. The project was approved to translate the Community Resilience Model (CRM) in Khmer. The Cambodian community in Long Beach was trained in CRM, and one of the certified Countywide Resource Management (CRM) Teachers took the training to Cambodia on his personal time, and trained hundreds of Cambodians there in this model as well. The CAN worked very closely with communities and how to best reach the Latino and Black populations during COVID-19 could help without creating any vicarious trauma. Learning sessions were set up to hear back from the communities on what created mistrust and wariness of government entities, especially around testing and vaccination. The perspectives and beliefs of participants were respected, and accurate and up to date information was delivered consistently.

When families were infected with COVID-19, support was also provided through food deliveries, provision of housing assistance to avoid displacement, internet connection for children's schooling. During this time, there was civil unrest, gun violence, racism and a lack of understanding and/or tolerance for many populations and communities.

The CAN project has expanded the provision of culturally and linguistically competent services across all the INN 2 communities. Every decision made and training considered for implementation are discussed across providers, to meet the current needs of communities and to address those most in need of being reached, supported and educated, about COVID-19, inclusivity, necessary resources and linkages, etc.

In addition, the CAN project has expanded education related to mental health needs and access to mental health supports as needed. The concept of the project was to inform the community at large, in all manners possible how to recognize trauma, how it may manifest itself in individuals, as well as communities that have faced communal trauma and how to address it. When individuals and families have not been able to be supported by the CAN, INN 2 programming, training, and education, they have been referred to mental health supports and services.

CAN STRATEGIES AND ACTIVITIES, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	The project proposal was developed in collaboration with local organizations, community members, faith-based organizations, schools, the police, their Health Neighborhoods, SALTs, etc. Much of the intent of the project was the connection to community, the creation of partnerships and community capacity building and education to inform, engage and activate communities.	Services will continue through June 30, 2023, when the project sunsets.	Meetings are recorded in an Events Tracker within INN2 Health Outcomes Management System (iHOMS).	• 2,001 meetings were attended in FY 21-22 by INN2 staff, including Community Partnership Meetings, Advisory Committee Meetings, SAAC/ Health Neighborhood Meetings and Other Meetings.
• Field-based services	Services for this project are primarily provided in the community. Reaching out to underserved priority populations in need and those impacted negatively by the COVID-19 pandemic. Information events were held, along with attending outreach and engagement events, door to door information sharing and PowerPoint presentations at the height of the pandemic. Education, training, and community events were also regularly held, both in person and virtually.	Services will continue through June 30, 2023, when the project sunsets.	Community-based outreach, trainings and events are recorded in an Events Tracker within iHOMS.	During FY 21-22, INN2 staff conducted: • 2,319 Community Outreach • 1,492 Community Events • 1,576 Trainings in the community
• Implementation of capacity-building projects based on the specific needs of targeted groups	All providers identified one or more issues facing their communities they wanted to work together to empower the community and find solutions. Specific strategies were chosen collaboratively with providers,	Services will continue through June 30, 2023, when the project sunsets.	The Wilder Collaboration Factors Inventory has been completed twice a year	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
via or in collaboration with stakeholder groups	community members, local organizations, etc. The strategies were as follows: 1. Working with 0-5 and their parents, 2. Training school staff regarding ACES 3. Unhoused TAY, Justice involved and reintegration issues 4. Employment and Unhoused older adults and Cultural Competency Projects with specific community priority populations.		(Feb and August) throughout the initiative to document capacity building and collaboration within partnerships (from the Partner's perspectives)	
• Investments in learning (e.g., Learning collaboratives and innovative models)	The project began and was funded for four years with INN dollars. The project scope was expanded with CARES Act and continued for a year with Prevention dollars. The project utilizes a developmental evaluation approach, which centers its data collection on promoting reflection and learning. The learning and evaluation team (collaboration between UCSD & Harder+Co.) facilitates quarterly Learning Sessions, which bring together INN2 partnership members to support peer learning and collaboration.	Services will continue through June 30, 2023, when the project sunsets.	The Learning Sessions are recorded, and Learning Briefs are developed to document each session.	There were three (3) Learning Sessions held virtually during FY 21-22: • July 13, 2021 (179 attendees) • October 12, 2021 (202 attendees) • April 12, 2022 (200 attendees)
• Multi-lingual/multi-cultural staff development and support	At the Department level, trainings were offered in Spanish and English and translation was offered in Spanish at all Learning Sessions and CAN PLAN meetings. At the local level, CAN were hired to represent the communities which they served; both ethnically and linguistically, along with any specialty populations, including lived experience as unhoused, a history of substance abuse, LGBTQ+,	Services will continue through June 30, 2023, when the project sunsets.	Trainings for partnership members are documented in an Events Tracker within iHOMS.	• 573 trainings for partnership members held in FY 21-22.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	transgender populations, etc. Allyship groups were formed at each provider and ongoing in-service trainings provided to staff across the entire provider, to better understand the project, their community, and the world. Providers had a training budget provided within their contract agreement to provide these supports and trainings.			

• Outreach and Engagement (O&E) activities	The project is primarily an outreach and engagement effort, sample activities include:
	• Distribution of COVID information
	• PPT provision door to door
	• Community Events
	• Tabling at outreach events
	• Direct outreach to priority populations:
	  ○ Unhoused Older Adults and TAY
	  ○ Justice Involved Individuals
	  ○ Cambodian, Black and Latino Communities
	  ○ Underserved populations
	• Food delivery for project participants
	• Training to communities regarding Trauma, CRM, ACES, COVID-19, etc.
	• Trainings to school staff regarding early identification of trauma.
		Services will continue through June 30, 2023, when the project sunsets.	Community-based outreach and group activities are documented in an Events Tracker within iHOMS.	• 5,812 Outreach
				• 3,247 Group Activities

• Integration of physical health, mental health, and substance use services	CAN provided information about isolation, masks, etc. When individuals were not connected to a Health Home and/or benefits, CAN were connecting them to services. Three of the providers had subcontractors who were medical providers and several of the	These services will continue through June 30, 2023, when the project sunsets.		

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	providers included subcontractors who provided substance abuse support and services. All providers referred to mental health, health and substance abuse services as needed, and provided wellness and resiliency activities for the participants as well.			
• Programs that target specific ethnic and language groups	There were several specific ethnic and language groups targeted in the project, including the Cambodian, Latino and Black communities. There were also specialty populations focused upon, which were the unhoused, Transitioned Age Youth (TAY), older adults, justice involved, LGBTQ+ and the transgender population.	Services will continue through June 30, 2023, when the project sunsets.		
• Provider communication and support	Providers are supported in a variety of manners through weekly check-ins with LACDMH staff, monthly lead agency meetings, monthly community partnership meetings, SALT meetings, Health Neighborhood meetings, quarterly Learning Sessions, monthly lead agencies with their subcontractors, monthly meetings with the evaluator and TA when needed, community CRM trainings, translation at all community meetings as needed.	Services will continue through June 30, 2023, when the project sunsets.		
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	The project was based on community capacity building, and thus the community was required to be included in the project from inception. Community members, organizations, leaders, representatives from law enforcement, city government, health neighborhood and SALT representatives, etc. attended community partnership meetings	Services will continue through June 30, 2023, when the project sunsets.		

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	discussed community/project issues, provided trainings, and discussed topics impacting the community at large, etc.			
• Utilization of the workforce's responses to cultural competence organizational assessments, surveys, and focus groups to address knowledge gaps and support advancements in cultural competence	There has been an ongoing effort to address cultural humility across the life of the project, along with encouraging and empowering inclusivity across the entire project. The project addressed the unrest and violence occurring across the county and the country. Consultants worked with individual projects around specific matters/ populations to bridge and work needing to be done within each community. Work was done across the project as well as with specific cross-project workgroups and learning and training was always shared at the quarterly learning sessions. The County and the LACDMH Anti Racism, Diversity and Inclusion (ARDI) Initiative began and has been integrating into and woven throughout the INN 2 project.	Services will continue through June 30, 2023, when the project sunsets.	The INN2 evaluation supported several opportunities to hear from CAN, utilizing both qualitative surveys and focus groups (conducted in fall 2022), and facilitating breakout discussions during CAN Plan meetings.	

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ADDITIONAL STRATEGIES UTILIZED BY CAN, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
Community Training and Education	The Community and Resiliency Model (CRM) training was provided to all CAN, who in turn took the skills into the community to share and teach participants, community members and providers. Many CAN were also trained in the CRM Teacher Training and became certified to provide community/school/ church, etc. trainings to share this model as much as possible across the project hyper-local areas. CRM has been delivered in English, Spanish and Khmer.	Services will continue through June 30, 2023, when the project sunsets.		

CONSUMERS SERVED BY CAN, FY 21-22

Program/Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability (specify)
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (Unknown or Chose not to Answer)	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
Community Ambassador Project (CAN)	37 (17%)	1 (<1%)	21 (10%)		98 (45%)	13 (6%)	10 (5%)	39 (18%)													

<table>
<tr><th>Program/Project</th><th>Consumers' preferred languages</th><th>Languages represented by Program staff</th></tr>
<tr><td>Community Ambassador Network (CAN) Project</td><td>Demographic data was not collected for INN2 participants at the recommendation of community stakeholders.</td><td>
<table>
<tr><th>Languages spoken by CAN</th><th>Percentage of CAN</th></tr>
<tr><td>ASL, English</td><td>0.46%</td></tr>
<tr><td>English</td><td>38.07%</td></tr>
<tr><td>English and Spanish</td><td>10.55%</td></tr>
<tr><td>English, Thai, Lao, & Khmer</td><td>0.46%</td></tr>
<tr><td>Hebrew</td><td>0.46%</td></tr>
<tr><td>Italian</td><td>0.46%</td></tr>
<tr><td>Khmer</td><td>4.13%</td></tr>
<tr><td>Khmer, Spanish, & Thai</td><td>0.46%</td></tr>
<tr><td>Khmer, Vietnamese, & English</td><td>0.46%</td></tr>
<tr><td>Korean</td><td>0.92%</td></tr>
<tr><td>Mandarin, Cantonese, & English,</td><td>0.46%</td></tr>
<tr><td>Sakha, Russian, Spanish, English</td><td>0.46%</td></tr>
<tr><td>Spanish</td><td>41.74%</td></tr>
<tr><td>Tagalog</td><td>0.46%</td></tr>
<tr><td>Tongan</td><td>0.46%</td></tr>
<tr><td>Grand Total</td><td>100.00%</td></tr>
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Crisis Residential Treatment Program (CRTP)

CRTPs are short-term, intensive residential programs that provide recovery-oriented, intensive, and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting. CRTPs provide services 24 hours per day, 7 days per week (24/7). CRTPs have a maximum bed capacity of 16 individuals per site. While the average length of stay in CRTPs is 10-14 days, an individual's maximum stay shall not exceed 30 days. CRTPs serve as an alternative to hospitalization, reduce the psychiatric inpatient days of individuals, and may serve as a resource for individuals who might otherwise be incarcerated without the appropriate community services. CRTPs are licensed by the California Department of Social Services (CDSS) as Social Rehabilitation Programs, with the mental health program component certified by the California Department of Health Care Services (DHCS) and are Medi-Cal certified. CRTPs are centrally accessed through LACDMH Intensive Care Division (ICD). County Hospital Psychiatric Emergency Services (PES) and inpatient treatment teams work collaboratively with LACDMH ICD liaisons to identify potential referrals to CRTPs. Urgent Care Centers (UCCs) refer individuals directly to LACDMH's ICD for authorization.

The target population for CRTP services is adults 18 years of age and older with mental illness, including, but not limited to individuals with co-occurring substance use disorders who may be incarcerated due to low level offenses, the incipience of which may be the result of, or associated with, their mental illness; and meet one of the following criteria: 1) Hospitalized with significant psychiatric symptoms and have been determined by the PES treatment staff, in collaboration with LACDMH ICD, to be appropriate for a CRTP, 2) Enrolled in an acute inpatient setting and have stabilized within days or hours of being on the inpatient unit and the inpatient treatment team working in collaboration with LACDMH ICD has determined the individual to be appropriate for clinical treatment at a CRTP level

of care, 3) Receiving UCC services and at risk of being placed in a higher level of care, and have been determined by the UCC treatment team in collaboration with LACDMH ICD to be appropriate for a CRTP level of care (this list is not exhaustive of the individuals that may be served at a CRTP); and LACDMH ICD will ultimately decide what populations are appropriate for CRTP services.

Based on the disparities data, systematic and strategic decisions were made relative to cultural and linguistic accessibility. To ensure the diverse cultural and linguistic needs of the communities are met, the CRTP programs provide services in 12 threshold languages for LA County. Additionally, to meet the cultural needs of the communities, services are being expanded to age groups and areas that have previously been underserved. Specifically, new CRTP programs began admitting clients in SA 6 and SA 2 and new contracts are being developed for additional CRTP programs to service other underserved areas and clients.

CRTPs contribute to LACDMH's provision of culturally and linguistically competent services through partnership and collaboration with new and existing contract providers. CRTPs at MLK and Olive View have opened are admitting clients in SA 6 and SA 2. The programs provide services that are culturally relevant, and in the language of choice for clients, consistent with goals and expectations of the LA County.

CRTP'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
1) Collaboration with faith-based and other trusted community entities/group	Active participation in Service Area (SA), Clergy Roundtable, LACDMH Faith-Based meetings	Ongoing	Case consultations supporting both community and churches/synagogues and parishes in crisis situations	
2) Co-location with the Department of Health Services (DHS)	Establishment of CRTP programs in all SAs and Supervisorial Districts, some in collaboration with DHS via utilization of space at DHS locations	Ongoing	Quality Assurance Division for Medi-Cal Certification, Lanterman-Petris-Short (LPS) Facility Designation Unit for LPS requirements, and use of Seclusion and Restraint Report	
3) Community education to increase mental health	Active participation in the SA Provider meetings as needed, partnerships with the local SA	Ongoing	Maintenance of open communication and sharing of resources	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
awareness and decrease stigma	chapters of National Alliance for Mental Illness (NAMI); including Spanish speaking NAMI chapters			
4) Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery	Active participation in Service Area Leadership Team (SALT), SA Providers Meeting and Clergy Meetings	Monthly	Regular reporting out of program activities and receipt of verbal community input	
5) Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments	Regular use of the language Lines available to LACDMH clinics	Ongoing	Confirmation that visitors can receive services in the preferred language of choice	
6) Interagency Collaboration	Partnerships with SA acute hospitals, post-acute facilities and Institutions for Mental Diseases (IMDs) to assist clients in need of access to residential mental health services	Ongoing	Referral reports, bed census reports and linkage activities with network providers for ongoing mental health services	
7) Integration of physical health, mental health, and substance use services	Co-location of some CRTP sites using space at DHS locations. Staffing by multi-disciplinary teams, including psychiatrist and	Ongoing	Regular communication and collaboration between DHS, DPH and ICD 24 Hour management and staff; and network	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	substance abuse counselors		provider regarding referrals, services delivery; this includes weekly and monthly meetings; or more frequently if needed	
8) Programs that target specific ethnic and language groups	Outreach and engagement of with community partners, specifically in underserved communities and for underserved populations, regarding the Resource Family Approval (RFA) process for 24 Hour CRTP contracting opportunities; and ongoing collaboration with existing provider interested in increasing capacity. Establishment and implementation of a robust ICD onboarding process beginning at the point of interest in contracting through the completion of Medi-Cal Certification and CIOB testing.	Ongoing	Regular communication and collaboration with existing and prospective providers	
9) Utilization of the workforce's responses to cultural competence organizational assessments, surveys, and focus groups	Monitor program services utilization and profile information, which include gender, race/ethnicity, primary language, age, housing, substance use, psychiatric diagnosis, and caregiver language	Semi-annually	Data initially developed for Medi-Cal recertification, and is applicable to monitoring demographics of clients served, as well as to monitor compliance with collecting these indicators	

CONSUMERS SERVED BY CRTP
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
CRTP									516	299	2	10						827			

Enriched Residential Care (ERC) Program

ERC ensures stable housing and quality of life for individuals who are experiencing homelessness or are at high risk of homelessness and need a higher level of care provided by a licensed facility. ERC ensures that clients can reside in the community and are supported in ways that promote recovery and stabilization. ERC provides a housing subsidy for individuals without adequate income to pay the Non-Medical Out-of-Home rate which allows individuals who need this type of housing but cannot afford it to access housing. Similarly, ERC can pay a higher enhanced rate to the facility operator for individuals with more intense and complex needs. Many of them have high acuity needs and require extra supports to maintain housing at Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs).

These unlocked facilities are licensed through the State and provide 24-hour care and supervision, medication management, three (3) meals per day and assistance with activities of daily living. At the direction of the Board of Supervisors, this program also supports efforts to preserve the stock of this valuable housing resource as many licensed residential care facilities across the County have been closed due to underfunding, causing housing instability for highly vulnerable individuals for whom it may be challenging to find new housing without these resources. One effort to address this issue is the State funded Community Care Expansion (CCE) program which will provide funding for facilities to make needed repairs as well as subsidies to cover operating deficits to remain operational.

While ERC does not have site control over the various Community-Based licensed residential facilities that the program funds, ERC does all that is possible to ensure that

placement options are accessible to the clients that they serve. Efforts include collecting information about each facility across all SAs. Information is available to service providers making placements through the Mental Health Resource Locator and Navigator (MHRLN). This system offers real time vacancy information for facilities in all geographic areas of LA County, as well as details of the level of care each facility can provide and language capacity. ERC also collects data about clients and enrollments to ensure that the population served is reflective of the larger LACDMH client population and the homeless population which has an over-representation of the Black/African American.

All ERC's projects seek to promote culturally competent services that aim at ensuring that the County's most vulnerable individuals with acute needs have stable and supported housing. By providing trainings to Community-Based facilities and by collaborating broadly with system partners, ERC promotes high quality of care that is sensitive to the needs of residents with serious mental illness. ERC maintains constant contact with clinical staff to ensure clients served by ERC are continuously connected to appropriate mental health services and collaborates to reduce barriers to engaging in care and to prevent eviction and the risk of experiencing homelessness.

ERC'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Community education to increase mental health awareness and decrease stigma	Coordinate trainings for residential facility administrators and staff to promote increased understanding and competency. Examples of trainings: harm reduction, trauma informed care, interventions for individuals with psychotic disorders, de-escalation, and managing psychiatric emergencies, among others.	These webinars started in 2020 and ran through the first half of FY 21-22. They terminated at the beginning of 2022.	Administrators were able to receive free Continuing Education Units (CEUs) for attending trainings and attendance was recorded.	Four (4) cultural competency-related trainings were provided from the start of FY 21-22 until the start of 2022 when they were terminated.
• Implementation of new technologies to	LACDMH launched Mental Health Resource Locator	Facility operators could access the	Monthly bed availability updates were requested for	Approximately 69 facilities registered in the

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
enhance the Department's service delivery	and Navigator (MHRLN), a searchable database of licensed care facilities to assist service providers in locating appropriate licensed housing for their clients, allowing providers to search by geographic region as well as languages spoken.	system to upload bed availability in their facility and case managers would register for access to the system to search for placement.	every facility in the database to ensure accuracy of bed availability.	system and 97 case managers registered for access to the system.
• Interagency Collaboration	ERC collaborated on at least a monthly basis with various system partners including directly operated and contracted clinics across the County, Department of Health Services (DHS), Community Care Licensing Division (CCLD), Department of Public Health (DPH), Long Term Care Ombudsman, Brilliant Corners, and others.	Collaborations were ongoing and important in ensuring that the licensed residential care facilities and clients residing in them are well supported.	Meetings were scheduled on a monthly basis and as needed to address varied issues as they arise.	One (1) meeting with DHS and DPSS were held each month with representatives from Patients' Rights in attendance on some occasions and one (1) meeting with Brilliant Corners was held each month.
• Trainings/case consultation	ERC provided training to service providers on the ERC program, requirements and guidelines including the level of acuity required to qualify. ERC staff provide consultation to providers around challenging client situations and	This happened on an almost daily basis and is ongoing. Additionally, virtual trainings for case managers were held on a semi-regular basis.	All referrals were reviewed for completeness and thoroughness and immediate feedback was provided by ERC staff.	While case consultation occurred daily, formal trainings on the ERC program were provided to case managers every six (6) months.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	collaborate to ensure clients can obtain needed services and level of care and to retain their housing.			
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	ERC participated in many activities that solicit stakeholder feedback, from licensed facilities around strategies to ensure these critical resources were able to continue operations in light of ongoing funding struggles.	Ongoing	ERC staff participated in Countywide meetings, such as Service Area Leadership Team (SALT) meetings, for updates on client care. LACDMH programs received feedback in these meetings as well.	LACDMH implemented two (2) of the recommendations, including developing a bed tracking system and seeding a licensed residential care association.
• COVID-19 responsiveness at clinical and administrative program level.	ERC was at the forefront of response to COVID-19 in licensed residential facilities. This included: distributing information on COVID-19 response and infection control, assistance with coordinating testing and vaccinations, facilitating access to Personal Protective Equipment (PPE), providing telephonic technical assistance and guidance, and monitoring outbreaks and COVID related deaths.	These activities significantly decreased as facilities were able to manage COVID-19 independently and as the community prevalence rates of COVID-19 decreased. Most support shifted from ERC to DPH/DHS. However, supports were still available on an as needed basis in case of outbreaks.	Monitoring of COVID-19 was managed through the distribution of weekly surveys to operators to assess status of COVID-19 in their facility and assess needs for support. LACDMH ERC continued to have regular meetings with DPH, CCL and DHS to monitor outbreaks and COVID-19 related deaths and to organize collaborative technical assistance and trainings as needed.	ERC received data every week on current COVID-19 outbreaks and deaths at licensed residential facilities. They have decreased significantly since the beginning of the pandemic.

CONSUMERS SERVED BY ERC
FY 21-22

Program /Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify)	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
ERC	216	10	120	0	269	11	294	826	915	503	0	4	1	55					1,478 Not collected		Not collected

Note. ERC has not collected Sexual Orientation and Physical Disability data but will begin to collect this data. Race/Ethnicity data is not mutually exclusive. Total not listed is a combination of both Race & Ethnicity that were data was not provided.

Program/Project	Consumers' preferred languages	Languages represented by ARF/RCFE staff
Enriched Residential Care	Not collected	English, Spanish, Filipino, Tagalog, Korean, Russian

Faith-Based Advocacy Council (FBAC)

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

FBAC convened approximately 45 clergy, faith community leaders, nonprofit social services organization representatives, and LACDMH Outreach and Engagement staff in monthly meetings, training sessions, and activities during this fiscal year. LACDMH staff regularly emailed information to over 1,200 members. The FBAC Executive Board, consisting of two Co-Chairs and 12 active members met every month to guide the direction and work of FBAC. The group focused on decreasing stigma and increasing access to care by mobilizing leaders of diverse faith leaders throughout LA County to

integrate mental health information, resources, and messages into pastoral care, bulletins, sermons, social activities in their congregations.

Meetings were held virtually in English, using Microsoft Teams, with simultaneous interpretation provided in Korean and Spanish. Also, the FBAC participants learned about, accessed, and referred to mental health services. They integrated mental health messages and connected people experiencing mental health needs to relevant resources through their clergy or faith leader roles and faith community activities.

Full Service Partnership (FSP)

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

The FSP staff have used disparities data to help them understand areas of greatest need. They understand that Asian Pacific Islander (API) populations require additional capacity and services delivered in their primary language. The Department has worked with API alliance and increased FSP capacity across the County and in those specific areas identified in the disparities data collected. The FSP programs have contracted with agencies and continue to collaborate with those community partners serving the API population to ensure that their mental health service needs are met. The FSP programs directly address the disparities that were identified via their outcomes data collected by ethnicity/race. As a result, they have increased capacity for API in several specific areas in the County.

Furthermore, the FSP's quarterly meetings and ongoing trainings increase knowledge of not only the FSP program, but also in how to deliver appropriate and culturally competent services to their most vulnerable populations in LA County. Their ongoing communication and collaborative efforts with other community partners and agencies assist in reducing these disparities.

FSP'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring procedures and outcomes
• Collaboration with faith-based and other trusted community entities/groups	FSP programs contracted with various API community providers to ensure services are being delivered to their population in their primary language.	FSP continued to grow capacity for those identified underserved populations (Ongoing)	FSP looked at FSP outcomes and other data collected through several tracking/ monitoring systems. For example, Integrated Behavioral Information System (IBHIS), Service Request Tracking System (SRTS), RTS (Referral Tracking System), OMA (Outcome Measures Application), etc.
• Development and translation of public informing materials that address mental health education	FSP brochures were translated in Spanish and the FSP is in the process of translating them in other threshold languages, as they were been updated.	FSP continued to work on translating FSP brochures and other documents in the County's threshold languages.	Internal Monitoring/tracing of updated forms and translations
• Field-based services • Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"	65% of FSP services were field- based and were tracked by the Outcomes Division via the internal applications such as IBHIS. FSP continued to be flexible by allowing high acuity clients who may not meet exact eligibility requirements enroll in the program.	FSP continued to maintain 65% or higher field-based requirements and monitors the FSP providers who have struggled through the pandemic. FSP SA navigators and FSP Admin review referrals for their appropriateness into the program.	Ongoing monitoring and tracking via several LACDMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring procedures and outcomes
• Augmentation of mental health service accessibility to underserved populations • Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings. • Integrated Supportive Services. • Interagency Collaboration	After identifying underserved populations such as API, they worked with API alliance and have increased FSP capacity for the community agencies working with those populations. Agencies ensured that they have staff who were bilingual/multilingual to provide FSP services or work with interpreters/translators to ensure services were being delivered in the clients' primary language. They worked collaboratively with other agencies and programs to ensure that all of their clients' needs were met such as housing, establishment of benefits, substance use, LPS, etc.	Ongoing	Ongoing monitoring and tracking via several LACDMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.
• Provider communication and support • Trainings/case consultation • Utilization of the community's knowledge, feedback, and	FSP trainings for new staff. Adult and Child FSP Provider meetings were held on a quarterly basis to update FSP providers with changes to the program and listen to any concerns and issues that arise from delivering services to the community. They worked collaboratively with various agencies countywide to address and promote health and wellbeing	Ongoing	Ongoing monitoring and tracking via several LACDMH applications such as IBHIS, SRTS, FSP-RTS, FSP OMA.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring procedures and outcomes
capacity to promote health and wellbeing	by ensuring FSP services were delivered to their most vulnerable populations.		

CONSUMERS SERVED BY FSP, FY 21-22

Program/Activity	# Consumers Served by Race/Ethnicity					
	White	African American	Latino	API	American Indian	Other (Unreported)
Adult	1,532	1,958	1,726	302	66	1,278
Child	321	643	1,520	62	12	697
Older Adult	542	452	235	82	23	447
TAY	249	532	1,128	83	8	549

Geriatric Evaluation Networks Encompassing Services Intervention Support (GENESIS) Program

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

The older adult population in LA County is ethnically and racially diverse and it is estimated that by 2030 it will increase to about three million (https://www.bscc.ca.gov/wp-content/uploads/Demographic-Reference-Data-Los-Angeles.pdf). To promote healthy aging communities, it is imperative to increase quality of life by addressing the physical health and mental health needs of older adults. The GENESIS Older Adult Program is culturally sensitive and linguistically appropriate and aims to provide mental health services primarily for homebound, frail older adults, age 60 and above, with mental health and comorbid physical health disorders. The field-based staff consist of a social worker and nurse team to provide a comprehensive and holistic approach for the treatment and

wellbeing of older adults from diverse cultures. To address cultural competence, reduce linguistic barriers, and improve access to care for older adults residing in LA County, mental health services are delivered in various threshold languages such as Spanish, Russian, Farsi and Tagalog to address the needs of these specific communities.

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

During FY 21-22, the Outpatient Services Division Older Adult Anti-Stigma and Discrimination Team conducted 115 virtual community presentations outreaching to 1,510 LA County residents promoting mental health wellness and education about the services provided by the GENESIS Countywide Older Adult Program. These presentations were conducted virtually and in-person at various facilities targeting older adults. These presentations were delivered in a culturally sensitive and linguistically appropriate manner (English, Spanish, Farsi, Armenian, and Korean).

GENESIS PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Co-location with other county departments, e.g., Department of Children and Family Services (DCFS), Department of Public Social Services (DPSS), Department of Health Services (DHS), and Department of Public Health (DPH)	A Mental Health Clinician (MSW) was co-located, four hours per week, at the Antelope Valley Adult Protective Services (APS) office to provide consultation for APS staff working with older adults due to elder abuse reporting. • 10/4/2021 – Conducted Virtual training for 30 APS staff • 2/22/2022– Conducted Virtual training for 15 APS staff	Due to COVID-19 pandemic, co-location consultations pivoted from onsite/in-person to telephone.	Monthly log submitted with number of hours of consultation. For FY 21-22 total of 46 hours consultation and outreach for 67 individuals.	67 (individuals outreached)

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Field-based services	Field-based mental health assessment and services were provided in the community such as home, senior centers, parks, and community at large depending upon individual's need/request. Services included a bio-psycho-social assessment, nursing (head-to-toe) physical health assessment, and a myriad of mental health services including psychotherapy, family therapy, case management, medication management, linkage to resources, and benefits establishment.	Ongoing	LACDMH Integrated Behavioral Information System (IBHIS) electronic medical record documentation system: Approximately 26 assessments per month; and approximately 283 ongoing clients served for FY 21-22.	283 (ongoing clients served)
• Integration of physical health, mental health, and substance use services	Field-based multidisciplinary teams consisted of 1) social worker who provided psychosocial assessment, therapy to individual and family; 2) nurse provided head-to-toe physical examine, consultation with medical providers, and individual rehabilitation; 3) case manager ensured benefits establishment, housing retention, and resources such as in-home support and adequate food supply; 4) substance abuse counselor addressed substance use disorders providing counseling and resources; and 5) psychiatrist and Nurse Practitioner provided	Ongoing	LACDMH IBHIS electronic medical record documentation system: Approximately 26 assessments per month; and approximately 283 ongoing clients served for FY 21-22	283 (ongoing clients served)

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	medication management/prescriptions and consultation.			
• Trainings/case consultation	Older Adult Consultation Team (OACT) served as a geriatric-specialty multidisciplinary group to support to all clinicians working with Older Adults Consultants include: UCLA expert consultant, neuropsychologists, geriatric psychiatrists, pharmacist, social workers, nurses, nurse practitioners, clinical pharmacists, medical case workers & community workers, Adult Protective Services, Office of Public Guardian and FSP.	Ongoing Older Adult Consultation Team (OACT) bi-monthly consultation meetings	Approximately four to five case consultations per month for FY 21-22 for total of forty-four consultations. 12-25 participants (per case consult)	12-25 (participants per case consult)

CONSUMERS SERVED BY GENESIS PROGRAM
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
GENESIS Countywide Older Adult Program	14 %	0.3 %	3.2 %		28 %	3.4 %	26 %	26 %	31.9 %	68 %											

Health Neighborhoods (HN)
HN brings together physical health, mental health, and substance use disorder providers to establish and enhance collaborative relationships and promote the integration of whole-person care. Participating service providers are linked to an extensive network of governmental and community supports including, but not limited to: County and city agencies, educational institutions, housing services, faith-based groups, vocational supports, advocacy and non-profit organizations, prevention programs, social services, etc. These providers come together with vital input from the community to enhance the health and wellbeing of neighborhood residents.

Advantages for providers who participate in a HN:

- Screen consumers for health, mental health, and substance use disorder issues with the knowledge that there is an array of providers to refer to depending on need
- Have greater ability to effectively coordinate care for consumers seen by multiple participating providers (e.g., physical health, mental health, and substance use disorder providers)
- Use a variety of culturally and linguistically appropriate health, mental health, and substance use disorder providers to meet the needs of a diverse consumer population
- Improve treatment adherence and clinical outcomes for consumers through the addition of health, mental health, substance use disorder, and community services and supports
- Decrease duplication of services by improving communication and care coordination while containing costs
- Increase providers' understanding of supportive services in the community that may assist in the well-being of those served

HN recruits participants from diverse backgrounds through outreach and engagement efforts based on feedback from community members regarding current community resources. The HN representatives are able to gather observational and antidotal data to understand disparities in cultural and linguistic accessibility to services.

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

Health Neighborhoods increase access to mental health services and eliminate disparities by making meetings open to diverse communities. Health Neighborhood attendees are encouraged to share meeting information with other community members to increase participation. Projects and activities focus on outreaching to the diverse populations within each Health Neighborhood. Providers and networks collaborate on community projects that vary racially, ethnically, and culturally and bring their expertise

to connect and reach those diverse groups. This type of collaboration greatly contributes to the Department's mission of culturally and linguistically appropriate services.

HEALTH NEIGHBORHOOD'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	The HN conducted monthly meetings of LACDMH service and community partners including Health, Public Health, faith-based, substance use, and other providers.	HN meet monthly	Attendance tracking	N/A
• Trainings/case consultation	Case consultation and linkage to service providers	Ongoing	Follow-up	N/A
• Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	Outreach activities and community-based events.	Limited to virtual events due to the pandemic.	New participant tracking and outreach.	N/A

HEALTH NEIGHBORHOODS BY SERVICE AREA (SA)

SA	Health Neighborhood (HN) Name
SA 1	• Antelope Valley
SA 2	• Northeast San Fernando Valley • Panorama City/Van Nuys
SA 3	• El Monte • East San Gabriel Valley
SA 4	• Hollywood • Boyle Heights
SA 5	• Mar Vista-Palms Intergenerational Wellbeing/Intergen • Venice Marina Del Rey

SA	Health Neighborhood (HN) Name
	• Pico-Robertson
SA 6	• South Los Angeles
SA 7	• Southeast Los Angeles
SA 8	• Long Beach • Hawthorne-Lennox

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

HOME teams support the Department's mission to be both culturally and linguistically competent. HOME teams are comprised of staff who come from a multitude of backgrounds and experiences who can effectively engage individuals in the community. Meaningful relationships are essential in being competent providers. Services are provided where the client is at, in person, and making every attempt to meet the client's needs. In addition, the HOME program looks at demographic composition of community being served and composition of the team serving that community to ensure that appropriate culturally and linguistically accessible services are available.

The fundamental mission of the HOME program is to provide services to clients who are unable to obtain traditional services. Services are rendered in the field in the hardest to reach places in non-traditional manners. Teams collaborate with other LACDMH partners, LACDHS, Los Angeles Homeless Services Agency (LAHSA), and any community entity who can support the mission. The teams are trained regularly on new techniques and best practices to serve the most disenfranchised individuals in the county. The HOME teams are regularly thinking outside of the box to do whatever it takes to meet the client's needs, many times outside of what one might consider mental health. The team approaches the whole person and assess and engages in meaningful activities to support the client. The HOME staff are "concierge" teams to engage, link, support and follow clients through various stages of recovery.

HOME PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	HOME teams participated with faith-based organizations and community groups to engage the clients and locate and provide resources to the underserved.	Completed and ongoing	Meetings and conversations	
• Community education to increase mental health awareness and decrease stigma	HOME team provided regular education in the community when engaging in outreach as well as participation in community meetings for participants to learn about services and trainings on how to engage those with mental illness.	Completed and ongoing	Ongoing training and feedback	This occurs in every interaction with the community. Presentations to Council Districts, Board offices, City officials etc.
• Field-based services	All services performed by this program are in the field.	Completed and ongoing	Outcome data collection	100%
• Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	The team had been a part of creating new policies around medication delivery in the field to support clients who are unable to attend to this task independently.	Completed		
• Augmentation of mental health service accessibility to underserved population	The program's goal was to provide mental health services in the hardest to reach places and for those who are unable to access or unwilling to access services.	Completed but always in progress to find new and innovative ways to serve	Monitoring caseloads to ensure clients being served meet focal population	100%
• Interagency Collaboration	An essential function of the program was to work collaboratively with the other outreach teams in the homeless services arena	Completed but also always in progress. Collaboration is ongoing	Regular meetings, feedback, surveys	Creation of interagency planning and outreach. This happens

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	including Los Angeles Homeless Services Agency, Housing for Health, street medicine teams and community partners			daily across the County.
• Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	The staff of the HOME team represent a multitude of cultural backgrounds and utilize numerous languages to engage the community when doing outreach.	Completed and ongoing	Ensuring during hiring process and attempts at retention	
• Integration of physical health, mental health, and substance use services	The HOME team was comprised of individuals who can provide all these services. When additional support is needed, the team links clients to these services within the community and with the lowest barriers possible.	Completed and ongoing	Ensuring during hiring process and attempts at retention	
• Trainings/case consultation	The team provided training to community partners, organizations, and stakeholders regularly. There was a regular case consultation for homeless services sector as well as with other LACDMH of Mental Health partners.	Completed and ongoing		

CONSUMERS SERVED BY HOME PROGRAM
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
7933A SA1 HOME	48				14	1	30	6	50	48.8		1.3									
7922A SA2 HOME	17				18	3	38	23	50.8	49.2											
7921A SA3 HOME	16		10		32	6	18	18	45.6	53.5		.9									
7924A SA4 HOME	32	1.28	2.56		13	4	26	21	61.5	37.8	.6										
7701A SA4 Skid Row HOME	43	1.96	.98		12	3	16	22	61.8	37.3	.98										
7934A SA5 HOME	31	1.49	3		12	3	33	16	49.3	50.7											
7917A SA6 HOME	51		2.24		13	4	13	17	38.8	61.2											
7929A SA7 HOME	11		3		33	7	28	18	52.5	47.5											
7935A SA8 HOME	35		1		10	1	25	27	54.5	45.5											

Note. Number reported in the table above is percentage (%). Total number of consumers served by HOME for FY 21-22 is 1,800.

Program/Project	Consumers' preferred languages	Languages represented by Program staff
7933A SA1 HOME	English and Spanish	English and Spanish
7922A SA2 HOME	English and Spanish	English, Spanish and Tagalog
7921A SA3 HOME	English, Spanish and Mandarin	English and Spanish
7924A SA4 HOME	English and Spanish	English and Spanish
7701A SA4 Skid Row HOME	English, Spanish and others	English, Spanish and Portuguese
7934A SA5 HOME	English and Spanish	English and Spanish
7917A SA6 HOME	English and Spanish	English, Spanish, Mandarin
7929A SA7 HOME	English and Spanish	English and Spanish
7935A SA8 HOME	English and Spanish	English, Spanish, Khmer

Housing and Job Development Division (HJDD) - Housing and Supportive Services Program (HSSP)

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

LACDMH remains key partners in discussions about equity issues in the homeless service system. An example is utilizing the California Policy Lab report and recommendations to determine changes in the system to eliminate inequities. The report revealed that the Coordinated Entry System survey used to determine vulnerability and housing needs has equity concerns for Black/African Americans and women. As a result, the University of Southern California (USC) and University of Los Angeles (UCLA) are working with system partners including individuals with lived experience of homelessness to develop a new tool using data to ensure the questions are not racially and gender biased. LACDMH has a Deputy Director on the Coordinated Entry System Triage Tool Research and Refinement Core Planning Workgroup with the researchers who are developing the new tool. LACDMH also has two housing specialists who are participating in piloting the new tool.

Another example of how they work to ensure services are culturally and linguistically appropriate is that, per the contract, providers are expected to hire staff who represent the cultural and linguistic needs of the population they serve. In addition, the HSSP program provides services at PSH locations to reduce barriers caused by lack of transportation.

HSSP'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Community education to increase mental health awareness and decrease stigma	HSSP administrative staff coordinated and provided trainings for staff working at Permanent Supportive Housing locations to promote increased understanding and competency around serving clients who experienced homelessness and had a serious mental illness. Training included overview of mental health conditions, crisis intervention, case studies, etc.	Ongoing	Meetings, Presentations/ Speakers/In-Service Trainings	
• Field-based services	HSSP providers contracted with LACDMH HJDD provide field-based services onsite at clients' homes, in project-based and scattered site settings. Bringing services on site to the clients reduces barriers and makes the services more accessible.	Ongoing	Meetings, Program Reviews / Site Reviews	
• Interagency Collaboration	HSSP staff collaborated on at least a monthly basis with various system partners including Housing for Health (HFH), Department of Public Health – Substance Abuse Prevention & Control (SAPC), Brilliant Corners, and others through regularly scheduled bi-weekly and monthly meetings.	Ongoing	Meetings	
• Integrated Supportive Services • Integration of physical health, mental health, and substance use services	Services were an integrated care model that include ICMS, HSSP and CENS. Services are field- based as they are on site at the housing development. Training was provided to the service providers as needed on the integrated service model expectations which were also detailed in the Statement of	Ongoing	Meetings, Program Reviews/ Site Reviews	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	Work LACDMH has with the HSSP providers.			
• Provider communication and support	HSSP staff had regularly scheduled meetings with providers to offer case consultation, technical assistance, and monitor adherence to program goals.	Ongoing	Meetings, Phone Calls	
• Trainings/case consultation	HSSP coordinated training for providers as needed. HSSP staff also provide case consultation to providers around challenging cases and collaborate to ensure goal of helping clients maintain their housing.	Ongoing	Meetings, Phone Calls, and/or Presentations/ Speakers/In-Service Trainings	
• Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriateness and equity	HSSP staff met regularly with Department of Health Services - Housing for Health (HFH) staff to discuss: improving service coordination, ensuring equitable service delivery, and disparities faced by participants and how to reduce these disparities	Ongoing	Meetings	

CONSUMERS SERVED BY HSSP
FY 21-22

Program /Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
HSSP	1,330	53	56	0	680	16	1,059	239	1,443	1,282	6	14	1	0					2,753		Unknown

Program/Project	Consumers' preferred languages	Languages represented by Program staff
HSI / HSSP	English, Spanish	English

Law Enforcement Teams (LET)

This co-response/mutual aid model pairs a LACDMH mental health clinician with a law enforcement officer. The primary mission of LET is to respond to 911 calls or patrol officer requests for assistance on calls involving mentally ill, homeless, or high-risk individuals.

The LET ensures that the individuals in crisis receive appropriate, specialized care, and safe transportation to the treatment facilities. LET and LACDMH's Psychiatric Mobile Response Team (PMRT) support one another as resources permit.

The LET utilizes data to decide on the needs of services to be delivered. Crisis Services adapt to the needs of the community based on their linguistic and cultural needs. For example, if a call comes and requires a Russian speaking, the call will be assigned to a team that has the language capability to ensure services delivered in an effective and culturally sensitive manner.

Linkage Programs

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

Men's Community Re-Entry Program (MCRP)

MCRP is a mental health forensic program that is based on evidenced models to increase prosocial methods of living and reduce maladaptive behaviors. The mission of MCRP is to reduce recidivism and facilitate community reintegration by treating mental health symptoms and modify poor decision-making behaviors that impair a client's ability to meet his needs. The population of MCRP consists of justice-involved men 18 to 65 years of age who present with high criminogenic risk factors and moderate acuity of mental illness. The clients must commit to program participation for a minimum of one year and maximum 18-24 months.

MCRP program utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to the communities served. MCRP has identified that there are certain types of individuals who have committed a specific type of crime (i.e., sex offenses) that tend to be rejected more from housing, employment, educational institutions or even treatment programs. As a result, this data/information has helped the program to advocate for these individuals' rights, especially the right for housing and services. The MCRP staff have met with Public Defenders, community representatives, and other professionals to address such need. Individuals who have been convicted of a sexual offense are part of a specific group being discriminated for their criminal background.

In general, justice-involved men are more discriminated against compared to justice involved-women, not only for their criminal background, but also for the type of mental health illness they have been diagnosed with. Opportunities are less for these men, especially when it comes to services in the community. This data has helped MCRP to address the need in the community to better serve these individuals and help them in the process of rehabilitation and reintegration.

The MCRP's projects/activities are reflective of the LACDMH's goal to render services based on the client's cultural needs and language as well as intellectual capacity. The program also has access to language interpreters, including ASL interpreters, if needed.

Justice-involved individuals are identified as one of the most underserved groups. Reasons for this is their continual involvement in the justice system, their resistance toward treatment, and high risk for recidivism. By increasing the efforts to outreach, engage and implement projects/activities, these individuals' mental health, cultural, intellectual, and other non-criminogenic needs are being addressed.

MCRP'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Designation and tracking ethnic targets for MCRP	MCRP created an internal system to track the ethnic targets. This helped the program to know the client's ethnic group and attempt to match the client with a staff who might be able to meet his cultural needs, and/or consider service array that meets these needs.	In process	• Different statistic graphs were added to the client roster to determine the composition of the treated population. • MH Supervisors conducted monthly QA audits and in-person evaluations to gather data. • Access to LACDMH Power BI reports also helped to track ethnic groups MCRP serves.	Demographics of clients/clinical staff: <u>Clients</u> White- 15% Hispanic/L- 37% B/AA- 36% Multi- 5% Unreported- 7% <u>Staff:</u> Latino- 47% B/AA- 29% White- 0.9% Asian- 12%
• Field-based services	Field-based services were rendered to clients who are part of the program to educate and monitor their wellbeing. Concurrently, cultural needs were addressed, especially when they felt that they were being discriminated by housing programs, landlords, or educational institutions.	MCRP staff were working collaboratively with staff members from Interim Shelters, Residential Programs and Sober Living Facilities and addressed any disparities in terms of race, culture, or special needs.	Contact took place with the aforementioned on a weekly basis to identify the following: 1. Discrimination based on race or legal situation 2. Rejection of job or housing applications due to client's legal status 3. Decline of services due to culture, language, sexual orientation or legal status	Questionnaire/ Survey was in the process of being developed to report any form of discrimination, disparity, or injustice by an organization, housing program, landlord or service provider.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			Formal consultations took place at least once a month to make sure client's needs were addressed.	
• Interagency Collaboration	Collaborative discussion between forensic programs to address the cultural needs of the clients; panel discussion with experts to better serve the target population.	Collaborative meetings continued to take place three (3) times a month or when needed. Consultation with the following agencies/ systems: • Probation • Public Defender's Office • Social Model Recovery • Los Angeles Centers for Alcohol and Drug Abuse (LACADA) • Other Justice Involved programs	During these collaborative meetings program procedures and outcomes are discussed to determine the effectiveness of the program.	Based on Risk Assessment conducted every six (6) months: • 60% are experiencing homelessness • 74% experience homelessness • 89% report having a substance abuse problem. • 91% experience financial problems. • 100% justice-involved • 12% Justice Involved Individuals (JII) who have committed sexual offenses • 7% JII who have committed arson offense • 6% Undocumented • 68% Robbery/Theft Offense • 85% Adverse Family Background
• Multi-lingual/multi-cultural staff	LACDMH provides trainings to Spanish speaking staff to	Outreach and Engagement staff are better	Spanish speaking supervisor will need to meet with staff on	Language needs:

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
development and support Outreach and Engagement (O&E) efforts	help them learn and understand the specific clinical terminology when working with Spanish speaking clients. Terminology was used for better expression and cultural sensitivity when assessing clients.	equipped when assessing clients at jail and/or courthouses. Team has better knowledge of Spanish clinical and case management terminology.	a regular basis to address any obstacles, training needs or determine their effectiveness in addressing multicultural/ multilingual needs. Determine how many staff members have attended trainings in Spanish.	• 10% are Spanish speaking monolingual • 8% Unknown • 76% are English speaking • 47% of MCRP are Spanish speaking Staff • Less than 10% have knowledge of Spanish clinical terminology.
• Provider communication and support	Case consultations were being held. They were an excellent way of providing feedback and support when addressing cultural disparities or obstacles to the Responsivity Principle of the Risk-Need-Responsivity (RNR) Model.	Case consultations took place on a weekly basis. Clinicians and case managers are assigned to present a case addressing clinical and cultural factors pertaining to a client.	Management team attended the case consultation meeting and assessed the effectiveness of the meeting. Provided focus and structure on clinical/cultural needs.	The following are outcomes of scheduled time used for communication and support: 27% of monthly hours of work is spent on case consultation and in-service trainings.
• Partnerships with other Health Departments (DHS, DMH and DPH) on initiatives regarding cultural competence, linguistic appropriate-ness, and equity	Partnerships between DHS/DMH/DPH were initiated to address reentry needs for the justice involved population. Additionally, collaborative work between the Office of the Public Defender, LACDMH and Substance Abuse Treatment	The aforementioned meetings took place on a monthly or bi-weekly basis. The meetings are at the beginning phase of development.	• Track number of referral coming from the Collaborative Courts using Microsoft Teams application. • Determine how many cases are being provided with co-occurring services both by LACDMH and SA Residential Treatment Providers.	10% of referrals are coming from Collaborative Court identifying high levels of substance use and moderate to high acuity of Mental Illness (MI). 68% of referrals come from Court Linkage with specific needs such monolingual speakers, homeless, special needs.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	providers initiated to address the lack of housing and treatment services provided for the most disadvantaged clients who are in need of intensive services.		• Determine appropriateness of referral and match with the program and capacity of program to meet the needs.	10% of referral come from Public Defender's Office- high acuity of mental illness and multiple co-occurring disorders. The rest comes from various programs.

ADDITIONAL STRATEGIES UTILIZED BY MCRP
FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Partnerships for reentry program clients to support educational and vocational goals	Addictions Studies Counselor Training certificate program in partnership with East LA College. Dream Project – access to private donors to nominate reentry clients for funding of vocational education.	Employment and Education Specialists meet with schools and employers. Employment and Education Group has initiated. Multidisciplinary team becoming more familiar with the aptitude and abilities of each client.	• Monthly meeting takes place between Education and Employment Specialists and schools • Psychologist conducts testing to identify strengths and areas needing improvement • Identify level of readiness for education and/or employment	1. 98% of clients were unemployed 2. 23% had a learning disability 3. 76% showed deficits in problem-solving skills. 4. 15% demonstrated interest in school and/or education. 5. 98% were at the onset of the process.
• Sexual Identify and Health areas needing attention and treatment.	• Meet with medical staff from jail prior to conditional release to identify the health needs of inmates. • Develop Health Group to address their needs such as living with and	In Progress.	• Developed a Committee to begin addressing the aforementioned needs. • Identify areas of discussion that will	In need of identifying measurable goals using instruments and/or questionnaires.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	treating HIV and other health conditions. • Work in collaboration with the Los Angeles Gay and Lesbian Center to develop a curriculum that will address the emotional and psychological needs of the LGBT justice-involved clients.		be included in the curriculum. • Consult with the Los Angeles Gay and Lesbian Center	
• Fatherhood and developing family connections for JI men.	• Developed support group to address this gender specific need for men that has been historically neglected or denied. • Worked in collaboration with DCFS to identify the terms and conditions that are being set for some of the men in order to achieve reunification. • Removed biases or pre-conceived ideas that might prevent professionals from properly serving this population.	In progress	• Developed a Committee to begin addressing the aforementioned needs. • Identify areas of discussion that will be included in the curriculum.	In progress

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CONSUMERS SERVED BY MCRP
FY 21-22

Program /Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability (specify)
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
MCRP 7995	55	0	0	0	57	7	23	10	152		0	0	0		2	8	128			14	3

Program/Project	Consumers' preferred languages	Languages represented by Program staff
MCRP 7995	English and Spanish	English and Spanish

Women's Community Re-Entry Program (WCRP)

WCRP provides clinic-based and field-based mental health services to women with a history of incarceration. The mission of WCRP program is to empower women with hope, alternatives, and skills for a better tomorrow. The main goal is to assist women who have been incarcerated to reintegrate and become successful members of their communities. WCRP is a field-based program and the WCRP services are available countywide by referral, call-in and walk-in. Their services are available in Spanish, Armenian, Korean and Tagalog.

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

WCRP staff also recognize and address the cultural and linguistic needs of their clients. WCRP staff consists of bilingual and bicultural Community Health Workers from diverse backgrounds. In addition, the WCRP staff regularly participate in trainings related to the

forensic population and utilize this information to inform outreach and engagement practices and the identification of culturally competent resources.

CONSUMERS SERVED BY WCRP
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify)	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
WCRP	54	1	0	0	0	12	12	93 (unknown)	0	200	1	0	0		unknown	unknown	unknown				

Maternal Mental Health (MMH)
MMH program provides specialized mental health services tailored to address the unique experiences that parenthood presents. MMH is designed to support families who may be currently pregnant, plan to become pregnant, or post-partum, typically up to two years after childbirth. Services are tailored to meet specific cultural competency. For example, MMH has groups that target specific groups of women (i.e., African American support group, Teen Parent support group, Pregnancy and Infant Loss). The clinicians are also trained in cultural competence. These services are open to all birthing people.

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

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

In addition, Social Determinants of Health data at the SA level was reviewed and evaluated to ensure that underserved communities, such as the Latino and Latinx, API, and African American groups were provided with mental health community support and education, linkage, and resources pertaining to maternal mental health. Furthermore, data pertaining to mental health disparities in LA County was utilized to determine the areas, ethnic/cultural groups, and linguistic needs for the targeted population for this program. It must be noted that the Electronic Medical Record (EMR) system, Integrated Behavioral Information System (IBHIS) currently does not collect demographics that are linked to pregnancy or maternal health services.

The table below illustrates examples of the MMH program's strategies and activities dedicated to enhancing cultural and linguistic competence during FY 21-22 by Service Area (SA).

SA 1 MMH - ANTELOPE VALLEY MHC (AVMHC) & OUTREACH AND ENGAGEMENT, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Community education to Increase mental health awareness and decrease stigma	The SA MMH Leads provided outreach and educational presentations and support groups to community agencies, community members, faith-based organizations, and participate in community resource fairs throughout the County, informing them of their services and providing education on the mental health needs of pregnant women.	Ongoing	The SA MMH Champions provided outreach and educational presentations to community agencies, faith-based organizations, and participate in community resource fairs throughout the County informing them of their services and providing education on the mental health needs of pregnant women. In SA 1, the following groups were offered to community members: Mom Squad; African American Women Empowerment Group;	Average weekly attendance per group is 5-12 women for each program.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			Pregnancy and Infant Loss Group Spanish Groups, Operation Motherhood.	
	To promote services and raise awareness for MMH services, Antelope Valley Mental Health Center (AVMHC) hosted an event to raise awareness for MMH services and support in the Antelope Valley.	Ongoing annually	AVMHC Partnered with ten community providers: DMH, DPH, Children's Center of the Antelope Valley- WE DO Department of Health Services Department of Health Services- Mama's Program Liberty Dental Barts Altadonna Community Health Center Women, Infants & Children Program Antelope Valley Partners for Health Cal MHSA provided resources to raise awareness for Maternal Mental Health services in the Antelope Valley.	Served 234 community members raising awareness to Maternal Mental Health issues.
• Interagency Collaboration - Triage/case Consolation	The MMH Leads regularly interfaced with DHS, DPH, and other governmental entities to address community needs and linkage services to mental health resources.	Ongoing	Working in collaboration with these agencies support the MMH's mission to provide community education, reduce mental health disparities and stigma. In addition, LACDMH actively worked with DHS to make referrals to the Transitional Aged Youth (TAY) Full Service Partnership (FSP) Program, the Young Mothers and Babies FSP program, and the MMH Champions Program.	DHS refers 6-12 mothers to LACDMH for ongoing mental health services on a monthly basis in each SA.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Interagency Collaboration	The MMH Leads regularly interfaced with DHS, DPH, Department of Children and Family Services (DCFS), and other governmental entities to address community needs and linkage services to mental health resources.	Ongoing	Working in collaboration with these agencies support their mission to provide community education, reduce mental health disparities and stigma. In addition, LACDMH actively worked with DHS to make referrals to the Transitional Aged Youth (TAY) Full Service Partnership (FSP) Program, the Young Mothers and Babies FSP program, and the MMH Champions Program.	
• Outreach and Engagement	Linking with other service providers	Ongoing	Referrals were sent to the MMH Champions, who regularly monitor new incoming clients.	LACDMH is referred 10-15 clients by various providers on a monthly basis.
• Collaboration with faith-based and other trusted community entities/groups	In SA 1, they actively collaborated with DPH and the Antelope Valley African American Infant and Maternal Mortality outreach and engagement workgroup to increase awareness about African American mortality rates and promote mental health. In addition, the SA 1 MMH Lead tabled the Black Maternal Health Expo and presented on Maternal Health in the African American Community. Lastly, they partnered with Women's Pavilion and other agencies.	Ongoing / Annual	The purpose of the workgroup was to decrease maternal mortality and birth related death by addressing racial disparities. In addition, these collaborations increase awareness about maternal health for all populations as well as addressing unequal maternal care for disadvantaged populations.	presentation was conducted to over 65 participants in the community.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	The partnerships in SA 7 include: Mexican American Opportunity Foundation, Montebello YMCA, and Eastern Los Angeles Regional Center.			
• Training/Case Consultation	Consultation and support to the following community entities/groups Operation Motherhood Group; The Village African American Mental Health Support group; High Desert DHS OBGYN Clinic; MOMMA DHS program; the Service Area 7 Birth to Five DCFS Collaboration; and LA County Health Services' MAMA's Neighborhood Program.	Ongoing	They continued requests for these consultations targeting different ethnically diverse communities in the County.	Over five (5) trainings were conducted on Perinatal Mental Health and Black Maternal Health
• SA 8 Maternal Mental Health Champions Program	This program provided psychotherapy and psychiatric services focused on perinatal mental health. Further, consultation and linkage services to LACDMH for DHS-wide MAMAS Program are coordinated. In addition, Perinatal Depression, Anxiety, and mental health education, supportive, and preventative mental health activities/skill-building groups (in English and Spanish) were conducted within the SA.	Ongoing	The purpose of the MMH Champions Program in SA 8 was to increase awareness about maternal health for all populations as well as addressing unequal maternal care for disadvantaged populations.	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Co-location with other County Departments	In SA 1 and SA 8, collaborating with DPH and DHS to increase awareness about maternal mental health issues and how that impact pregnant women from underserved communities. They provided co-located services at different sites and areas within LA County as an effort to increase community reach and engagement.	Ongoing	The co-located efforts increased awareness about maternal health for all populations as well as addressed unequal maternal care for unserved and hard-to-reach communities.	
• Field-based Services	The Young Mothers and Babies Full Services were field-based and provided comprehensive mental health services for pregnant and parenting young women and their infants or toddlers through a trauma-informed, developmentally-biologically respectful, and relationship-based approach.	Ongoing	The program provided field-based services in SA 7. The clinical staff which is composed of mental health clinicians, a nurse, and case managers also provide in-home services as a way to increase engagement with underserved/hard to reach populations.	

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CONSUMERS SERVED BY SA 1 MMH – ANTELOPE VALLEY MHC (AVMHC) & OUTREACH AND ENGAGEMENT, FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
African American Women Empowerment Group	27									27											
Mom Squad	1				2		3			6											
International Maternal Mental Health	66	3	6		78	34	47		78	149				7					134		
Operation Motherhood	16	2	1		76	12	44			151	3		2		1	4			23		
The Village	44					11				55			2		2	3			10		

Program/Project	Consumers' preferred languages	Languages represented by Program staff
African American Women Empowerment Group	English	English
Mom Squad	English	English
International Maternal Mental Health	English and Spanish	English and Spanish
Operation Motherhood	English and Spanish	English and Spanish
The Village	English	English

SA 4 MMH - HOLLYWOOD MENTAL HEALTH CENTER
FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Building a specialized MMH workforce	Developed specialized team to address need for accurate and compassionate MMH care to clients	Developed	Monitored by supervisor	Clients referred to the specialized team as indicated by pregnancy, post-partum.

SA 6 MMH - AUGUSTUS F. HAWKINS FAMILY MENTAL HEALTH CENTER (AFHFMHC), FY 21-22

Department wide strategies and more	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Co-location with other county departments.	Active collaboration with DHS to increase awareness about Perinatal Mood and Anxiety Disorders (PMADS) and psychosis and how they impact pregnant persons from unserved/underserved communities.	Ongoing	The co-located efforts increased awareness about maternal health for all populations as well as address unequal maternal care for unserved and underserved groups. In addition, the co-location sites facilitated the referral process to mental health services, as LACDMH clinicians could readily screen and assess for mental health symptoms and medical necessity eligibility.	
• Interagency Collaboration	Collaboration with DHS Women's Clinic at Martin Luther King Outpatient Clinic and DHS-wide MAMA's Neighborhood Program, DPSS, WIC and DCFS.	Ongoing	The collaboration among agencies allowed LACDMH to increase mental health services, education, and awareness of Perinatal Mood and Anxiety Disorders and psychosis (PMADs) to SA 6 consumers. Moreover, the collaboration facilitates	

Department wide strategies and more	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			accessibility to mental health services that include psychotherapy, medication management and case management services to DHS consumers.	
• Flexibility in FSP enrollment such as allowing "those living with family" to qualify as "at-risk of homelessness"	SA 6 consumers referred to the LACDMH MMH Program with a history of Severe Mental Illness (SMI) and in need of intensive mental health services are immediately referred to SA 6's FSP for comprehensive mental health services. The FSP team was composed of a clinician, case manager, nurse, and psychiatrist providing field-based services to at risk underserved and unserved populations.	Ongoing	The flexibility of enrollment to SA 6 FSP at AFHFMHC allows for MMH Champions to easily link at-risk consumers struggling with PMADs and have a history of SMI, to intensive, comprehensive mental health services.	
• Collaboration with faith-based and other trusted community entities/groups	SA 6 MMH Champions staff collaborated with Baby 2 Baby, and Hellen Keller Park.	Ongoing	Outreaching and collaborating with community-based entities/groups resulted in securing essential baby supplies for SA 6 consumers. The collaboration also allowed for LACDMH staff to reach new audiences and increase awareness and education about PMADS and accessibility to LACDMH services.	
• Trainings/Consultations	SA 6 LACDMH MMH Champions provided support and consultation to DHS MLK Women's Clinic and DHS MAMA's Neighborhood Program	Ongoing	MMH Champions were continuously available to consult regarding potential clients for LACDMH services. In addition, MMH Champions had a standing	

Department wide strategies and more	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			meeting with DHS staff at MAMA's Neighborhood and Women's Clinic for case consultations.	
• Engagement and outreach activities			MMH Champions provided the following groups to SA 6 community members: • Minds of Mothers (MOMi) • Life Skills Group • After Glow Support Group • Parenting & Substance Use Classes • Financial Group	

SA 7 MMH - ROYBAL FAMILY MENTAL HEALTH'S YOUNG MOTHERS AND BABIES FULL-SERVICE PARTNERSHIP (FSP) PROGRAM & SA 7 PERINATAL AND EARLY CHILDHOOD MENTAL HEALTH CHAMPIONS TASK, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	"Shifting Physiology through Reiki to create Safe and Meaningful Dyadic Relationships" Presented by: Rocio Ortiz Luevano, L.C.S.W., Infant-Family and Early Childhood Mental Health Specialist (IFECMHS) Supervisor of the Young Mothers & Babies FSP Program.	Completed		One presentation provided to the SA 7 Clergy Roundtable
• Community education to increase mental health awareness	Presentation on Perinatal Depression provided to the consumers of LA Care Community Resource Center in LA to help educate consumers and	Ongoing		Presentation on Perinatal Depression provided to 20 consumers of LA Care Community

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
and decrease stigma	reduce stigma and raise awareness around Perinatal Mood and Anxiety Disorders.			Resource Center in LA
• Field-based services- Service Area 7 Roybal Family Mental Health's Young Mothers and Babies Full Service Partnership (FSP) Program	The Young Mothers and Babies Full Services Partnership (FSP) Program provided comprehensive mental health services for pregnant and parenting young women and their infants or toddlers through a trauma informed, developmentally-biologically respectful and relationship-based approach.	Ongoing	The program was allocated 25 children's slots and 25 adult shots, totaling 50 slots. Currently, the program's enrollment was over capacity in children's slots and building capacity for the adult slots.	For FY 21-22, 110 clients were served by the Young Mothers and Babies FSP Program.
• Outreach and Engagement (O&E) activities- Service Area 7 Roybal Family Mental Health's Young Mothers and Babies FSP Program	The Young Mothers and Babies Full Services Partnership (FSP) Program provided comprehensive mental health services for pregnant and parenting young women and their infants or toddlers through a trauma informed, developmentally-biologically respectful and relationship-based approach.	Ongoing	The program provided Outreach and Engagement activities for potential clients.	The number of clients in O&E fluctuated. Two (2) Adults in O&E and seven (7) Children in O&E.
• Integration of physical health, mental health, and substance use services- Service Area 7 Roybal Family Mental Health's Young Mothers	The Young Mothers and Babies Full Services Partnership (FSP) Program provided comprehensive mental health services for pregnant and parenting young women and their infants or toddlers	Ongoing	The Young Mothers and Babies Full Services Partnership (FSP) Program had a Registered Nurse (RN) on staff who provided well baby and medical evaluation activities to	The number of clients provided well baby and medical evaluation activities varies.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
and Babies FSP Program	through a trauma informed, developmentally-biologically respectful and relationship-based approach		the mothers in their program.	
• Trainings/case consultation	"Shifting Physiology through Reiki to create Safe and Meaningful Dyadic Relationships" Presented by Rocio Ortiz Luevano, L.C.S.W., IFECMHS Supervisor of the Young Mothers & Babies FSP Program.	Ongoing		This training was provided to: • SA 7 Southeast LA Health Neighborhood • SA All Staff Meeting • Staying Connected and Informed Hall Series • Clergy Roundtable • SALT 7 • SA 7 Birth to Five Collaborative

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CONSUMERS SERVED BY SA 7 MMH- ROYBAL FAMILY MENTAL HEALTH'S YOUNG MOTHERS AND BABIES FULL-SERVICE PARTNERSHIP (FSP) PROGRAM, FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
Roybal Family Mental Health's Young Mothers and Babies Full-Service Partnership (FSP) Program	1 %	2 %	2 %		92 %	1 %	2 %		30 %	58 %						2 %	98 %				

Program/Project	Consumers' preferred languages	Languages represented by Program staff
Roybal Family Mental Health's Young Mothers and Babies Full-Service Partnership (FSP) Program	English and Spanish	English and Spanish

My Health Los Angeles (MHLA) Behavioral Health Expansion Project

LACDMH is utilizing MHSA funding to support mental health prevention services and/or activities focused on prolonged engagement to help build protective factors and reduce/manage risk factors associated with the onset of serious mental illness of low income, MHLA participants. The services are being provided at Community Partner Clinics contracted by DHS and DMH is the project administrator.

The MHLA Behavioral Health Expansion Project was designed and implemented to address disparities in mental health service provision among a population that had been traditionally uninsured and underserved. Its mission is to incorporate mental health prevention-based services via 28 community health clinics, which are providing medical services throughout Los Angeles communities via the DHS program known as My Health LA.

The project contributes to LACDMH's goal of delivering culturally and linguistically competent services by providing mental health prevention services in a less stigmatizing venue such as community-based comprehensive health care clinics. The target population is traditionally underserved, mostly monolingual Spanish-speaking individuals who are uninsured and have low income.

In fact, many LA County residents do not have Medi-Cal or other health insurance, so they have very limited options to receive mental health services for low-level acuity depression and anxiety. The MHLA Behavioral Health Expansion Project's mission is to ensure that LA County residents who are uninsured and underserved can access vital mental health-based services.

MHLA'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
Pertinent to the 31 Countywide strategies, the MHLA program endorses the following: • Collaboration with faith-based and other trusted community entities/groups • Community education to increase mental health awareness and decrease stigma • Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery • Augmentation of mental health service	For each of the six (6) strategies noted in this table, LACDMH utilized a variety of activities (noted here) such as ongoing technical assistance calls individually with each clinic and in group meetings with various roundtables (CEOs, CMOs, BH Directors, and QI Managers) from the clinics and the Clinic Association. Examples of the content of such calls included ways of messaging to the communities that these Mental Health Prevention services are available, also working with clinics medical teams to increase their collaboration with their behavioral health teams on how to do warm handoffs. LACDMH works with DHS to make	Status and progress in each of these six (6) areas remained fluid as this is a pilot program, and so changes and improvements were constantly evolving as this project moves into its 3rd fiscal year of implementation. Challenges of implementation were met with and resolved through a scope of project adjustment as needed and agreed upon by all parties to the extent possible.	LACDMH through technical assistance calls was continually working with Community Partners (CPs) on reviewing a clinic's business and clinical workflow, to see what improvements can be made which might increase the access to these services. LACDMH routinely conducted Quality Improvement (QI) virtual site reviews with each CP to go over claiming, data submission,	

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
accessibility to underserved populations • Integration of physical health, mental health, and substance use services • Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	sure the dedicated DHS-MHLA website was having its web postings updated for public view and access. Another example of how this program looked to enhance its collective cultural competence was by having made sure that 100% of the exercises in its three (3) LACDMH created Mental Health Prevention curriculums were available in Spanish to ensure the population served as access to key materials in their preferred language.	For example, expanding the use of allowed outcome measures (added the PHQ-2) to be incorporated in a mental health services prevention screening process to help the clinics medical teams that are doing some of the initial mental health prevention screenings.	as well as a review of documentation.	

CONSUMERS SERVED BY MHLA
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
MHLA BH Expansion Project	42		894		25,835	32	220		9,614	17,972				17							

Program/Project	Consumers' preferred languages	Languages represented by Program staff
MHLA BH Expansion Project	Top five: English, Spanish, Armenian, Korean, and Thai	Community Providers were able to offer services in these languages.

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

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

SE Program utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to the communities by reviewing data (e.g., penetration rate and client demographics) provided by the LACDMH Quality and Improvement (QI) Unit and implementing strategies to identify and recruit volunteers from diverse backgrounds. For example, the SE program includes volunteers from the API, Latino, Russian, and African American communities.

The Outpatient Services Division administrative team continuously outreaches to Older Adult LACDMH programs/mental health providers and takes into account their cultural needs to identify appropriate placement for Older Adult Service Extenders. During the FY 21-22, the Outpatient Services Division had twenty-six (26) SEs representing multiple ethnic backgrounds, cultural groups, and language capabilities. Eight (8) Older Adult SEs volunteered at LACDMH Directly Operated clinics, and twelve (12) Older Adult SEs volunteered at LACDMH Contracted Providers. Six (6) Older Adult SEs were in the process of completing the requirements for placement.

The Older Adult SE Program increases access to mental health services by helping clients navigate the mental health system. This is accomplished through SEs sharing their lived experiences from a culturally and linguistically appropriate perspective.

OLDER ADULT (OA) SERVICE EXTENDERS (SE) PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
Multi-lingual/multi-cultural staff development and support	Sample training activities 8/23/2021 (video presentation) Attendees: 13	Service Extenders (SEs) shared their experiences of working with clients from diverse cultural	SE quarterly meetings are well-attended by SEs. The meeting agenda is	8/23/21: 13 Attended 12/31/21: 13 Attended

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	Topics: "Managing your Stress/Self-Care strategies" presentation "Good Sleep" Applying for Community Health Worker (Human Resources presentation) 12/13/21 Attendees: 13 Topics: "Discover your Passion" presentation "Holiday Blues" presentation 04/18/22 Attendees: 12 Topics: COVID-19 update by Department of Public Health "The Impact of Compassion Fatigue and the Importance of Self-Care" presentation	backgrounds and receive feedback from facilitators and their peers. SEs were regularly invited to attend relevant training opportunities to enhance their knowledge and capacity to promote health, well-being, and access to underserved populations.	carefully designed to support SEs and to enhance their skills of working with diverse Older Adults in Los Angeles County. The program manager and designated staff inform SEs upon receipt of these trainings, and as needed, assist and support the SEs to participate.	04/18/22: 12 Attended

Prevent Homelessness and Promote Health (PH)²

(PH)² is a LACDMH Countywide field-based program that provides assessment, crisis intervention, short term intervention and linkage to ongoing mental health services and other supportive services. People previously homeless, currently housed, who are at risk of returning to homelessness due to untreated or under treated serious and persistent mental illness are referred by Intensive Case Manager Service (ICMS) providers with the intent of ameliorating mental health symptoms putting them at risk of losing their housing.

(PH)² uses an interdisciplinary approach through coordination with Department of Health Services (DHS), Housing for Health (HFH) Intensive Case Managers (ICMS), LACDMH, and other community service providers to address risk factors threatening the stability of Permanent Supportive Housing (PSH). All services are provided in the community where the individual lives to promote access to care. (PH)² conducts triage, risk assessment, crisis evaluation and response, coordination of supportive services, brief clinical interventions, and linkage to appropriate level of ongoing mental health services to achieve long-term housing stability and prevent recidivism to homelessness.

Each referral is reviewed to meet program criteria and provide the full scope of services available. Every individual/family referred to this program is met with culturally competent clinicians who regularly participate in state-of-the-art cultural competency trainings. (PH)² has, six (6) Bilingual Spanish staff, and all staff have access to and are proficient in utilizing interpretation services which include a list of approved contractors for language interpretation as well as American Sign Language (ASL) services. The program also has three (3) veteran staff who can speak to people who have experience with having served in the military. They have one staff with Peer certification as well. Their lived experience is an amazing benefit not just for staff but to the population they serve. In addition, they have two (2) staff who have completed special studies and keep abreast of current developments in the area of LGBTQIA+. The projects and activities of (PH)² program have been contributing to LACDMH's provision of culturally and linguistically competent services. The program provides mental health stabilization addressing risk factors of all adult persons who are at risk of returning to homelessness regardless of race/ethnicity, gender/gender identity/ culture or spoken language. It is their goal to identify staff who reflect the population they serve.

(PH)² PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Consultation to gatekeepers	Monthly meetings with Intensive Case Managers (ICMS) to discuss cases	Ongoing	Meetings took place four to seven (4-7) times a month. Cases are	Up to three (3) ICMS agencies present cases to LACDMH and DHS. A total of 167 cases were

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	with mental health needs.		brought to case conferencing for assignment to this program.	accepted during this period. Eighty-three evictions prevented.
• Countywide FSP Networks to increase linguistic/cultural access	Assessing for FSP criteria and conducting linkages when indicated.	Ongoing	Data collected in IBHIS Activity Log	18 Referrals were made to FSP and accepted for services.
• Field-based services	Target population: individuals who previously experienced homelessness or at risk of returning to homelessness were met in the community where they live.	Ongoing	Data collected in IBHIS	167 individuals received mental health stabilization services.
• Augmentation of mental health service accessibility to underserved populations	Target population: individuals who previously experienced homelessness at risk of returning to homelessness. Only one other program currently providing similar services: Housing Supportive Services.	Ongoing	Gatekeeping accepts all referrals that meet target population regardless of location w/in LA County, language, ethnicity/race, gender/gender identity.	167 individuals received mental health stabilization services
• Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in	Staff had access to and were proficient in utilizing interpretation services which include a list of approved contractors for language	Ongoing	Data collected in IBHIS.	Seventeen (17) Monolingual Spanish individuals were served and one (1) monolingual Polish was served.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
clinical appointments as well as the Cultural Competency Committee, UsCC subcommittees, SALTs, mental health commission, and other stakeholder group meetings	interpretation as well as American Sign Language services (ASL).			
• Integrated Supportive Services	All services available were utilized for stabilization: In-Home Supportive Services (IHSS), Benefits connection such as Countywide Benefits Entitlement Services Team (CBest) & General Relief, Utility assistance, Food, PPE, Pet supplies, Primary care, Clothing, Basic necessities.	Ongoing	Data collected in IBHIS	Linkages: IHSS: 33 Benefits: 28 Utility assistance:2 Food:49 PPE: 117 Pet Supplies: 32 Primary Care: 107 Clothing:43 Basic necessities:135
• Interagency Collaboration	Daily collaborative calls with ICMS providers, coordination of care with Mental Health (MH) providers of past services for re-linkage as well as to DO and contracted MH providers for current services. Consultation with Adult Protective Services (APS),	Ongoing	Data Collected in IBHIS	

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	Law Enforcement, Housing Specialist			
• Integration of physical, mental, and substance use services	○ Training provided to ICMS and HFH staff. ○ Each referral resulted in consultation with referring party ○ Bi-weekly case consultation with Housing for Health ○ Collaborative outreach with LACDMH and ICMS	Ongoing	IBHIS Activity Log	102 DHS collaborative cases were carried during this period
• Integration of physical health, mental health, and substance use services	Assessment of needs identify areas of support needed. Staff worked collaboratively with Housing for Health nurses to provided evaluation and treatment. Conversely Housing for Health identifies individuals that need mental health services and both DHS and LACDMH utilize SASH hotline and substance abuse treatment providers.	Ongoing	IBHIS Activity Log	Seventy-one (71) referrals accepted with SUD issues. 102 referrals accepted for collaborative outreach/engagement with DHS.

CONSUMERS SERVED BY (PH)[2]
FY 21-22

Program /Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
(PH)[2]	48	1	5	1	38	6	31		88	63	2										Chronic health condition: 14
																					Mobility Disability: 25
																					Hearing: 1
																					Seeing: 2

Program/Project	Consumers' preferred languages	Languages represented by Program staff
Prevent Homelessness Promote Health (PH)[2]	Spanish	Spanish

Prevention and Early Intervention (Older Adults) - Anti-Stigma & Discrimination (ASD)

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

The older adult population in LA County is ethnically and racially diverse and it is estimated that by 2030 the older adult population, ages 60 and older, will increase to about 3 million (https://www.bscc.ca.gov/wp-content/uploads/Demographic-Reference-Data-Los-Angeles.pdf).

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

The Older Adult ASD's projects/activities contribute to LACDMH's provision of culturally and linguistically competent services. For example, the ASD team regularly outreaches to Senior Centers, Senior Housing locations, Faith Based Organizations, and other community-based settings where older adults gather to provide presentations, taking into account their cultural/language needs.

During FY 21-22, the Older Adult ASD Team participated in 115 events and conducted virtual and in-person community presentations outreaching to 1,510 LA County residents. These events include countywide educational presentations, community meetings, and collaboration with various agencies. The presentations were conducted in-person and virtually at various facilities targeting older adults. These presentations were delivered in a culturally sensitive and linguistically appropriate manner (English, Spanish, Farsi, Armenian, and Korean). The Older Adult ASD promotes access to mental health services by conducting community presentations related to mental health and wellness for older adults. This includes providing information regarding how to access mental health services throughout LA County.

PREVENTION AND EARLY INTERVENTION (OLDER ADULTS)- ASD PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with Faith-Based and other trusted community entities/groups	Community Presentations: Clergy Breakfast Meeting 12/10/2021 Church Program 8/5/2021 11/4/2021 3/3/2022 6/2/2022	Presented on various topics related to mental health: Grief and Loss; Hoarding; Know the Scams, Don't Be a Victim; Discover Your Passion; Holiday Blues	SA6 SA8	107 Participants

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Community Education to increase mental health awareness and decrease stigma	Community Presentations in English, Spanish, Farsi, Armenian and Korean Various Settings (Virtual and in-person): Community Centers Senior Centers Senior Housing Senior Health Fair Other (Library and City Hall)	Topics of Presentations: Depression and Anxiety; Good Sleep for Emotional Well-being; Health, Wellness and Wholeness; Hoarding; Holiday Blues; Social Isolation; Late-Life Transitions; Preserving your Memory; Resiliency; Know the Scams, Don't Be a Victim; Stress Management; Emotional Intelligence; Bullying; Managing your Medication; How Much is Too Much; Discovering your Passion; Don't Let Loneliness Harm your Health; Good Balance; Meditation and Mindfulness; Senior Health Fair	Countywide Presentations: (Virtual and In-Person) Number of Presentations Per Service Area: _____ SA1: 3 SA2: 27 SA3: 4 SA4: 14 SA5: 18 SA6: 6 SA7: 28 SA8: 15 Total Virtual and In-Person Number of Presentations:115	Virtual and In-Person Presentations (Number of Participants Per Service Area): SA1: 20 SA2: 269 SA3: 41 SA4: 407 SA5: 165 SA6: 70 SA7: 379 SA8: 159 Total Number of Virtual and In-Person Participants: 1,510
• Field-based Services	Community Presentations in the following languages: English, Spanish, Farsi, Armenian and Korean Various Settings Community Centers Senior Centers Senior Housing Senior Health Fair Other (Library and City Hall)	Topics of Presentations: Depression and Anxiety; Good Sleep for Emotional Well-being; Health, Wellness and Wholeness; Hoarding; Holiday Blues; Social Isolation; Late-Life Transitions; Preserving your Memory; Resiliency; Know the Scams, Don't Be a Victim;	Countywide In-Person Presentations: Number of Presentations Per Service Area: _____ SA1: 3 SA2: 15 SA3: 3 SA4: 5 SA5: 3 SA6: 5 SA7: 11 SA8: 2	In-Person Presentations: (Number of Participants Per Service Area): SA1: 20 SA2: 135 SA3: 27 SA4: 77 SA5: 29 SA6: 53 SA7: 197 SA8: 32

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
		Stress Management; Managing your Medication; Discovering your Passion; Senior Health Fair	Total Number of In-Person Presentations: 47	Total Number of In-Person Participants: 570

Promotores de Salud Mental and United Mental Health Promoters (UMHP) Program
The Promotores de Salud Mental and United Mental Health Promoters (UMHP) Program strives to reduce the stigma associated with mental illness among underserved cultural and linguistic communities in Los Angeles (LA) County by increasing awareness about mental health issues, removing barriers, and improving timely access to culturally and linguistically appropriate care and resources. The Promotores de Salud Mental Program was a pilot program initiated in 2010-2011 within the Latino, Spanish-speaking community. The UMHP Program is the multi-cultural expansion of the original program and the UMHP expansion started in November 2020. The unified programs merge a community leadership/peer-to-peer approach with support, guidance, and training from LACDMH-licensed clinicians. In addition, Senior and Supervising Community Health Workers who once served as Promotores and/or peer advocates provide mentorship and share knowledge and lived experiences to support the Mental Health Promoters further.

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

Promoters are from the communities they serve, and prior to the 2020 pandemic closures, they delivered face-to-face mental health workshops and resources in safe, trusting spaces within their communities. Following the pandemic Stay Home orders, Promoter activities shifted to virtual platforms, and for FY 21-22, the number of in-person workshops consistently increased each month. Further, close partnerships with LA County Board of Supervisors (BOS) staff were initiated in April 2021 to conduct vaccine outreach activities in person at vaccination sites and other community locations.

By the end of FY 21-22, the Promotores/UMHP Program had recruited and onboarded 159 Promoters. Breakdown by Service Area (SA), language and cultural community are shown in the following tables.

PROMOTERS BY LANGUAGE

SA	Amharic	Arabic	Chinese	English	Khmer	Korean	Spanish	Total
1				1			11	12
2				1		1	11	13
3			2	4		6	16	28
4	1			3		5	12	21
5				4		1	3	8
6				9			17	26
7				1		1	19	21
8		1		7	2	1	19	30
Total	**1**	**1**	**2**	**30**	**2**	**15**	**108**	**159**

PROMOTERS BY CULTURAL COMMUNITY

SA	AI/AN	API Cambodian	API Chinese	API Filipino	API Korean	AA*	Hispanic	Hispanic/ API Filipino	Middle Eastern/ European	Total
1						1	11			12
2					1	1	11			13
3	1		2		7	1	17			28
4					5	4	11	1		21
5					1	4	3			8
6						8	18			26
7	1				1		18		1	21
8	2	2		1	1	4	17	2	1	30
Total	**4**	**2**	**2**	**1**	**16**	**23**	**106**	**3**	**2**	**159**

***** Five (5) Promoters supported community members with physical disabilities and two supported the LGBTQIA2-S communities.
AA= African American

The UMHP program has utilized data related to mental health and social determinants of health, for example:

- LA County Daily COVID-19 Data [1]
- LACDMH Annual Quality Improvement Report and Work Plan, 2019 [2]
- LA County Key Indicators of Health [3]
- Mapping L.A. Neighborhoods [4]

[1] http://publichealth.lacounty.gov/media/Coronavirus/data/index.htm
[2] http://file.lacounty.gov/SDSInter/dmh/1077410_2019AnnualQIReport_Final.pdf
[3] http://publichealth.lacounty.gov/ha/docs/2015LACHS/KeyIndicator/PH-KIH_2017-sec%20UPDATED.pdf
[4] Mapping L.A. - Los Angeles Times (latimes.com)

These and other references have been cited to understand how the Social Determinants of Health (e.g., immigration status, economic burden, geographic region, social connection/isolation) interact with health disparities and COVID-19-related risk factors. These risk factors adversely and disproportionally impacted monolingual Spanish-speaking and other underserved priority populations in LA County. Communities of color bear a high and unequal burden in accessing and receiving health and mental health services. The impact of COVID-19 on already marginalized communities further exacerbates long-standing inequities that pervade the health care system and society at large. The communities served by the Promoters have been hardest hit by the pandemic, with residents getting sick and dying from COVID-19 at rates far exceeding White and primarily English-speaking communities. Each community in LA County has its own unique set of challenges, and Promoters, being from the communities they serve, are acutely aware of these challenges. Demographic data used by the UMHP program, further inform targeted outreach and service needs, including implementation of culturally relevant and geographically accessible referrals to areas in greatest need. Promoters' unique skills set allow them to provide culturally relevant services to address residents' most pressing mental health concerns while adeptly shifting their efforts when needed to focus on emerging and rapidly evolving situations.

Furthermore, the Promotores de Salud Mental and the UMHP program contribute to LACDMH's provision of culturally and linguistically competent services by focusing on the following activities and services:

- Reducing stigma - Through shared life experience, Promoters normalize the experience of living with a mental health condition. Through self-reflection and appropriate self-disclosure, Promoters are better able to support community residents in examining their thoughts and feelings about mental health issues.
- Educating communities - Promoters inform their communities about the signs and symptoms of mental health conditions and the impact of COVID-19 on mental and emotional health. Presentations address the impact that social determinants of health, such as neighborhood and physical environment, socioeconomic status, and social support networks may have on how individuals and families experience mental health conditions, and how they are treated. Promoters are not only trained on specific modules, but also on core competencies, such as how to engage communities, active listening and public speaking.
- Assisting community residents in accessing care – Promoters map their targeted community to identify culturally appropriate and geographically accessible resources, and link community residents with a wide range of services as appropriate. Based on the resident's needs and preferences, Promoters are the bridge between community members and formal and informal service settings, making referrals to settings such as support groups, women's centers, regional centers, Head Start, University of Southern California (USC) Wellness, community-based organizations, and mental health programs.

For residents facing cultural, linguistic, and economic barriers to mental health resources, providing the opportunity to receive services from knowledgeable members of their own communities means that significant mental health problems can begin to be addressed sooner and possibly be prevented from becoming worse with time. The program provides

an effective, economically feasible approach to offer culturally responsive grass-roots mental health outreach, engagement, and education to communities that may feel mistrust of government organizations or otherwise be unable to access mental health resources.

THE PROMOTORES DE SALUD MENTAL AND UMHP STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	Workshop presentations at faith-based locations	Promising Progress, continuing and increasing overall.	Location data is collected via MS Forms after each workshop is completed.	Number of workshops conducted at churches: 425
• Development and translation of public informing materials that address mental health education	Ongoing collaboration with Speaker's Bureau (SB) for review of translated material for cultural and linguistic accuracy as well as support in translation of documents. Cultural and linguistic adaptations of workshop material in Spanish, Korean, Chinese, Arabic, Amharic and Khmer	Promising Progress During FY 21-22, the work began to translate the PowerPoint workshop presentations in Korean, Chinese, Arabic, Khmer, Amharic.	Data was collected via MS Forms after each workshop is completed	Number of workshops conducted in diverse languages to the community: o 6,228 Spanish o 160 Korean o 29 Khmer o 17 Chinese o 18 Arabic o 1 Amharic Number of workshops conducted in English: 901 Total workshop attendees: 64,097

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Community education to increase mental health awareness and decrease stigma	15 workshops presented in the community to facilitate dialogue on mental health stigma and increase awareness of signs and symptoms to prevent and mitigate mental health struggles.	Promising Progress The average number of workshops increased from 561 per month in FY 20-21 to 613 per month in FY 21-22.	Data was collected via MS Forms after each workshop is completed.	Total Countywide Workshops conducted by Mental Health Promoters to the community: 7,354
• Consultation to gatekeepers	Program staff presented to the various cultural and regional stakeholder groups to notify of the program goals and efforts to reach diverse communities as well as to ask for support with promoting the job opening in their communities. The program presented at the Cultural Competency Committee (CCC) and Underserved Cultural Communities (UsCC) periodically to update cultural/linguistic stakeholders of the program efforts to reach their communities. Korean staff and Promoters consulted with newspaper staff about stigma in the Korean community.	Promising Progress Korean Promoters were interviewed by a Korean newspaper.	Data was collected via MS Forms for outreach.	Program staff presented the program efforts and job opportunities at the Access for All UsCC, SALT 4, American Indian/Alaska Native UsCC and at the Cultural Competency Committee. Korean Promoters were interviewed by a Korean newspaper.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic competent service delivery	Program staff presented to the various cultural and regional stakeholder groups including Service Area Leadership Team (SALT) and UsCCs to notify of the program goals and efforts to reach diverse communities as well as to ask for support with promoting the job opening in their communities.	Promising Progress Outreach and engagement continued	Data was collected via MS Forms for outreach.	Program staff presented the program efforts and job opportunities at the Access for All UsCC, SALT 4, American Indian/Alaska Native UsCC and at the Cultural Competency Committee. The program staff was involved in the Alliance for Health Integration (AHI) Community Health Worker Advisor Committee with participation from the three Health Departments (DMH, DPH, DHS) in an effort to create a plan for departmental cross training, effective recruitment, equitable pay, and cultural and linguistic diversity in the workforce.
• Field-based services	The primary effort was to conduct workshops in natural spaces and in-person. Due to the COVID-19 Pandemic, workshops were also provided virtually.	Increasing each month post-COVID from 15% in July 2021 to 34% in June 2022	Data was collected via MS Forms	Total number of in-person workshops: 1,755 (24%) Total number of virtual workshops 5,599 (76%)
• Collaborations to enhance the cultural and linguistic competence	Ongoing Spanish presentation at DPH Wellness Clinics.	Promising Progress	Data collected via invoice process and outreach logs and MS Forms	Whitter DPH Wellness Clinic total 64 workshops

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
within and across Departments of Health Services, Mental Health, and Public Health	Ongoing collaboration with DPH Leads Free Home Project due to Spanish speaking residents being impacted by lead contamination. Participation in DPH/DHS COVID-19 vaccine events			2,489 hours spent conducting Lead prevention outreach for DPH Leads Free Home Project. 35,088 Board of Supervisors-Collaborative Vaccine Events in SA 3, SA 4, and SA 7 (e.g., Community Centers, Schools, Food Distribution Events, Parks, Housing Sites, Swap Meets, etc.). 4,698 Vaccine events at DPH Points of Dispensing (PODS): Balboa Sports Complex, Encino, Ted Watkins Memorial Park, Senior Citizens Center, Commerce and Eugene A Obregon Park
• Augmentation of mental health service accessibility to underserved populations	The workshop presentations provided culturally relevant examples, stories and content that resonate with communities.	Promising Progress in out-reaching to cultural and linguistic communities.	PowerPoint presentations developed in consultation with community members with expertise in underserved communities; data collected via MS Forms	The program touched 64,097 workshop participants and provided 5,567 linkages and outreach to 123,115 community members.
• Multi-lingual/multi-cultural staff development and support	Ongoing recruitment of diverse staff: Black/African American staff, American Indian/Alaska Native,	Promising progress Staffing includes a total of 159 diverse	The program will continue until recruitment goals are reached.	Recruitment tracking spreadsheet and projected and actual summary tables, updated continuously.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	Latinx, Korean, Cambodian, Arabic, Chinese, Filipino, Ethiopian, Easter/Middle Eastern European	Promoter vendors and Community Health Worker (CHW) staff		
• Outreach and Engagement (O&E) activities	Diverse program staff participated in health fairs sponsored by various cities, Board of Supervisors, schools, community partners. Staff also participated in culture specific media interviews, print, radio, web, television including Spanish and Korean specific outreach.	Promising Progress shown by the increased number of community members outreached from 31,591 in FY 20-21 to 123,115 in FY 21-22.	Data was collected via MS Forms	6/22/2022: Korean MH Promoters were interviewed by a mainstream Korean newspaper. UMHP provided outreach to 123,115 community members at community centers, schools, food distribution events, parks, housing sites, swap meets, vaccination sites and other community events.
• Programs that target specific ethnic and language groups	The program actively outreached to the Latino, Latinx, Black/African American, Asian Pacific Islander, Eastern/Middle Eastern European, LGBT+, Individuals Living with Physical Disabilities, American Indian/Alaska Native.	Promising Progress; in FY 20-21, workshops were provided in English and Spanish; in FY 21-22, workshops were provided in 7 languages	Data was collected via MS Forms	Workshop Attendees included: Arabic 189 Amharic 22 Khmer 270 Chinese 129 English 8,716 Korean 1,357 Spanish 53,414 TOTAL 64,097
• School-based services	School based services with emphasis on parental support and education using a cultural lens. Workshops were provided at parent resources centers, Parent-Teacher Association groups, after school programs.	Promising Progress Staff continued to reach out to schools in communities where workshops have not previously been conducted	Data was collected via MS Forms	Number of parental support and education workshops conducted at school settings: 1,947.

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Trainings/case consultation	Clinicians provided cultural and linguistically diverse trainings to the Community Health Workers/Mental Health Promoters, so they are effective in providing workshops to the community. Clinicians provided clinical consultation when diverse workshop participants need triage or culture/language specific mental health resources.	Promising Progress Ongoing training was provided	Data was collected via MS Forms	Promoters received foundational (80 hours) and ongoing training, including developing their expertise within their communities on mental health issues and conditions, prevention and self-care, presentation strategies, and assisting residents in accessing resources when mental health interventions are needed.
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	The program utilized the Popular Education approach emphasizing community empowerment through education as well as the importance in community feedback. The program incorporated feedback into workshop topics.	Promising Progress Promoters and program staff continue to address shifting priorities including learning and delivering new training content as information evolves and is updated.	PowerPoint presentations developed in consultation with community members with expertise in underserved communities; and - data collected via MS Forms	15 workshops developed in consultation with community experts, to facilitate dialogue on mental health stigma and increase awareness of signs and symptoms to prevent and mitigate mental health struggles.

Program Accomplishments
*7,354 Total Workshops with 64,097 Participants (primarily Spanish-speaking)
5,567 Total Referrals documented (primarily Spanish-speaking)
Vaccine Outreach events reaching an estimated 39,786 residents; Other outreach 83,329 (123,115 total)
Activities by UMHP in different languages for FY 21-22

Program/Project	Consumers' preferred languages	Languages represented by Program staff
United Mental Health Promoters and Promotores de Salud Mental	English, Spanish, Korean, Mandarin, Khmer, and Arabic	English, Spanish, Korean, Mandarin, Khmer, and Arabic
Leads Free Home LA Collaboration with DPH	Spanish	Spanish

Psychiatric Mobile Response Team (PMRT) and Therapeutic Transportation Team (TTT)

PMRT consists of LACDMH clinicians and community health workers designated per Welfare and Institutions Code 5150/5585 to perform evaluations for involuntary detention of individual determined to be at risk of harming themselves or others or who are unable to provide food, clothing, or shelter because of a mental disorder.

PMRT enables successful triage of each situation involving mentally ill, violent, or high-risk individuals. Law enforcement-based interventions during a crisis involving an individual experiencing psychiatric mental health issues can often increase the risk or danger to the individuals or those assisting. PMRTs' specialized triage of each situation yields engagement, support, and recovery-focused interventions from mental health clinicians. PMRT provides caring, deescalating and less traumatizing approaches to crisis intervention and whenever possible avoids outcomes that involve hospitalization, incarceration, or additional injury. PMRT's tactics support clients and their families through trust and attention, and ultimately contribute to reducing stigma surrounding mental health and accessing help.

TTT is a pilot program which expands the current reach and impact by integrating LA County mental health experts into the emergency response for calls that come into 911 system or go directly to the LA City Police Department or LA City Fire Department. The pilot program has embedded a team of LA County mental health experts 24 hours a day, seven (7) days a week, in five (5) LA City Fire stations across the County to co-respond or take lead on incoming emergency calls related to, or presumed to involve, an individual experiencing a mental health crisis.

Data is utilized to determine the services to be delivered in the PMRT. Crisis Services adapt to the needs of the community based on their linguistic and cultural needs. For example, if a crisis call comes and requires a Russian speaking clinician, the call will be assigned to a team that has the language capability to ensure services are delivered in an effective and culturally sensitive manner.

Public Information Office (PIO)
LACDMH PIO is responsible for managing and facilitating the Department's communication activities, including:

- Interview, photography, filming, and audio recording requests
- Social media
- Announcements to the LACDMH mailing list
- Maintaining the Department's public event calendar
- Public service announcements (PSAs)
- Organizational branding
- Event promotion
- Graphic design and layout
- Marketing campaigns
- Communication partnerships and collaborations

While the PIO does not directly utilize disparities data, it does take into consideration LA County's diverse communities and audiences in planning and implementing its marketing and communication activities in collaboration with Cause Communications during FY 21-22.

During FY 21-22, LACDMH continued outreaching to LA County communities to provide support and promote mental health via multiple hyper local/ethnic media outlets. Hyper local/ethnic media were used to promote mental health messages. The messaging focused on coping with COVID-19 challenges, promoting resilience and wellbeing, support via the Department's 24/7 Help Line, online resources offered by LACDMH and partner organizations, virtual and in-person wellbeing events, and free subscriptions to Headspace and iPrevail. Examples of hyperlocal targeted media products include digital billboards; Metro and bus line advertisements; radio and TV spots; and posters, displays and handouts at commonly frequented community sites.

The PIO team, in collaboration with LACDMH ARDI Division and other County partners, continued to educate LA County residents about the Department's services in a culturally and linguistically competent manner, whether through media interviews, paid media advertising, and facilitating Outreach & Engagement events and opportunities – elevating residents' awareness of mental health issues and available resources offered by LACDMH and its partners. Furthermore, by presenting information in diverse languages and with a trusted source (e.g., an expert from their culture who speaks their language) or with materials translated into residents' preferred language, the PIO aims to reduce barriers to access LACDMH's services and resources. Any additional information about the PIO is available at https://dmh.lacounty.gov/press-center.

PIO'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Interagency Collaboration	Held collaborations with DHS & DPH's PIOs to share and disseminate messaging to promote wellness (upcoming events, COVID-19 safety & response) through physical materials, website content & social media postings – translating and interpreting in other languages as needed.	Ongoing		
• Community education to increase mental health awareness and decrease stigma	Worked with LACDMH Speakers Bureau (SB) to connect experts with LA's ethnic/cultural media to educate their audiences on various mental health issues, especially in relation to COVID-19. This included both proactive media outreach (through expert pitches) as well as responding to media requests.	Ongoing	After providing information or setting up interviews, the PIO team monitored the respective outlets for coverage.	
• Development and translation of public informing materials that address mental health education	Where appropriate and possible, the PIO team collaborated with the SB to generate translated versions of outreach materials, including fact sheets, flyers, brochures, and posters related to mental health and wellbeing.	Ongoing		
• Collaboration with faith-based and other trusted community entities/groups	The PIO's office worked regularly with Community-Based Organizations (CBO) and Faith-Based Organizations (FBO) to disseminate messaging regarding mental health issues as well as services/resources available through Department and its partners to support personal and community wellbeing. This included: - Promotion of partnership events	Ongoing	Varies depending on how CBOs/FBOs report out on their communication activities	

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	- Providing informative materials (flyers/brochures) & promotional items for events - Connecting CBOs/FBOs with appropriate services or experts			

School Based Community Access Point (SBCAP) The SBCAP team provides mental health education and resources to school communities and their stakeholders to raise awareness and increase accessibility to support. SBCAP offers technical assistance to school districts to help enhance their mental health protocols and infrastructure. SBCAP aims to strengthen the school communities by decreasing mental health barriers and helping the school community prioritize emotional wellbeing.

The SBCAP team oversees several Prevention School Programs. Among them,

1. Community Schools Initiative (CSI) with Los Angeles County Office of Education (LACOE) The LACOE Community Schools program is a whole child framework for school improvement. A community school is a hub of its neighborhood aimed at disrupting poverty and addressing inequities. The program highlights areas of need and leverages community resources to integrate top quality academics, enrichment, health and social services, and opportunities to learn and thrive for all students.
2. Trauma and Resilience- informed Early Enrichment (TRiEE) Program with Los Angeles Unified School District (LAUSD). The TRiEE Program believes that providing educational intervention and supports early in a child's life can result in long lasting positive changes for a family. Therefore, LAUSD TRiEE program focused its school efforts with Early Education Centers (EEC) in each SD utilizing the Student Equity Needs Index (SENI) Data.
3. Well-Being Centers (WBC) with Department of Public Health (DPH). The DPH WBC are a partnership with DPH, Planned Parenthood Los Angeles (PPLA), and DMH. The WBC are implemented at high school campuses across LA County. The WBC make preventative health care accessible to young people throughout the County by bringing youth-focused health and wellness services to students. The program provides education to students on physical and sexual health as well as mental health and wellbeing.

The following provides a summary of SBCAP Team activities and supports for FY 21-22:

SBCAP Team Direct Services:

- Provided approximately 42 workshops/presentations to the school community
  - Two (2) presentations on Unaccompanied Minors – Approximately 80 attendees
  - Approximately 40 workshops/presentations to participating school communities to increase mental health awareness, capacity building, and wellbeing – WBC and CSI schools – with an average of 15-25 participants per workshop
- Facilitated the 4th Annual School Symposium
  - Approximately 400 attendees
- Tabled events to share mental health resources and reduce stigma

    - Participated in approximately 16 community/school events to raise awareness and provide resources – where each event usually had 50+ participants
- Implemented the “Officer of the Day process” to support school districts that did not have a Memorandum of Understanding (MOU) with a mental health provider. The SBCAP team referred and linked 178 families to mental health services
- Created and disseminated flyers/handouts and workshops to support mental health through the SBCAP Website and/or the UCLA Wellbeing4LA Learning Website.
- Youth Listening sessions
    - Supported five (5) youth panels to engage youth and understand their perspective on mental health

LACOE Community Schools (CSI) accomplishments:

- 642 cumulative recorded partnerships
- 22,838 total direct contacts for outreach (students and caregivers)
- 1,657 total referrals were received by LACOE CSI sites (students and caregivers)
- 2,468 individual families were served
- 1,338 direct services were provided (students and caregivers)
- 887 total events were held across CSI sites
- The total monetary value of donations received across CSI sites was $425,567

LAUSD Trauma- and Resilience- informed Early Enrichment (TRiEE) accomplishments:

- 39 EEC sites reaching about 2,700 families
- 3941 macro services and 1414 direct services
- 191 consultation calls and 207 referrals
- 219 SEL interventions and 1800 SEL kits were distributed to students and families.
- 90 staff professional development trainings
- 61 parent workshops

DPH Well-Being Center (WBCs) accomplishments:

- 39 WBC sites, 11 LACOE sites and 28 LAUSD sites with about 160 students participating in the WBC Peer Leadership program

The SBCAP Team and its program with LACOE, LAUSD, and DPH, help bring resources to the school community. Through the LACOE CSI and LAUSD TRiEE, SBCAP and its partners have been able to address the cultural and linguistic needs of the school community. Utilizing the community schools’ model, CSI and TRiEE programs act as hubs in the community, readily available to link students and families to key resources such as health care, education, housing and employment services. The SBCAP team supports these efforts by filling in gaps for school districts that do not have these supports.

Additionally, the SBCAP team works closely with Chief Executive Office (CEO) ARDI to identify ways to access the most up to date community information available within Los Angeles County. This will allow SBCAP to make informed decisions and continue to meet the needs of highly vulnerable areas including those with cultural and linguistic need.

Spanish Support Groups (SSG)

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

SSG increases access to mental health services and contributes to reducing disparities by engaging and training mental health consumers who are linguistically and culturally diverse. In this sense, they highlight the life experience as consumers or family members and the path of recovery of most of the support group facilitators, who, together with the numerous trainings received and accumulated wisdom, are experts and Peers, and could deserve their own workspace. For example, when necessary, peers accompany members to the clinics or help them get connected to the services that they need. Thus, Spanish-speaking Peers bring significant help to new members and to consumers who have been in the system for many years. They motivate others to take steps, starting with the idea that "if he/she can succeed then I could do it too."

During FY 21-22, LACDMH had 20 SSG operating in most SAs. Another year of the lingering COVID-19 pandemic challenged the SSG to find creative and safe ways of connecting. For example, the SSG continued their weekly sessions by teleconference, thereby mobilizing solidarity and mutual support via technology. Group sessions also provided outlets for boredom and stress by supporting group members in daily living activities such as online schooling and working from home, interspersed with useful information and opportunities to explore healthy habits, physical activities, and hobbies. Likewise, SSG participants benefited from having a space to learn about ways of creating quality interpersonal relationships, practicing tolerance, effective communication, and conflict resolution skills.

The weekly sessions were comforting, and the SSG leaders and Peers did an excellent job creating, monitoring, and supporting the solidarity networks that provided hot foods to vulnerable residents in the community who could not leave their homes. Additionally, the inclusion of artistic animation and expression network helped participants overcome adversity and improve mood and general outlook on life.

The SSG utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to the communities and their activities contribute to LACDMH's provision of culturally and linguistically competent services. For example:

- SSG are strategically located within organizations trusted by the Latino and Latinx community such as churches, libraries, community centers and hospitals. These groups attract high-risk participants who are not accessing mental health services due to stigma or lack of information.

- Consumers and family members who are advanced in their own process of recovery are trained in leadership skills to facilitate support groups and then are mentored to implement and run support groups in Spanish.
- From the support groups and with the experience accumulated over the years, the empowered members are serving their community in actions of prevention and promotions of mental health. Also, several group members have become LACDMH workers.
- SSG offer psychoeducational materials in Spanish, inspired by the needs and strengths of consumers and the community.
- The SSG activities to advance recovery were facilitated by Peers within mental health clinics. Peers or "Compañeros de camino" (in Spanish) are incorporated into leadership teams and provide valuable assistance to others. As mental health consumers, peers maintain an active connection to their clinic or mental health center. Consequently, they are excellent liaisons for group members who require encouragement to get to the clinic, as well as for consumers who are advanced in their recovery and need to take new steps to reintegrate into everyday life.
- Family members, like consumers, have a place in support groups. Many experienced worry and uncertainty. The emotional support of empowered families who have lived experience with loved ones who have mental illness allows newcomers to learn how to manage their emotions and how to support the recovery process.
- Support Groups facilitate the expression of the cultural protective factors as empowerment tools, such as music, theater, arts and crafts, gastronomy, familism and opportunities to celebrate various cultural events. Engaging in these activities provides participants a unique opportunity to display and develop their skills while bonding with other consumers over shared experiences of wellness and recovery. LACDMH staff has designed curriculums and an implementation process for four (4) trainings related to art and mental health:
  - Theater training: It aims to help participants express and regulate their emotions, develop skills, improve communication skills and body expressions, and increase awareness to combat stigma.
  - Painting training: Painting has a healing power and allows for a creative outlet for repressed emotions and helps individuals appreciate their self-worth.
  - Arts and Crafts training: The act of building artistic objects or decorations helps participants feel empowered and creative, develop new skills, and feel useful.
  - Music training: Music and songs influence the emotion and can refresh moods. It also stimulates the creative sensibilities, the mind, and helps liberate from suffering or isolation.

Additionally, the SSG delivers an annual event for May is Mental Health Month. For CY 2022, the event was held virtually on May 25, 2022. The theme of the event was “Support Groups and COVID-19.” After a prolonged social isolation, the event provided a valuable vehicle to celebrate recovery achievements, communicate hope, highlight the value of solidarity, and give members opportunities to participate in panel presentations, tributes, and art exhibitions.

SSG STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	Prior to the pandemic, five (5) groups met weekly at local church sites, six (6) at local libraries, seven (7) at health and mental health clinics, and two (2) at local service centers. Due to the pandemic, groups have met via teleconference and virtually.	Promising progress Goal was to re-establish the in-person groups in FY 22-23.	Attendance sheets were obtained. Monitoring practices are being re-evaluated.	A total of 20 groups met weekly during FY 21-22.
• Programs that target specific ethnic and language groups	The SSG targeted the cultural needs and addressed barriers that exist in the Latino community by locating them in trusted spaces, facilitation in Spanish, no pre-requisites required to join the group thus facilitating access to undocumented community members.	Promising progress	Attendance sheets were obtained. Monitoring practices are being re-evaluated.	A total of 20 groups met weekly during FY 21-22.
• Utilization of community's knowledge, feedback, and capacity to promote health and wellbeing	Spanish-speaking Peers brought significant help to new members and to consumers who have been in the system for many years. They motivated others to take steps, starting with the idea that "if he/she can succeed then I could do it too." Each group was made-up of volunteers, in some cases with more than 12 years of experience	Promising progress	Attendance sheets were obtained. Monitoring practices are being re-evaluated.	A total of 20 groups met weekly during FY 21-22.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	in that role. They were excellent liaisons for group members who required encouragement to get to the clinic, as well as for consumers who were advanced in their recovery and needed to take new steps to reintegrate into everyday life.			
• Post COVID-19 interventions	The groups offered activities to combat loneliness facilitated by Peers to combat loneliness. Peers or "Compañeros de camino" (in Spanish) were incorporated into leadership teams and provide valuable assistance to others. As mental health consumers, peers maintained an active connection to their clinic or mental health center.	Promising progress	Attendance sheets were obtained. Monitoring practices are being re-evaluated.	A total of 20 groups met weekly during FY 21-22.

SSG ADDITIONAL ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Projects/Activities/Strategies	Status / Progress	Monitoring / Outcomes / Findings
• Support Groups in Spanish	The support groups that were offered face to face, prior to the pandemic, are being offered via telephone (participants connect to a conference call line provided by LACDMH). The groups are facilitated by LACDMH volunteers with lived experience (consumers, family, and community	Participants have reported their appreciation for these groups as they provide a safe space and support network amid the physical distancing regulations.

Projects/Activities/Strategies	Status / Progress	Monitoring / Outcomes / Findings
	members) including sixteen (16) Wellness Outreach Workers. Following group meetings, members had the opportunity to engage the creation of art projects, which were shared in future support group sessions.	
• Community Empowerment and Mental Health Training	Twelve (12)-week classes were provided for members of the Support Group leadership teams to participate in community outreach and empowerment actions.	28 graduates participated in community outreach tasks and established collaboration with other local agencies.
• Latino and Latinx Community Outreach through the Arts Project	Weekly classes facilitated by art teachers were offered including arts & crafts, painting, music, and theater.	12 distinct classes were offered during FY 21-22. Participants displayed their final products (i.e., paintings, wood carvings, crochet scarves, vests, and custom jewelry) during cultural events throughout the year.
• Leadership and Support Groups Facilitator's Training	This twelve (12)-week training was offered to individuals interested in becoming support group facilitators.	20 graduates from this training reinforced leadership teams and facilitated the opening of new support groups in the community.
• End of Year Celebration	The main purpose of this event was to celebrate the graduation of those who completed the trainings and to thank and highlight the achievements of the existing support group facilitators throughout the year.	Approximately 100 individuals participated in this community event and to celebrate their individual and collective achievements.
• "Salud Mental y Bienestar" Newsletter	The newsletter featured the activities of the support groups members and highlighted the achievements on their road to recovery and empowerment.	Two (2) newsletters were published during FY 21-22.
• Development of psychoeducational bulletins on mental health topics and selection of on-line	Four (4) bulletins were created with content relevant to discussions during support group discussions. The bulletins included real life experiences	The bulletins were emailed to an estimated 200 Spanish Support Group participants containing information.

Projects/Activities/Strategies	Status / Progress	Monitoring / Outcomes / Findings
inspirational reading materials for use by Spanish Support Groups to promote resiliency and mental health through motivational stories identified by participants	from members, their recovery trajectory, available resources and messages of encouragement, hope, and motivation. The bulletins were distributed to group participants at the beginning of the COVID-19 pandemic. Reading materials were also developed to help members cope with social isolation.	
• Solidarity Support Network Teams during Pandemic Times	Members of support groups, organized in solidarity and through community networks, and provided vital assistance with hot food, medicine, and other essential items to people at risk of contagion or those who were in quarantine due to COVID-19.	Members of the support network made 250 protective masks made of fabric for people in need. 50 isolated people received hot food each day. Peers made phone calls to approximately 200 Spanish Support Group members to check in and remind them of upcoming group meetings.
• Network of art, animation, and emotional support in COVID-19 Pandemic times	The support group virtual meetings included motivational content (i.e., music, poems, and more) selected by members and/or art instructors. These activities made significant contributions to the groups sessions and strengthen member connections.	17 group members joined the network. During SSG sessions, the contribution of our artists was crucial. For example, listening to comforting melody played on the guitar helped improve the mood of members who were feeling sad and helped them get out of bed. Likewise, the happy songs made those experiencing isolation smile. The reading of poems reinforced collective resilience within the groups.
• Returning to daily life activities: Group leaders organized small groups comprised of 2-3 persons to get out of the house in order to confront COVID-19 fears.	After a year of confinement and still with peaks of contagion, for work and other needs, people needed to go out, but fears reappeared generating the feeling that home was the only safe place. The SSG understood that these were normal reactions and the	15 support groups transitioned from COVID-19 confinement via these small groups. Complying with the sanitary measures, six SSG leaders met with two to three members

Projects/Activities/Strategies	Status / Progress	Monitoring / Outcomes / Findings
	support groups leaders developed exit strategies.	from their respective groups and began outings that gradually expanded in time, distance, and variety of activities. Three months later, most of the members of the groups had started to return to daily life.
• Return of the SSG Celebration for May is Mental Health Month	After the suspension due to the pandemic, the long-awaited event returned virtually in CY 2022. Part of the annual motivation of the members was to meet again, share and feel that they were supported while facing their personal struggles.	250 people participated in the virtual event.

SSG LOCATIONS BY SERVICE AREA

	SA	Support Group name	Days/Time	Location
1	**SA 1**	Antelope Valley SG	Tuesdays 3-5 pm	Antelope Valley Wellness Center 335-B East Ave. K-6, Lancaster, CA 93535
2	**SA 2**	North Hollywood SG	Fridays 10 am-12 pm	Valley Plaza Library 12311 Vanowen St. North Hollywood CA 91605
3 *	**SA 3**	Baldwin Park	Wednesdays 4-6 pm	Tery G Muse Family Center 14305 Morgan St. Baldwin Park CA 91706
4 *	**SA 3**	El Monte SG	Fridays 4-6 pm	Pacific Clinic 9864 Baldwin Pl El Monte CA 91731
5 *	**SA 4**	Placita Olvera SG	Wednesdays 9-11 am	Queen Los Angeles Church 535 N Main St Los Angeles, CA 90012
6 *	**SA 4**	El Sereno SG	Tuesdays 6-8 pm	El Sereno Library 5226 Huntington Dr S. Los Angeles, CA 90032
7 *	**SA 4**	Highland Park SG	Mondays 9-11 am	Arroyo Seco Library 6145 N Figueroa St Los Angeles CA 90042

	SA	Support Group name	Days/Time	Location
8 *	**SA 4**	Pico Union SG	Thursdays 10 am-12 pm	SSG-BACUP 515 Columbia Ave Los Angeles CA 90017
9 *	**SA 6**	West Central SG	Thursdays 4-6 pm	West Central MHC 3741 Stocker St Los Angeles CA 90063
10 *	**SA 6**	Compton SG	Wednesdays 10 am-12 pm	Compton Library 240 W Compton Blvd Compton CA 90220
11	**SA 7**	East LA SG	Thursdays 10 am-12 pm	Anthony Quinn Library 3965 Cesar E Chavez Ave Los Angeles CA 90063
12 *	**SA 7**	Whittier SG	Thursdays 6-8 pm	Presbyterian Hospital 12401 Washington Blvd Whittier CA 90602
13 *	**SA 7**	Huntington Park SG	Fridays 10 am-12 pm	Rio Hondo W Center 2677 Zoe Ave H Park CA 90255
14 *	**SA 7**	Cerritos SG	Fridays 1-3 pm	Rio Hondo MHC 17707 Studebaker Road Cerritos CA 90280
15 *	**SA 7**	South Gate	Fridays 9-11 am	Fe y Esperanza Lutheran Church 13431 Paramount Blvd South Gate CA 90280
16 *	**SA 8**	Torrance SG	Tuesdays 4-6 pm	Harbor UCLA MC 1000 W Carson St Torrance CA 90509
17 *	**SA 8**	San Pedro SG	Wednesdays 4-6 pm	San Pedro Church 575 W O'Farrell St. San Pedro CA 90731
18 *	**SA 8**	Hawthorne SG	Tuesdays 9-11 am	San José Church 11901 W 119 St Hawthorne CA 90250
19	**SA 8**	Lennox SG	Wednesdays 9-11 am	Lennox C. Serv. Center 4343 Lennox Blvd Lennox CA 90304
20 *	**SA 8**	Wilmington SG	Mondays 4-6 pm	Sagrada Familia Church 1122 E Rubidoux St Wilmington CA 90744
21	**SA 8**	Lawndale SG	Wednesdays 10 am-12 pm	Lawndale Library 14615 Burin Ave Lawndale CA 90260

(*) For reasons of the COVID-19 pandemic and social distancing health measures, since March 2020, 16 SSG met via video or teleconference.

School Threat Assessment Response Team (START)

START is a collaborative program with educational institutions and law enforcement designed to prevent school violence by identifying students at risk and providing an immediate comprehensive response and case management. This is achieved by utilizing

LACDMH staff to provide threat prevention and management assistance to educational institutions and law enforcement agencies throughout the LA County. START staff, in collaboration with schools and first responders, have responded to numerous incidents in elementary, middle, high school, college and trade school campuses — preventing stated or perceived threats from escalating into more serious and potentially violent situations.

Key Components of START include:

- *Training and program consultation*: START provides educational and training programs for select audiences, including school faculty, administrators, campus security, first responders, parents, and students. These training programs are designed to improve understanding about the dynamics, behaviors, and characteristics of school shooters, as well as improving situational awareness and timely responses to improve campus safety and wellbeing.
- *Early screening and identification*: START provides case-by-case consultations for individuals or situations of concern. Educational institutions are supported in adopting a multidisciplinary approach to help prevent and mitigate potentially volatile situations.
- *Assessment*: START can assist schools in creating or completing a complete assessment of individual, familial, situational, and social factors relevant to the perceived, implied, or stated threat.
- *Intervention*: In collaboration with educational institutions and law enforcement agencies, START can provide appropriate responses to threats of violence. The response options can include further assessment and ongoing monitoring, counseling, psychiatric treatment, anger management training and arrest/detention.
- *Case Management and Monitoring:* START staff can also provide post-intervention services such as case consultation and management, linkages to relevant support services and periodic follow-ups and reviews.

The START program utilizes data to determine the services to be delivered. Crisis Services adapt to the needs of the community based on their linguistic and cultural needs.

Transitional Age Youth (TAY) Drop-In Centers

TAY Drop-In Centers are an entry point to the mental health system for Seriously Emotionally Disturbed (SED) and Severe and Persistently Mentally Ill (SPMI) TAY who are homeless, or in unstable living situations. TAY accessing Drop-In Centers have an opportunity to build trusting relationships with staff, and when ready and willing, connect to needed services and supports to best meet their goals toward stability and recovery.

TAY Drop-In Centers' strategies contribute to LACDMH's provision of culturally and linguistically competent services by addressing the cultural and linguistic needs of the youth from their perspective. Contract providers ensure that staff providing services have similar cultural and linguistic backgrounds to those clients being served. For example, in order to engage the TAY population at the Drop-In Centers, Seeking Safety groups are offered by a trained licensed clinical professional or licensed waived clinician. These groups give TAY an opportunity to address risk factors including trauma, alcohol/drug use, rejection from peers/family, and interpersonal conflict/stress.

In addition, the TAY Drop-In Center's activities increase access to mental health services through outreach and engagement services to those youth who may be homeless or in unstable living situations. These youth and young adults often have complex trauma resulting from experiences of abuse in their homes, streets, and their communities. The complex trauma may manifest in their inability to maintain relationships, keep jobs, or stay in school, often putting them at risk of unemployment, school dropout, incarceration, and future victimization. Furthermore, disparities data is utilized to prepare and implement countywide trainings to both the LACDMH staff and the eight (8) TAY Drop-In Centers.

TAY DROP-IN CENTERS' STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	TAY Drop-In Centers hosted annual youth events inviting local community groups and agencies that promote mental, physical and spiritual health to the youth	On-Going	Contract Management and Monitoring Division (CMMD) staff attended the event and provides technical assistance as needed.	There are eight (8) LACDMH contracted Drop-In Centers that the QRM team monitors
• Community education to increase mental health awareness and decrease stigma	The Drop-In Centers provided an array of different activities and groups that are inviting to all youth from the community while at the same time educating the participants on the importance of mental health and reducing stigma.	On-Going	Drop-In Centers submitted monthly activity logs promoting the activities and groups. CMMD staff reviewed the calendar for appropriateness. TAY Navigation teams from outreach and engagement services.	Monthly monitoring of activity logs and comparison to the Performance Requirement Summary and Statement of Work.
• Field-based services	During the height of the COVID-19 pandemic, the TAY Drop-In Centers changed the way services were rendered. The Drop-In Center staff	On-Going	Drop-In Centers submitted monthly activity logs promoting the activities and groups. CMMD	Monthly monitoring of activity logs and comparison to the Performance Requirement

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	went out to meet the youth in the community to continue to provide critical basic services such as food and clothing.		staff reviewed the calendar for appropriateness. TAY Navigation teams from outreach and engagement services.	Summary and Statement Of Work.
• Multi-lingual/multi-cultural staff development and support Outreach and Engagement (O&E) efforts	TAY Drop-In Centers hired staff who have similar cultural and linguistic backgrounds to the youth's. The staff received annual cultural competence training.	On-Going	CMMD and the TAY Navigation teams met with DIC Staff to address any language or cultural capacity issues.	Monthly monitoring of activity logs and comparison to the Performance Requirement Summary and Statement of Work.

Transitional Age Youth (TAY) Navigation Team

TAY Navigation Team is a field-based team comprised of clinicians, medical case workers (serving in the role of Housing Specialists), a substance use counselor, and a Community Health Worker who work with TAY, ages 16-25, countywide. Each Service Area (SA) has one clinician and one housing specialist assigned. The team assists youth, often unhoused, through the various human services systems to link to mental health, housing, and other essential services. The staff also provide clinical consultations to the County Departments and organizations while outreaching and engaging TAY who are referred.

A key role for the TAY staff is in the Enhanced Emergency Shelter Program (EESP) located in SAs 4 & 6. The EESP offers a warm, clean, and safe place to sleep, hygiene facilities, hot meals, and case management services. Each youth in the EESP is assigned to one of the clinicians and housing specialists to work with the youth and refer to needed mental health support as well as a more permanent housing plan, and employment resources.

The TAY population has a high percentage of members of the LGBTQIA2-S community. One of the EESP is the LGBT Youth Center which shelters a good percentage of their youth. In FY 21-22, the Youth Center had a capacity of 20 beds. These beds were consistently full or nearly full. This knowledge has informed their training planning to ensure the staff are better trained on the needs of this population, including examination of personal biases, use of language, and inclusiveness at the workplace.

Occasionally, the Gatekeeper gets a call from a youth or family member/interested party who is monolingual Spanish. The TAY Navigation team has Spanish-speaking staff who follow up on those calls and refer appropriately. Additionally, they make every effort to match monolingual Spanish-speaking TAY in the EESP to one of their staff who is Spanish-speaking. These staff also assist in any needed advocacy. They also have a Korean-speaking staff who works with monolingual Korean speakers who call for services.

Each of the TAY Navigation staff is involved in community outreach to TAY population. The staff is varied racially, ethnically, and culturally, which broadens the services they can provide. The TAY Navigation staff, including their supervisors, provide consultation to the EESP shelter staff on cultural issues that may arise among their youth in the shelters, and this is due to the trusting relationship that has been developed over the years. This type of collaboration greatly contributes to the Department's mission of culturally and linguistically appropriate services.

The TAY Navigation team's primary mission is to work with unhoused TAY – to link them to housing, mental health resources, and to enhance TAY overall functioning in the community long-term. TAY Navigation staff visit the TAY Drop-In Centers in each SA on a weekly basis to outreach to TAY. These outreach and engagement activities are all designed more specifically to identify potential clients to make mental health services more accessible to youth. Additionally, they work to educate the staff working in the shelter homes on disparities, particularly around the LGBTQIA2-S population.

TAY NAVIGATION TEAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Development and translation of public informing materials that address mental health education	In collaboration with the PIO, the TAY Navigation team revised their Spanish language TAY flyer for distribution onto their website and social media.	Ongoing	Visible on LACDMH's website and distributed during presentations and by request.	N/A
• Community education to increase mental health awareness	"It's OK to Not be OK" on 5/12/2022. Presented to the LA P3 collaborative which includes schools, community colleges,	Completed	Survey of participants brought positive feedback	130 people in attendance

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
and decrease stigma	City and County organizations.			
• Field-based services	Shelter visits by TAY Navigation team area conducted in the field, and clients were seen two (2) times/week. Staff also visited the TAY Drop-In Centers.	Ongoing	Staff monitored (timecards and supervision)	Each Navigation Team staff was field-based.
• Interagency Collaboration	TAY Navigation team regularly interfaced with DCFS as well as DPSS to address clients' needs and link to resources.	Ongoing	Monitored during supervision of staff.	In FY 21-22, the majority of the 635 EESP clients were linked to DPSS. Many of them have DCFS social workers or past history.
• Outreach and Engagement (O&E) activities	TAY Navigation team of staff visited the TAY Drop-In Centers in each service area on a weekly basis to outreach to TAY. Outreach presentations that described the navigation Team, navigation and its resources. Attendees learned how to refer clients through our Gatekeeping process.	Ongoing Ongoing	Daily check-in emails between staff and supervisors. They responded to any request from a community-based organization or team that wants to know more about their services.	Co-location one day/week. TAY Navigation team provided three (3) of these activities in FY 21-22, in SAs 4, 6 and 7.

CONSUMERS SERVED BY TAY NAVIGATION TEAM
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
EESP	245	6	12	1	181	103	80	10	415	132	76			9							

(Note: TAY Navigation Team did not ask clients what their sexual orientation is during their screening process.)

Program/Project	Consumers' preferred languages	Languages represented by Program staff
TAY EESPs	English and Spanish	English, Spanish and Korean

Telemental Health (TMH)

The goal of the TMH Program is to provide psychiatric services to areas of LA County that need psychiatrists (i.e., short-staffed clinics, remote parts of LA County). The program's overall goal is to use technology to improve care, access to care, treatment adherence and outcomes, and client satisfaction.

The TMH Program provides psychiatric medication evaluation and management (E+M) services, also called Medication Support Services by Medi-Cal, for LACDMH clinics throughout LA County. The program has one (1) full time mental health psychiatrist, twelve (12) part time internal registry psychiatrists and sixteen (16) part time external (non-DMH employee) registry psychiatrists. Duties include the following:

1. Initial Medication Assessments are conducted 'face-to-face' and are usually lengthy; aimed at deriving a detailed history to obtain an accurate and complete diagnostic picture that will anchor the prescription of psychotropic medications for the unique client. In addition, the assessment aids in establishing how the medications prescribed support the client-generated goals of treatment.
2. Comprehensive Medication Services are conducted 'face-to-face' and are aimed at expanding the initial medication assessment or adult initial assessment or focusing on a new and emergent problem. These services enhance medical decision making of

moderate complexity and may result in changes in medications prescribed or in the adjustment of medication dosages by the psychiatrist or nurse practitioner.

3. Brief Medication Visits are conducted either 'face-to-face' or by telephone with the client or with a collateral whom the client has granted consent. They require only a brief history or problem-focus that is of low to moderate complexity, including the evaluation of safety and effectiveness of medications with straightforward decision-making regarding renewal or simple dosage adjustments in a stable client by a physician or nurse practitioner, or a Mental Health Counselor Registered Nurse if no medications are changed.
4. The Telemental Health and Consultation team provides medication review, medication counseling/education and prescriptions as permitted by their licensure with documentation in the medical record of each client. Prescriptions are sent through the electronic medical record system. There will be no dispensing or storing of medication at the unit site.

TMH Program provides services remotely which may allow services for more culturally diverse communities.

TMH PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Increase access to medication support services	Hired and distributed registry doctors.	Ongoing	Monitored caseloads in clinics throughout the County	Caseloads per psychiatrist
• Provide novel psychiatric treatments to the county	Started providing esketamine and accepting referrals throughout the county. Trained doctors and nurses to provide esketamine.	Ongoing	Track client mood, number of clients served.	PHQ-9 depression rating scales

Training Unit

The Training Unit coordinates most of the Department-wide training offerings both to Directly Operated and Contracted programs. A substantial number of training offerings are led and directly coordinated by programs such as 0 to 5, Specialized Foster Care, Juvenile Justice, Adult Forensic, Veterans and Outpatient services (Children, TAY, Adult and Older Adult). The Training Unit is also tasked with management and implementation

of the Mental Health Services Act (MHSA) – Workforce Education and Training (WET) Plan in the LA County. The MHSA Workforce Education and Training Plan funds programs, which prepare the present and future workforce to service the unserved/underserved communities in Los Angeles. These programs include:

- Interpreter Training –trains bilingual staff performing interpreter services and is intended to enhance the service by addressing the complex roles of interpreter services, reviewing interpreting models, identifying standards of practice, and problem-solving challenges that present when interpreting.
- Charles Drew Affiliation Agreement- Pathways to Health Academy – Year long academic and internship program for high school students in South Central Los Angeles (African American/Latino community specific) with a behavioral health concentration including mental health.
- UCLA Affiliation Agreement – Public Mental Health Partnership (PMHP) UCLA Public Partnership for Well Being Agreement. This agreement provided specialized training relevant to mental health direct services as well as outreach and engagement staff (Promotoras and/or other field-based direct service staff) serving historically unserved underserved communities.
- Psychiatric Residency Program – Funds a two-year psychiatric resident training program based in South Central Los Angeles with rotations in the community that include inpatient, emergency psychiatric room and outpatient experiences.
- Mental Health Psychiatrist Loan Repayment/Mental Health Psychiatrist Recruitment Incentive/ Mental Health Relocation Expense Reimbursement Programs – Recruits and retains psychiatrists specific to service provision to outpatient, homeless, street mental health including other important service initiatives.

Training Unit		
Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Public Mental Health Partnership (PMHP) *(UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)* The mission of the UCLA-DMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County (LAC); and to do so in the context of a transparent, trusting partnership with the Los Angeles County Department of Mental Health (DMH) that generates benefits for both the University and public health communities. The PMHP is comprised of two sections focused on serious mental illness -- the Initiative for Community	Ongoing	During the reporting period, the PMHP delivered 111 live trainings and 387 anytime trainings with over 819.5 training hours, with an attendance of 13,026 participants. The training team provided trainings on a wide variety of topics including Person Centeredness, Cultural Humility, and Psychiatric Disorders and Symptoms. The training topics delivered to the most participants include “Crisis & Safety Intervention” (1,598 participants) and “Continuous Quality Improvement” (1591 participants)

<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program.</td><td></td><td>
<table>
<tr><th>Topic Name</th><th>Number of Trainings</th><th>Training Hours</th><th>Number of Participants</th></tr>
<tr><td>Cultural Humility</td><td>26</td><td>76</td><td>1774</td></tr>
<tr><td>Crisis & Safety Intervention</td><td>28</td><td>85</td><td>1598</td></tr>
<tr><td>Continuous Quality Improvement</td><td>78</td><td>81</td><td>1591</td></tr>
<tr><td>Ethical Issues</td><td>9</td><td>22.5</td><td>1417</td></tr>
<tr><td>Manualized Evidence-Based Practices</td><td>31</td><td>65.5</td><td>1150</td></tr>
<tr><td>Psychiatric Disorders & Symptoms</td><td>16</td><td>60.5</td><td>943</td></tr>
<tr><td>Co-Occurring Disorders</td><td>19</td><td>70.25</td><td>781</td></tr>
<tr><td>Service Delivery Skills</td><td>16</td><td>17</td><td>579</td></tr>
<tr><td>Team-Based Clinical Services</td><td>46</td><td>71.5</td><td>541</td></tr>
<tr><td>Provider Wellbeing</td><td>35</td><td>51.5</td><td>457</td></tr>
<tr><td>Trauma</td><td>10</td><td>40</td><td>439</td></tr>
<tr><td>Manualized Evidence-Based Practices (HR)</td><td>19</td><td>46</td><td>395</td></tr>
<tr><td>Person Centeredness</td><td>13</td><td>47</td><td>383</td></tr>
<tr><td>Everyday Functioning</td><td>14</td><td>16</td><td>244</td></tr>
<tr><td>Manualized Evidence-Based Practices (ROC)</td><td>13</td><td>20.75</td><td>244</td></tr>
<tr><td>Persistent & Committed Engagement</td><td>4</td><td>6</td><td>190</td></tr>
<tr><td>Manualized Evidence-Based Practices (TIC)</td><td>2</td><td>3</td><td>177</td></tr>
<tr><td>Whole Person Care</td><td>8</td><td>40</td><td>143</td></tr>
<tr><td>TOTAL:</td><td>387</td><td>819.5</td><td>13026</td></tr>
</table>
</td></tr>
<tr><td><u>Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T)</u> (UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)

BASIC T: The Hispanic Neuroscience Center of Excellence (HNCE) had two broad area of focus: 1) work with Promotores de Salud and 2) build relationships with faith- and community-based organizations (FBO/CBO). For both groups, the Center provided training on psychological first aid and recovery to help reduce stigma around mental health topics and care. In the final quarter of the fiscal year, BASIC-T focused on completing the training of its postdoctoral fellows in neuropsychology as part of the Pipeline Program and adapting a series of prior live-interactive trainings developed for LACDMH to be produced as videos in both English and Spanish to facilitate</td><td>Ongoing</td><td>During the reporting period, the HNCE delivered 56 trainings with 101 training hours, with an attendance of 986 participants. With guidance from the HNCE, the Promotores program was strengthened going from 120 to almost 300 Promotores and 47 clinicians, expansion of the Spanish language arm of the program, and the opportunity to offer services in other languages. The team has created resources and worked to support mental health ministries with local faith-based organizations including the Los Angeles Diocese, to help reach communities that were previously unreachable and raise awareness of mental wellbeing outside of clinics. The training team provided bilingual trainings in English and Spanish on a wide variety of topics, including mental health stigma among communities of color during COVID-19 and support groups for isolated older adults and parents of children with developmental disabilities during COVID-19. Some of the training topics that were delivered to the most participants in FY 21-22 included Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches (159 participants) and Culturally Competent COVID-19</td></tr>
</table>

<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>broader dissemination of culturally and linguistically responsive content for the Latina/x community.

During the 4th quarter, BASIC-T continued to make progress in training neuropsychology fellows as part of its Pipeline program. It also worked to adapt and transition previously developed live and interactive training content to a format that could be digitized to facilitate additional asynchronous learning opportunities. This included the production of a total of 32 videos: 24 (12 in English, 12 in Spanish) focused on the United Mental Health Promoter Curriculum, and 8 videos (4 in English, 4 in Spanish) focused on the theme of FBOs and CBO Mental Health Ministries. BASIC-T also continued to migrate a large cache of previously recorded interviews and informational PSAs on various mental health topics within Spanish language media that were produced as part of its FBO and CBO engagement strategy during the COVID-19 pandemic.

The HNCE has developed a strong relationship with Spanish media and Catholic radio and TV to get information out on a weekly basis to communities, filling a void where Spanish language information on mental health had not existed before.</td><td></td><td>Mental Health Intervention with Community Based Organizations (431 participants).

<table>
<tr><th>Topic Name</th><th>Number of Trainings</th><th>Training Hours</th><th>Number of Participants</th></tr>
<tr><td>Culturally Competent COVID-19 and Creating Mental Health Ministries (including Psychological First Aid & Skills for Psychological Recovery) for Faith Based Organizations and Churches</td><td>20</td><td>39.5</td><td>826</td></tr>
<tr><td>Culturally Competent COVID-19 Mental Health Intervention with Community Based Organizations</td><td>30</td><td>36</td><td>431</td></tr>
<tr><td>Culturally Competent COVID-19 Skills for Psychological Recovery for Faith Based Organizations and Churches</td><td>6</td><td>8.5</td><td>191</td></tr>
<tr><td>Virtual Support Groups for Isolated Older Adults during COVID-19 (Genesis)</td><td>10</td><td>22</td><td>163</td></tr>
<tr><td>An introduction to creating a Mental Health Ministry</td><td>60</td><td>120</td><td>233</td></tr>
<tr><td>Child Abuse Prevention During COVID-19</td><td>45</td><td>45</td><td>118</td></tr>
<tr><td>COVID-19 and Impact of Childhood Disorders-Other Bipolar, PTSD, ODD, Conduct Disorders</td><td>16</td><td>24.5</td><td>244</td></tr>
<tr><td>Drug and Alcohol Use and Prevention During COVID-19</td><td>5</td><td>12</td><td>87</td></tr>
<tr><td>Family Violence Prevention During COVID-19</td><td>3</td><td>6</td><td>74</td></tr>
<tr><td>Depression and Anxiety - Separation anxiety, generalized anxiety, panic disorder, severe depression, persistent depression—English Pediatrics</td><td>3</td><td>6</td><td>71</td></tr>
<tr><td>Neurodevelopmental Disorders - Learning disabilities, intellectual disability, autism, ADHD—English Pediatrics</td><td>2</td><td>4</td><td>38</td></tr>
<tr><td>Grief, Loss and Resilience—Spanish Lifespan</td><td>2</td><td>4</td><td>33</td></tr>
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<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Impact of COVID-19 on Anxiety Disorders with Adults—English Lifespan</td><td>4</td><td>8</td><td>183</td></tr>
<tr><td>Impact of COVID-19 on Anxiety Disorders with Adults—Spanish Lifespan</td><td>1</td><td>2</td><td>20</td></tr>
<tr><td>Suicide Prevention During COVID-19—Spanish Lifespan</td><td>4</td><td>10</td><td>153</td></tr>
<tr><td>Cultural and linguistic considerations when assessing Latina/o patients</td><td>6</td><td>12</td><td>311</td></tr>
<tr><td>Culturally Competent COVID-19 Psychological First Aid for Faith Based Organizations and Churches</td><td>3</td><td>6</td><td>159</td></tr>
<tr><td>TOTAL:</td><td>56</td><td>101</td><td>986</td></tr>
</table>
</td></tr>
<tr><td>Psychiatric Residency Program: Charles Drew University (CDU) Agreement

The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Alliance of Health Integration contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County.

CDU Clinical Rotations:

<u>PGY-1: 6 Psychiatric Residents</u>
1 month of university onboarding is done at CDU
VA Long Beach (Inpatient Psychiatry): 4 months
Rancho Los Amigos (In-patient Medicine): 2 months
Rancho Los Amigos (Neurology): 2 months
Kedren (Outpatient Medicine): 2 months
Harbor-UCLA (Emergency Psychiatry): 1 month

<u>PGY-2: 6 Psychiatric Residents</u>
VA Long Beach (Inpatient Psychiatry): 1 month
VA Long Beach (Consultation and Liaison): 2 months
VA Long Beach (Emergency Psychiatry): 1 month
VA Long Beach (Substance Abuse): 2 months
VA Long Beach (Geriatric Psychiatry): 1 month
Kedren (Inpatient Psychiatry): 3 months
Resnick Neuropsychiatric Hospital UCLA (Child and Adolescent Psychiatry): 2 months</td><td>Ongoing</td><td>Outcomes FY 21-22

PGY-1: 6 psychiatric residents

PGY-2: 6 psychiatric residents

PGY-3: 6 psychiatric residents

PGY-4: 6 psychiatric residents

Total: 24 psychiatric residents</td></tr>
</table>

<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>The above PGY 2 rotation times represent averages. Individual resident rotations vary in their second year depending on areas of focus.

<u>PGY-3: 6 Psychiatric Residents</u>
Rotations in DMH Directly Operated Clinics and Programs:
Augustus F. Hawkins MHC
West Central MHC
Compton MHC Child & Adolescent Psychiatry
Women's Community & Reintegration Center
Harbor UCLA Medical Center HIV Clinic

<u>PGY-4: 6 Psychiatric Residents</u>
Rotations in DMH Directly Operated Clinics and Programs:
Augustus F. Hawkins MHC
West Central MHC
Street Psychiatry/HOME Team and Disaster Service
Collaborative Care/Telepsychiatry
CDU Didactics Training</td><td></td><td></td></tr>
<tr><td>LACDMH + UCLA General Medical Education (GME) – (UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)
Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry.</td><td>Ongoing</td><td>During the reporting period, the 12 trainees provided a total of 7,073 patient visits during their public psychiatry rotations.

Outcomes FY 21-22

<table>
<tr><th>NCSP</th><th># Fellows/Residents</th><th>Estimated # of Patient Visits</th></tr>
<tr><td>Adult Psychiatrist/ Researcher</td><td>1</td><td>862</td></tr>
<tr><td>GME</td><td></td><td></td></tr>
<tr><td>Adult Psychiatry Residency</td><td>3</td><td>1,124</td></tr>
<tr><td>Child Psychiatry Fellowship</td><td>4</td><td>1,672</td></tr>
<tr><td>Geriatric Psychiatry Fellowship</td><td>1</td><td>1,098</td></tr>
<tr><td>Forensic Psychiatry Fellowship</td><td>3</td><td>2,317</td></tr>
<tr><td>Total</td><td>12</td><td>7,073</td></tr>
</table>
Total number of patient visits in FY 20-21 and FY 21-22 combined</td></tr>
<tr><td>LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees – (UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)</td><td>Ongoing</td><td>Provided 114 patient visits</td></tr>
</table>

<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits.

NCSP serves to advance and promote the work of clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with LACDMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a PhD. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country.

LACDMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include:
• Participating in coursework, the equivalent of a master’s program or auditing as an option.
• Conducting up to 20% clinical work with LACDMH and participate in leadership activities.
• Conducting one to four projects, at least one of which is in partnership with LACDMH.
• Participating in a policy elective their second year when possible.
• Attending annual NCSP meetings and other local and national meetings.
• Access to research funds and a mentorship team</td><td></td><td></td></tr>
<tr><td>Navigator Skill Development Program
Health Navigation Certification Training
This program trains individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. Training was limited during the COVID-19 pandemic, and training was delivered to one cohort.</td><td>Ongoing</td><td>During FY 21-22 a total of 22 individuals completed the training, of these 60% spoke a threshold language (other than English), and all represented un- or under- served communities.</td></tr>
<tr><td>Interpreter Training Program
The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English-speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the</td><td>Ongoing</td><td>FY 21-22 Outcomes:
<table><tr><th>TRAINING</th><th># OF ATTENDEES</th></tr><tr><td>Increasing Armenian Mental Health Clinical Terminology</td><td>7</td></tr></table></td></tr>
</table>

<table>
<tr><th colspan="3">Training Unit</th></tr>
<tr><th>Strategies</th><th>Status/ Progress</th><th>Monitoring/ Outcomes/Findings</th></tr>
<tr><td>language and cultural gap in the delivery of services in public mental health.</td><td></td><td><table>
<tr><td>Increasing Mandarin Mental Health Clinical Terminology</td><td>17</td></tr>
<tr><td>Increasing Spanish Mental Health Clinical Terminology</td><td>88</td></tr>
<tr><td>Introduction To Interpreting in Mental Health Settings</td><td>22</td></tr>
<tr><td>Therapeutic Cross-Cultural Communication</td><td>11</td></tr>
<tr><td>TOTAL</td><td>145</td></tr>
</table></td></tr>
<tr><td>Learning Net System
LACDMH has developed an online registration system called eventsHub, which manages both registration and payment for trainings and conferences coordinated by the Department. eventsHub is fully operational with most if not all clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes.</td><td></td><td>Enhancement and maintenance of eventsHub continued through FY 22-23.

This system allowed non-staff (Peers, general public) to register and attend appropriate training resources.</td></tr>
<tr><td>Intensive Mental Health Recovery Specialist Training Program
This training program prepares individual, mental health consumers and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor. Successful completion of this program ensures that participants are qualified to apply for case management level career opportunities in the public mental health system.</td><td>Ongoing</td><td>Two cohorts received this training. Of the 39 individuals that began this training, 37 completed the training with 77% identifying themselves as members from unserved or underserved communities, 47% reported speaking a second language, and 90% indicated having lived experience as peers or family members. Of those that completed the training, 38% have secured employment, with all but one working in the mental health field.</td></tr>
<tr><td>Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System
The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates and caregivers for employment in the public mental health system. During FY 21-22, LACDMH delivered the following training. For the upcoming Fiscal Years, the Department will continue to develop new training offerings for these populations.

<u>Peer Focused Training</u>

Intentional Peer Support (IPS) Core Training:
It is based on an innovative practice that has been developed by and for people with shared mental health experiences. The training focuses on building and growing connected mutual</td><td>Ongoing</td><td>In FY 21-22, 15 people completed the IPS Core training.</td></tr>
</table>

Training Unit		
Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
relationships. In this interactive training, participants learn the principles of IPS, examine and challenge assumptions about how we have come to know what we know, and explore ways to create relationships in which power is negotiated, co-learning, and how to offer support beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices and has been widely used as foundational training for persons working in both traditional and alternative mental health settings.		
Online Wellness Recovery Action Plan (WRAP): This training is an introduction to WRAP® and teaches how to utilize it to increase personal wellness and improve quality of life. The training is highly interactive and encourages participation and sharing from all present. It also lays a broad foundation for building and supporting a skilled peer workforce. Participants will learn to apply the Key Concepts of Recovery and use tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. The history, foundation, and structures of WRAP® are also discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training.		During FY 21-22, two online WRAP Seminars were provided. A total of 24 participants have completed this training.
Online Wellness Recovery Action Plan (WRAP) Facilitator Refresher Training: The WRAP® Refresher Training is an interactive training to sharpen and expand facilitation skills of trained facilitators to further engage groups they facilitate in the implementation of their Wellness Recovery Action Plan®. Participants in this training will be expected to interact in learning activities and demonstrate their own experience with WRAP®. This training is designed for the current WRAP facilitators who will lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how using WRAP® can be beneficial.		A total of six (6) people were recertified to facilitate the WRAP groups for the department.
Wellness Recovery Action Plan (WRAP) Facilitator Training: This training equips participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provides an experiential learning environment based on mutuality and self-determination. Participants are expected to join in interactive		One WRAP Facilitator Training has been provided in FY21-22 and seven (7) participants have successfully completed the training. They are now able to facilitate the WRAP groups for departmental programs.

Training Unit		
Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants will be able to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Lastly, participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how using WRAP® can be beneficial. **Parent Partners Training Program** This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings increasing the availability of a workforce oriented to self-help, personal wellness and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports the employment of parents and caregivers of children and youth consumers.		During FY 21-22, a total of 2,387 individuals received this training through 26 training offerings.
Licensure Preparation Program (LPP) In an effort to increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors and Psychologists.	Ongoing	During FY 21-22, LACDMH subsidized 58 individuals across these professions, with 55% self-identifying from a un- or under- served community, and 48% speaking a threshold language in addition to English.
FINANCIAL INCENTIVE PROGRAMS **Mental Health Psychiatrist Student Loan Repayment Incentive** LACDMH offered a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at DMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the Mental Health Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years, which equates to a lifetime total of $250,000.		During FY 21-22, two (2) mental health psychiatrists participated in this program.

Training Unit		
Strategies	**Status/ Progress**	**Monitoring/ Outcomes/Findings**
Mental Health Psychiatrist Recruitment Incentive Program This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at LACDMH, and an additional payment of $25,000 upon completion of the second year of continuous service.		During FY 21-22, one (1) individual was recruited and awarded.
Mental Health Psychiatrist Relocation Expense Reimbursement Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by LACDMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves employment within one-year from the start date, the full reimbursement amount must be repaid.		During FY 21-22, no individuals were awarded.

The trainings offered by the Training Unit provide opportunities for acquiring and enhancing knowledge and a skill set important to the delivery of direct mental health services. Trainings inform of underserved communities present and historical experiences within a foundational context relevant essential for mental health services. For detailed information regarding workforce capacity building efforts, see the Criterion 6.

Underserved Cultural Communities (UsCC) Subcommittees

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

UsCC Subcommittees include:

- Black and African Heritage
- American Indian/Alaska Native

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

Each UsCC subcommittee is allotted one-time funding totaling $200,000 per fiscal year to focus on CSS-based capacity-building projects. This unique opportunity draws on the collective wisdom and experience of community members to determine the greatest needs and priorities in their communities. To remove barriers to mental health services access, the UsCC projects use novel, creative, culturally, and linguistically appropriate, non-traditional outreach and engagement approaches. All projects target unserved, underserved, and inappropriately served populations and demographics. Project proposals are created and submitted via a participatory and consensus-based approach.

Intended Outcomes:

- Increase mental health awareness to all communities within the LA County
- Identify and address disparities faced by target populations
- Reduce stigma and discrimination that may impede one from accessing mental health supports and services by educating and empowering communities to understand the importance of mental health care
- Increase access to care for mental health services provided by LACDMH and contracted providers

The goals of the UsCC Capacity Building Projects include increasing knowledge about mental illness, increasing access to mental health resources, decreasing stigma related to mental illness, and decreasing discrimination individuals from the specified UsCC communities may experience. These projects are not intended for the delivery of mental health services but to increase access to care by unserved, underserved, and inappropriately served populations who are uninsured/uninsurable regardless of age (i.e., children, TAY, adult, and older adult). Projects are designed consistent with the language and cultural needs and demographics of those communities. The UsCC capacity-building projects are community-based and include culturally effective outreach, engagement, and education to respond to historic and geographic disparities resulting in barriers to services.

An overview of each UsCC subcommittee's projects for FY 21-22 is provided in the following table.

Note:

The workflow of the UsCC Unit was disrupted by the COVID-19 pandemic, which resulted in project completion delays and roll overs into FY 22-23.

UsCC CAPACITY BUILDING PROJECTS
FY 21-22

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Access for All UsCC	1. Three (3) Needs Assessment capacity-building projects	The Access for All UsCC conducted three (3) Needs Assessment capacity-building projects in FY 20-21.	Completed	Reports released in early CY 2022 concluded that a total of 121 individuals participated in focus groups (45 in the deaf/hard-of-hearing group; 35 in the physical disabilities group; and 41 in the blind/visually disabled group). Findings indicated that key barriers faced by people with disabilities include financial stress, lack of transportation to access mental health services, difficulty navigating health insurance plans, lack of understanding of disability culture, and lack of digital access to services and resources. To maximize impact and effectiveness, LACDMH determined that future countywide needs assessments will be managed centrally.
American Indian/Alaska Native (AI/AN) UsCC	1. AI/AN Traditional Wellness Gatherings	A facilitator was hired to implement the AI/AN Traditional Wellness Gathering Project. This project aimed to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in Los Angeles (LA) County, as well as increase community member engagement in the LACDMH stakeholder process.	In process, expected completion date 11/30/23	As of May 8th, 2023, the Wellness Gatherings have been scheduled for the months of June-October 2023. Final outcomes will be shared once the project is completed by November 30th, 2023.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
American Indian/Alaska Native (AI/AN) UsCC		Additionally, this project utilized traditional methods of healing such as language, prayer, spirituality, history, songs, and food to build connections and reclaim these traditions to improve overall health outcomes.		
	2. AI/AN Mental Health Community Engagement Campaign	The campaign reinforces that LACDMH is committed to support AI/AN community members. It is tailored to resonate with the AI/AN community, reaching members using video-based content with culturally appropriate messages, distributed in the places where they already seek information and using visuals/design that complement LACDMH's current public outreach efforts. The Campaign production and distribution of five (5) videos that will serve as the centerpiece of the engagement efforts. The Campaign is designed to run for 12 weeks to ensure the consultant implements the project in a manner that complies with LACDMH advertising/branding principles.	In process, expected completion date 9/15/23	As of May 8th, 2023, the five (5) videos have been developed and will be posted via social media during the months of June-August 2023. Final outcomes will be shared once the project is completed by September 30th, 2023.
	3. AI/AN Mending the Hoop	The objectives of this project include engaging this population into conversations about mental health and	In process, expected completion date 6/30/23	As of May 8th, 2023, the Mending the Hoop event has been scheduled for May 20th, 2023. Final outcomes will be

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
American Indian/Alaska Native (AI/AN) UsCC		creating healing spaces for community members to come together to improve overall health outcomes.		shared once the project is completed by June 30th, 2023.
	4. AI/AN Youth Academy	This project aims to promote mental health services, reduce stigma, and increase the capacity of the public mental health system in LA County, as well as increase community member engagement in the LACDMH stakeholder process. Parameters for Academy participants: • (20) AI/AN TAY (aged 16-24) to participate in the Youth Academy. • Of the 20, at least ten (10) should identify as having lived experience either personally or as a family member/caregiver for someone with mental health conditions and some experience utilizing public mental health services. • Inclusion of a mental health stigma reduction program, art breakouts focused on traditional forms of healing, and athletic workshops.	Completed	The Academy was held via Zoom on five (5) consecutive Thursdays from December 29, 2022 to January 26, 2023, with a make-up session on February 2, 2023. Despite recruiting 20 participants, only nine (9) attended the first session on December 29th, with an additional five (5) stating that they missed the session due to the holidays or a misunderstanding of the start date but joined on January 5, 2023. However, the 14 group members who joined the 2nd session demonstrated full commitment to the Academy. The final cohort consisted of 14 AI/AN participants aged 16-24, with a gender mix of nine (9) females and five (5) males. Some findings included: • Out of the 20 participants recruited, 14 made a commitment to attend all five (5) consecutive workshops, with many having to adjust their work, school, or home schedules in order to do so. • The AI/AN TAY Population is more knowledgeable of and open to discussing the mental health struggles that they and their peers face. They also prioritize it and recognize the importance of mental wellness.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
American Indian/Alaska Native (AI/AN) UsCC				• The AI/AN TAY Population is aware of and already changing the stigma surrounding mental health. • AI/AN are comfortable seeking help and reaching out to peers. Asking for help for mental health is viewed as a strength rather than a weakness. • AI/AN TAY youth are eager to learn more about their culture and community. • All 14 participants expressed their desire to continue attending future academies and to refer others to participate as well. • Facilitators were able to connect to teens/young adults who are not traditionally open or comfortable sharing with adults. The youth spoke very candidly and were transparent in their discussions. • The art activities served as a helpful tool for enhancing self-expression. While 85% of our youth stated that they are comfortable seeking help for themselves or others, they also expressed that services are not usually immediately available. When services become available, the crisis has passed and/or they have worked through the issue that caused them to seek help. 1) SMS/text messaging was the preferred method of communication with the AI/AN TAY population in LA County and

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
American Indian/Alaska Native (AI/AN) UsCC				should be utilized when possible. 2) Many of the youth participants expressed that school counselors do not seem to understand their needs and generalize all. 3) TAY Youth were not generally aware of the services specific to their age range. 4) Providers did not seem in touch with their stressors (i.e., school performance, money). The Community Forum, which aimed to facilitate an intergenerational discussion about the mental health challenges faced by AI/AN TAY in LA County, was promoted through various social media channels and community networks. However, despite these efforts, the facilitator faced difficulties in attracting a large number of participants, highlighting the lack of interest that older generations may have in discussing mental health issues, as previously expressed by the youth. Results from the Community Surveys show 57.14% of participants strongly agreed the event provided new information and resources that would be useful to their families, learned something new about themselves/their family, were able to connect with others, and as a result of the event will do something different with their family.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Asian Pacific Islander (API) UsCC	1. Korean Mental Health Navigation Services	The focus of this project is to develop Korean Mental Health Navigation Services that target the first-generation immigrant Korean community in SA 4 to disseminate information on mental health resources, link to services, and provide mental health awareness workshops.	Projected Completion Date: October 31, 2023	Monitoring is being done by email communication and virtual meetings. This project is still in process and outcomes will be shared once completed.
	2. 1000 Cranes – Healing Through Arts and Culture	The goal of this project is to outreach, educate, and increase knowledge on traumatic stress and common mental health disorders utilizing a non-stigmatizing and empowering approach to help the API community begin the healing process.	Projected Completion Date: June 30, 2023	Monitoring is being done by email communication and virtual meetings. This project is still in process and outcomes will be shared once completed.
	3. Promoting Mental Health Wellness in South Asian Americans	This project focuses on reducing the stigma surrounding mental health for the South Asian community in LA County by providing a space for them to talk about mental health in a congruent setting with bilingual, bicultural South Asian mental health community ambassadors.	Projected Completion Date: June 30, 2023	Monitoring is being done by email communication and virtual meetings. This project is still in process and outcomes will be shared once completed.
	4. Cambodian Americans – Oral History of 1.5 Generation	The goal of this project is to develop oral histories on the mental health impact of trauma on Cambodian American adults living in LA County who were children during the Khmer genocide.	In progress	Monitoring is being done by email communication and virtual meetings. This project is still in process and outcomes will be shared once completed.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Asian Pacific Islander (API) UsCC		Another goal is to fill a gap in knowledge and understanding as to the mental health impact of the historical trauma as a result of genocide of Cambodian Americans who arrived in the U.S. as children.		
Black and African Heritage (BAH) UsCC	N/A	The BAH UsCC projects that had been slated for FY 21-22 were rolled over to FY 22-23. Therefore, BAH UsCC did not have any projects to report for FY 21-22.	N/A	Outcomes will be reported in the next FY year.
Eastern European/ Middle Eastern (EE/ME) UsCC	1. The Russian and Farsi speaking Mental Health Film Project	This project targets the Russian and Farsi speaking communities of LA County at large by promoting mental health services, increasing mental health awareness and education, and reducing stigma. Two (2) films (one for each community) will be made. Via these films, the Russian and Farsi speaking community members will get an inside look into the world of those who suffer from a mental health condition. Further, the Russian and Farsi speaking community will be educated on how to access mental health services and understand some of the cultural biases associated with suffering from a mental health condition.	Completion Date: Project is scheduled to be completed on 8/14/2023	Outcomes for FY 21-22: This project is going well. The filming of the movies has been completed, and it is in the editing process. After the movies are edited, they will be submitted to LACDMH for approval. Afterwards, the two (2) films will air various times on YouTube and feedback will be collected from community members about the films. Farsi and Russian community members who reviewed scripts of the movies for inclusion of important mental health cultural aspects and cultural relevance expressed positive feedback.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Eastern European/ Middle Eastern (EE/ME) UsCC		The films will air various times in LA County. After the film presentations, a twenty-minute discussion with the writer, director, and theater production manager will also be recorded, which will include information about mental health issues that the film has addressed. This project began on 8/8/2022.		
	2. The Arabic Healing Through Art Mental Health Outreach Project	This project consists of ten (10) art events, one (1) time a month, for ten (10) consecutive months, utilizing painting to express thoughts and feelings and open the door for healing. The events are conducted in one SA and last a total of four (4) hours in length. The art events are facilitated by an art therapist, who engages participants in mental health group discussions.	Completion Date: June 30, 2023	Outcomes for FY 21-22: The vendor is in the process of finalizing recruitment of participants and identifying venues where the art events will take place. The Arabic Mental Health Art Event Project has been somewhat slow moving. There were art events where only four or five (4 or 5) people showed up, as a result, vendor had to reschedule the events a few times. Some of the challenges of the project are stigma attached to mental health and community members declining to open up about their personal and mental health issues. Arabic culture is a private type of culture and community members do not want to talk about their own, or their family's mental health issues, or personal problems. This is the reason for the lower number of participants to complete the recruitment process. The vendor continues to come up with other, nontraditional ways of reaching this community.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Eastern European/ Middle Eastern (EE/ME) UsCC				Mental health art events will be a place where participants will feel comfortable enough to share their personal issues through art.
Latino UsCC	1. Healing Grief and Loss Through Community	This project targets the Latino community at-large. Latinos are over-represented in occupations with higher COVID-19 exposure risk and are experiencing a disproportionate number of deaths as a result. This project engages the Spanish-speaking community in non-stigmatizing conversations around grief, loss, and death and the relation to mental health issues. It also provides linkage and resources.	In progress	The consultant reported interest and registration for participating in these community conversations has been high. Participants have had the opportunity to get connected with longer term grief and loss support groups and have been provided with LACDMH's ACCESS Line and information. The consultant identified the need for these type of conversations for youth based on feedback from participants, including one youth who was unable to participate due to being under 18 years of age. Conversations in person as well as virtual have had a similar turnout.
	2. La Cultura Cura: Engaging the Traditional Arts in Healing	The project targets the Latino community County-wide focused on individual adults and youth. As documented by a Surgeon General report, only about 20% of the Latino community with mental health challenges speak to their doctor about their mental health. Negative cultural attitudes contribute to Latino communities living in the U.S. perceiving a lower need for mental health care despite common	In progress	The project has completed in two out of three phases. The first phase workshop development, community outreach, and invitation for community to participate. The second phase involved the Consultant conducting a series of four (4) workshops in four (4) different SAs with a focus on culture and traditional arts, healing, and mental health. Both phases were successful as evidenced by the consultant meeting participant target goals.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Latino UsCC		mental health conditions increasing among the Latino population. Stigma, language barriers, and inequities in mental health care continue to be key barriers to the Latino community receiving culturally responsive mental health services. Research has shown that engagement in cultural practices enhances physical and mental health, positive self-perception, desire to grow and learn, self-actualization, community involvement, and increased clarity of future goals. The consultant partners with Mental Health Promotors from three (3) different SAs of LA County to present a mental health workshop series that integrates cultural knowledge and healthy coping when facing emotional and mental distress.		Workshops were provided virtually and hybrid successfully.
	3. Empowering Latino Youth as Mental Health Advocates	The primary objectives of this project are to empower Latino youth as the experts in developing innovative strategies using media arts to reach other Latino youth throughout LA County, provide education about the importance of mental health care, destigmatize mental health issues	In progress	Consultant has completed three (3) Phases out of four (4) Total Phases for the project. Youth stories have been recorded and are currently being reviewed and edited. Some participating youth have been linked to services: two (2) youth.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
Latino UsCC		amongst Latino youth, develop culturally sensitive resources/tools, and to increase Latino youth engagement in the LACDMH stakeholder process. A bilingual Spanish-speaking consultant was hired to recruit 20 Latino youth from three Service Areas (SA 3, SA 4, SA 6) of LA County to form a Cohort of mental health youth advocates. This project will include outreach and recruitment of Latino youth who will create mental health oral stories representing their diverse mental health experiences to use as a social media stigma reduction and mental health education effort. The media art created will be produced for distribution throughout LA County.		Consultant reported receiving support and working with four (4) different high schools. Approximately 20% of youth who reported interest in participating were not eligible based on initial screening as they either had unmet mental health needs that required participating in mental health services prior to participating or were not ready to talk about their mental health struggles publicly and refused linkage due to high personal/family stigma.
LGBTQIA2-S UsCC	1. LGBTQIA2-S Griot Project	This project involves two (2) components: The first will include outreach and engagement of a minimum of twenty-five (25) Black and African-American LGBTQIA2-S elders and youngers (elders aged 50 and older and youngers aged 25 and younger) into a cohort. Within the cohorts, at least ten participants identified as having lived experience either personally or as a family member/caregiver	Completed	The pre-test and post-test included eleven (11) items that focused on the respondent's knowledge about availability of mental health services within their community, the use of cultural practices in service of their mental well-being, as well as inquiries regarding support received from their family of origin, the Black community, and their religious community. Respondents were also asked about whether they had created a family of choice as a means of support. The results

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
LGBTQIA2-S UsCC		as well as experience utilizing public mental health services. Cohort members meet a minimum of eight (8) times to create narrative videos/interviews of the elders' histories. The second component involves conducting a community forum to present the finalized narrative videos/interviews.		showed little variability between pre/post test measures. This may be explained in part by the brief nature of the project (e.g., the group lasted only eight sessions) and that many of the questions asked spoke to issues that have more to do with external factors for which the participants have little control (e.g., "I feel supported in my sexual orientation within my family of origin" and "I feel supported by my religious community"). Although a questionnaire. The post-test included four (4) qualitative questions that proved to be much richer in data about the positive impact that cohort members received from participating in the project.
	2.LGBTQIA2-S Panthera Project	This project involves three (3) components: The first component outreaches and engages 25 Black transmasculine community members into a Cohort. Cohort members meet a minimum of 10 times to provide education on workplace rights as it relates to harassment, how to access mental health during and after encounters with harmful work environments, and education of community members on how to navigate toxic workplace environments while safeguarding their mental health. Additionally, the meetings address the root	In process, expected completion date 6/30/23	As of May 8th, 2023, the final cohort meetings are being conducted. Final outcomes will be shared once the project is completed by June 30th, 2023.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
LGBTQIA2-S UsCC		causes of financial inequality that threaten self-sustainability amongst Black transmasculine community members. The meetings also provide attendees with resources in the pursuit of affirming gainful employment and financial literacy in order to improve mental health outcomes. The second component involves Facilitator and Cohort members designing a survey specific to Black transmasculine community members to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community in a culturally sensitive way. This survey also gathers data relative to the employment needs amongst this community and the impact on mental health when facing toxic work environments. The goal is for a minimum of 100 Black transmasculine community members in LA County to complete the survey. The third component involves reporting out on the findings of the cohort		

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
LGBTQIA2-S UsCC		meetings and survey results.		
	3. What We Think (Black Gay Male Elders Project)	This project involves three (3) components. The first component engages a minimum of twenty-five (25) Black Gay Male Elders (aged 50+) into a cohort. Cohort members meet a minimum of ten (10) times to develop a survey to be disseminated to Black Gay Male Elder community members throughout LA County. The goal of the survey is to identify the specific mental health concerns experienced by this underserved community and any gaps in service delivery, as well as learn how to best serve this community The second component involves conducting two (2) community town halls focused on the broader issues of aging, and in particular amongst the Black Gay Male Elder population. The third component involves reporting out on the findings of the cohort meetings, survey results, and town halls.		As of May 8th, 2023, the Townhall meetings are being scheduled. Final outcomes will be shared once the project is completed by June 30th, 2023.
	4. Black LGBTQ+ Community Outreach & Engagement Project	This project involves four components. The first includes multi-stakeholder engagement that involves leading and managing a collaboration with multiple	In progress	As of May 8th, 2023, the final summary report is being developed. Final outcomes will be shared once the project is completed by June 30th, 2023.

Stakeholder Group	Capacity Building Project Name	Description	Status/ Progress	Monitoring/ Quantifiable Outcomes/ Findings
LGBTQIA2-S UsCC		Black LGBTQ+ stakeholders that jointly addresses Black LGBTQ+ community priorities. The second component involves Black LGBTQ+ community education and empowerment involving closed biweekly meetings with community members that focus on specific issues of individual segments of the Black LGBTQ+ community. The third component involves Black LGBTQ+ community outreach and engagement events to hold discussions on Black LGBTQ+ community needs where pertinent information is shared with community stakeholders and input from community members is gathered. The fourth component consists of a community needs assessment and gap analysis.		

Urgent Care Centers (UCCs)

Mental Health UCCs serve to divert individuals from LA County and private hospital emergency departments and avoidable engagement with law enforcement and incarceration. This is accomplished through the development of an individualized plan for all persons served, focused on recovery and wellness principles that will promote successful reintegration into the community. UCC partners with the network of County-Operated and Contracted mental health providers, as it is common for consumers to initiate their services at the UCC and continue with their established provider after services are provided.

Services provided at the UCCs include:

- Screening and triage
- Brief clinical assessment
- Medication evaluation and medications services
- Identification of immediate case management needs
- Identification of acute psychological needs and provision of crisis intervention services as needed
- Linkage to community providers for ongoing services

UCCs were developed with the follow goals in mind:

- Provide quality crisis intervention and stabilization services and support
- Reduce the utilization of hospital emergency rooms, unnecessary psychiatric inpatient unit hospitalization
- Reduce incarceration
- Reduce law enforcement involvement in mental health crisis calls and contacts
- Reduce the utilization of hospital emergency rooms and unnecessary psychiatric inpatient unit hospitalization
- Improve participation rates in outpatient mental health services, case management programs, crisis and other supportive residential programs and intensive services programs
- Ensure clients' and/or their family members' satisfaction with the crisis stabilization services received
- Increase the percentage of individuals who, within 15 and 30 days have not returned for crisis services at a County or private hospital emergency department.

Based on the disparities data, systematic and strategic decision were made by the UCC relative to cultural and linguistic accessibility. Through partnership and collaboration with new and existing contracted providers, and to ensure diverse cultural and linguistic needs of the communities are met, the UCC programs provide services in the 12 threshold languages for LA County. Additionally, to meet the cultural needs of the communities, services are being expanded to age groups and areas that have previously been underserved. Specifically, an adolescent and adult UCC programs were established in SA 2; and an adult UCC program is being established in SA 7; and the first UCC program in the County for children ages 3 years to 12 years is being developed.

Furthermore, the UCC programs' capacity has been expanded. For example, an adolescent UCC program was added through partnership with community providers and an adult UCC program was established at Olive View in SA for adults and adolescents. The program provides the services that are culturally relevant, and in the language of choice for clients, consistent with goals and expectations of the LA County.

UCC'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Collaboration with faith-based and other trusted community entities/groups	Active participation in SAs, Clergy Meetings, and Community Faith-Based Committee Meetings	Ongoing	Case consultations supporting both community and churches/synagogues and parishes in crisis situations	
• Co-location with the Department of Health Services (DHS)	Establishment of Crisis Stabilization Units in all SAs and Supervisorial Districts, some in collaboration with DHS staff	Ongoing	Quality Assurance Division for Medi-Cal Certification, Lanterman-Petris-Short (LPS) Facility Designation Unit for LPS requirements, and use of Seclusion and Restraint Report	
• Community education to increase mental health awareness and decrease stigma	Active leadership and collaboration in the Provider Meetings as needed, partnerships with the local SA chapters of National Alliance for Mental Illness (NAMI); including Spanish speaking NAMI chapters	Ongoing	Maintenance of open communication and sharing of resources	
• Continuous engagement with committees, subcommittees, and taskforces that address cultural and linguistic	Active leadership and partnership in Service Area Leadership Team (SALT), SA Providers Meeting and Clergy Meetings	Monthly	Regular reporting out of program activities and receipt of verbal community input	

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
competent service delivery				
• Implementation of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	Modifications to UCC workflow to accommodate influx of visitors and clients, and to maintain the health and safety of all visitors and staff	Ongoing	No reported known transmission of COVID-19 within the facility among staff or visitors, ensuring that services are provided without delays or disruptions	
• Coordination of language interpreter and close captioning services in real time services for consumer, family member, and community member participation in clinical appointments	Regular use of the language lines available to LACDMH clinics	Ongoing	Confirmation that visitors can receive services in the preferred language of choice	
• Interagency collaboration	Partnerships with SA Community-based agencies to assist clients with access to urgently needed mental health services	Ongoing	Direct service reports, direct service detail reports, linkage activities with partner agencies for ongoing mental health services	
• Integration of physical health, mental health, and substance use services	Collaborate and ensure staffing by board-certified addiction psychiatrists, partnership with DHS and the LACDMH Pharmacy in the Crisis Stabilization Unit to provide both mental health and physical	Ongoing	Regular communication with the LACDMH pharmacy, regular management team meetings which include crisis stabilization unit supervisor, weekly meetings with California State University (CSU) staff,	

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
	healthcare medications as needed, close working collaboration with DHS programs co-located on the campus identified DHS sites.		coordination as needed between LACDMH and DHS supervisors and managers.	
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	Active leadership and participation in Service Area Leadership Team (SALT), SA Providers Meeting, community, and Clergy meetings	Ongoing	Regular reporting out of program activities and receipt of verbal community input.	
• Utilization of the workforce's responses to cultural competence organizational assessments, surveys, and focus groups to address knowledge gaps and support advancements in cultural competence	Monitor program services utilization and profile information, which include gender, race/ethnicity, primary language, age, housing, substance use, psychiatric diagnosis, and caregiver language	Ongoing	Data initially developed for Medi-Cal recertification, and is applicable to monitoring demographics of clients served, as well as to monitor compliance with collecting these indicators.	

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CONSUMER SERVED BY UCC
FY 21-22

Program	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify Other & Unknown)	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
UCC	9,110	168	1,762		14,285	215	7,010	2,290 & 232	20,616	16,157	115	115									

Veterans Peer Access Network (VPAN)

The VPAN program helps veterans and military family members navigate often complicated systems so that they receive the services deserved. The VPAN is the first-ever community-driven support network serving veterans and their families in the U.S., and the Veteran Peer Access Network connects County Departments, non-profits, the U.S. Department of Veterans Affair (VA) and LA City programs. VPAN is led by veterans for veterans. The network embodies the #YouMatter ideal – that veterans deserve hope, well-being, and a greater quality of life as valued members of the LA County community. VPAN serves:

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

VPAN places trained Veteran Peers on the ground in LA County communities to assist in connecting Veterans to the services they need as they transition out of the military and into LA County.

VPAN utilizes disparities data in the planning and implementation of strategies to make services culturally and linguistically accessible to communities. Some examples include:

- Veteran Affairs (VA) is drastically under-utilized and VPAN strives to provide for veterans and military families to have timely access to the VA

- Most community providers are not aware of veteran specific resources or what veteran may qualify for services at the VA
- High numbers of veterans experience homelessness. VPAN provides intensive street outreach and engagement to those veterans to get them permanently housed. VPAN also has a "Projects for Assistance in Transition from Homelessness" (PATH) contract which allocate funding for 2.5 full-time employees working specifically with veterans who are experiencing mental illness and homelessness
- Through a study with the County Medical Examiner - Coroner's office, VA and DMH, we found that veterans are four times more likely to die by suicide than non-veterans in LA County. The creation of a Suicide Prevention Coordinator addresses this disparity and assists with monitoring high risk veterans to reduce this number
- The Veteran Peer Access Network Support line offer services in all 13 threshold languages. The VPAN Support line is open 9 a.m. to 8 p.m., 7 days a week, including holidays, 1-800-854-7771, option #3
- VPAN's continued success is evident in its progress. For example, the Rally Points (Access Center) within the Supervisorial Districts (SD) continue to evolve. The VPAN contractor Volunteers of America Los Angeles-Supervisor District 2 recently moved from a challenging location in Compton to a much more accessible venue in Hawthorne. Another VPAN contractor, GOODWILL-Supervisor District 3 is planning a move from Granada Hills to Sherman Oaks for similar reasons, while a third contractor, Jobs, Vision, and Success-Supervisor District 5 is finalizing their relocation from remote Lancaster to an office in Palmdale across from a shopping center and convenient to public transportation. All these actions were done in response to the needs of the community.

VPAN and all its subprograms and projects are designed specifically for veterans. VPAN members strongly believe veteran culture is a unique subculture that requires specific trainings and culturally competent services. The VPAN program actively identifies disparities and provides culturally and linguistically competent services to veterans residing within LA County, many of whom are already identified as minority in the community at large. Many veterans may not feel comfortable engaging with non-veteran providers as they tend to use a different style of communication and experience stressors differently from non-vets' population due to history of trauma. For this reason, VPAN intentionally recruits veterans and family members of veterans as providers who can bring a shared lived experience to their engagement with the LA Veteran community.

VPAN's Veteran Peer Service teams and the Department of Military & Veteran Affairs' (MVA) Veteran Service Navigators are distributed at "rally points" across LA County, in addition to MVA's Headquarters at Bob Hope Patriotic Hall. Each rally point, one in each of LA County Supervisorial Districts and operated in partnership with a community-based organization, serves as a hub to provide assistance and support to veterans and the Mil Vet family. Mil Vet family members include any family member of a veteran or of those still serving (e.g., active duty, National Guard, and reserves). Veterans and their families are encouraged to drop in at these sites or contact the respective rally point in their supervisorial districts to receive resources and services. Making VPAN services accessible to all, VPAN staff also provides virtual supportive services through the VSee platform.

The VPAN program has increased access to mental health services and reduced disparities. For example, the VPAN's Support Line continues to provide support to veterans and military family members seeking emotional support and field services. The Support Line offers interpreter services, offering all 13 threshold languages. During FY 21-22, the information related to access to interpreter services was included in the VPAN's program material, such as flyers, banners, including social media posts. VPAN providers collaborated in various community events that contributed to the Department's provision of access to culturally and linguistically competent services.

VPAN is all pro-accessibility. Because it is a community-driven support network, the VPAN Veteran Support Line provides coverage from 9 am – 8 pm, seven (7) days a week, including holidays. The VPAN agents can immediately create referrals for mental health services as needed and respond to referrals within 2-3 days. Agents on the Support Line can directly transfer calls to ACCESS when callers require more immediate assessment and crisis management. They utilize a low barrier approach with minimal eligibility criteria. In the coming years, their goal is to move VPAN field operations to seven (7) days a week which will allow the VPAN team to respond to the field immediately as needed. In addition, the Network has also coordinated many community events that helped increase access to Mental Health services, including Peer-to-Peer support.

VPAN'S PROGRAMS/TRAININGS RELATED TO GROWING CULTURALLY AND LINGUISTICALLY COMPETENT WORKFORCE, FY 21-22

<table>
<tr><th>Training Program</th><th>Activities addressing each strategy</th><th>Status/ Progress</th><th>Monitoring practices</th><th>Quantifiable Outcomes</th></tr>
<tr><td>• Community education to increase mental health (MH) awareness and decrease stigma</td><td>VPAN Veteran Support Line; Agents on the line provide resources to callers about mental health services and normalize the process of seeking MH services.
VPAN Field based team participants in many community events to reduce stigma for veterans seeking MH</td><td>On going</td><td>Quarterly customer satisfaction surveys, in which the following questions are asked:

1. Are you receiving/or did you receive the services that you need (ed)?

2. How did you hear about the VPAN?

3. Would you refer a friend or</td><td>Outcome: * out of 311 clients that agreed to participate in the survey

1. Are you receiving/or did you receive the services that you need(ed)?

<table><tr><td>No</td><td>59</td><td>19%</td></tr><tr><td>Undetermined</td><td>35</td><td>11%</td></tr><tr><td>Yes</td><td>214</td><td>69%</td></tr><tr><td>Grand Total</td><td>308</td><td></td></tr></table>
2. How did you hear about the VPAN?

<table><tr><td>Another Veteran</td><td>27</td><td>9%</td></tr><tr><td>CBO/VSO</td><td>39</td><td>14%</td></tr><tr><td>College</td><td>4</td><td>1%</td></tr><tr><td>Community Event</td><td>26</td><td>9%</td></tr><tr><td>DMH</td><td>8</td><td>3%</td></tr></table></td></tr>
</table>

<table>
<tr><th>Training Program</th><th>Activities addressing each strategy</th><th>Status/ Progress</th><th>Monitoring practices</th><th>Quantifiable Outcomes</th></tr>
<tr>
<td></td>
<td>services. We participated in many in-person events during this reporting year, we also continue to provide services virtually if requested by the veteran or military family member.</td>
<td></td>
<td>family member to VPAN?</td>
<td>
<table>
<tr><td>Family Member</td><td>9</td><td>3%</td></tr>
<tr><td>Friend</td><td>30</td><td>10%</td></tr>
<tr><td>Mail</td><td>1</td><td>0%</td></tr>
<tr><td>Other</td><td>45</td><td>16%</td></tr>
<tr><td>Social Media/Internet</td><td>13</td><td>5%</td></tr>
<tr><td>TV</td><td>2</td><td>1%</td></tr>
<tr><td>VA</td><td>83</td><td>29%</td></tr>
<tr><td>Grand Total</td><td>287</td><td>100%</td></tr>
</table>

3. Would you refer a friend or family member to VPAN?
<table>
<tr><td>No</td><td>25</td><td>8%</td></tr>
<tr><td>Undetermined</td><td>36</td><td>12%</td></tr>
<tr><td>Yes</td><td>249</td><td>80%</td></tr>
<tr><td>Grand Total</td><td>310</td><td></td></tr>
</table>
</td>
</tr>
<tr>
<td>• Multi-lingual/multi-cultural staff development and support</td>
<td>VPAN hired staff that are bilingual (Spanish, Arabic, Vietnamese, etc.) in an effort to outreach to military family members that are monolingual speakers residing in LA County.</td>
<td>On going</td>
<td>This is monitored on a weekly basis by soliciting feedback from direct staff providing services in a specific community.</td>
<td>Languages represented by Program staff:
• English: 15 staff
• Spanish: 5 staff
• Greek: 1 staff
• Tagalog: 2 staff
• Arabic: 1 staff
• Vietnamese: 2 staff
• Armenian: 1 staff
• French: 1 staff

The VPAN strives to hire veterans or military family members to their workforce. Their direct service staff consist of 90% veterans.</td>
</tr>
<tr>
<td>• Outreach and Engagement (O&E) efforts</td>
<td>VPAN participated in community events and delivered presentations at partner agencies on veteran services and benefits.</td>
<td></td>
<td>Outreach staff will report back to VPAN leadership on gaps in services that they see or received from the community. VPAN leadership uses</td>
<td>A total of 215 presentations were done across Supervisorial Districts 1, 2, 3, 4, and 5</td>
</tr>
</table>

Training Program	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
			these feedbacks as guide in training development for inter and intra-agency work.	
• Integration of physical health, mental health, and substance use services	VPAN aimed to assist veterans and their families holistically. VPAN works closely with VA for healthcare, LACDMH Directly Operated Clinics and community partners for mental health, substance abuse treatment and serves veteran such as Banyan Treatment Center.	On going	Supervisors meet weekly with staff for case consultation.	780 weekly supervision sessions with staff providing direct client care.
• Provider communica-tion and support	VPAN leadership team met with Southern California Grant Makers (SCG)/ Community-Based Organizations (CBOs)-(contracted providers) on a weekly basis to assist with program development and monitoring.	Weekly meeting and ongoing	VPAN leadership met bi-weekly	SCG: 52 meetings per year VPAN COB: 24 meetings per year

Training Program	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
• Trainings/case consultation	VPAN supervisors and managers provided ad hoc trainings and case consultation to CBO peers. VPAN staff attend various community events to present on topics relevant to veteran needs to the public.	Ongoing as needed	Monthly meeting to review training needs for VPAN, track attendance, and develop future training topics.	From these consultations, feedbacks from staff, VPAN leadership developed or coordinated trainings directly responding to the gaps and needs from staff.
• Investments in learning (e.g., Innovation Plan)	VPAN collaborated with UCLA, Southern California Grant makers (SCG), and internal LACDMH training division to create trainings specific to veteran population.	Ongoing /monthly meeting	Monthly meeting to review training needs for VPAN, track attendance, and develop future training topics.	16 trainings provided in FY 21-22. In addition, all VPAN staff, and contractors accessed the DMH+UCLA, VPAN learning community. A virtual on-line community training portal that makes training and education for LACDMH VPAN Veteran and family Peer Navigators easily accessible.

VPAN'S ADDITIONAL STRATEGIES & ACTIVITIES FOR CULTURALLY AND LINGUISTICALLY COMPETENT SERVICES, FY 21-22

<table>
<tr><th>Department wide strategies</th><th>Activities addressing each strategy</th><th>Status/ Progress</th><th>Monitoring practices</th><th>Quantifiable Outcomes</th></tr>
<tr>
<td>• Co-location with other county departments</td>
<td>VPAN Head Quarters is at Bob Hope Patriotic Hall which belongs to Dept. of Military and Veteran Affairs (DMVA). Staff are stationed in the lobby and work closely with DMVA staff on cases to ensure veterans are linked appropriately not falling through the cracks. VPAN staff are also collocated at various Rally Points (Jobs, Vision, Success - JVS, Volunteers of America -VOA, Los Angeles, U.S.S Battleship Iowa, Goodwill) to enhance partnership with Community Based Organizations servicing vets and military family members. A VPAN rally point is a walk-in site where any veteran or family member can receive support or connection to services and benefits. They are also locations</td>
<td>On going

VPAN staff are co-located with the listed veteran serving organizations across the various supervisor districts. Staff are present at the Rally point two (2) times a week, covering the site full time to ensure that veterans and military family members are connected to services immediately.</td>
<td>VPAN leadership met weekly to ensure coverage at the various community access points, Rally Point sites.</td>
<td>Five Rally Points established with 38 Community Access Points strategically selected at various high frequency community locations.

List of Rally Points
<table>
<tr><th>Sup. District/ Agency</th><th>Email</th><th>Location</th></tr>
<tr><td>1-JVS SoCal</td><td>vpan@jvs-socal.org</td><td>1180 Durfee Ave. South El Monte, CA 91733</td></tr>
<tr><td>2 – VOALA</td><td>vpan@voala.org</td><td>5155 Rosecrans Ave, Ste 100 Hawthorne, CA 90250</td></tr>
<tr><td>3 - Goodwill SoCal</td><td>vpangoodwill@goodwillsocal.org</td><td>10324 Balboa Blvd. Granada Hills, CA 91344</td></tr>
<tr><td>4 - Battleship Iowa</td><td>vpan@veteranswest.org</td><td>250 S. Harbor Blvd. Los Angeles, CA 90731</td></tr>
<tr><td>5 - JVS SoCal</td><td>vpan@jvs-socal.org</td><td>38345 30th St. E, Suite A-1 Palmdale, CA 93550</td></tr>
<tr><td>VPAN HQ – Bob Hope Patriotic Hall</td><td>veterans@dmh.lacounty.gov</td><td>1816 S. Figueroa St. Los Angeles, CA 90015</td></tr>
</table>
</td>
</tr>
</table>

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	where events and trainings will take place for the veteran community. VPAN also established Community Access Points at various locations within each teams Supervisorial District (libraries, Vet Centers, community colleges, religious institutions)			
• Integrated Supportive Services	VPAN aimed to assist veterans and their families holistically. VPAN work closely with DMVA for benefits establishment, VA for healthcare, LACDMH Directly Operated clinics and community partners for housing, substance abuse treatment and more.	On going	Unite Us, a technology platform used by VPAN to help track referrals and outcome of linkage, helps inform types of services most often requested. Cases are open for at least 90 days to ensure proper linkage. Monthly housing survey to track number of Veterans were matched & placed in permanent housing.	Out of 524 cases opened in FY 21-22, 293 cases needed more than one type of services and were linked to resources. 29 veterans who experienced homelessness were matched and housed in permanent housing.
• Field-based services	VPAN services were performed in	On going	Weekly supervision with	40% of VPAN clients are veterans who experienced homelessness

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	the field. VPAN conducts homeless outreach, home visit, and collaborating with PMRT/MET on high-risk cases		staff, weekly COS report notes.	and received services in the field while they were unhoused.
• Continuous engagement with committees, subcommit-tees, and taskforces that address cultural and linguistic competent service delivery	Los Angeles Veterans Collaborative (LAVC) met monthly to discuss topics that impact the veteran community in LA County	On going	VPAN Leadership have weekly meetings with LAVC Director where updates were provided on trends and challenges in the veteran serving community	VPAN supported 12 LAVC meetings during FY 21-22. Improvement on workflow, increase engagement with service providers.
• Interagency Collaboration	VPAN aimed to assist veterans and their families holistically. VPAN works closely with Community Based Organizations (CBOs); (Jobs, Vision, and Success; Volunteers of America; U.S.S. Battleship Iowa; Goodwill of Southern California), Dept. of Military and Veteran Affairs (DMVA) and CalVet for benefits establishment, VA for healthcare, DMH Directly Operated clinics-DOs for mental	On going	Daily Sync-Ups between DMH and CBOs, Biweekly meeting with CBO Program Managers, Monthly meeting with DMVA,	Counts of Community Events that VPAN hosted, joined, collaborated, and/or presented listed based on Supervisorial District (SD): SD1: 96 SD2: 9 SD3: 10 SD4: 67 SD5: 23

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	health and community partners for housing, substance abuse treatment and more. VPAN supported the Veteran Experience Action Center (a VA National campaign) to outreach to veterans and assist with ease of access to benefits and services. Veterans Experience Action Centers (VEAC) bring together VA, state, local, and non-profit resources for Veterans and their families to offer virtual 1-on-1 personalized assistance with benefits and services.	Once a year	Pre-event training and coordination meetings, post-event debriefing calls with all participating partner agencies.	Total number of veteran callers: 465. Out of the 465 callers, 74 were Peer Support Services requests routed to VPAN for assistance and linkage.
• Post COVID-19 interventions	VPAN Support Line was created at the onset of the pandemic to support unique emotional needs of veterans in LA County.	On going	Lead support line agents monitor calls using the VCC to ensure appropriate services level, and call disposition.	10,546 calls received and dispositioned by VPAN support line agents during FY 21-22, all calls were monitored for quality assurance purposes. Callers needing urgent care were successfully transferred to ACCESS for follow up appointment as required.
• Augmentation of mental health service	VPAN reviewed research and data which highlights	On going	VPAN implemented on-going	130 cases reviewed, 102 of reviewed cases were flagged for SP

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
accessibility to underserved populations	that military/ veterans are a significantly higher risk for suicide. As such VPAN implemented unique strategies and adaptations to general mental health services to meet the needs of this under-served population. Specifically, VPAN activated and augmented staff resources and roles in order to provide immediate accessibility to mental health services and crisis intervention to this population. Further, VPAN in its attempts to prevent suicide in the veteran population and to be part of the multimodal approach to veteran suicide prevention, created and implemented a peer-based suicide prevention protocol (this protocol included veteran cases being reviewed, high risk for suicide veterans being identified, tracked, and intensive peer		weekly QA reviews, especially for high-risk veteran cases. QA often reviewed charts to evaluate quality and compliance with documentation practice standards and provides corrective feedback to staff.	Protocol provided resources/linkage to mental health. Future goal is to pilot a study on impact of VPAN Peer Suicide Prevention Protocol in hospitalization and/or high-risk behaviors.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	services being provided)			
• Utilization of the community's knowledge, feedback, and capacity to promote health and wellbeing	VPAN leadership participated in The Los Angeles Veterans Collaborative activities (LAVC). LAVC is a structured network of public, private, and government agencies working together to reduce suffering and improve the lives of veterans, service members, and military families in LA County. This was achieved through strategically improving and coordinating their access to services, reducing barriers to care, and influencing policy.	Ongoing /meets monthly	Once a month, 9 am -12 pm	The Los Angeles Veterans Collaborative met monthly, twelve times, *2nd Wednesday of every month, 9am-12pm*, alternating from in-person to virtual. The network meeting agenda includes break out group, *subcommittees*. The ten focus groups/committees included: 1. Women Veterans; 2. Families and Children; 3. Housing and Homelessness; 4. Legal and Re-Entry; 5. Behavioral Health 6. Recreation and Rehabilitation; 7. Higher Education; 8. Career Advancement; 9. Health and Wellness 10. Faith-Based.
• Implementa-tion of new departmental policies and procedures that improve the quality and timeliness of delivering mental health services	VPAN Support line helped with prevention and increase access to care for veterans experiencing stress. If callers on the line needed additional mental health support, they were referred to VPAN peer support to assist with linkage to care in a timely	On going	Daily monitoring of Unite Us, a referral processing system that allows for tracking of service request/referral. The platform is a tool to monitor access to care timeliness, including referral	The VPAN program engaged two (2) full time gatekeepers that track request for services daily, 7:30 am-6:00 pm. All requests for services were assigned to providers and dispositioned daily.

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes
	manner. VPAN referral response time was up to 2-3 business days and at times, on the same day.		disposition, which in turn help improve access to care and immediate responses from providers.	
• Implementation of new technologies to enhance the Department's service delivery	VPAN support line used VCC (Virtual Contact Center). VCC application assist with ability to track calls, monitor calls, and transfer back to ACCESS as needed if caller needs urgent help.	New technologies were to enhance the Department's service delivery goals.	Lead support line agents monitored calls using the VCC to ensure appropriate services level, quality, and call disposition.	10,546 calls received and dispositioned by VPAN support line agents during FY 21-22. All calls were monitored for quality assurance purposes. Callers needing urgent care were successfully transferred to ACCESS for follow up appointment as required.

CONSUMERS SERVED BY VPAN
FY 21-22

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physical Disability
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
VPAN (DMH + Community Base Organizations); Support line, Permanent housing, PATH	640	32	31		745		918	873	2,574	595			5	84						2,734	1,063

Program/ Project	Race/Ethnicity								Gender Identity						Sexual Orientation						Physi-cal Disa-bility
	African American	American Indian/Alaska Native	Asian and Pacific Islander	Eastern European/Middle Eastern	Latino/Latinx	Multiracial	White	Not listed (specify	Male	Female	Transman/Transmasculine	Transwoman/Transfeminine	Non-Binary/Gender Fluid	Unknown	Bisexual	Gay or lesbian	Straight or heterosexual	Another sexual orientation not listed	Do not know	Decline to respond	
and Suicide Prevention																					
Veteran experience Action Center, VEAC; This is annual virtual access to care/services event	17.7 %	3.5 %	17.7 %		25.7 %		46 %	5.3 %	83 %	16 %											

Program/Project	Consumers' preferred languages	Languages represented by Program staff
Veteran Peer Access Network Support line	English	English, Spanish, Greek, Tagalog, Arabic, Vietnamese, Armenian and French
Permanent Housing	English	English, Spanish, Greek, Tagalog, Arabic, Vietnamese, Armenian and French
Suicide Prevention Coordinator	English	English, Spanish, Greek, Tagalog, Arabic, Vietnamese, Armenian and French
Projects for Assistance in Transition from Homelessness, (PATH)	English	English, Spanish, Greek, Tagalog, Arabic, Vietnamese, Armenian and French
Veteran experience Action Center, VEAC	English-speaking	English, Spanish, Greek, Tagalog, Arabic, Vietnamese, Armenian and French

Wellness Outreach Workers (WOW) Program

WOW staff are LACDMH-badged volunteers with lived experience who provide peer support in Directly Operated (DO) programs. They work with the treatment teams to assist clients on their path to wellbeing and recovery. The purpose of this program is to provide ongoing peer support of wellness and recovery to vulnerable adult clients;

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

The WOW Program has been contributing to LACDMH's provision of culturally and linguistically competent services. During FY 21-22, there were thirty-nine (39) WOW volunteers representing multiple ethnic backgrounds, cultural groups, and language capabilities in Spanish, Korean, Chinese, Khmer, Russian, and Greek. WOW volunteers served throughout LA County DO programs and a total number of 4,948 volunteer service days were completed. WOW volunteers provided information on community resources by establishing a welcoming environment in the clinic setting, and helping visitors navigate the services. Also, peer to peer support was provided by facilitating virtual and groups, conducting appointment reminders and warmline calls, and providing linkage to community services and COVID-19 resources. In addition, the WOW volunteers were involved in the treatment team to offer peer perspective.

The WOW volunteers are consumers advanced in their own recovery and are willing to share their lived experiences to promote recovery among their peers. They also provide assistance in navigating the mental health system by facilitating virtual support groups and providing linkage to community services and resources. WOW volunteers are a culturally and linguistically diverse group which includes volunteers with special skills from the following diverse communities: Latino, African American, Russian, Korean, Chinese, Greek, and LGBTQ.

WOW PROGRAM'S STRATEGIES AND ACTIVITIES RELATED TO CULTURAL AND LINGUISTIC COMPETENCE, FY 21-22

Department wide strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
• Multi-lingual/multi-cultural staff development and support	Bimonthly WOW meetings on 8/11/2021 10/17/2021 1/24/2022 3/14/2022 5/23/2022	During FY 21-22, WOW team continued to support current WOW volunteers placed in LACDMH Directly Operated Wellness centers to improve access to mental health services and provide peer to peer support.	20-30 WOW volunteers attended the bimonthly meetings. Meeting agendas addressed areas of diversity and strengthened supportive service skills in working with adult consumers.	20-30 WOW Volunteers attended the bimonthly meeting

Criterion 3 APPENDIX

Attachment 1: 2023 Cultural Competence Plan CR 3 Acronyms

Attachment 1_Acronyms CR 3_Upc

Attachment 2: Mental Health Services Act (MHSA) Annual Update FY 22-23

MHSAAnnualUpdateFY2022-23.pdf

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 4

Cultural Competency Committee

August 2023

Criterion 4: Cultural Competency Committee: Client/Family, Member/Community Committee, and Its Integration of the Committee within the County Mental Health System

I. LACDMH Cultural Competency Committee

A. Description, Organizational Chart, and Committee Membership

The Cultural Competency Committee (CCC) serves as an advisory group for the infusion of cultural competence in all Los Angeles County Department of Mental Health (LACDMH) operations. Organizationally, the CCC is housed within the Anti-Racism, Diversity and Inclusion (ARDI) Division - Cultural Competency Unit (CCU). The CCC membership includes the cultural and linguistic perspectives of consumers, family members, advocates, Directly Operated (DO) programs, Contracted providers, and community-based organizations. Additionally, the CCC considers the expertise from the Service Areas' (SA) clinical and administrative programs, front-line staff, and management essential for sustaining the mission and goals of the Committee.

CCC Mission Statement and Motto

The mission is to "Increase cultural awareness, sensitivity, and responsiveness in LACDMH's response to the needs of diverse cultural populations to foster hope, wellness, resilience, and recovery in our communities." In recognition of the richness of cultural diversity, the Committee's motto is "Many Cultures, One World."

CCC Leadership

The CCC is led by three (3) Co-Chairs who are elected annually by members of the Committee. The co-chairs come directly from the community and represent lived and shared experience with mental health conditions. The roles and responsibilities of the Co-Chairs are to:

- Facilitate all monthly meetings
- Engagement of members in Committee discussions
- Collaboration with the ARDI Division-CCU in the development of meeting

agendas, planning of committee activities, vetting of Unit's projects and fulfillment of Cultural Competence Plan Requirements and the National Standards for Culturally and Linguistically Appropriate Services (CLAS)
- Appointing of ad-hoc subcommittees as needed
- Communicating the focus of the CCC's goals, activities, and recommendations at various Departmental venues
- Representing the voice of the CCC membership at the Department's "YourDMH" and Stakeholder Groups Leadership meetings, and the community at large

The Department's Ethnic Services Manager (ESM) monitors all activities pertaining to the CCC and provides technical support to the Co-Chairs, members, and the committee at large. The ESM is also the program manager for the ARDI Division - CCU and is an active member of the Departmental Quality Improvement Council (QIC). This structure facilitates communication and collaboration for attaining the goals as set forth in the Department's QI Work Plan and the Cultural Competence Plan (CCP) to reduce disparities, increase capacity, and improve the quality and availability of services. Relevant CCC decisions and activities are regularly reported to the membership at the monthly Departmental QIC meeting.

For Calendar Year (CY) 2022, the CCC leadership was composed of:
- Three Co-Chairs from the community
- LACDMH ESM

In accordance with its bylaws, the committee operates under the following principles:
- The CCC actively engages with and amplifies the collective voice of consumers; family members; community members; cultural groups and brokers; peers; staff from LACDMH Directly Operated, Legal entities/Contracted and administrative programs; and Community-Based Organizations
- CCC meetings are held on a monthly basis and are open to everyone
- The CCC embraces all elements of culture and advocates for equity and inclusion of all cultural groups inclusive of, but not limited to:
    - Age
    - Country of origin, degree of acculturation, generation
    - Educational level obtained
    - Family and household composition
    - Gender identity and sexual orientation
    - Health practices, including use of traditional healers
    - Language
    - Perceptions of health and well being
    - Physical abilities or disabilities; cognitive ability or disabilities
    - Political beliefs
    - Racial and ethnic groups
    - Religious and spiritual characteristics
    - Socio-economic status

Source: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A blueprint for Advancing and Sustaining CLAS policy and Practice, April 2013

(See Attachment 2: CCC Bylaws for additional details)

B. Policies, procedures and practices that assure members of the CCC reflect the community

CCC Membership

During CY 2022, the CCC had a total of one hundred and forty (140) active members. The CCC membership consisted of representatives from different cultural and linguistic groups, different roles, and walks of life including consumers, family members, caregivers, community members, advocates, peers, and LACDMH stakeholder groups. Among them are the Underserved Cultural Communities subcommittees (UsCC), Service Area Leadership Teams (SALT), consumer-run organizations, community-based organizations, State and local advocacy agencies, mental health providers, and Los Angeles County sister Health Departments. The functions of the LACDMH-affiliated members include volunteers, peers, management, and staff from administrative and clinical programs.

The richness of the CCC's diversity can be easily appreciated across multiple elements of culture including race and ethnicity, linguistic capability, gender identity, gender pronouns, sexual orientation, physical and cognitive abilities and disabilities, and a wide variety of agency affiliations.

<u>Race and Ethnicity</u>

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

- African American
- American
- Armenian
- Asian
- Black, Black American
- Caucasian
- Chicana
- Guatemalan
- Hispanic
- Indígena (indigenous) Latina
- Korean
- Latino(a)
- Latino Chinese
- Mexican American
- Native Indian
- South Asian
- Spaniard/Latino/American Indian

- Spanish
- Vietnamese
- White

Language

The linguistic diversity of the CCC for CY 2022 consisted of the following eleven (13) languages:

- Armenian
- Cantonese
- English
- German
- Farsi
- Korean
- Japanese
- Malayalam
- Mandarin
- Maya
- Spanish
- Swahili
- Tagalog

Gender and Gender Pronouns

Out of 140 members, fifty-five (55) self-identified as male and eighty-five (85) as female. All CCC members reported being cisgender. The gender pronouns endorsed by the membership include:

- He/him/his
- Her/hers/they
- Queer
- She/her/hers
- They/them
- They/we
- We/us

Sexual Orientation

The committee's diversity in terms of self-reported sexual orientations included heterosexual, lesbian, and gay.

LACDMH Stakeholder Group Affiliations

- Access for All Underserved Cultural Communities Subcommittee (UsCC)
- American Indian/Alaska Native (AI/AN) UsCC
- Asian Pacific Islander (API) UsCC
- Black & African Heritage (BAH) UsCC
- Eastern European/Middle Eastern (EE/ME) UsCC
- Latino UsCC

- Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Two-Spirit (LGBTQIA2-S) UsCC
- Mental Health Commission (MHC)
- Service Area Leadership Teams (SALT) 1-8

LACDMH Program Representation

1. *Directly Operated Programs*
    - Adult Protective Services (Workforce, Development Aging & Community Services)
    - Urgent Care Centers
    - Augustus Hopkins Psychiatric Hospital
    - Edward Roybal Comprehensive Mental Health Center
    - Hollywood Mental Health Services
    - West Central Mental Health Services
    - Downtown Mental Health Services
    - East San Gabriel Valley Mental Health Center
    - Harbor Psychiatric Crisis Unit
    - Northeast Mental Health Clinic
    - Pacific Asian Counseling Services
    - Rio Hondo Community Mental Health Center
    - San Antonio Mental Health Services
    - San Pedro Mental Health Services
    - South Bay Mental Health Services

2. *Contracted/Legal Entity Providers*
    - Alafia Mental Health
    - Asian Pacific Counseling and Treatment Centers (APCTC)
    - Didi Hirsch
    - Gateways Hospital
    - Hillsides
    - Koreatown Youth and Community Center
    - San Fernando Valley Community Mental Health Clinic (SFVCMHC)
    - Shields for Families
    - Southern California Health and Rehabilitation Program (SCHARP) & Barbour Medical Associates
    - Star View Behavioral Health
    - Star View Community Services
    - Stars Inc.
    - Tarzana Treatment Center
    - The Village Family Services
    - Trinity Youth Services

3. *LACDMH Administrative Programs*
    - Anti-Racism, Diversity and Inclusion (ARDI Division-Cultural Competency Unit (CCU), inclusive of LGBTQIA2-S Specialist

- Health Neighborhoods
- Help Line-ACCESS Center
- Peer Resource Center
- Service Area Leadership Teams (SALT) 1 - 8

CCC Members' Agency Affiliation in the Community at Large

CCC members contribute a rich combination of organizations representing different aspects of community life. The list below specifies the community organizations represented by the CCC membership.

1. Consumer-Based Organizations
   - Asian Coalition
   - ARDI Division -Spanish Support Groups
   - Los Angeles County Client Coalition (LACCC)

2. Community-Based Organizations
   - Academy of East Los Angeles (AELA)
   - ACCESS Los Angeles County
   - Amanecer Semillas Charter Schools
   - Black Mental Health Task Force
   - Cal Voices
   - California Institute for Behavioral Health Solutions
   - California State University Northridge
   - Catholic Archdiocese Los Angeles
   - Child & Family Center
   - Disability Rights California (DRC)
   - East Los Angeles Women's Center (ELAWC)
   - Greater Los Angeles Agency on Deafness (GLAD)
   - Helping Youth Counseling Inc. (HYCINC.)
   - Mental Health Los Angeles
   - Mundo Maya Foundation
   - National Alliance on Mental Illness (NAMI) Antelope Valley
   - NAMI South Bay
   - Native American Veterans Association
   - Olive Support Services
   - Pacific Islander Health
   - Path.org
   - Q Youth Services
   - Scholars First Academy
   - Semillas Sociedad
   - Southern California Resource Services for Independent Living (SCRS-IL)
   - Sunrise Horizon Foster Family Agency
   - The Children's Center of the Antelope Valley
   - The Help Group
   - Wellnest Los Angeles

- Wheatley Institute
- Win Los Angeles (in-home mental health therapy)

3. Los Angeles County Departments
   - Department of Children and Family Services (DCFS)
   - Department of Public Health (DPH)
   - Department of Workforce Development, Aging and Community Services
   - Department of Health Care Services (DHCS)
   - Department of Health Services (DHS)

4. Additional Government Entities not listed above
   - National Disability Rights (NDR)
   - California Health & Human Services Agency (CHHS)
   - Office of Statewide Health Planning & Development (OSHPD)

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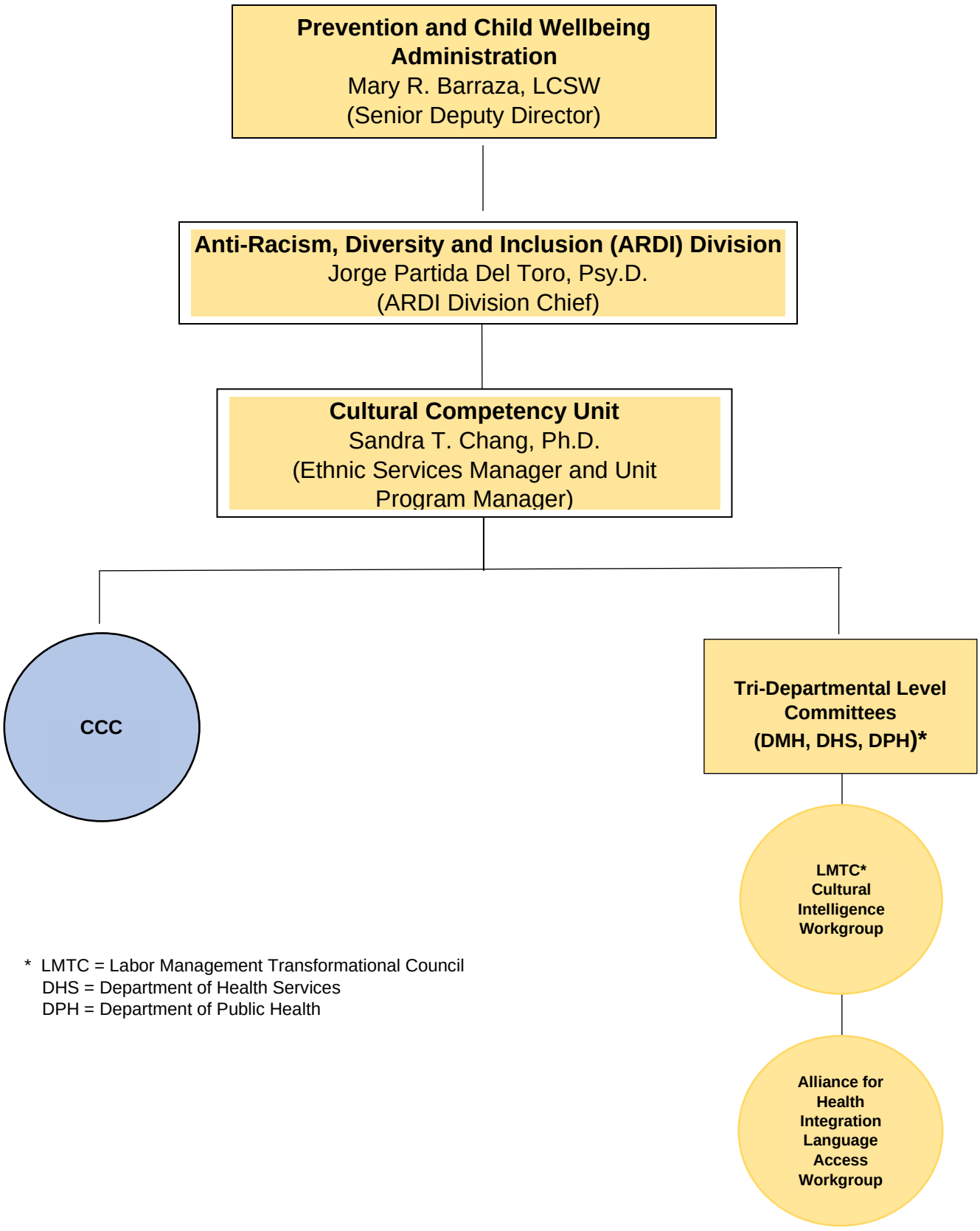
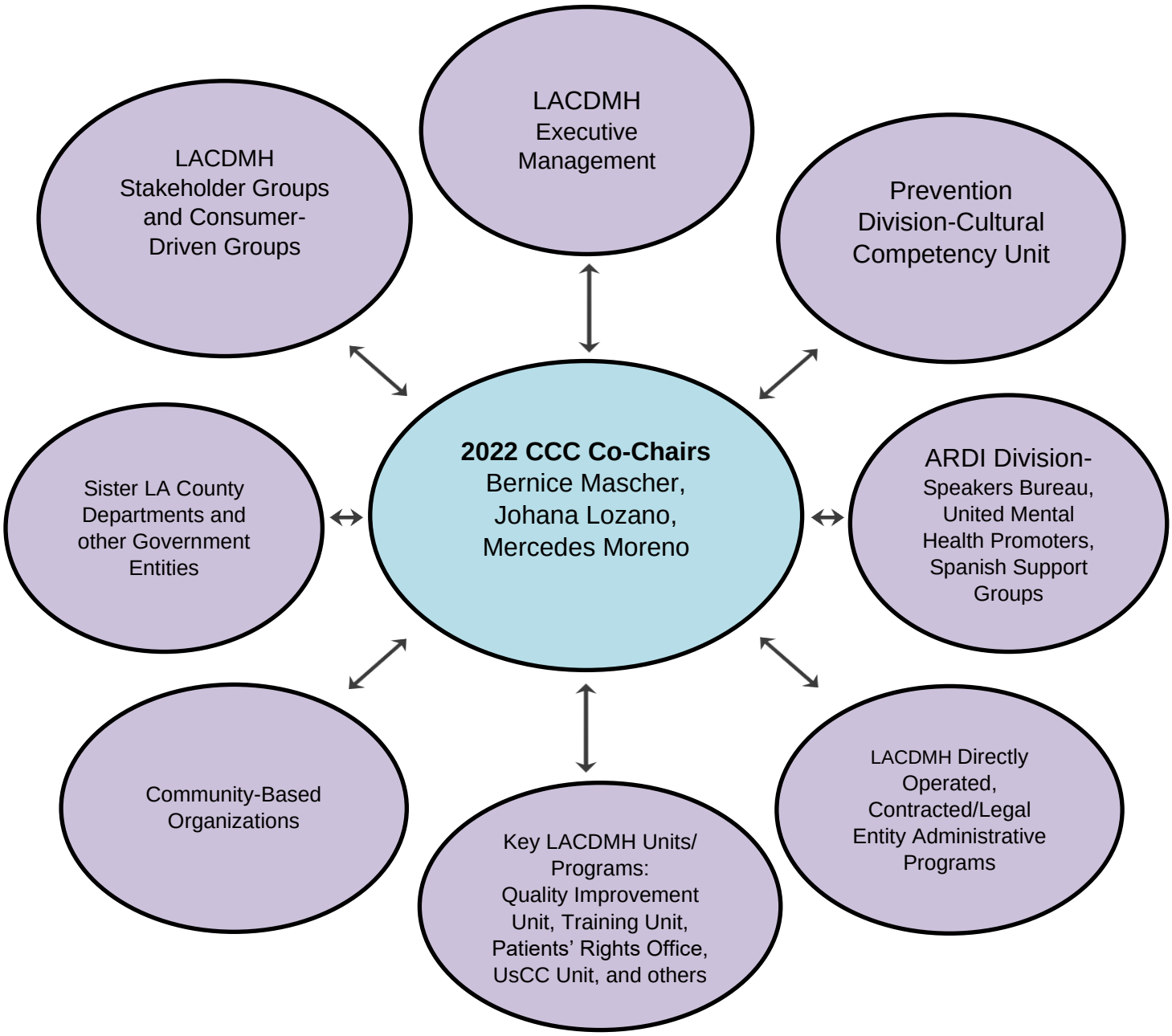
C. Organizational Chart of the CCC, CY 2022



* LMTC = Labor Management Transformational Council
DHS = Department of Health Services
DPH = Department of Public Health

II. CCC integration within the Mental Health System

CCC Departmental Partnerships and Collaborations, CY 2022



A. Evidence of policies, procedures, and practices that demonstrate the CCC's activities.

The CCC embodies and carries out the Cultural Competence Plan Requirements pertinent to Criterion 4 as mandated by the Department of Health Care Services. LACDMH P&P 200.09 "Culturally and Linguistically Inclusive Services" defines the CCC

as follows: The ***Cultural Competency Committee*** serves as an advisory group for the infusion of cultural competency in all LACDMH operations. Administratively, the CCC is housed within the ARDI Division-CCU. Per DHCS Cultural Competence Plan Requirements, all Counties are mandated to have an established committee to address cultural issues and concerns with representation from different cultural groups. The CCC membership includes the cultural perspectives of consumers, family members, advocates, peers, staff from Directly Operated (DO) providers and legal entities/contracted providers, and community-based organizations. The CCC advocates for the needs of all cultural and linguistic groups. Additionally, the CCC considers the expertise from the Service Areas' clinical and administrative programs, front line staff, and management essential for sustaining the mission of the Committee.

P&P 200.09 also specifies LACDMH's recognition of the role of the CCC as an advisory body for cultural competence and states that "LACDMH clinical and administrative programs support the activities of the CCC by participating in monthly meetings and contributing toward the fulfillment of committee goals and activities (i.e., delivering presentations, providing information regarding program outcomes, and implementing the committee recommendations in projects and initiatives)."

CCC Activities and Workflow

At the end of each CY, the CCC holds an annual retreat to review its goals, activities, and accomplishments; vote on cultural competency objectives to be undertaken for the next year; and reinforce the collaborative team atmosphere among Committee members. Once the CCC identifies areas of organizational cultural competence to be addressed, it proceeds to operationalize its goals and objectives. For CY 2022, the CCC membership decided on a model based on monthly presentations scheduled by strategically selected LACDMH programs and initiatives related to cultural competence. This model ensures the engagement of the CCC as an advisory body to provide recommendations for the planning, implementation, and evaluation of cultural diversity and cultural competence-related efforts.

Throughout the year, CCC members actively identified initiatives of interest to be presented during monthly committee meetings. At the end of each presentation, the committee provided feedback and recommendations to ensure the inclusion of cultural competence in all LACDMH services. Presenter programs and units are invited back to provide updates and follow-ups on CCC recommendations. The table below summarizes the presentations and discussions of the CCC during CY 2022.

TABLE 1: SUMMARY OF PRESENTATIONS PROVIDED TO AND TOPICS OF DISCUSSIONS HELD BY THE CCC, CY 2022

MONTH	TITLES OF PRESENTATIONS AND DISCUSSIONS
January	1. Collaborative CCC and ARDI Division-CCU Project: Cultural Traditions and Connections (CT&C) Column
February	2. Commemoration of Black History Month: Special Panel Presentation 3. Anti-Racism, Diversity and Inclusion (ARDI) Division Update
March	4. 2022 Diversity and Multicultural Calendar Update
April	5. Overview of the Indigenous People's/First Nation Fact Sheet: A Historical Perspective
May	6. Commemoration of Asian Pacific Islander (API) American Heritage Month
June	7. Utilization of 711 Services
July	8. Commemoration of National Minority Mental Health Month & Juneteenth
August	9. Recognizing the Signs of Early Psychosis 10. United Mental Health Promoters (UMHP) Program Cultural Diversity Panel Presentation
September	11. ARDI Division Action Plan
October	12. LACDMH's Partners in Suicide Prevention Team 13. ACCESS California/Cal Voices
November	14. Commemoration of National Native American Heritage Month
December	15. Annual Retreat – Reflections on CCC Accomplishments CY 2022

* Due to the ongoing COVID-19 pandemic, CCC meetings continued to be held via a virtual platform.

III. A. 1. Review of County Programs and Services

The CCC serves as an advisory group to the Department as mandated by the DHCS Cultural Competence Plan Requirements (CCPR). The CCC invites, collects, analyzes, and provides feedback and recommendations to departmental programs and initiatives to strengthen LACDMH's cultural and linguistic responsiveness to LA County diverse communities. The collective voice of the CCC is also represented at the Service Area Leadership Team (SALT) meetings. This practice ensures that the voice and recommendations of the committee are heard at these system wide decision-making meetings. The voice of the CCC is also amplified by the Co-Chairs' participation in the UsCC Leadership Team. Working together, the CCC and UsCC subcommittees advocate for the needs of underserved cultural groups and the elimination of mental health disparities.

The CCC also has an impact on the system of care by inviting and scheduling presentations from various LACDMH programs. These presentations take place during the monthly meetings. Feedback is either provided via the committee at large or via ad-hoc workgroups, when the Committee deems that an in-depth project review is necessary. The primary goal of the CCC is to ensure that cultural competence and linguistic appropriateness are included in new LACDMH projects and initiatives. When deemed necessary, the Committee will request presenters to return with updated information or work products to ensure the feedback has been incorporated. Below is a summary of presentations delivered at CCC monthly meetings during CY 2022. It is important to point out that the summary does not capture the richness of CCC discussions and interactions with the presenters. Rather, the summary is comprised of selected excerpts that illustrate the depth of CCC discussions and member recommendations.

1. **Cultural Traditions and Connections Magazine**
   In January 2022, the Cultural Competency Committee (CCC) membership welcomed this presentation on the Cultural Traditions and Connections (CT&C) Magazine, and its subsequent ongoing column and blog. The project has its roots in the CCC's "Share your Culture" meeting segment. As a result of the COVID-19 pandemic and the shift to virtual meetings, the ESM proposed the development of the newsletter to unite members in a collaborative effort with the ARDI Division-CCU that would reduce COVID-19's imposed social isolation, increase a sense of positive energy and hope, and foster cross-cultural learning, understanding, sensitivity, and appreciation. The goal of the newsletter is to promote the sharing of cross-cultural knowledge, appreciation for diverse cultural traditions and walks of life. The opportunity to submit content is open to everyone, to embody the newsletter motto, "for the community by the community." The CT&C column is featured in LACDMH's "Connecting Our Communities," Newsletter, which is distributed every month to over 36,000 subscribers in Los Angeles County. This project involves participation from the community as well as LACDMH staff. In this platform, everyone has an opportunity to share ancestral teachings, personal stories, poems, historical dates of remembrance, holidays, and festivities throughout the year.

CCC Feedback

- Members provided ideas for the CT&C newsletter column content highlighting that everyone can learn about different cultures and ways of living from anecdotal stories. Members also demonstrated enthusiasm about creating mental health content that was informative and helpful to column readers. Additional content ideas shared for the column included featuring artwork, collages, photographs, poetry, and recipes. The CCC agreed to form a workgroup specifically designed to implement the quarterly CT&C newsletter column. Several members signed up for the workgroup during the meeting.

2. Commemoration of Black History Month: Special Panel Presentation

In February 2022, the CCC coordinated and hosted a panel presentation on Black History Month in collaboration with the Black and African Heritage UsCC subcommittee. The CCC disseminated flyers to all DMH Stakeholders and other groups. Among them, included the Underserved Cultural Communities (UsCC), Service Area Leadership Teams (SALT), Service Area Quality Improvement Committees (SA QIC), and the Speakers Bureau (SB). The featured speakers were members of LACDMH Speakers Bureau and leadership from the nonprofit African Communities Public Health Coalition and the Black and African Heritage UsCC Co-Chair. These dynamic presenters centered on African American history of resilience in the United States. The panelists covered details regarding national programs such as the 1619 Project, Jim Crow, and the Civil Rights Movement. The membership learned about local efforts by the Black Mental Health Task Force focusing on self-care and celebration as well as building positive relationships with African American clients and community members.

CCC Feedback

- This presentation was described by the membership as timely and relevant. Recommendations from the members included: 1) continuing discussions between the CCC and the BAH and American Indian/Alaska Native (AI/AN) UsCC subcommittees with the goal of informing their capacity building projects, and 2) for LACDMH to be mindful that intergenerational trauma is experienced by the African American community and several communities of color such as Armenian, Cambodian, Japanese, and Salvadorean, among many others.

3. Anti-Racism, Diversity and Inclusion (ARDI) Division Update

In February 2022, Dr. Jorge Partida, ARDI Division Chief, provided the CCC with an update on the ARDI Division. The membership was given the historical background of how the ARDI Division was formed in June 2021. CCC members were informed that the ARDI Division was charged with two major areas of focus: to transform the work environment, and to create a more just, transparent, equitable and participatory process that addresses anti-Black racism particularly, but racism of all other cultures and races in the Department. The CCC learned that ARDI will assess whether the services that are provided by the Department are culturally competent, linguistically accessible and that DMH is addressing systemic barriers to access of care issues. ARDI will look at the services provided, make sure they are effective outcome measures, and that the Department closely evaluates the efficacy of the work. CCC

membership also learned about the ways DMH has the responsibility in the community and its workforce by looking at how the Department engages and creates spaces at the table for our leaders to participate in the decision-making process and in the development of programs and services within the Department internally.

CCC Feedback

- This presentation was described by the membership as informative and relevant to the committee's function in the system of care. Recommendations made by members were that the ARDI Division pursue safe spaces for consumers and family members who experience disabilities, promote the hiring of peer specialists in LACDMH's workforce, pursue culturally sensitive solutions to reduce health disparities, and address current mental health issues being faced by underserved communities, and take into account consumer culture.

4. 2022 Diversity and Multicultural Calendar Update

In March 2022, LACDMH's Ethnic Services Manager shared with the CCC that the 2022 Diversity and Multicultural Calendar is now posted on the DMH website. Anyone can now access the calendar. CCC members learned that the calendar summarizes months of awareness, specific dates of remembrance, and historic and upcoming celebrations by date. The CCU introduced the Diversity and Multicultural Calendar at all UsCC subcommittees and Faith-Based Advocacy Council to vet and gather stakeholder input on its content. All stakeholder groups were invited to find inspiration in the calendar to submit content for the CT&C column. The calendar will be refreshed every year and it is intended to guide and inspire new content for the CCC's Cultural Traditions & Connections (CT&C) Newsletter Column.

CCC Feedback

- The members expressed excitement about the multicultural calendar being available to the public on the Department's website. Suggestions were made for CCC meetings and presentations to be informed by the Diversity and Multicultural Calendar's months of awareness and commemorations. The CT&C column was identified as a great platform for showcasing articles and anecdotes that relate to different cultural celebrations and dates of observance. Of particular interest is promoting the voice of youth and students.

5. Overview of the Indigenous Peoples/First Nation Fact Sheet: A Historical Perspective

In April 2022, the CCC welcomed a presentation by Ms. Sylvia Gonzales-Youngblood and Mr. Shannon Rivers, which focused on the Poor People's Campaign Fact Sheet that Mr. Rivers created along with his colleague Larry Smith. Mr. Rivers informed the CCC that the reason Indigenous people are involved with this fact sheet and the Poor People's Campaign is because of the support received from Dr. Martin Luther King Jr. for First Nations people. Dr. Martin Luther King Jr. supported the First Nations bus boycotts, this created a mutual respect and admiration from the Indigenous community. Dr. King also supported American Indian rights. CCC members were educated on some facts that included: Indigenous Peoples and their respective First Nations are connected to their traditional homelands but have their own distinctive

cultures, traditions, and pre-colonial and colonial histories since European contact. Also, within the U.S., Native Americans/American Indians/Alaska Natives/Native Hawaiians comprise 2% of the entire United States population. Lastly, Indigenous Peoples are experiencing protracted violence of ongoing land loss and displacement that began with the Doctrine of Discovery. The Doctrine of Discovery is one of the clearest expressions of the "distorted moral narrative of religious nationalism," which the Poor Peoples Campaign has taken a core stand against.

CCC Feedback

- This presentation was received with great interest and appreciation by committee members. The richness of information provided by the presenters generated an active Q&A dialogue, yet no specific recommendations or suggestions were provided.

6. Commemoration of Diversity Month & May is Mental Health Month: Asian Pacific Islander (API) American Heritage Month

In May 2022, the CCC coordinated and hosted a special panel presentation on API American Heritage Month in collaboration with experts from the community and the API UsCC subcommittee. Members learned facts regarding the immigration history of Asian Pacific Islander communities in the United States. Examples included:

- The first Asians to come to America was in 1635 and they arrived in Mexico City.
- The large-scale of migration of Asian immigrants to California in 1848 was during the California Gold Rush.
- In the 1800s, the Bubonic plague was a world pandemic. During this time, many Chinese immigrants were transported to San Francisco.
- In the early 1900's, Asian immigrants numbered in the hundreds and were a substantial presence in Bellingham, Washington. Asian immigrants sustained small communities with their restaurants, pool halls, and barber shops. Due to sustained campaigns of racism and exclusion, little to nothing of these communities remains in the city today.
- By 1950, city census data specified only eight individuals of Asian ancestry.
- Based on the New York City Asian American State Bar, the Asian community experienced three significant massacres: 1) In the 1870s, Los Angeles was a violent city of nearly 6,000 people in which lynchings and mob justice were commonplace. 2) the Roth Springs Massacre occurred in Wyoming in which coal miners were in fear of losing their jobs and 3) the Hells Canyon massacre took place in Oregon.
- From 1942 to 1945, it was the policy of the United States government that people of Japanese descent including U.S. citizens be incarcerated in isolated camps. By the time the internment program ended in 1944, a total of 2,264 Japanese and Latin Americans, including U.S. citizens had been incarcerated in the United States. Nearly 900 of them were exchanged for American civilians in Japan.

CCC Feedback

- The presenters were praised for their insightful presentations. The historical facts included in the presentation enticed CCC members to ask questions about the past and current impact of such violence in the Asian community. Reflections also

gave way to sharing real-life experiences that presenters and their families went through during these difficult times. A mindful discussion was also held about the scapegoating and acts of hatred perpetuated against Asian communities as a result of the COVID-19 pandemic.

7. Utilization of 711 Services

In June 2022, the CCC membership welcomed a presentation by Mr. Elliot who is a member of DMH's Speakers Bureau and a Commissioner for the Disabilities Commission in Santa Monica. Mr. Elliot stated that he will be giving a high-level overview of the California Relay Services (CRS) and 711, which is used interchangeably with other resources for persons with physical disabilities. He explained the different types of services and devices available for persons who have speech, hearing, and combined hearing and vision disabilities. Mr. Elliot provided information on the speech-to-speech resource and the captioned phone service. He also informed CCC members that there is a Spanish relay service available at no cost to consumers. CCC members learned about Video Relay Services (VRS) on a YouTube demo and other great resources using a smartphone to text 911 for emergency situations. The CCC members were provided with links to helpful information about 711.

CCC Feedback

- CCC membership welcomed the opportunity to learn about and comment on 711 services. Many of them have direct experiences accessing 711 services and shared their perspectives. The feedback gathered pointed to reluctance to use 711 by many persons who, due to physical disabilities, need specialized assistance. 711 services were described as impractical and not user-friendly. The Department was advised not to rely on 711 as the main source of accessibility support for persons with disabilities.

8. Commemoration of National Minority Mental Health Month & Juneteenth

In July 2022, the CCC, in collaboration with the Anti-Racism, Diversity, and Inclusion (ARDI) Division, launched a special event to honor National Minority Mental Health Month and Juneteenth. The committee welcomed guests, which included all stakeholder groups such as Underserved Cultural Communities' (UsCCs), Service Area Leadership Team (SALT), Service Area Quality Improvement Committee (SA QIC), Faith-Based Advocacy Council (FBAC), and Los Angeles County Department of Mental Health (LACDMH) staff. The purpose of this significant event was to promote multicultural knowledge and appreciation while all attendees learned how LACDMH has continued to evolve over the years, especially in light of the newly established ARDI Division. The event included the following elements:

- Land Acknowledgement
- Labor Acknowledgement
- Panel presentation with five key speakers as follows:
  1) Mr. Harold Turner, Executive Director of the National Alliance on Mental Illness (NAMI) Urban Los Angeles, shared his personal experience joining NAMI as a family member of a loved one experiencing a mental health crisis.

2) Ms. Yvette Townsend-Retired Deputy Director provided an overview of DMH's trajectory over four decades. From the 1970's to 2000's highlighting departmental strides and work that continues to require strategic attention.
3) Dr. Jorge Partida, LACDMH ARDI Division Chief, presented a brief history of DMH's ARDI Division: rationale for its implementation, structure, focal areas, internal and external as related to delivery of mental health services.
4) Mr. James Coomes, Program Manager at LACDMH Olive View Urgent Care Center and Speakers Bureau member, represented by Dr. Sandra Chang, ESM. Mr. Coomes shared a background information on Juneteenth, its relevance and ways of commemorating this historical event within his church.
5) Ms. Keris Myrick former Chief of Peer and Allied Health Professionals for LACDMH spoke about the peer movement and peer advocacy movement since the 1970s.

- Collectively, and as relevant, the speakers shared about their collaborative work with Ms. Bebe Moore Campbell and how the Mental Health field has evolved. They shared information on the organizations they represent and delivered the message that all legacies exemplified during this event need to continue in order to combat mental health stigma, implement effective anti-racism strategies, and address cultural and linguistic needs of underserved communities.

CCC Feedback

- The members welcomed the opportunity to learn about the legacy of many community leaders search as Bebe Moore Campbell and the newly established ARDI Division. Recommendations were made for the CCC to commemorate the National Minority Mental Health Awareness Month every year, and for information about the newly established ARDI Division to be posted on the Department 's website. Adding this information would directly inform the public of LACDMH's efforts to combat racism and practice equity and inclusion in the services provided to the community.
- An aftermath of this event was the committee's interest in continuing to include land and labor acknowledgements in future monthly meetings. Specific recommendations were made not to have them follow one another. Rather, for the land acknowledgement to be read at the beginning and the labor acknowledgement to be recited at the end of the meeting, with opportunities to interchange their placement on meeting agendas. Intentional discussions followed based on the CCC's interest in pursuing the development of a video that features the history, importance, and relevance of land acknowledgements. Per a follow-up meeting with CCC and AI/AN UsCC former and current co-chairs, this project would be developed in partnership during CY 2023.

9. Recognizing the Signs of Early Psychosis

In August 2022, a presentation was provided to the CCC membership by Dr. Wettimuny, Practice Lead for the LACDMH Portland Identification and Early Referral (PIER) Program. Dr. Wettimuny explained the goal of the program is to support youth and families in achieving life goals and maintain wellness beyond their time in

treatment. Dr. Wettimuny focused her presentation on the signs and symptoms of early psychosis, what kind of treatment can help keep early psychosis from progressing to a chronic disorder, and treatment options through DMH. She stressed the importance that community plays in helping youth who are experiencing early psychosis. CCC members were informed about the challenges youth face when they do not connect mental health treatment until their symptoms are severe enough to disrupt daily living such as home, school, and social life. Often youth end up being hospitalized or justice involved. Dr. Wettimuny briefly went over what is "early psychosis." Dr. Wettimuny clarified that psychotic experiences can be a part of normal human experiences. In fact, 1 in 10 people report hearing voices sometime in their life. It is important to note that not everyone who has had this experience ends up being diagnosed with psychosis. She emphasized it is important for anyone who may be having disruptive experiences, particularly young people, seek help right away. The earlier a young person is diagnosed, the less likely they are going to have more symptoms or severe symptoms in the future. The CCC learned that early intervention treatments have shown to be effective in reducing the chances that symptoms develop into chronic psychosis. Dr. Wettimuny highlighted the importance of educating the community about the signs of early psychosis and reviewed this information with the membership.

CCC Feedback

- Committee members expressed appreciation for this informative presentation. UsCC Co-chairs in attendance also articulated their interest in inviting Dr. Wettimuny to deliver the same presentation at their subcommittee meetings. Members asked specifically for resources available for parents seeking behavioral interventions, support plans and mental health assessments for school-aged children. A recommendation was made for the expansion of this program to all Service Areas.

10. United Mental Health Promoters (UMHP) Program Cultural Diversity

In August 2022, the United Mental Health Promoters Program facilitated a panel presentation to the CCC which included examples of the cultural and linguistic representation of the United Mental Health Promoters. Panelists were asked the following three questions:

- How do UMHP promote wellbeing within their respective cultural/language community?
- What does culture-specific wellness look like for their communities?
- How do they provide culture-specific services?

The panelists identified the engagement strategies they use during UMHP presentations and outreach events for their respective cultural communities. For example, disseminating information at community resource fairs, drawing Inferences about the impact of culture on mental health and help seeking behaviors, incorporating cultural practices within workshops, sharing personal experiences to combat the mental health stigma in communities of color, educating the community on stress management, utilizing sensitive language when delivery mental health presentations, emphasizing the importance of prevention and early intervention, providing mental health referrals to the community. The UMHP presenters

unanimously encouraged CCC meeting participants to attend their workshops to learn about the various topics and services provided by LACDMH.

CCC Feedback

- The UMHP program received multiple congratulatory statements from the committee for the advancement in recruiting promoters from different cultural and linguistic backgrounds. Members asked questions regarding how community education is delivered by promoters, especially during COVID-19 times. The committee also asked questions regarding the most requested presentation topics UMHP delivered from the community since the program started.

11. ARDI Division Action Plan

In September 2022, the CCC learned about and provided feedback for the LACDMH ARDI Division's Action Plan. The presentation was delivered by Dr. Sandra Chang, ESM and ARDI Division-CCU Program Manager. Presentation highlights included:

- Rationale for the ARDI Division implementation
- Framework to achieve racial equity in LACDMH is based on the following six interconnected themes:
  - Anti-Black racial awareness, acknowledgment, and education to promote intrapersonal growth
  - Staff well-being and empowerment
  - Hiring, supervision, and professional advancement
  - Antiracist, culturally congruent and responsive services
  - Partnerships and collaborations across Los Angeles County, city departments, and community stakeholders
- Commitment, accountability, and respondent responsiveness of executive management and departmental leadership
- ARDI Division components:
  - Cultural Competency Unit (CCU)
  - Language Assistance Services Support
  - ARDI Trainings
  - United Mental Health Promoters Program (UMHP)
  - Spanish Support Groups
  - Speakers Bureau (SB)
- The five ARDI Division domains: training, leadership, communication, outcomes, and environment.

CCC Feedback

- CCC members thanked Dr. Chang for this important presentation. She was praised for delivering the content in manageable manner and relatable language. The committee recognizes that ARDI work to combat racism, promote equity, and uplift cultural diversity will be challenging and laborious. The recommendation was made for the ARDI Division to provide updates for the committee to ascertain how the work is progressing and identify potential areas of mutual involvement and collaboration.

12. **LACDMH's Partners in Suicide Prevention Team**

In October 2022, the CCC membership welcomed a presentation on death by suicide, and what is going on in terms of individuals who may present with suicidal ideation, and suicidal behaviors. CCC members were informed if participants at any time feel agitated or triggered, there is the Suicide & Crisis lifeline, and the new 9-8-8 lifeline available for anyone at any time. The Lifeline links a person who may have experienced or may need assistance to process difficult experiences. The 9-8-8 lifeline connects anyone with a trained counselor. CCC members learned that the trainings that Partners in Suicide Prevention center on making sure that the appropriate language is being used. The CCC membership was educated on the meaning and differences between suicidal ideation and thinking or planning a suicide, and a suicide attempt. The members also reviewed year-to-date data provided by Didi Hirsch Crisis Line for Southern California in terms of caller demographics, types of contact (whether call or text) and reasons for contact with the crisis line. Another data set presented was specific to the Teen Line, for callers ranging between eight and eighteen years of age. The presenter reiterated the importance of utilizing non-stigmatizing language when trying to help someone who is in crisis. Terms to be avoided include: "committed suicide, completed suicide, successful or unsuccessful suicide attempt." Rather, sensitive terms such as "death by suicide, or they took their life." The committee had the opportunity to review data regarding Didi Hirsch Crisis Line calls received from adults and youth. Adult callers reported experiencing depression due to the pandemic, relationship issues, intent to engage in self-injury or cutting, and health concerns. In comparison, young callers reported relationship issues with family, friends, and romantic interests. Many youths reported anxiety, stress, depression, suicidal ideation, child abuse, and loneliness.

CCC Feedback

- The CCC voiced concerns about Didi Hirsch's capacity to serve the cultural and linguistic diversity in Los Angeles County. Recommendations were made for help line workers to receive trainings regarding cultural humility and how to effectively serve the LGBTQIA2-community. Another recommendation made was for the help line to circulate pamphlets/brochures countywide to inform the community about services in often visited sites such as supermarkets, churches, community colleges, and schools.

13. ACCESS California/Cal Voices

In October 2022, the Cultural Competency Committee welcomed a presentation by ACCESS California/Cal Voices on Cal Voices. The CCC members learned that Cal Voices was founded in 1946 and is the oldest operation peer-run consumer agency in California. It is a peer-run organization that hires people with lived experience. Cal Voices is funded by the California Mental Health Services Act (MHSA/Prop 63) and the Council on Criminal Justice and Behavioral Health (CCJBH). ACCESS stands for: Advancing Client and Community Empowerment through Sustainable Solutions. CCC members were informed that ACCESS' Current contract is with CCJBH as a "Lived Experience Project" (LEP) for the Southern and Superior Regions of California. The goal of this contract is to execute activities that reduce the involvement of youth and adults with behavioral health needs in the

criminal/juvenile justice systems. Their subject matter experts, "ambassadors" must have lived experience in criminal justice or behavioral health. The CCC was provided with examples of the various ways the ambassadors provide advocacy, education, outreach, collaboration, and networking activities in their regions alongside with consumers, community members, and all other stakeholders. Ambassadors represent the voices, concerns, and needs of their communities and inform ACCESS of community-wide trends. They promote awareness to the community on mental health, criminal justice, and ACCESS events.

CCC Feedback

- The committee conveyed appreciation for the presentation and resources provided by the speaker. ACCESS ambassadors were praised for their important advocacy work across a variety of social needs including housing, peer services, mental health, and work-related trainings, among many others.

14. Commemoration of National Native American Heritage Month

In November 2022, the CCC welcomed the Anahuacaulmecac school, the first indigenous school to teach in maternal language in Los Angeles County. CCC members were informed about the school's programing, its emphasis on indigenous knowledge and the entire human being. The CCC learned the importance of physical health through sports but also through dance and ceremony. Mental health is very important to the school. The school is one of a few that still offers meditation. CCC members were taught that mornings are spiritual and a place to come together as a community and understand the day's purpose. The Anahuacaulmecac school received permission to open their schools on Osugna territories of the Shoshone Nation. They strive for academic success creative and transformative ways of developing partnerships that allow them, with their vision, to be globally minded. In 2009, the school became the first International Baccalaureate World School authorized by the FDA as a Public World School in Los Angeles. CCC members were also educated that the school is now a national Indigenous Resurgence Practitioners School. Through their National Resurgence Practitioners network, the school created math and Indigenous math-based programs, teacher education, and filmmaking in Papaleo, Guerrero, Mexico, in the Nahuatl communities. This played an important role for the school in helping with language preservation and initiatives. The school established a local coalition with other tribes and organizations, called the Indigenous Education Nahuatl Coalition focused on uplifting the needs of Indigenous LAUSD students. Various initiatives were being pursued by the school, such as a language justice platform that both identifies language communities, especially among youth, as well as advocating for existing laws and policies that support Indigenous language education. The presenters highlighted the contributions of the Anahuacalmecac School for having the largest number of American Indian and Indigenous students representing a variety of Indigenous affiliations and languages.

CCC Feedback

- The CCC members welcomed this presentation and emphasized the need to preserve native cultures and to strive for cultural pluralism, cultural humility, and empowerment. Several questions were asked regarding how the school

promotes an inclusive and empowering educational experience that honors and supports indigenous students and their families, values their heritage, and prepares them for future social challenges. Recommendations were made for the school to be mindful about the mental health needs of indigenous communities and to disseminate culturally appropriate resources for families interested in services. CCC members underscored that continuous prevention and early intervention services need to be delivered equitably through collaborations with various community-based organizations serving indigenous communities to create significant systemic changes.

15. Annual Retreat – Reflections on CCC Accomplishments CY 2022

In December 2022, LACDMH Ethnic Services Manager (ESM) delivered the 2022 CCC Annual Report comprised of a month-to-month account of the committee's activities and accomplishments.

The CCC's most salient 2022 accomplishments include:

- First article authored by the CCC published in the Cultural Traditions and Connections Column. Title: "What Works for me and my Mental Health."
- Completion of the first multicultural calendar for LACDMH as a collaborative effort of the CCU with the CCC, UsCC and FBAC for their cultural input
- Co-planning, coordination, and delivery of a CCC-ARDI Division Event commemorating Bebe Moore Campbell National Minority Mental Health Awareness Month and Juneteenth
- Feedback and recommendation to six DMH programs to ensure cultural and linguistic inclusion and intentionality.
- CCC representation in the 2022 Speakers Bureau Multicultural Conference via 1) delivery of a workshop on "Cultural Safety" delivered by CCC Co-Chairs along with expert community presenters and 2) participation in a panel presentation featuring leaders from the CCC, UsCC and FBAC

Additionally, the CCC co-chairs, as workgroup leads, provided a brief account of the work pursued during the year. The committee voted for the workplan to include a combination of workgroup(s) and LACDMH program presentations.

III. CCC's Reports to the Quality Improvement Council

The ESM represents the CCC at the monthly Quality Improvement Council (QIC) meetings. Additionally, the ESM oversees the administrative support and technical assistance provided to the CCC Co-Chairs and membership. As a standing member of the Departmental QIC, the ESM provides updates and presentations on the CCC activities as well as the ARDI Division-CCU's projects. This structure accomplishes several goals: 1) fosters communication, 2) facilitates the advancement of cultural and linguistic competence in the system of care, and 3) promotes a sense of responsibility toward the attainment of Cultural Competence Plan goals to reduce disparities and improve the quality and availability of services.

Another level of connection and collaboration with the Departmental QIC involves working directly with the Service Area-based Quality Improvement Committees (SA-QIC). The ESM and ARDI Division-CCU provide presentations on cultural and

linguistic competence-related projects and new initiatives to the SA-QIC. Furthermore, the CCC invites the SA-QIC memberships to the CCC's monthly meetings and special presentations. This practice increases cross-committee knowledge and understanding, promotes collaborative efforts that focus on cultural and linguistic competence, and facilitates access to the collective wisdom and expertise of these committees**. (*See attachment 1: CCC special presentation flyers)**.

IV. Review of the Year and CCC Co-Chair reflections

The CCU engaged the three co-chairs engaged in an active discussion on their experience leading the CCC during CY 2022. Below is a brief summary of their reflective comments.

Co-chair Johana Lozano, who has been an active member of the CCC for many years, stated that CCC provided a safe space and place where consumers learned and shared ideas, provided support for others, uplifted and gave a voice to the needs of all cultural groups and provided advocacy. She described her perspective on the CCC's accomplishments as follows:

- Providing an open forum and safe space for individuals who identified as First Nation to speak about their heritage, history, and current experiences
- Listening to the concerns and providing action-oriented support to CCC members who are Mental Health Promoters by engaging program leaders to address their programmatic questions
- Promoting the visibility of the CT&C newsletter column and seeing it flourish despite the lack of financial incentives for community contributors.
- Increasing the recognition of the CCC as one of LACDMH's stakeholder groups and gaining equity for CCC co-chairs to receive stipends for their leadership activities
- Most importantly, when consumer members reported feeling unseen, not heard, or disrespected, the CCC leadership took the time to meet with them to address concerns and find common ground.

Co-chair Mercedes Moreno's reflection was that the CCC is a safe place where she has participated as a member for several years and experienced a nurturing group where she can openly share about her Salvadorean culture. She is proud to serve as the first Older Adult co-chair for a LACDMH stakeholder group, adding that the CCC is modeling equitable leadership opportunities for persons in different stages in life. In her own words, "Now, I am a co-chair in this wonderful committee."

Finally, Co-chair Bernice Mascher shared she experienced many joys this past year with the CCC. Ms. Mascher expressed feeling blessed and honored to work so closely with the CCU and its membership. She appreciates the hard work, input, and wonderful comradery and synergy of the CCC. She stated, "As one of three Co-chairs, I enjoyed our lively planning meetings, the warm acceptance of our LACDMH

liaison, and the energetic passion of fellow CCC participants. It was great to team up with so many others and share experiences, knowledge, concerns, goals, and efforts on various topics that led to presentations, recommendations for the Department, and the development of meaningful workgroups and projects. This last year was a healing year in many ways. Coming out of COVID-19 with personal loss, community changes, and new ways of living resulted in much reflection and evaluation. The CCC created a unique place for these processes as opportunities were given to discuss tools and activities that helped our mental health, survival, and sense of hope via stories, poems, and inspirational words through the Cultural Traditions & Connections Workgroup and Blog. We also celebrated our diversity and grew our awareness by building a Multicultural Calendar, which prompted energetic conversations that led to vital presentations around race, culture, language, equity, wellness, and trainings for staff.

Our awareness and knowledge grew in areas such as land acknowledgments, labor acknowledgments, Lunar New Year traditions and special holidays such as Juneteenth, the power of peers, the important work of the Promotores de Salud/United Mental Health Promoters, the importance of suicide prevention and early recognition of signs of psychosis, and updates on ACCESS California and participation in revising LACDMH cultural competence policies and procedures. Additionally, a new space and platform gave co-chairs and community members a chance to share knowledge and experience in panels and presentations around wellness at the Speakers Bureau Multicultural Community Conference held in the month of December. We closed 2022 on a high note and watched each other "shine."

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Criterion 4 APPENDIX

Attachment 1

CCC Meeting Agendas and flyers, CY 2022

Attachment 2

CCC Bylaws and CCC Virtual Meeting Code of Conduct

CCC Bylaws
Updated 12-8-2021.

CCC Code of
Conduct for Meetin

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LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 5

Culturally Competent Training Activities

August 2023

Criterion 5: Culturally Competent Training Activities

I. LACDMH Cultural Competence Training Plan

The LACDMH Cultural Competence Training Plan aims to increase the workforce's cultural awareness, understanding, sensitivity, responsiveness, multicultural knowledge, and cross-cultural competencies, all of which are essential to effectively serve our culturally and linguistically diverse communities. This plan is based on the Cultural Competence Plan Requirements, which affirm that 100% of employees must receive annual cultural competence training, inclusive of clerical/support, financial, clinical/direct service, and administration/management at Directly Operated, Legal Entities/Contracted, and Administrative programs whether directly employed, contracted, subcontracted, or affiliated.

This three-year training plan presents employees with options to fulfill their annual cultural competence training requirement. The plan also avails staff the opportunity to engage in a personal evaluation of their training needs and customize their training profile. The goals of providing a customizable training plan are to:

- Engage the workforce in individualized cross-cultural skill set development
- Promote exploration of new professional areas of interest
- Equip staff with multiple opportunities to enhance their professional service delivery
- Expand staff's insights regarding the vital role of cultural competence in decreasing disparities and promoting health equity
- Deepen employees' cross-cultural compassion, humility, and empathy in working with consumers and co-workers from different cultural backgrounds

Additionally, the training plan includes blended learning opportunities that offer a combination of online and instructor-led trainings. By strategic design, the plan includes a broad spectrum of trainings that focus on specific elements of culture and cultural groups.

In accordance with DMH Policy No 614.02, In-Service Training, LACDMH is committed to provide training activities with the purpose of preparing staff to perform specific functions, tasks, and procedures necessary for the operation of their programs or units. All Department employees are eligible for in-service training according to the needs of their specific assignments.

- This policy enhances staff capabilities to carry out mandated requirements associated with their positions.
- Supervisors were expected to 1) work with employees in identifying training needs and 2) to notify the Quality, Outcomes and Training Division - Training Unit of training needed for their programs. Supervisors may authorize or require an employee's attendance at any approved in-service training conducted within LACDMH. The in-service training must be job related and should directly add value to employees' work performance.

Table 1: LACDMH Three-Year Training Plan, FY 19-20 through FY 21-22

The chart below exemplifies what a program-specific and/or employee-personalized training plan may involve. Training titles cover far beyond the examples listed below. Please refer to Table 2 for a complete listing of unique training titles offered during FY 21-22.

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
FY 19-20		
<u>Innovative training feature 1</u> • Positive Psychology and Well-being for Clinicians and Consumers Addressing Burnout, Compassion Fatigue, and Secondary Trauma in the COVID-19 Era	• LACDMH Cornerstone Learning Link • LACDMH app for Network Adequacy: Provider and Practitioner Administration (NAPPA) • ARDI Division -CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing Specialty Mental Health Services (SMHS) o Practitioners providing direct services
<u>Innovative training feature 2</u> • Suicide Prevention and COVID-19: A Training for Disaster Services Workers and Warm Line Workers	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 3 • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Community-Based Organizations	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 4 • Emotional Wellbeing in the Wake of COVID-19: A Culturally Competent Mental Health Intervention with Faith-Based Organizations	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 5 • Suicide Prevention and COVID-19: A Training for DSW-Shelter Workers	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 6 • Pediatric Psychology COVID-19 Response: Considerations for using Telehealth with Latino/Bilingual Children and other Diverse Youth	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 7 • Building and Maintaining Recovery and Resiliency through the Pandemic: A Culturally-Competent Approach	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training alternative 1 • Cultural competence related SMHS offered by the Training Unit. Training bulletins available via the intranet Examples of new training offerings: o DMH Clinicians: Culturally Competent COVID-19 Mental Health Intervention with Faith-Based Organizations and Churches Resilience Check-ins with DMH Clinicians involved in the Speakers Bureau	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training alternative 2 • Foundational Cultural Competence Training	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training alternative 3 • Language Interpreter Series o Introduction to Interpreting in Mental Health Settings o Use of Interpreter Services in Mental Health Settings o Therapeutic Cross-Cultural Communication	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
FY 20-21		
Innovative training feature 1 Racial Trauma in the Cambodian Population and Implications for Clinical Work	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 2 A Different Look into the African American Community and Mental Health Treatment	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 3 Armenian Genocide-Experience of Collective Trauma: Integrating Loss and Trauma: When More is Too Much	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 4 Engaging the Muslim American community	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Innovative training feature 5 Racial Equity: Racism and Mental Health	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training Alternative 1 • Integration of Cultural Competence in the Mental Health System of Care [designed for newly hired staff and offered during New Employee Orientation]	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training Alternative 2 • Cultural Competence related – SMHS offered by the Training Unit. Training bulletins available via the Intranet	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
Training Alternative 3 • Annual cultural competence related conferences	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Training Alternative 4 • Language Interpreters Series o Introduction to Interpreting in Mental Health Settings o Advanced Mental Health Interpreter Training o Use of Interpreter Services in Mental Health Settings	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services
Innovative training feature 1 • A Deeper Look into the African American Community and Mental Health Treatment	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services o

TRAINING OPTIONS	TRACKING MECHANISM	TARGET STAFF
<u>Innovative training feature 2</u> • Unique Issues in Counseling Deaf and Hard of Hearing Mental Health Consumers	• LACDMH app for NAPPA • ARDI Division-CCU Annual Cultural Competence Training Attestation for Administrative Programs	• Available to all staff including: o Directly Operated o Legal Entities/Contracted o Administrative o Management o Clerical/support o Staff providing SMHS o Practitioners providing direct services

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Training Plan Specifications
LACDMH can choose a training option described as an "Innovative training feature" or other training alternatives.

A. Innovative Training Features
Refers to any trainings, including conferences that have been provided through the Quality, Outcomes and Training Division - Training Unit.

B. Foundational Cultural Competence Trainings
- "Cultural Competency (CC) 101"

The ARDI Division-CCU developed a basic cultural competency training in response to the External Quality Review Organization (EQRO) recommendation that system-wide training in cultural humility and cultural sensitivity be provided. The training, "Cultural Competency 101," was originally designed as a train-the-trainer model for the Service Area Quality Improvement Committee (SA QIC) members. This online learning has been made available to the entire LACDMH workforce, including Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs.

Part 1: Basic definitions, regulations related to cultural competency, LACDMH strategies to reduce mental health disparities, and LACDMH demographical and client utilization data [Duration: 37 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6638
Part 2: Cultural humility, client culture, stigma, elements of cultural competency in service delivery, and resources [Duration: 30 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6640
Part 3: Cultural competency scenarios and group discussion [Duration: 18.5 minutes]
http://lacountymediahost.granicus.com/MediaPlayer.php?clip_id=6639

- "Implicit Bias and Cultural Humility"
  This virtual training was developed by the ARDI Division-CCU as a training that applies to all employee functions. The objectives of this training include engaging participants in a personal understanding of implicit bias, identifying ways to address personal and professional biases, and answering a personal call to practice cultural humility. This training facilitates the participants' awareness of how implicit bias impacts the quality of services provided and LACDMH's internal work environment.
- "Diversity Skills for the 21st Century Workforce"
  This four-hour class is geared toward assisting all employees in broadening and deepening their understanding, experience, and critical thinking skills regarding cultural and personal differences, and effective interpersonal communication in the workplace. The course content is highly interactive and emphasizes introspection about one's own identity and how that identity either facilitates and/or hinders workplace interactions. Through group discussions and guided

experiential activities, participants are encouraged to cultivate various tools to help them appreciate the similarities and differences of diverse groups and individuals within the workplace. This course includes a brief review of the County Policy of Equity (CPOE) and related policies and laws that aim to ensure an environment in which all individuals' contributions are valued, and their rights protected.

- "Integration of Cultural Competence in the Mental Health System of Care"

This training is provided by the ARDI Division-CCU to all LACDMH new employees during the New Employee Orientation. This training provides information on the CLAS definition of culture, County of Los Angeles demographics, federal, state, and county regulations governing cultural competency, the Cultural Competence Plan Requirements, mental health disparities, and Departmental strategies to reduce disparities in care.

C. Specialty Mental Health Services

The cultural competence-related trainings offered by the LACDMH Training Unit incorporates a multiplicity of cultural elements:

- Age group diversity (Children, Transition Age Youth, Adults, and Older Adults)
- Persons who are deaf and hard of hearing
- Persons with justice system involvement
- Persons experiencing homelessness
- Persons with intellectual and physical disabilities
- Language interpreter services
- Race and ethnicity
- Racism
- Gender identity
- Sexual orientation
- Substance use and co-morbidity
- Spirituality
- Trauma-informed services
- Veterans

Some of the trainings are offered in a language other than English, such as Spanish, Farsi, Chinese, and Khmer. Cultural competence is also a specific topic for clinical supervision trainings. Culture-specific conferences also provide an opportunity for the workforce and consumers to benefit from topics relevant to mental health disparities and culturally appropriate services for underserved/unserved communities, such as Latinos and Asian Pacific Islanders. ***(See section II below for specific details)***

D. Language Interpreters Series

The language interpreter training series is available to all LACDMH workforce, including administrative/management, clinical, and support/clerical staff. The Department recognizes that even though administrative/management staff do not

routinely perform language interpreter services, their positions may involve significant public contact, which requires use of their bilingual skills. Additionally, the trainings are strategically planned and include a series of threshold language specific Mental Health Terminology trainings along with offerings specific for who utilize interpreters. The following language interpreter trainings are available for bilingual-certified staff:

- *Introduction to Interpreting in Mental Health Settings*
  This three-day language interpreter training series is designed for bilingual staff that who are proficient in English and another language. The main purpose of the training is to ensure that the bilingual workforce accurately interprets and meets the requirements of Federal and State laws pertaining to language interpreter services. The introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter. The course provides the interpreters with knowledge and skills related to models of interpreting, mental health terms, standards of practice, cultural interpreting, and skills to address common challenges when interpreting. Development and maintenance of specialized mental health glossaries based on the interpreter's level of proficiency in both languages is included in the training. Role-playing, memory exercises, videos, and interactive exercises offer an opportunity to practice the newly acquired skills.
- *Advanced Interpreting in Mental Health*
  This training is designed specifically for the clerical and clinical staff who facilitate bilingual and bicultural communication in mental health settings. The training provides the knowledge and skills necessary for effective communication between mental health providers and consumers who are limited English proficient (LEP). The ethical principles that guide the work of Mental Health Interpreting and the ethical decision-making process are addressed. Exercises, group activities, role-playing, and videos are incorporated in the training to enhance integration of material. This is not a language enhancement program. However, resources to access Mental Health terminology in several languages are provided. The use of psychometric tests across languages is not included.
- *Cross-Cultural Communication and the Therapeutic Use of Interpreters*
  This workshop is designed to train monolingual English-speaking psychiatrists and clinicians to work effectively with interpreters and to ensure equality of access and service delivery in meeting the requirements of Federal and State laws. This workshop offers practitioners an opportunity to enrich their understanding of the diverse idioms of distress; culture bound syndromes, cultural constructions, and explanatory mental health beliefs. It provides participants with knowledge and skills to understand the unique dynamics that play out in the therapeutic triad among the provider, consumer, and interpreter. Some of these dynamics include language, culture, verbal and non-verbal communication, and communication in low and high context culture. Strategies to improve communication and service delivery within the therapeutic triad are outlined and practiced. To maximize

effective communication, techniques are modeled and practiced throughout the training session.

- *Increasing Mental Health Clinical Terminology training offered in various threshold languages such as Spanish, Armenian, and Mandarin for FY 21-22*

  This training aims to increase cross-cultural knowledge and skills, specifically to improve clinicians' and bilingual staff's vocabulary and the use of terms related to the provision of mental health services, including assessment, diagnosis, treatment, and crisis intervention. Additionally, topics cover common challenges in interpreting and providing services in the target language. For example, the use of incorrect or misleading terminology, misunderstanding of information, misdiagnosis, inappropriate diagnosis, and other unintended consequences. This training is designed for participants of varying levels of language proficiency.

LACDMH conducts bilingual proficiency examinations and certifications for its bilingual employees. In accordance with LACDMH Policy No. 602.01, Bilingual Bonus, a certified bilingual employee possesses "a valid Language Proficiency Certificate issued as a result of the County's Bilingual Proficiency Examination, which tests for proficiency to speak, read, and/or write the language.

- Candidates tested for bilingual proficiency as part of the examination process, if successful, are issued a Language Proficiency Certificate.
- Successful candidate names are placed on the eligible lists. Hiring managers select candidates from the eligible lists when foreign language skills are needed, including translation of materials and/or interpreter services by diverse LACDMH Programs/Units.
- Candidates who are selected from the eligible lists are employed on the condition that they use their bilingual skills while holding the position and may participate in translation of materials or interpreter services upon solicitation by various LACDMH Programs/Units."

E. Training Alternatives for Managers and Supervisors

In addition to the Cultural Competence-related trainings for staff providing Specialty Mental Health Services, learning opportunities are available specifically to managers and supervisors through the Training Unit. Examples of FY 21-22 offerings include:

- Advanced Clinical Supervision: Improving Outcomes for Diverse Clients
- Best Practices in Multicultural Clinical Supervision
- Cultural Humility in Clinical Supervision

F. Gender Bias Training Series

Developed by the County of Los Angeles Department of Human Resources (DHR) in partnership with the Women's and Girls Initiative

- Understanding and Tackling Gender Bias in the Workplace
- Diversity Makes Simple Series for Line Staff and Supervisors
- Employee Essentials

G. Tracking and Reporting Mechanisms

Directly Operated, Legal Entities/Contracted Providers, and Administrative Programs are regularly reminded that 100% of their employees must complete annual training in cultural competence The following guidelines are provided for the tracking and reporting of this requirement:

- Completion of the cultural competence training shall be monitored and tracked at all staff levels (e.g., clerical/support, administrative/management, clinical, subcontractors, and independent contractors)
- Program managers/directors shall monitor, track, and document (e.g., training bulletins/flyers, sign-in sheets specifying name and function of staff, and/or individual certificates of completion, etc.)
- Program managers/directors make available upon request by the Federal, State and/or County the annual cultural competence training provided to staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors
- Program Directors/Managers of Directly Operated Programs may attest to the completion of annual cultural competence training by 100% of their staff in the Fourth Quarterly Monitoring Report for every Calendar Year (CY)
- Program Directors/Managers of Legal Entity/Contracted Providers may attest to the completion of annual cultural competence training by 100% of their staff in the Annual Quality Assurance Monitoring Report for every CY
- The implementation of the NAPPA app has facilitated the tracking of completed annual cultural competence training by provider site and practitioner. The ARDI Division-CCU is in the process of developing a similar online process in collaboration with the Chief Information Office Bureau (CIOB) for administrative programs. Meanwhile, an Annual Cultural Competence Training Attestation form is required from Program Managers as evidence of annual completion of cultural competence training. The completed and signed attestation form is submitted to the Cultural Competency Unit's mailbox at dmhcc@dmh.lacounty.gov. When Program Managers/Directors reported less than 100% of staff completion of annual cultural competence training, a revised form is required to be resubmitted once the goal of 100% completion is reached.

(See Criterion 5 Appendix, Attachment 1: ARDI Division-CCU Annual Cultural Competence Training Attestation form

COVID-19 significantly impacted the Department's training operations. The Training Unit faced unprecedented challenges and continued to evolve in order to maintain high standards in training coordination and delivery. As of March 2020, all training offerings shifted from in-person/live to a virtual platform. Training coordinators became subject matter experts in delivering trainings virtually utilizing Microsoft Teams, which markedly increased the technological knowledge and competence of the Unit. Furthermore, the Training Unit offered services to record and edit trainings for virtual distribution throughout the system of care.

Additionally, the Training Unit continued to develop its online training registration system, EventsHub, funded by the MHSA Workforce Education and Training Plan. Most clinical trainings are now managed through EventsHub. These trainings are available to LACDMH staff, contractors, and community partners who are eligible to participate in Department-sponsored training. Once training participants establish their EventsHub account, they can easily register, receive confirmation of registration, complete training evaluations, and access attendance or continuing education certificates.

II. Annual Cultural Competence Trainings

LACDMH provides a plethora of training offerings during each fiscal year (FY), with topics covering a wide spectrum of culturally relevant issues: race/ethnicity, age group, underserved cultural populations, lived experience, language interpreter trainings, and culture-specific conferences. While these trainings target clinical skill acquisition, licensed administrative and management staff also attend these trainings to learn about clinical service delivery updates and their application to clinical supervision. Additionally, at the beginning of each FY, the Training Unit contacts the administrators for the Cultural Competency Committee (CCC) and Underserved Cultural Communities (UsCC) subcommittees to solicit stakeholder input into new cultural competence-related trainings that could be implemented.

The Training Unit enforces guidelines for the inclusion of cultural responsiveness in all trainings. These guidelines specify the following:

- Trainers are expected to incorporate cultural references in trainings and are monitored by training coordinators
- Training bulletin notices include learning objectives referencing cultural issues/ concerns relevant to the topic. A checkbox was added to the bulletins to inform the participants when a training meets the cultural competence training requirements
- Training evaluations collected from participants are reviewed to ensure the training met the cultural inclusion objectives. When participant evaluations indicate that the cultural inclusion objectives were not followed or important cultural issues were not covered, training coordinators follow up by reviewing the evaluation results with the trainer to ensure similar issues are considered in future training offerings

  (See Criterion 5 Appendix, Attachment 2: Inclusion of Cultural Responsiveness in Trainings)

Furthermore, the Training Unit tracks training attendance by staff function via a training evaluation form at the request of the ARDI Division-CCU. Training participants self-report their staff function by choosing among the following options:

- Direct Service, County
- Direct Service, Contractor
- Support Services

- Administration/Management
- Religious/Spiritual Population
- Community Organization
- Community Member
- Mental Health Board
- Interpreter
- Other staff function not specified above

(***See Attachment 3: LACDMH Training Evaluation Form)***

Trainings offered by the Training Unit align with areas of cultural competence specified in the Cultural Competence Plan Requirements. Each year, the ARDI Division-CCU collaborates with the Training Unit in analyzing the cultural competence-related themes covered in each training. This practice allows LACDMH to ensure that cultural competence trainings expose staff to various levels of skill acquisition. Examples of training content themes include:

- Race/ethnicity-specific trainings
  - Cultural formulation
  - Multicultural knowledge
  - Cultural sensitivity
  - Cultural awareness
  - Best practices
- Racial/ethnic equity
- Age group specialized trainings
- Lesbian, Gay, Bisexual, Transgender, Questioning, Queer Intersex, Asexual, Two-Spirit (LGBTQIA2-S)
- Client culture/family inclusion
- Social/cultural diversity
- Service integration and outcomes
- Co-occurring disorders
- Language interpreter services
- Underserved populations (i.e., persons involved with the justice system, persons experiencing homelessness, gender, sexual orientation, and age group specific) ***(See Criterion 5 Appendix, Attachment 4: Cultural Competence Trainings by Content Category.***

Table 2: Examples of Cultural Competence-Related Specialty Mental Health Trainings Offered by the Training Unit, FY 21-22

Title of Trainings
African American
A Deeper Look into the African American Community and Mental Health Treatment
Addressing Racial Trauma in the African American Community
How to Treat Race-Based Stress/Trauma: Clinicians Serving Communities of Color
How to Treat Race-Based Trauma in Children and Families of Color
Psychological Theories and Diagnostic Formulations for the African American Population
Things that Make Men Cry
American Indian/Alaska Native (AI/AN)
Gardening for Healing Utilizing Traditions (GHUTS)
The Positive Indian Parenting Model
Children: Birth to Five
0-5 Diagnostic Classification
0-5 Diagnostic Classification: 0-5 Revised Edition
Introduction to the DMH Infancy, Childhood & Relationship Enrichment (ICARE) Initial Assessment
Typical and Atypical Development (Birth through Five)
Children
Child and Family Team Facilitator Training
Engaging Fathers & Other Adult Males in the Child and Family Team Process
Early Adversity and Brain Development in LA County Clients
Fostering Crucial Conversations about Race with Children and Families
Fostering Crucial Conversations Training
Grief and Loss: Supporting Children, Youth and Families
Promoting Placement Stability: Utilizing the Child and Family Team Process
The Impact of Domestic Violence/Intimate Partner Violence on Children and Youth
Underlying Needs: A Strengths/Needs-Based Service Crafting Approach

Title of Trainings
Disabilities
Effective Techniques in Working with Individuals with Mild to Moderate Cognitive Impairment
Mental Health Strategies for Individuals with Co-occurring Developmental Disabilities (CDD)
Unique Issues in Counseling Deaf and Hard of Hearing Mental Health Consumers
Co-Occurring Disorder
Seeking Safety: An Evidence – Based Model for Trauma and/or Substance Abuse
COVID – 19
Stay Safe and Well: Navigating and Thriving in Uncertain and Tumultuous Times
Understanding & Addressing Racial Trauma in a Post-COVID Society
Diverse Populations
Engaging the Muslim American Community
Working with People who are Black, Indigenous, and People of Color (BIPOC)and Lesbian, Gay, Bisexual, Transgender, Questioning, and Queer Plus (LGBTQ+)
Forensic
Forensic Mental Health – Back to Basics
Legal and Ethical Considerations: Working with Forensically Involved Individuals
Risk Assessment for Violence – Forensic Focus
Gender Identity
LAC DMH Quarterly Psychiatry Meeting. Sexual and Gender Diversity: Terminology and Techniques Every Mental Health Professional Should Know
General Cultural Competency
Cultural Humility: Crucial Reflections
Diversity: Skills in the 21st Century Workforce
Human Immunodeficiency Virus (HIV)
HIV Assessment and Treatment in the Age of Survival
Juvenile Justice System
Adapted Dialectical Behavioral Therapy (DBT) Core Training for Juvenile Justice Staff
DBT Interventions for Juvenile Justice-Involved Youth: From Problems to Goals and Successful Reunification

Title of Trainings
Fetal Alcohol Spectrum Disorders Among Detained Youth: Increasing Awareness and Improving Outcomes
Fundamentals in Effective Work with LGBTQIA2S Youth in Juvenile Justice Settings
Justice Involved Mental Health (JIMH) – Creating a Culture of Safety
Law and Ethics 101 for Juvenile Justice Mental Health Professionals
Suicide Risk Reduction, Assessment and Treatment in Juvenile Justice Settings – Part 1
Suicide Risk Reduction, Assessment and Treatment in Juvenile Justice Settings – Part 2
The Edge of Compassion: Staying Well While Working in High-Stress, Trauma Exposed Juvenile Justice Settings
Trauma-Informed Treatment of Juvenile Justice Youth Part 1: Assessment & Diagnosis
Trauma-Informed Treatment of Juvenile Justice Youth Part 2: Treatment Planning & Interventions
Language Interpreter
Increasing Armenian Mental Health Clinical Terminology
Increasing Mandarin Mental Health Clinical Terminology
Increasing Spanish Mental Health Clinical Terminology
Introduction to Interpreting in Mental Health Settings
LGBTQIA2-S
Core Practice Concepts in Working with LGBTQIA+ Youth
Effective Treatment and Intervention, Including Families of LGBTQIA2S Youth in Juvenile Justice Settings
Improving Access to Gender Affirming Treatment: Writing Letters of Support for Transgender Clients
Latino and Latinx
Emotional CPR (eCPR) - Spanish
Towards the Reduction of the Duration of Untreated Psychosis in the U.S. Latinx Community
Trauma Informed Care for Spanish Speaking Clinicians Working with Monolingual Clients – Spanish
Racial Equity and Racial Trauma
Racial Trauma in Cambodian Population and Implications for Clinical Work

Title of Trainings
Racial Trauma in LatinX Population and Implications for Clinical Work
Service Integration
Integrated Core Practice Model Foundational Training
Social Determinants of Health
Spirituality
Being Trauma and Healing Informed Towards the American Indian/Alaskan Native Population
Substance Use Disorders (SUD) & Co-Occurring Disorders (COD)
Mindfulness-Based Practices for Mental Health Professionals Working with Addiction Populations
SUD/COD & Harm Reduction & Crisis Intervention Training
Supervisors/Management
Advanced Clinical Supervision: Improving Outcomes for Diverse Clients
Best Practices in Multicultural Clinical Supervision
Cultural Humility in Clinical Supervision
Veterans
Intimate Partner Violence, Veterans, and Their Families
Military Culture Awareness
Serving the Grief and Bereavement Needs of Veterans

Data source: LACDMH Training Unit

Total number of unique training titles = 70.

In addition to Training Unit learning opportunities, cultural competence-related trainings may be recommended and coordinated by program managers based on the collective training needs of their staff.

Table 3: Examples of trainings offered at the program level for FY 21-22*

Program Name	Title of Trainings
California Work Opportunity and Responsibility for Kids (CalWORKs)	• How to Treat Race-Based Trauma in Children and Families of Color – This training examined the effects of racial trauma on children and families of color and its implications for clinical work. It explored the impact intergenerational racial trauma has had on families of color in relation to their physical and mental health.
Homeless Outreach and Mobile Engagement (HOME)	• Implicit Bias and Cultural Competency - The purpose of the training was to promote cultural competence and understand the County Policy of Equity, to help learners mitigate implicit biases and improve cultural competence. • Diversity - Skills for 21st Century Workforce - The purpose of this training was to promote an inclusive workplace environment in which each person is valued for his/her unique gifts and talents, to capitalize on the innovation inherent in diverse work groups: and to assure that each person is valued based on individual characteristics rather than on stereotypes. The HOME program staff also participated in additional trainings such as ○ Cultural Competency – Cultural & Communication in the Workplace ○ Becoming an Ally to the LGBTQ+ Community - Increasing Awareness and Good Practices ○ Asian American and Pacific Islander (AAPI) Phases of Treatment: Crisis Intervention ○ Understanding and Increasing Providers' Cultural Sensitivity to South Asian Clients' Needs in Mental Health Treatment
Maternal Mental Health Antelope Valley	• Gender Identity and Awareness - This training provided an overview of different gender identities and descriptions. • Mental Health in the Latinx Community - This training provided awareness of mental health in the LatinX community. • Black Maternal Health Training - The purpose of this training was to bring awareness regarding the implicit bias in black maternal health to providers. • Gender Identity and Awareness - This training provided an overview of different gender identities and descriptions.
Prevent Homelessness, Promote Health	• Diversity: Skills for the 21st Century • Implicit Bias & Cultural Competency • Racial Trauma in the Latinx Population & Implications for Clinical Work - Staff who attended this training provided an in-service to the entire program.
Roybal Family Mental Health's Young Mothers and Babies FSP	• DC: 0-5™ - This comprehensive training targeted advanced clinicians from fields of mental health, health, and early intervention. It discussed the history and background leading to the development of a specialized diagnostic classification system for infancy and early childhood. Developmentally informed, relationship-based, contextual, and culturally competent diagnostic approaches for infants were covered. Participants learned about each axis in this multi-axial diagnostic approach including

Program Name	Title of Trainings
	Axis I clinical disorders. Included in the training was a review of the recently revised diagnostic manual developed and published by Zero to Three (ZTT), the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-5). Knowledge and expertise related to this diagnostic tool are increasingly valued as a complement to the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM V) and the International Classification of Diseases (ICD). • Introduction to the DMH infancy, childhood & relationship enrichment (icare) initial assessment By Guadalupe Cortez & Rocio O. Luevano - This training focused on developing the participant's skills in the observation of dyads and assessment techniques to address the needs of the birth to five population. An in-depth overview of the Los Angeles County Department of Mental Health's Infancy, Childhood, and Relationship Enrichment (ICARE) Initial Assessment will be provided. Also, reflective practice interventions were incorporated to enhance understanding, engagement, and service to consumers from diverse cultural backgrounds.
School Threat Assessment Response Team (START) and Therapeutic Transportation Team (TTT)	• Law and Ethics • De-Escalation Techniques • Implicit Bias and Cultural Competency • TRAP-18 (in service) The START Program reported these additional training opportunities • Ideology of clients posted violent threat (in-service) • SAVRY (in service) • Case presentations (bi-weekly staff meeting) – presented by clinicians to shed light on the cultural factor(s) and their impact on the assessment impressions and presenting problems
Assisted Outpatient Treatment (AOT)	• Creating occupational resiliency: implementing self-care strategies to prevent secondary traumatization while working in the behavioral health field - This training addressed the stress hazards and psychological demands associated with the provision of mental health services to vulnerable populations. It specifically addressed the hazards of compassion fatigue, burnout, and vicarious traumatization that can diminish therapists' capacities for therapeutic effectiveness over time and lead to decreased well-being, exhaustion, and lack of purpose in their professional and/or paraprofessional roles. The training provided information on trauma-informed care, and on the latest research findings in stress and psychological resilience as applied to care providers. This will help participants identify ways to promote their own psychological resilience as well as encourage a collective responsibility to foster health and wellbeing among the personnel within their respective agencies.

Program Name	Title of Trainings
	• Creating occupational resiliency: implementing self-care strategies to prevent secondary traumatization while working in the behavioral health field - This training addressed the stress hazards and psychological demands associated with the provision of mental health services to vulnerable populations. It specifically addressed the hazards of compassion fatigue, burnout, and vicarious traumatization that can diminish therapists' capacities for therapeutic effectiveness over time and lead to decreased well-being, exhaustion, and lack of purpose in their professional and/or paraprofessional roles. The training provided information on trauma-informed care, and on the latest research findings in stress and psychological resilience as applied to care providers. This will help participants identify ways to promote their own psychological resilience as well as encourage a collective responsibility to foster health and well-being among the personnel within their respective agencies. • Implicit Bias and Cultural Competency: An Introduction - This curriculum introduced the fundamental concepts of implicit bias and cultural competency. It also provided practical techniques that each learner can use to develop an individualized development plan to mitigate implicit biases and improve their cultural competence. The curriculum consisted of two modules. • Understanding the stress response - Participants learned how to classify stressful situations into one of five different stress types. Describe two parts of the brain that have significant roles in responding to stress: the amygdala and the hypothalamus. Identify two chemicals, adrenaline and cortisol, within the body that support stress response and have negative consequences when they are constantly activated. How to apply a simple self-care worksheet to assist individuals in recognizing their individual stressors. • AOT 101 training - AOT program description process and referral. • AOT and Conservatorship to NAMI - AOT program description process and referral.
Veteran Peer Access Network (VPAN)	• Recovery Opportunities – Peer Navigation - 2 weeks - Depression and Bipolar Support Alliance (DBSA) - Peer Support training provided foundational information for peers to learn how to support veterans in the community. • Veterans Family Wellness Center (VFWC); Veteran - UCLA - The training taught peers how to assess the needs of veterans and their families. It ensured peers know. • Family Peer Navigation Training (VFPN) – 3 days - how to help veterans and their family be directly connected to healthcare programs and other services. • 4 Point Training (Trauma Informed Care for the Military) – 2 days - Provided foundational information about roles, responsibilities, customer service, and professional boundaries. Foundational information included mandated reporting procedures and informed consent. Many veterans who have served have experienced trauma. This training promoted safe and empowered decision making by clients. It would also reduce power

Program Name	Title of Trainings
	struggles and staff burnout. This training helped staff to understand the impact of trauma on safety, decision-making, and coping. • Military Culture Awareness –. - Introduction to military ethos, military organization and roles, stressors and resources, and treatment resources and tools. Helped staff develop cultural humility to serve the veteran population. • Serving the Bereavement Needs of Veterans and Their Families – 2 days, 3 hrs./day - Veterans need the same things non-veterans and their families need when a loss is experienced comfort, sympathy, emotional support of friends and family, knowledge, coping skills, time, and healing. Issues may arise with career-military families when there is a death or major loss; the family may find themselves far away from their family and support system. Because military families have not established roots, there may not be a network of support that facilitates effective grieving. On the other hand, because of these frequent moves, families of veterans may readily reach out for support because they have learned how to ask for help and form new bonds quickly. • Boundaries and Ethics- For Veterans and Military Family members - Provided foundational information about roles, responsibilities, customer service, and professional boundaries. Foundational information included mandated reporting procedures and informed consent. • Veteran Intimate Partner Violence / Prevention and Intervention - Training for veteran intimate partner violence. How to recognize the signs, safety plan, and identify available resources.
Outpatient Care Services (OCS) Transitional Age Youth (TAY) Drop-In Centers	• LGBTQI2-S TAY Toolkit Trainings – This 6-hour training curriculum for local mental health providers on LGBTQ awareness, bullying prevention, and clinical interventions.
Housing & Job Development Division (HJDD) Housing and Supportive Services (HSSP)	• Cultural Competency (CC) 101 - General overview of CC (basic definitions, regulations related to CC, LACDMH strategies to reduce mental health disparities, LACDMH demographical and client utilization data.
Enriched Residential Care Program (ERC)	• Cultural Competency (CC) 101 - General overview of CC (basic definitions, regulations related to CC, LACDMH strategies to reduce mental health disparities, LACDMH demographical and client utilization data.
Men's Community Re-Entry Program (MCRP)	• Cultural Humility: Crucial Reflections – This training increased participants' knowledge of privilege, bias and microaggressions, and how these impact the work of mental health service providers and their interactions between children, families, and systems of care.

Program Name	Title of Trainings
	• Implicit Bias and Cultural Competency: An Introduction – This course introduced the fundamental concepts of implicit bias and cultural competency. It also provided practical techniques that each learner can use to develop an individualized development plan to mitigate implicit biases and improve their cultural competence. • Legal and Ethical considerations: Working with Forensically involved Individuals – This training focused on legal and ethical considerations relevant to working with Forensic/Justice involved consumers. An overview of the criminal justice system in Los Angeles County and how mentally ill consumers navigate through the forensic system was discussed. Other topics included confidentiality, privilege, reporting requirements, PHI, HIPPA, informed consent, agency/policy procedures, and appropriate documentation. The training identified the various sources of current legal policies, defined patient-provider privilege, and reviewed how to recognize signs of compromised boundaries (i.e., accepting gifts and inappropriate physical/personal boundaries). Ethical decision-making approaches relevant to individual and team accountability were addressed, as well as self-awareness and its applicability to Forensic/Justice involved program delivery service. • Suicide Prevention Service Provider Training – Suicide remains an urgent mental and public health problem that negatively impacts the population of Los Angeles County across all age groups, cultures, ethnicities, and economic levels. This training explored general risk factors, risk assessment, prevention (strength-based), and interventions. Clinical staff learned to identify techniques to ask specifically about suicide and intervene in the most appropriate and effective manner. Skills for effective clinical assessment, safety planning, record documentation, interventions, and management of individuals at risk for suicide were reviewed. Also discussed were suicide statistics, risk and protective factors, cultural disparities, COVID-19, and suicide. • County Policy of Equity – This 45-minute course was designed to help supervisors and managers understand the rights of employees to be free from discrimination, unlawful harassment, retaliation, and other inappropriate conduct. The course covered key points of the County Policy of Equity. • Race and Trauma within Communities of Color – Destigmatizing mental illness in communities of color; addressing trauma and the impact in the psychosocial functioning of the individual in relation to race; understanding the impact of mental illness in the culture and family system. • Just Culture – This module provided the workforce member with the basic knowledge on Just Culture and its concepts and principles. This training was for all Health Agency workforce members and helped create a kinder

Program Name	Title of Trainings
	and fairer workplace that provided safer services to the community. Target Audience: All Health Agency Workforce members (DHS, DPH, DMH). • Applying the Risk-Need-Responsivity Principles (RNR) and Level of Service/Case Management Inventory (LS/CMI) in Your Practice – The RNR model was an evidence-based practice for working with justice-involved individuals to reduce recidivism. This training covered the theory and research behind RNR and the mental health recovery model at the clinical and organizational levels. Clinic-level considerations included risk assessment, the concept of responsivity, and appropriate interventions based on individual risk factors. Considerations when effecting change at an organizational level were addressed. The training included a discussion of the dual roles of helping and public safety when working with justice-involved consumers. Lectures, small group exercises and interactive group discussions were utilized. • Problem-Solving Therapy (PST) in Forensic settings – Problem-solving Therapy (PST) was a cognitive-behavioral approach centered toward improving a person's ability to cope with stressful life experiences. Two major goals of problem-solving therapy were: 1) adaptive world view toward problems of daily living, and 2) effective implementation of problem-solving behaviors. Forensic consumers are at increased risk for recidivism if they have difficulty identifying and solving everyday problems. This training provided participants with a foundation for competencies in assessing and developing problem-solving interventions. Assessment of problem-solving ability and style is measured through Proctoring the Problem-Solving Inventory – Revised (SPSI) Participants learned how to administer, score, and interpret the five SPSI-R scales: Positive Problem Orientation, Negative Problem Orientation, Rational Problem Solving, Impulsivity/Carelessness Style, and Avoidance Style. The results were used to develop interventions and measure progress in overcoming problem-solving difficulties. • Assessment and Treatment of Impulse-Control Disorders in Forensic Settings – The goal of this training was to develop knowledge and competence to assess and treat impulse-control disorders as well as disorders characterized hyperactivity-impulsivity. This training provided participants with a foundation for competencies in assessment, treatment, and prevention of Impulse-Control Disorders/Behaviors. Assessment of impulsivity involves a combination of self-report questionnaires, neuropsychological tests, interview strategies, and diagnostic impressions. Examples of these measures using real life cases were used to train the participants with assessment processes. Treatment of impulsive disorders and behaviors mainly consists of cognitive behavioral therapy (CBT), pharmacotherapy, family therapy, support groups, and other self-help approaches. The intricacies of CBT for this population, especially strengthening self-regulation, will be described in experiential role-play

Program Name	Title of Trainings
	format. Finally, in the prevention section, crime was contextualized as a result of situational opportunity, and lack of self-regulation that progresses from childhood conduct problems and adolescent delinquency to later offending. Early identification to commence timely interventions with family involvement, aimed at learning to delay immediate gratification and inhibiting undesirable behavior were discussed.
Child Welfare Division (CWD)	• Cultural Humility: Crucial Reflections - This training increased participants' knowledge of privilege, bias, and microaggressions and how these impact the work of mental health service providers and their interactions between children, families, and systems of care. Discussion addressed recognizing and understanding how one's beliefs and attitudes affect the assessment of the child and family's experience; identifying strategies to reduce the impact on service delivery; and recognizing how to incorporate cultural humility to ensure successful treatment outcomes. Other opportunities encourage participants to explore their thoughts and beliefs around privilege, bias, and microaggressions as it relates to their work with children and families to mitigate further traumatization. Ultimately, understanding one's biases and its implications on children and families within systems of care is integral to providing trauma-informed care to ensure the safety, permanency, and wellbeing of children and youth. • Fostering Crucial Conversations about Race with Children and Families - This training described the implications of structural racism that can result in racial disparities in treatment. Summarizes the effects of Historical and Racial Trauma on children and youth in mental health treatment. Describes the importance of culturally adapted treatments when working with children and families who identify as Black, Indigenous, & People of Color (BIPOC). Identifies two strategies to have crucial conversations related to race to help increase engagement with children and youth.
GENESIS	• Chronic Pain in Older Adults: A Neuroscience-Based Psychological Assessment and Treatment Approach: This training examined relationships between stress, emotions, the brain, and subtypes of chronic pain. These included, but not limited to, recognizing racial and health disparities as important psychosocial stressors. In addition, the trainer identified disparities in care for the treatment of patients with chronic pain. • OACT-Psilocybin as Treatment for Existential Anxiety and Demoralization in Terminal Illness: This training discussed the history of psychedelic use in general, for medicinal and spiritual purposes around the world. The presentation also discussed its recent resurgence as a means of treatment for a variety of psychiatric conditions, and specifically for advanced cancer, focused on potential palliative effects in end-of-life settings associated with existential anxiety, distress, and demoralization. • Sleep: An Overview, Select Disorders in Older Populations and Treatment This training focused on sleep disorders, which disproportionately affect older populations and relevant information for clinicians and non-clinicians working with older adults.

Program Name	Title of Trainings
	• Neuropsychiatric Manifestations of COVID-19 This presentation provided a brief overview of societal effects of the COVID-19 pandemic on mental health.
Prevent Homelessness Promote Health (HP)	• Diversity: Skills for the 21st Century • Implicit Bias & Cultural Competency • Racial Trauma in the Latinx Population & Implications for Clinical Work - Staff who attended this training provided an in-service to then entire program.
Wellness Outreach Workers (WOW)	• Compassion Fatigue - This presentation provided a brief overview of compassion fatigue signs and symptoms (physical, cognitive, behavioral, and emotional). Also, work-related compassion fatigue and its impacts were reviewed. The importance of self-care and implementing effective self-care strategies were discussed. • Languishing: Discover your Passion Social Isolation – This training provided information on: o What is languishing? o What are some challenges brought on by the pandemic? o What are some strengths of older adults? o How to shift from languishing to flourishing? o Definition of passion o How to find your passion o Distractions o Barriers o Solutions • Grief and Loss (English & Spanish) - This presentation provided information about grief and loss faced by older adults that can be a challenging experience. Furthermore, this presentation defined grief and loss, explained the components of the grief process and described the symptoms of grief. Provided culturally appropriate tips on coping strategies when facing a loss.
Peer Resource Center (PRC)	• Intentional Peer Support (IPS) Advanced Training - 24 hours (hrs.) - This online Advanced Training supported the IPS practice by: enacting the principles and tasks using real-life scenarios, heightening self-reflection, enhancing ways of building mutual connections and sustaining the practice. Participants learned co-reflection which is a vital practice where people regularly come together to reflect on their relationships using the IPS framework. This included an opportunity to examine relationships, look at assumptions, and sustain the tasks and principles. This training focused on using crisis to connect, maintain mutuality and create a culture of healing. Working through challenging situations, participants explored what it means to be trauma-informed, how to navigate conflict and develop flexible boundaries, and how to implement pro-active crisis planning and prepare for evaluation. • INTENTIONAL PEER SUPPORT (IPS) CORE TRAINING - Online (40 hrs.) - Intentional Peer Support was an innovative practice that was developed by and for people with shared mental health experiences that focused on how to build and grow connected mutual relationships. In this interactive

Program Name	Title of Trainings
	training, participants learned the principles of IPS examine and challenge assumptions about how we have come to know what we know, and to explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices; and has been widely used as a foundational training for people working in both traditional and alternative mental health settings. **IPS Co-Reflection Follow-up sessions**: These follow up sessions took place after participants attended the IPS Core Training. The Co-Reflection sessions will allow participants, who attended the IPS Core Training, to support each other to reflect on and develop their practice of Intentional Peer Support. • Wellness Recovery Action Plan (WRAP) - This training equipped participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provided an experiential learning environment based on mutuality and self-determination. Participants were expected to join in interactive learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants were able to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery related issues to groups or organizations. Lastly, participants were expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work**.** • Online Wellness Recovery Action Plan (WRAP) Facilitator Refresher Training (24 hrs.) - The WRAP® Refresher Training is an interactive training to sharpen and expand facilitation skills of trained facilitators to further engage groups they facilitate in the implementation of their Wellness Recovery Action Plan®. Participants in this training were expected to participate in interactive learning activities and demonstrate their own experience with WRAP®. This training was for the current WRAP facilitators who lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery related issues to groups or organizations. Participants were expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work. • Developing Your Own Wellness Recovery Action Plan - This training is an introduction to WRAP® and how to use it to increase personal wellness and improve quality of life. The training was highly interactive and encouraged participation and sharing from all present. It also laid a broad foundation for building and supporting a skilled peer workforce. Participants learned to apply the Key Concepts of Recovery and used tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. History, foundation, and structures of WRAP® were discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training. • QPR (Question, Persuade, Refer – 2 hrs.) - QPR is designed to inform non-clinical professionals manage situations in which individuals may be at risk of suicide. QPR aims to provide strategies to engage suicidal individuals in distress, provide hope, and refer to those who can formally assess and

Program Name	Title of Trainings
	intervene. This training targeted employees providing Peer and parent support services, who are working/in contact with populations at risk for suicide among all age groups. Topics addressed in the training included: suicide facts/research data, risk factors/protective factors, and teaches "gatekeepers" interventions using three basic suicide intervention skills: question, persuade and refer. The training also incorporates a PowerPoint presentation, audio/visual material, and interactive activities which support enhancement of knowledge and skills important to the work/contact with populations with suicide risks**.** • Online Law and Ethics for Peer Professionals (6 hrs.) - This training addressed effective strategies for assisting Peer Support Specialists navigate legal and ethical issues associated with delivery of mental health services. Discussion will include ethical decision-making considerations that address common field and services dilemmas that present. A review of standard practices, appropriate boundaries and behaviors relevant to working in a treatment team are also covered. Lastly, the training incorporated peer relationship understandings (within legal and ethical contexts) to train participants about protecting, respecting, and empowering mental health consumers to meet their recovery goals. • Recovery Oriented Tools for Trauma-Informed Services (Online) - The best practices for care in the mental health setting included an awareness of any potential trauma experienced by clients. The use of recovery model as a foundational standard provided a strength perspective that enhances resiliency. This training provided a foundation for recognizing trauma and practical examples of incorporating resiliency-based recovery model strategies to avoid re-traumatization. Topics included elements in identifying the intensity of the trauma, principles of the recovery model, and self-help strategies that impact perceptions of trauma. Additionally, this training discussed how culture, family systems, and building coping strategies might enhance resiliency in mental health service delivery. • Supervising Peer Support Specialists (2 days) - This training provided information and education on what Peer Support is, how to incorporate Peer Specialists into the current mental health programs, and how to provide effective Peer Supervision. • Honest, Open, Proud (HOP) (12 hrs.) - This online training focused on reducing the self-stigma associated with mental illness and how to share one's lived experience as a DMH staff who is providing peer support services to mental health consumers, parents and/or family members. Participants learned the necessity and importance of effective self-disclosure in self-empowerment and providing peer support services. This training covered four modules: 1) Considering the Pros and Cons of Disclosing; 2) Different Ways to Disclose; 3) Telling Your Story to provide peer support services; and 4) How to use disclosure in one's work as a Peer Support Service Specialist.

Program Name	Title of Trainings
Community Ambassador Network (CAN)	• Panel presentation: Champions, Advocates, and Partners: Connecting with Local Leaders - Four local leaders with lived experience of building community connections joined the Learning Session for a panel discussion. • Presentation: Cultural Humility and Trauma-Informed Practice - Evaluation team members facilitated a group discussion about the intersection between being trauma-informed in your work and cultural humility. • Keynote: Telling your Story. Developing a Communication Mindset - Lauren Kay (Strategic Communications Consultant) shared strategies for fostering a communication mindset

III. Monitoring of staff's skills/post skills learned in trainings

The Training Unit collects targeted outcomes for selected trainings scheduled throughout the year. Staff and managers collaborate to select which trainings will be assessed for to evaluate participant skill acquisition. Program needs determine which trainings are assessed on the following outcomes:

- Training cost
- Additional training needs
- Adequacy of content
- Clinical impact
- Knowledge/skill transfer

The Training Unit analyzes outcomes, to refine ongoing trainings, justify renewing training contracts, and plan for future trainings.

(See Criterion 5 Appendix, Attachment 5: Examples of trainings with one-month follow-up conducted by Training Unit)

Criterion 5 Appendix

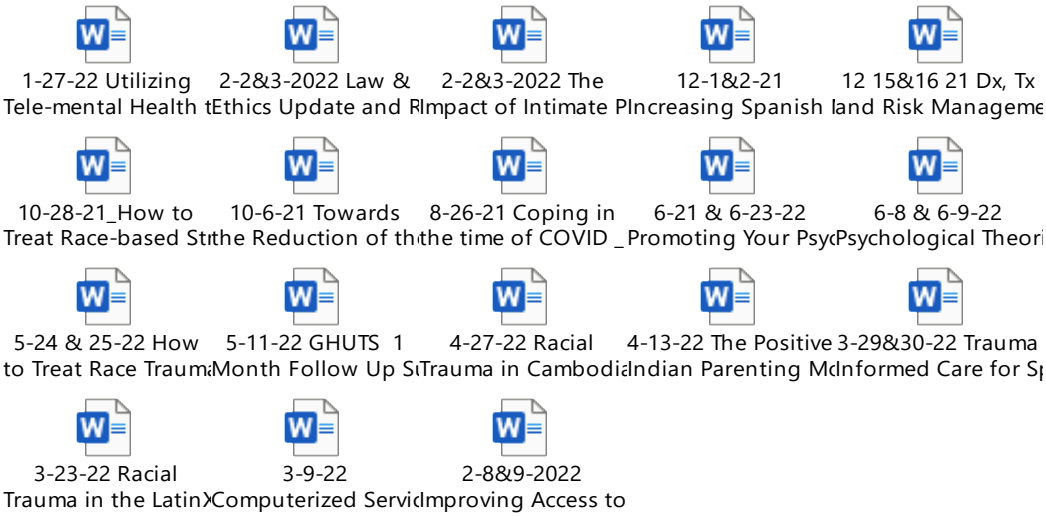
Attachment 1: ARDI DIVISION-CCU Annual Cultural Competence Training Attestation form

Attachment 2: Inclusion of Cultural Responsiveness in Trainings

Attachment 3: LACDMH Training Evaluation Form

Attachment 4: Cultural Competence Trainings by State content category and sample training bulletins, FY 21-22

Attachment 5: Examples of trainings with one-month follow-up conducted by Training Unit, FY 21-22



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 6

County's Commitment to Growing a Multicultural Workforce

August 2023

Criterion 6: County's Commitment to Growing a Multicultural Workforce

I. Recruitment, Hiring, and Retention

LACDMH is committed to growing a multicultural and language proficient workforce to serve our communities with quality services provided by those that increasingly reflect the population served. Despite the myriad of challenges resulting from the large size and the cultural diversity of the County, the Department continues its efforts to recruit, hire, train, and retain culturally and linguistically competent staff through these strategies:

- Equip English-monolingual clinical staff with culturally responsive and linguistically competent language interpreters
- Integrate eligible consumers, family members, and parent advocates/parent partners into the public mental health workforce in peer, para-professional, and professional staff functions
- Retain workforce members representing cultural and linguistic underserved communities via tuition reimbursement and loan forgiveness programs
- Build collaborations with higher education institutions to promote mental health careers. This effort includes creation of pike lines for students to consider LACDMH employment upon completion of their academic degrees
- Provide the mental health workforce with a myriad of quality cultural competence trainings to enhance the service delivery at all points of contact
- Build the linguistic capability of the system of care by paying bilingual bonus to staff from Directly Operated programs
- Offer interpreter training to bilingual certified employees who are interested in providing language interpretation services
- Provide training for monolingual English-speaking staff on how to use language interpreters effectively

II. Examples of LACDMH workforce development via the Training Unit

1. **Public Mental Health Partnership (PMHP)** The mission of the UCLA-LACDMH Public Mental Health Partnership (PMHP) is to implement exemplary training and technical assistance activities focused on vulnerable populations with serious mental illness in ways that build excellence in public mental health care across Los Angeles County; and to do so in the context of a transparent, trusting partnership with LACDMH that generates benefits for both the University and public health communities. The PMHP is comprised of two sections focused on serious mental illness -- the Initiative for Community Psychiatry (ICP) and the Full-Service Partnership (FSP) and HOME Training and Implementation Program.

2. **Bilingual and Spanish Interdisciplinary Clinical Training (BASIC-T)**
   BASIC T: The Hispanic Neuroscience Center of Excellence (HNCE) had two broad foci: 1) work with Promotores de Salud and 2) build relationships with faith- and community-based organizations (FBO/CBO). For both groups, the HNCE provided

training on psychological first aid and recovery to help reduce stigma around mental health topics and care. In the final quarter of the fiscal year, BASIC-T focused on completing the training of its postdoctoral fellows in neuropsychology as part of the Pipeline Program and adapting a series of prior live-interactive trainings developed for LACDMH to be produced as videos in both English and Spanish to facilitate broader dissemination of culturally and linguistically responsive content for the Latina/x community.

During the 4th quarter, BASIC-T continued to make progress in training neuropsychology fellows as part of its Pipeline Program. It also worked to adapt and transition previously developed live and interactive training content to a format that could be digitized to facilitate additional asynchronous learning opportunities. This included the production of a total of 32 videos: 24 (12 in English, 12 in Spanish) focused on the United Mental Health Promoter Curriculum, and 8 videos (4 in English, 4 in Spanish) focused on the theme of FBOs and CBO Mental Health Ministries. BASIC-T also continued to migrate a large cache of previously recorded interviews and informational PSAs on various mental health topics within Spanish language media that were produced as part of its FBO and CBO engagement strategy during the COVID-19 pandemic. The HNCE has developed a strong relationship with Spanish media and Catholic radio and TV to get information out on a weekly basis to communities, filling a void where Spanish language information on mental health had not existed before.

3. **Psychiatric Residency Program: Charles Drew University Agreement**
   The County Board of Supervisors formed the Los Angeles County Health Agency in 2015 to better integrate the Departments of Health Services, Mental Health and Public Health. The Health Agency contracted with Charles Drew University to develop a new psychiatric residency program and to manage, administer, and coordinate training of resident physicians at DHS and DMH facilities, as well as the University itself and private non-profit facilitates contracted by or in partnership with the County. The first class started in Academic Year 2018-2019 with trainees ranging from Post Graduate Year I to IV. The first class will graduate in June 2022.

4. **LACDMH + UCLA General Medical Education (GME) –** (UCLA Public Partnership for Wellbeing Agreement)
   Psychiatry Residency and Fellowships Professional Trainees – Public Psychiatry
   Professional trainees of the UCLA Graduate Medical Education program at the Jane and Terry Semel Institute for Neuroscience and Human Behavior consisted of adult residents and fellows specializing in child and adolescent, geriatric, and forensic psychiatry.

5. **LACDMH + Semel Institute National Clinician Scholars Program (NCSP) Professional Trainees – (UCLA PUBLIC PARTNERSHIP FOR WELLBEING AGREEMENT)**
   Public Psychiatry Professional trainees of the LACDMH + Semel Institute position for National Clinician Scholars Program consisted of 1 Adult Psychiatrist/Researcher who provided 114 patient visits. NCSP serves to advance and promote the work of

clinician leaders (physicians, nurses) who address health equity over the course of their career, through postdoctoral training as part of the National Clinician Scholars Program, with LACDMH as their sponsor. The National Clinician Scholars Program is a multi-site program for all physician specialties and nurses with a Ph.D. The program provides training in partnered research, quality improvement, health services and policy research and leadership. Scholars are selected within a competitive process with applicants from across the country. LACDMH funds one fellowship slot at a time (new fellows eligible every two years). Scholars Program activities include:

a. Participating in coursework, the equivalent of a master's program, or auditing as an option.
b. Conducting up to 20% clinical work with LACDMH and participate in leadership activities.
c. Conducting 1-4 projects, at least 1 of which is in partnership with LACDMH.
d. Participating in a policy elective in their second year when possible.
e. Attending annual NCSP meetings and other local and national meetings.
f. Access to research funds and a mentorship team

6. Navigator Skill Development Program Health Navigation Certification Training

This program trains individuals employed as community workers, medical case workers, substance abuse counselors, peer specialists, and their supervisors on the knowledge and skills needed to assist consumers navigate and advocate in both the public health and mental health systems. Training was limited during the COVID-19 pandemic and delivered to one cohort.

7. Interpreter Training Program

The Interpreter Training Program (ITP) offers trainings for bilingual staff currently performing or interested in performing interpreter services and monolingual English-speaking mental health providers. The use of linguistically and culturally competent interpreters is important to bridging the language and cultural gap in the delivery of services in public mental health. Interpreter Training – Provides training to bilingual staff performing interpreter services and is intended to enhance the service by addressing the complex roles of interpreter services, reviewing interpreting models, identifying standards of practice, and problem-solving challenges that present when interpreting.

8. Learning Net System

The Department has developed an online registration system called eventsHub that manages both registration and payment for trainings and conferences coordinated by the Department. eventsHub is fully operational with most if not all, clinical training administratively processed by the system inclusive of posting, registration, and other training logistics important for tracking purposes.

9. Intensive Mental Health Recovery Specialist Training Program

Intensive Mental Health Recovery Specialist Training Program prepares individuals, mental health consumers, and family members to work in the mental health field as psycho-social (recovery) rehabilitation specialists. This program is delivered in partnership with a mental health contractor. Successful completion of this program

ensures that participants are qualified to apply for case management-level career opportunities in the public mental health system.

10. Expanded Employment and Professional Advancement Opportunities for Peers, Parent Advocates, Child Advocates, and Caregivers in the Public Mental Health System

The Department continues to develop new, innovative training opportunities to prepare peers, parent advocates, child advocates, and caregivers for employment in the public mental health system. During FY 21-22 the Department delivered the following training. For the upcoming Fiscal Years, the Department will continue to develop new training offerings for these populations. Examples of peer focused trainings include:

A. Intentional Peer Support Core Training:
   This is an innovative practice that has been developed by and for people with shared mental health experiences that focuses on building and growing connected mutual relationships. In this interactive training, participants learn the principles of IPS, examine and challenge assumptions about how we have come to know what we know, and explore ways to create relationships in which power is negotiated, co-learning is possible, and support goes beyond traditional notions of "service." This innovative curriculum details the difference between peer support and other helping practices and has been widely used as foundational training for people working in both traditional and alternative mental health settings.
B. Online Wellness Recovery Action Plan (WRAP)
   This training is an introduction to WRAP® and how to use it to increase personal wellness and improve quality of life. The training is highly interactive and encourages participation and sharing from all present. It also lays a broad foundation for building and supporting a skilled peer workforce. Participants will learn to apply the Key Concepts of Recovery and use tools and skills to address encountered thoughts, feelings, and behaviors for improved states of wellness. The history, foundation, and structures of WRAP® will be discussed. Successful completion of this training fulfills the prerequisites for the WRAP® Facilitator Training.
C. Online Wellness Recovery Action Plan (WRAP) Facilitator Refresher Training
   The WRAP® Refresher Training is an interactive training to sharpen and expand the facilitation skills of trained facilitators to further engage groups they facilitate in the implementation of their Wellness Recovery Action Plan®. Participants in this training will be expected to interact in learning activities and demonstrate their own experience with WRAP®. This training is for the current WRAP facilitators who will lead WRAP® groups, work with others to develop their own WRAP®, and give presentations on mental health recovery-related issues to groups or organizations. Participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work.
D. Wellness Recovery Action Plan (WRAP) Facilitator Training
   This training equips participants to facilitate WRAP® classes in the community and within their organizations. The WRAP® Facilitator training provides an experiential learning environment based on mutuality and self-determination. Participants are expected to join in interactive learning activities and demonstrate their own experience with WRAP®. Upon completion of this training, participants will be able

to lead WRAP® groups, work with others to develop their own WRAP® and give presentations on mental health recovery-related issues to groups or organizations. Lastly, participants are expected to have a solid working knowledge of WRAP® and share their experiential knowledge of how WRAP® can work.

E. Parent Partners Training Program

This training program promotes knowledge and skills relevant to individuals interested in working as Parent Advocates/Parent Partners in the public mental health system servicing families and their children. It enhances resilience and wellness understandings, increasing the availability of a workforce oriented to self-help, personal wellness, and resilience grounded in parent advocate/parent partner empowerment. Lastly, the training program supports the employment of parents and caregivers of children and youth consumers.

11. Licensure Preparation Program (LPP)

To increase the pool of licensed mental health professionals, the Department offers subsidized study preparation material for Part 1 and Part 2 licensure examination for Social Workers, Marriage and Family Therapists, Licensed Professional Clinical Counselors and Psychologists.

12. FINANCIAL INCENTIVE PROGRAMS

A. Mental Health Psychiatrist Student Loan Repayment Incentive

LACDMH offers a financial incentive towards the outstanding balance of student loans for full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one-year of continuous service at LACDMH and have active, unpaid, graduate, or medical, student loans. Eligible psychiatrists who have not participated in or have received funds from the Psychiatrist Recruitment Incentive program, will receive a maximum annual amount of up to $50,000 for a period of five years which equates to a lifetime total of $250,000.

B. Mental Health Psychiatrist Recruitment Incentive Program

This program targets recruitment of potential Mental Health Psychiatrists for employment in the public mental health system. For eligible full-time Mental Health Psychiatrists and Supervising Mental Health Psychiatrists who have completed one year of continuous service in LACDMH and who have not participated in or received funds from the Student Loan Repayment Incentive program, a one-time award of $50,000 will be granted consisting of $25,000 upon completion of the first year of continuous service at LACDMH, and an additional payment of $25,000 upon completion of the second year of continuous service.

C. Mental Health Psychiatrist Relocation Expense Reimbursement

Available to full-time, newly hired Mental Health Psychiatrists or Supervising Mental Health Psychiatrists who have been recruited by LACDMH. The maximum reimbursement amount for eligible relocation expenses is $15,000. If the employee leaves LACDMH within one-year from employment start date, the full reimbursement amount must be repaid.

III. Workforce Augmentation through hiring efforts

In addition to the 12 workforce development programs mentioned above and consistent with the CLAS standards, LACDMH builds its culturally and linguistically

competent workforce by creating culture-specific job vacancies across a variety of positions. Examples include:

- Clinical Pharmacist
- Clinical Psychologist I and II – Spanish-speaking
- Community Health Worker
- Intermediate Typist Clerk
- Mental Health Clinical Supervisor
- Mental Health Clinician
- Mental Health Counselor, Registered Nurse
- Mental Health Promoter
- Nurse Practitioner - psychiatric mental health
- Occupational Therapist
- Pharmacy Supervisor
- Psychiatric Social Worker II- Spanish-speaking
- Relief Mental Health Psychiatrist
- Supervising Mental Health Psychiatrist

IV. Workforce enhancements involving mental health lived and shared experience

LACDMH recognizes and values the expertise and contributions of peers, family members, community members with lived and shared mental health experience, and natural leaders from the community. Examples of programs implemented to incorporate and increase the workforce capacity to serve the culturally and linguistically diverse communities of Los Angeles County include:

1. United Mental Health Promoters (UMHP) Program

LACDMH continued its efforts to strengthen and incorporate the voices of natural community leaders trained as mental health promoters to serve as bridges between LACDMH and underserved communities in Los Angeles County. During FY 21-22, LACDMH accomplished the recruitment and onboarding of 159 UMHP representing various cultural and linguistic backgrounds such as American Indian/Alaska Native, Cambodian, Chinese, Filipino, Korean, African American, Latino, Eastern European/Middle Eastern, and Latino and Filipino combined.

Program activities take place across the eight Service Areas and center around stigma reduction, community education, and enhancing mental health service accessibility. The UMHP Program merges a community leadership/peer-to-peer approach with support, guidance, and training from LACDMH licensed clinicians. In addition, Senior and Supervising Community Health Workers who once served as Promotores and/or peer advocates provide mentorship and share knowledge and lived experiences to support Mental Health Promoters further. Collectively, the United Mental Health promoters delivered 7,354 workshops on various mental health topics with an outreach to 64,097 community residents. Their activities also include 5,567 referrals to various mental health and social services.

The topics off the UMHP presentations include:

- Mental health and stigma
- Understanding the pression and growing resilience
- Understanding anxiety and building resilience
- Family violence awareness, prevention, and resilience
- Understanding the impact of addiction and mental Wellness
- Grief, loss and resilience
- Child abuse prevention and resilience
- Suicide awareness comma, prevention and resilience
- Childhood disorders: neurodevelopmental
- Childhood disorders: anxiety and depression
- Childhood disorders: behavioral issues
- Immigration, adaptation and resilience
- COVID-19 and its impact on the brain

2. Community Ambassador Network Program (CAN)

The Community Ambassadors Network (CAN) program was designed to hire, train, and certify community members as "lay" mental health workers in the neighborhoods where they reside. In this capacity, the Community Ambassadors function as local access agents, problem-solvers, and system navigators who connect community members with resources relevant to their needs. All the Ambassadors take an equity-centered, trauma-informed approach to care, known to be essential in improving the emotional, physical, and spiritual wellbeing of underserved communities. During FY 21-22, the CAN continued to reach out to underserved populations regarding the COVID-19 pandemic. CAN activities included dissemination of accurate information regarding testing, vaccinations, multiple variant updates, door-to-door provision of personal protective equipment (PPE) as well as distribution at outreach events, and food delivery to infected families, among others. The CAN Program prioritizes support of communities who self-identify as Black, Asian, Indigenous, and individuals of Color, all of which have been disproportionately impacted by systemic racism and inequality. The Ambassadors help nurture healthy and racially equitable communities by empowering them, raising awareness, and mobilizing change while promoting employment opportunities in the most disenfranchised communities.

The CAN program has wide cultural and linguistic representation of Los Angeles County communities. Among them, African American, American Indian/Alaska Native, Asian Pacific Islander, Eastern European/Middle Eastern, Latino and Latinx, White, and Multiracial communities. The languages spoken by the Ambassadors include ASL, Cambodian, English, Hebrew, Italian, Lao, Thai, and Vietnamese.

CAN services and activities are primarily provided in the community and focus on outreach to underserved in marginalized priority populations. During FY 21-22

the CAN particularly focused on outreaching to persons impacted negatively by the COVID-19 pandemic. Specific activities were held at the height of the pandemic in the community to disseminate accurate information regarding the COVID-19 virus. Additionally, the ambassadors engaged in disseminating information door-to-door utilizing PowerPoint presentations. Accomplishments include 2,319 outreach contacts, 1,492 Community Event and 1,576 Trainings in the community.

V. Additional workforce enhancements and specialties

Furthermore, concerted and consistent efforts to amplify and incorporate the voice of employees in the system of care are evident in the establishment of the LGBTQIA2-S consultation team, now known as the LGBTQIA2-S Champion Network.

1. LACDMH ARDI Staff Advisory Council (SAC)

As an advisory body to the Department, the ARDI SAC reports directly to the LACDMH director. The mission of the ARDI SAC is "to build an intra-departmental community of employees who are connected through a shared commitment to advancing racial equity and shaping the Department as an organization grounded in principles of anti-racism, diversity, and inclusion." LACDMH hired two specialized consultants to guide and support the work of the council.

The ARDI SAC was established in 2021 and was tasked with overseeing the implementation of an anti-racism action plan with all ALC (Action Learning Committee) goals identified, and a second goal was for the establishment of an ARDI Division within LACDMH tasked with, among other responsibilities, implementation of said goals. Following the murder of George Floyd in 2020 and the subsequent collective outcry for racial justice, particularly within our public institutions that impact the daily lives of so many Los Angeles County residents, a cohort of over 100 LACDMH staff members collaboratively generated an Action Plan to Achieve Racial Equity. The Action Plan to Achieve Racial Equity is fueled by a foundational belief that achieving racial equity within LACDMH requires a concentrated effort to dismantle anti-Black racism, along with other forms of intersectional oppression, through education and leadership transformation. Engaging LACDMH leadership in learning about the foundations and perpetuation of anti-Black racism and other forms of oppression, in addition to the ways that the Department can shift from hierarchical and punitive managerial procedures toward transformational leadership practices, will lead to greater wellbeing and empowerment for all LACDMH employees.

The ARDI SAC's activities are based on the Action Plan to Achieve Racial Equity in LACDMH 2022-2024, which was approved in April 2022 by the executive staff. Highlights of the Action Plan Goals and Actions include:

1. Increase staff awareness and acknowledgement of anti-Black racism through education to promote intra-personal growth.
   a. Develop and deliver high-quality, accessible trainings addressing anti-Black racism.
2. Enhance staff well-being and empowerment.
   a. Establish an Anti-Racism, Diversity, and Inclusion Staff Advisory Council.
   b. Create a safe work environment to discuss racial issues and concerns.
   c. Strengthen the department's Human Resources system.
3. Increase hiring, supervision, and professional advancement.
   a. Recruit Black clinicians and staff in LACDMH and support their advancement.
   b. Support the equitable advancement of People of Color staff.
4. Expand the service delivery system's capacity to provide anti-racist, culturally congruent and responsive services.
   a. Establish a Black, Indigenous and People of Color (BIPOC) Treatment Task Force.
   b. Develop outreach and education campaigns and expand the health promoters program targeting Black consumers and communities.
   c. Expand outreach and education campaigns and culturally congruent and responsive practitioners and practices.
5. Leverage partnerships and collaborations across Los Angeles County, City Departments, and Community Stakeholders.
   a. Improve the County Policy on Equity (CPOE) system.
   b. Strengthen multi-stakeholder community collaboration.
   c. Improve the crisis response system.
   d. Improve collaborative practices with the Department of Children and Family Services.

e. Increase the number of facilities to co-locate physical health and mental health services.
   a. Use digital technology to expand access to mental health services.
   b. Partner with school districts to improve student mental health outcomes.

6. Build strong commitment, accountability, and responsiveness of Executive Management and everyone in leadership roles.
   a. Executive Management commitment to anti-racism.

ARDI SAC Membership demographics

- Membership was expanded in early CY 2022 to 13 members with the intention to expand membership to address a significant lack of a few cultural experiences and identities. While it is important for each Council member to assert and express their own identities, the current Council is comprised of members who are Black, Latino and Latinx, Asian and Pacific Islander, American Indian and Alaska Native, and White; diverse genders and sexualities; from diverse faith backgrounds; peers and family members of mental health clients; Community Health Workers, clerical and administrative, licensed and license-eligible clinicians and supervisors, program managers and medical practitioners. The

Council is aware that LACDMH is ever evolving and continue to seek to identify, reflect and represent all the needs and identities within the workforce.

LACDMH programs represented by the ARDI SAC membership:

- Headquarters (countywide)
- ARDI Division
- Service Area 1 (SA1) Administration
- West Valley Mental Health Center, (SA2)
- East San Gabriel Valley Mental Health Center (SA3)
- Hollywood Mental Health Center (SA4)
- Peer Resource Center (SA4)
- Edelman Child and Family Mental Health Center (SA5)
- Augustus Hawkins Mental Health Center (SA6)
- The American Indian Counseling Center (SA7, Countywide services)
- Child Welfare Division (countywide)
- Countywide Psychiatric Mobile Response Team Program (countywide)

Accomplishments:

- Membership expansion to 13 members
- Development of a Leadership training and Statement of work with the intention to create a concentrated effort to dismantle anti-Black racism, white supremacy along with other forms of intersectional oppression through education and leadership accountability with the intention to transform the entire Department.
- Monthly meetings with Executive Management to continue working on building strong commitment, accountability, and responsiveness of Executive management and everyone in leadership roles
- Presentations at LACDMH Townhalls regarding the ARDI SAC activities and accomplishments
- Completion of Biweekly ARDI Staff Advisory Council Meetings and Quarterly meetings with the IGD/ALC members to continue expanding and discussing staff and community concerns
- Implementation of a training workgroup that developed the statement of work for the “Transformational Leadership Training” for LACDMH’s expanded management
- Continued the Council’s development to implement goals as defined in the action plan
- Development and publication of Department-wide statements in response to from traumatic community incidents for the LACDMH workforce. The goal of these statements is to demonstrate departmental support for all employees and uplift the various events that impact people of color throughout our nation and at a global level
- Co-authored articles in the departmental monthly newsletter “Hello DMH”
- Established collaborations with Labor Unions such as SEIU, AFSCME, and UAPD regarding upcoming Leadership training
- Development of partnerships in the community such as the Department of Economic Opportunity to explore future partnerships

2. LACDMH LGBTQIA2-S Clinical Consultation Team/ LGBTQIA2-S Champion Network

The primary aim of the LGBTQIA2-S Clinical Consultation Team is to enhance LACDMH's provision of culturally and linguistically responsive services for individuals with minoritized sexual and gender identities. Through sexuality and gender-affirming clinical consultation, the group's membership engages in collective capacity-building to ensure that participants are equipped with the necessary knowledge, skills, and frameworks to effectively respond to the needs and strengths of LGBTQIA2-S community members in LA County.

Research has consistently shown that affirming services, relationships, and environments are crucial in reducing mental health disparities and treatment outcomes for LGBTQIA2-S communities. The LGBTQIA2-S Clinical Consultation Team frequently discusses effective strategies to increase access to and engagement with mental health services through cultivating a safe, welcoming, and affirming environment for all LGBTQIA2-S community members and their loved ones.

The LGBTQIA2-S Clinical Consultation Team holds monthly meetings that are available to LACDMH and community mental health providers. The overall vision of the LGBTQIA2-S Clinical Consultation Team is to engage mental health providers in collective capacity-building related to affirming service delivery for LGBTQIA2-S community members. While there is a standing membership of approximately 30 providers across LA County who attend regularly, these meetings are open to anyone who could benefit from didactic education and/or clinical consultation. Members are invited to bring questions or concerns that are related to a specific case or client, clinical procedure (e.g., referral letters for gender-affirming treatment), and/or programmatic initiatives promoting a welcoming environment (e.g., expanding restroom access, updating intake forms). All individuals in attendance are encouraged to participate in the discussion to learn from and alongside each other.

Every LGBTQIA2-S Clinical Consultation Team meeting begins with a review of Shared Agreements and Community Guidelines; these include principles around respectful communication, sharing the space to allow everyone an equal opportunity to participate, and intersectional and trauma-informed frameworks. Many of the didactic elements of the Clinical Consultation Team meetings are centered on promoting equity for LGBTQIA2-S consumers and County employees, including gender-affirming clinical practice, intersectionality, and uplifting cultural events and observances throughout the year that celebrate communities within the LGBTQIA2-S umbrella. Meetings have also included guest presenters from within and outside of County departments to promote shared learning and expertise.

Many of the topics discussed in monthly LGBTQIA2-S Clinical Consultation Team meetings are participant-driven; that said, many of the topics or concerns illustrate well-founded disparities and inequities within our mental health system. This includes the disproportionate overrepresentation of BIPOC LGBTQIA2-S youth that are engaged in

our child welfare system; discussions have centered on working with specific clients and/or specific agencies to promote gender-affirming practice through an intersectional and trauma-informed lens. We also invited a guest speaker to present on gender-affirming practice with neurodivergent clients, with the awareness that neurodivergent consumers are more likely to have diverse or minoritized gender identities *and* that neurodivergent and gender-diverse consumers are currently inadequately served by our system of care.

The cultural and linguistic diversity of the consultation team can be easily appreciated across multiple elements of culture, including race and ethnicity, linguistic capability, gender identity, gender pronouns, and sexual orientation, among others.

Race and Ethnicity

- African American
- American Indian/Alaska Native
- Latino and Latinx
- White
- Multiracial

Language capabilities

- English
- French
- Spanish

Gender Identity

Out of 30 members who shared their SOGI information, the gender identity breakdown included:

- Cisgender (10)
- Man/masculine/masc (4)
- Non-binary (1)
- Woman/feminine/femme (8)

Gender pronouns

- He/him/his (7)
- She/Her/hers (12)

Sexual Orientation

The consultation team's diversity in terms of self-reported sexual orientations included:

- Heterosexual (9)
- Gay (6)
- Bisexual (3)
- Queer (2)

Accomplishments:

- Successful engagement of 30 LACDMH employees in the newly established LGBTQIA2-S Champion Network
- Engagement of members in 11 monthly meetings during CY 2022 with participation from LACDMH directly operated and administrative programs, contracted providers, and community-based agencies
- Delivery of 10 didactic presentations on affirming practice, underrepresented communities, and mental health disparities
- Multidirectional clinical and programmatic consultation provided based on the concerns and needs identified by ARDI SAC members.

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CR 6 APPENDIX

Attachment 1

CC Training Report
FY 21-22 05-10-23.xls

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM, DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

CRITERION 7

Language Capacity

August 2023

Criterion 7: Language Capacity

The Los Angeles County Department of Mental Health (LACDMH) strives to meet the linguistic needs of its diverse communities by recruiting and employing a multicultural and multilingual workforce, providing training opportunities for bilingual certified staff to become language interpreters, and contract with Legal Entities for the provision of culturally and linguistically competent programs. The County of Los Angeles has thirteen threshold languages, which include:

- Arabic
- Armenian
- Cambodian
- Cantonese
- English
- Farsi
- Korean
- Mandarin
- Russian
- Spanish
- Tagalog
- Vietnamese

Due to the size and diversity of Los Angeles County, LACDMH has determined threshold language profiles for each of our eight Service Areas (SAs), as detailed in Table 1 (below):

TABLE 1: SERVICE AREA BASED THRESHOLD LANGUAGES
CY 2021

Service Area	Threshold Languages
1	English and Spanish
2	Armenian, English, Farsi, Korean, Russian, Spanish, Tagalog, and Vietnamese
3	English, Mandarin, Spanish, Other Chinese, and Vietnamese
4	English, Korean, Russian, and Spanish
5	English, Farsi, and Spanish
6	English and Spanish
7	English and Spanish
8	Cambodian, English, Korean, Spanish, and Vietnamese

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

I. Efforts to increase LACDMH bilingual workforce capacity

According to information provided by the LACDMH Human Resources Bureau (HRB), approximately 1,727 employees from Directly Operated providers receive a bonus for speaking, reading, and writing in another language based on departmental certification. Out of the 1,727 bilingual certified staff, 1,727 receive it for speaking, 1,287 for reading, and 1,274 for writing proficiency.

The Department pays bilingual bonuses for employees hired by Directly Operated (DO) Programs in the following 39 languages. The listing is inclusive of threshold and non-threshold languages:

- American Sign Language
- Arabic
- Armenian
- Bulgarian
- Cambodian
- Cantonese
- Catalan
- Chinese
- Farsi
- Flemish
- French
- German
- Greek
- Hakka
- Hebrew
- Ilocano
- Italian
- Japanese
- Korean
- Laotian
- Mandarin
- Nahuatl
- Polish
- Portuguese
- Russian
- Samoan
- Spanish
- Swedish
- Tagalog
- Thai
- Toi Shan
- Turkish
- Urdu
- Vietnamese
- Visayan
- Yiddish

In addition to linguistic proficiency, bilingual certified employees must also possess knowledge of and sensitivity to the cultural background and needs of consumers served in languages other than English. The departmental practice of hiring employees with various bilingual capabilities and providing bilingual bonus compensation demonstrates the implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards Nos. 3, 5, 7, and 8.

Per LACDMH Policy No. 602.01, Bilingual Bonus, LACDMH bilingual certified employees possess a valid Language Proficiency Certificate issued through the County's Bilingual Proficiency Examination, which tests for proficiency to speak, read, and/or write the language. Bilingual compensation is paid to certified bilingual employees whose assignments require dual fluency in English and at least one other language, as well as knowledge of, and sensitivity toward, the culture and needs of the linguistic communities served by the Department. American Sign Language (ASL) is included within the category of other languages for purposes of this bonus. All LACDMH bilingual certified employees are placed on the eligible lists and are contacted when their skills in a language other than English are needed for translation of materials and/or language interpretation services by diverse LACDMH Programs/Units.
(See Criterion 7 Appendix, Attachment 1: LACDMH Policy on Bilingual Bonus).

The LACDMH Human Resources Bureau (HRB) is responsible for maintaining a current list of employees receiving a bilingual bonus. The list is categorized by employee name, payroll title, pay location, language, and language proficiency level (e.g., speaking, reading, and writing). They can be requested by LACDMH managers directly from the HRB.

Culturally Competence Trainings

The Department allocates funds for staff trainings and conferences each Fiscal Year (FY). A major portion of these expenditures is allocated for the provision of cultural competence trainings. Below is a brief list of sample expenditures for FY 21-22:

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

Examples of trainings offered to increase the linguistic competence of staff:

Introduction to Interpreting in Mental Health Settings

This three-day language interpreter training series is designed for bilingual staff who are proficient in English and in a second language. This introductory level training creates a structure for participants to understand the complex roles of the mental health interpreter. The purpose is to assist the Mental Health and Wellness programs by training the bilingual workforce to accurately interpret and meet the requirements of Federal and State law. This course provides the participants with the knowledge and skills pertaining to the role of interpreters, models of interpreting, mental health terminology, standards of practice, cultural interpreting, and skills to face challenges arising in the mental health field. This training also includes an introduction to glossary development and maintenance of specialized mental health glossaries based on the interpreters' level of proficiency in both languages.

These trainings are intended to increase cross-cultural knowledge and skills in serving communities that speak the threshold language targeted by the training. Training content aims to increase clinicians' and bilingual staff's vocabulary and use of terms related to the provision of mental health services such as assessment, diagnosis, treatment, and crisis intervention. Additionally, the training addresses challenges that may arise when performing services in the targeted threshold language (e.g., using incorrect or misleading terminology, misunderstanding of translated information, misdiagnosis, inappropriate diagnosis, and other unintended consequences). Participants also become familiarized with the challenges that may interfere with establishing rapport and treatment adherence.

Culturally and Linguistically Competent Programs

LACDMH also builds the linguistic capacity of the system of care by dedicating funding for culture-specific programs that increase service accessibility for underrepresented populations. For example, LACDMH allocates Community Services and Supports (CSS)

Planning Outreach and Engagement (POE) funding for the seven UsCC subcommittees' capacity building projects. Each UsCC subcommittee receives $200,000 per FY to implement culturally and linguistically competent projects, totaling $1,400,000. The membership from each subcommittee generates conceptual ideas for capacity building projects, which are turned into proposals by the UsCC Unit and presented for approval. The UsCC projects are voted on via a participatory and consensus-based approach within each subcommittee. Please refer to Criterion (CR) 1 and CR 3 for additional details.

Another example of a culturally and linguistically competent program at LACDMH is the Promotores de Salud Mental and United Mental Health Promoters (UMHP) Program, which operates in all eight Service Areas. During FY 21-22, LACDMH had a total of 159 Promotores de Salud Mental, of which 108 served the Latino communities in Spanish. The UMHP Program continued the hiring process and recruited over 50 multicultural Promoters who actively served LA County communities in Amharic, Arabic, Chinese, English, Cambodian, and Korean.

Language Assistance Services

LACDMH is committed to funding various types of language assistance services to enable consumers, family members, and the community at large to have meaningful participation in departmental stakeholder meetings and events in their preferred language. During FY 21-22, language assistance services included the following:

- $147,385 for language interpreter services, which allow consumers, family members and the community at large to participate in various departmental meetings and conferences
- $43,565 for language translation services provided for consumer, family members and community at large participation in stakeholder meetings
- $107,597 for Closed Captioning in Real Time (CART) services
- $139,646 for ASL services
- $210,504.16 for countywide translation services

II. Services to persons who have Limited English Proficiency (LEP)

Table 2 below summarizes language assistance services coordinated by the Cultural Competency Unit (CCU) inclusive of the following:

- American Sign Language (ASL)
- Cambodian
- Korean
- Spanish
- Closed Captioning/CART Services

During FY 21-22, the ARDI Division-CCU facilitated and processed language assistance services for 23 different stakeholder meetings. Often, these meetings were held monthly and required more than one type of language or communication accommodation.

TABLE 2: LANGUAGE ASSISTANCE FOR STAKEHOLDER AND COMMUNITY MEETINGS AND EVENTS, FY 21-22

MEETING AND EVENT	TYPE OF LANGUAGE ASSISTANCE PROVIDED	FREQUENCY
1. Cultural Competency Committee (CCC)	Spanish and Closed Captioning/CART	Monthly
2. Faith-Based Advocacy Council Executive Board	Korean	Monthly
3. Faith-Based Advocacy Council	Spanish	Monthly
4. Mental Health Commission Executive Committee	Spanish	Monthly
5. Mental Health Commission	Spanish	Monthly
6. Service Area Leadership Team (SALT) Co-Chair Meeting	Korean/Spanish	Monthly
7. SALT 1	Spanish	Monthly
8. SALT 2	Spanish	Monthly
9. SALT 3	Spanish	Monthly
10. SALT 4	Spanish and Korean	Monthly
11. SALT 5	Spanish	Monthly
12. SALT 6	Spanish	Monthly
13. SALT 7	Spanish	Monthly
14. SALT 8	Spanish	Monthly
15. Access for All UsCC	ASL	Monthly
16. Asian Pacific Islander UsCC	Cambodian and Korean	Monthly
17. Latino UsCC	Spanish	Monthly
18. UsCC and CCC Leadership Group	ASL/CART	Monthly
19. Peer Advisory Council	Spanish/ASL/CART	Monthly
20. SA-7 Staying Connected and Informed Town Hall Series	Spanish	Monthly
21. External Quality Review Organization (EQRO) - Focus Groups	Spanish	Annually
22. DMH Town Hall Special Events	Spanish, Closed Captioning/CART and ASL	Varies
23. Interdisciplinary Collaboration and Cultural Transformation Model	Korean	Monthly

Source: ARDI Division – Language Assistance Services Team

During FY 21-22, the ARDI Division's Language Assistance Services team coordinated the language assistance services for 23 different stakeholder groups. Most of these efforts required monthly coordination with language interpreter vendors and multiple departmental units. Additionally, several stakeholder meetings involved multiple

languages and/or a combination of more than one type of accommodation based on requests received from the community.

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

The LACDMH Help Line

Also known as the Call Center, this 24/7 resource has been expanded and renamed as the Help Line. The expansion of the Help Line includes the ACCESS Center, Emotional Support Services for LA County employees, and Veteran or Military Family Member Support. It serves as the primary entry point for callers seeking information regarding mental health services and supports. When callers request information related to mental health services and other social needs, the Help Line provides referrals to culture-specific providers and services that are appropriate and conveniently located.

The Help Line strives to meet the cultural and linguistic needs of callers by providing language assistance services in threshold and non-threshold languages at the time of first contact. Additionally, it provides equitable language assistance services to deaf and hard of hearing consumers and providers requesting ASL interpreter services for clinical appointments with psychotherapists and psychiatrists. The Help Line tracks the number of calls received in non-English languages. LACDMH's Help Line provides emergency and non-emergency services.

The Call Center provides end-to-end assistance in an efficient and user-centered manner and provides:

- Information & Referral
- Centralized Appointment Scheduling Pilot for Hospital Discharges in SA 3
- Warmline/Emotional Support
- Hotline/Crisis Response

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TABLE 3: CALLS RECEIVED BY THE LACDMH HELP LINE - ACCESS CENTER BY LANGUAGE, FY 21-22

LANGUAGE	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	TOTAL
AMERICAN SIGN LANGUAGE (ASL)*	1	1	2	1	4	3	1	3	1	1			**18**
ARABIC		2	5		2			2		2	1	1	**15**
ARMENIAN	2	7	5	4	2	1	1	6	1		4		**33**
BENGALI					1							2	**3**
BURMESE													**-**
CAMBODIAN (Khmer)			2	1							1		**4**
CANTONESE	4	2	2	4	6	1	5		6	7	2	3	**42**
DARI						1							**1**
FARSI	3	8	6	4	5	6	3	4	3	5	1	7	**55**
FRENCH		1			1	2							**4**
JAPANESE	1			2	2				1	1			**7**
KHMER	2							2			1	1	**6**
KOREAN	11	7	13	10	19	2	5	1	8	12	8	9	**105**
MANDARIN	9	14	7	15	6	8	10	12	12	11	9	7	**120**
PORTUGUESE					1								**1**
PUMJABI											1		**1**
RUSSIAN	3	1	4		2	8		2	3	9	3	4	**39**
SPANISH (LISMA)	143	126	191	149	169	120	159	170	197	216	227	238	**2,105**
SPANISH ACCESS Center (internal)	702	600	541	522	549	475	547	512	589	525	531	597	**6,690**
TAGALOG	1				2		1	1					**5**
THAI			13					1	2				**16**
URDU						1							**1**
VIETNAMESE		3	3	2	4		9	1	3	7	3	5	**40**
TOTAL	881	771	792	713	771	625	740	714	825	795	792	874	**9,311**

Data source: Help Line - ACCESS Center
* Data includes ASL calls received by the ACCESS Center after business hours.

Table 3 summarizes the total number of non-English language calls received by the ACCESS Center during FY 21-22. A total 21 language communities have remained active in accessing the ACCESS Center services. Most of the requests for non-English language calls, other than Spanish, were for Mandarin (N=120), followed by Korean (N=105), Farsi (N=55), Cantonese (N=42), Vietnamese (N=40), Russian (N=39), and Armenian (N=33).

With the implementation of the ARDI Division in the fall of 2021, this function was re-organized under two teams: the Help Line's ACCESS Center and the ARDI Division-CCU. Based on this re-organization, the ARDI Division-CCU fulfilled this function Monday through Friday, from 8:00 am to 5:00 pm. The Help Line's responsibility for booking ASL clinical appointments took place after hours, starting weekdays at 5:01 PM to 7:59 AM, on weekends and on holidays.

TABLE 4: SUMMARY OF APPOINTMENTS FOR ASL SERVICES
FY 17-18 to FY 21-22

Fiscal Year (FY)	Number of Assigned Appointments
FY 17-18	1,140
FY 18-19	983
FY 19-20	1,027
FY 20-21	629
FY 21-22	622
TOTAL	6,072

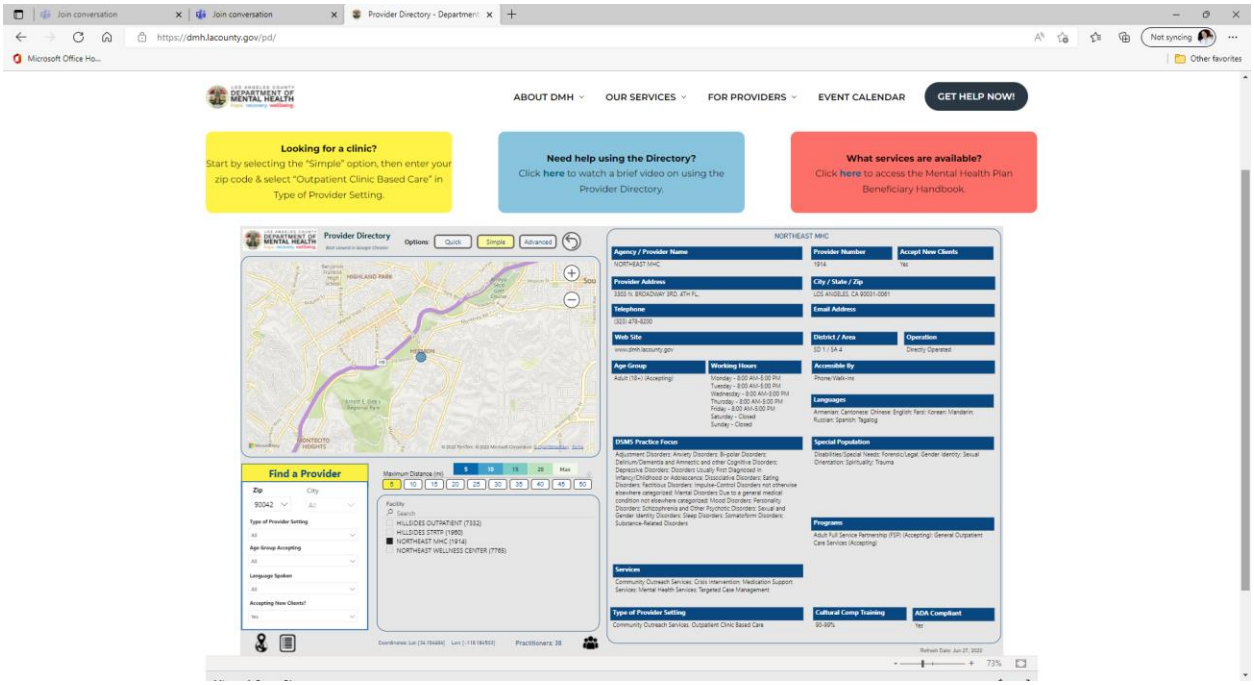
Data Source: DMH Help Line and ARDI Division – Language Assistance Services team.
Note: Data includes only interpreter services requests assigned to ASL interpreters available to provide service on a given date.

Table 4 presents the number of assigned ASL interpreter services appointments for the five prior FYs. For FY 21-22, ASL appointments were coordinated by the Help Line from July 2021 to March 2022. As of April 2022, the ARDI Division-CCU became responsible for coordinating ASL appointments during business hours. The Help Line remains the contact point for after hours, weekends, and holidays. A total of 622 ASL requests were processed during FY 21-22. The number of ASL appointments may vary based on the demand for ASL services requested by the deaf and hard of hearing community. One possible scenario is presented by consumers entering the system with more acute symptoms that require a greater frequency of treatment sessions. The decrease on number of requests may be due to the impact of COVID-19 pandemic.

Service Area Provider Directory

The Provider Directory is a primary tool developed by LACDMH to search for service providers in geographic locations that would be most convenient and accessible to consumers. Users can access information about geographically accessible LACDMH providers by typing in their zip code. They can also refine their search specifying the

maximum traveling distance. Once these stipulations are filled out, the system will generate a listing of all providers in closest proximity. Once users select their provider of choice, the Provider Directory will present practical information such as the provider's location, hours of operation, type of setting, Specialty Mental Health Services provided inclusive of specialized programs, languages in which services are offered, age groups served, special populations, ADA compliance, availability for new cases, and percentage of staff who have completed annual cultural competence training. The screenshot below is an example of a search result by a user. The Provider Directory can be accessed by the public via Internet at https://dmh.lacounty.gov/pd. LACDMH staff can also access this tool using the Provider Locator feature in the Intranet at https://lacounty.sharepoint.com/sites/DMH/SitePages/DMH%20Provider%20Directory.aspx



Language Interpreter Services

Language interpreter services are offered and provided to LEP consumers free of charge. LACDMH Policy No. 200.03, Language Translation and Interpreter Services, specifies the procedures to be followed by DO programs when language interpreter and translation services are needed ***(See Criterion 7 Appendix, Attachment 2: LACDMH Policy on Language Translation and Interpreter Services)***. The procedure for procurement of language interpreter services for meetings and conferences is also outlined in this policy. The language assistance services addressed in this policy include face-to-face, telephonic, and interpreter services for the deaf and hard of hearing as well as translation services. LACDMH Policy No. 200.02, Interpreter Services for the Deaf and Hard of Hearing Community, includes procedures to request emergency and non-emergency sign language interpreter appointments.

(See Criterion 7 Appendix, Attachment 3: LACDMH Policy No. 200.02, Interpreter Services for the Deaf and Hard of Hearing Community.)

LACDMH Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services addresses content pertinent to cultural and linguistic considerations in service delivery. Below is sample of this content:

1. General documentation rules
   Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMH Policy 401.03):
   - Visual and hearing disabilities
   - Clients whose primary language is not English
     - Clients should not be expected to provide interpretive services through friends or family members.
     - Oral interpretation and sign language services must be available free of charge (State Contract) NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention.
     - NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.
   - Cultural and/or linguistic considerations
     - When special cultural and/or linguistic needs are present, there must be documentation in the clinical record indicating the plan to address the cultural and/or linguistic needs.
     - If an exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled. NOTE: Culture is "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics."
   - Culture defines:
     - How health care information is received
     - How rights and protections are exercised
     - What is considered to be a health problem
     - How symptoms and concerns about the problem are expressed
     - Who should provide treatment for the problem
     - What type of treatment should be given

(Source: U.S. Department of Health and Human Services, Office of Minority Health (2013); The National Culturally and Linguistically Appropriate Services (CLAS) Standards.)

Cultural considerations may include but are not limited to racial/ethnic/national origin, religious/spiritual background or affiliation, gender, sexual orientation, other cultural considerations expressed by the consumer.

2. Assessments

Based on LACDMH Policy 401.03, Assessments are important in beginning to understand and appreciate who the client is and the relationship between the client's symptoms/behaviors and the client as a whole person. The Assessment enables the reader to see the role of language, culture and ethnicity in the client's life and documents the impact of significant supports, living situation, substance use, etc. on the mental health of the client. The Assessment identifies the client and their family's strengths as well as the stages of change/recovery for the client. The formulation generated in an Assessment allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery.

Change of Provider (COP) Form

According to LADCMH P&P 200.05, LACDMH recognizes that beneficiaries have the right to request a change in program of service and/or practitioner to achieve maximum benefit from mental health services. Consumers may request either a program of service and/or practitioner change by completing and submitting the Request for Change of Provider form. Consumers seeking a change of provider are under no obligation to specify the reasons and every effort is made by Program Managers to accommodate such requests. In order to improve the quality of programs and understand the nature of the request, Program Managers attempt to obtain information regarding the request from consumers. This process allows for the program of service to clarify any misunderstandings or resolve concerns at a level that is satisfactory to consumers. LACDMH's Quality, Outcomes and Training Division - Quality Improvement Team reviews data from Patients' Rights Office (PRO) regarding voluntary change of provider requests on a quarterly and annual basis to determine if there are any trends present.

The Change of Provider Form includes the following culture-related reasons for consumers to request a different program of service and/or practitioner:

- Age group gaps
- Gender
- Language concerns
- Does not understand me
- Insensitive/unsympathetic
- Treatment concerns
- Medication concerns
- Uncomfortable
- Not a good connection
- Change of schedule
- Attendance issues

- Lack of professionalism
- Preference for a previous provider
- Family members receiving services from the same provider
- I would like to have a second opinion
- Unforeseen reason
- Other- this option allows for the consumer to describe the reason(s) for seeking a change

IV. Required translated documents

In accordance with Federal and State guidelines, LACDMH supports the translation of clinical forms and informational materials into the threshold languages. LACDMH Policy and Procedure 200.03: Language Translation and Interpreter Service outlines standards regarding language translation and interpreter services to ensure that under no circumstances is a beneficiary denied access to mental health services due to language barriers. This policy emphasizes that non-English speaking or LEP consumers have the right to receive language assistance services in their primary or preferred language at no cost to them. It delineates the step-by-step procedures to be followed by service providers. The policy also provides definitions regarding the difference between language interpreter and language translation services and identifies the Los Angeles County threshold languages.

Furthermore, LACDMH Policy No. 602.01, Bilingual Bonus, specifies that bilingual certified employees will be contacted when the Department needs language translation and interpretation services. It also directs programs needing language translation and interpretation services to complete a Request for Interpretation/Translation Services (RITS) form, which should be sent to a supervisor at the level of Program Manager or above. The RITS form must be signed by the Program Manager and submitted to the Ethnic Services Manager for the tracking of forms, brochures, and other materials translated at the program level.

(See Criterion 7 Appendix for Policies cited in this section and Attachment 4: Request for Interpreter and Translation Services Form.)

The ARDI-CCU provides technical support to DO and Legal Entities/Contracted providers who seek information on the procedures to be followed for language translation completion and quality review for accuracy and cultural meaning. LACDMH's mechanism for ensuring accuracy of translated materials is field testing. Field testing takes place via document reviews by bilingual certified staff, consumers, family members, or consumer caretakers who volunteer to read and comment on the linguistic and cultural meaningfulness of the translated documents. Edits gathered from the reviewers are then provided to the contracted vendor for the finalization of the translated documents.

The Speakers Bureau (SB) has further expanded the Department's capacity to create culture-specific informational materials in the threshold languages for the diverse communities of LA County. These resources have been incorporated into the LACDMH webpage providing information on mental health resources in response to the COVID-19

pandemic. SB members have also been called upon to assist with the field testing of various public-facing materials such as program flyers, brochures, and consumer satisfaction surveys, among many others. SB members contribute their cultural and linguistic expertise to ensure cultural and language nuances, communication appropriateness, and clinical accuracy of reviewed materials. The ARDI-CCU is actively involved in the leadership and activities of the Speakers Bureau.

TABLE 5: SAMPLE LACDMH FORMS, BROCHURES, AND WEBPAGE RESOURCES TRANSLATED INTO VARIOUS LANGUAGES

Forms, Brochures and Webpage Resources	THRESHOLD & NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian/Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
ACCESS Brochure	X	X	X	X	X			X	X	X	X	X		X	X
ACCESS Center Flyer "We are Here to Help"	X	X	X	X	X			X	X	X		X		X	X
Acknowledgement of Receipt				X						X					
Advance Health Care Directive Acknowledgement			X	X				X	X	X		X			
Alleviating Fear and Anxiety During Essential Trips in Public		X		X				X		X				X	
Authorization for Use or Use/Disclosure of Protected Health Information (PHI)	X	X	X	X	X			X	X	X	X	X		X	X
Beneficiary Problems Resolution Process	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Brief Universal Prevention Program Survey v2: Age 6-11		X		X				X		X					
Brief Universal Prevention Program Survey v2: Age 12+		X		X				X		X					
Brief Universal Prevention Program Survey v2: Parents		X		X				X		X					
Caregiver's Authorization Affidavit			X	X				X	X	X		X			
Child and Family Team Meetings Brochure				X						X					
Consent for Services	X	X	X	X	X			X	X	X	X	X		X	
Consent for Tele-Psychiatric Services			X	X				X	X	X		X			
Consent to Photograph/Audio Record			X	X				X	X	X		X			
Coping with Stress During Infectious Disease Outbreaks	X	X	X	X	X		X	X	X	X	X	X		X	X
Coping with the Loss of a Loved One	X	X	X	X	X		X	X	X	X	X	X		X	X

Forms, Brochures and Webpage Resources	THRESHOLD & NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian/Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
Consumer Perception Survey (CPS) Announcement Flyers	X	X	X	X	X			X	X	X	X	X		X	X
Full Service Partnership (FSP) brochures				X						X					
Adult FSP Client Satisfaction Survey	X	X	X	X	X			X	X	X	X	X		X	X
GENESIS brochure										X					
Grievance and Appeal Forms	X	X	X	X	X			X	X	X	X	X			X
Hope, Wellness and Recovery	X	X	X	X	X			X	X	X		X		X	X
Innovation (INN) 4 Transcranial Magnetic Stimulation (TMS) Client Satisfaction Survey	X	X	X	X	X			X	X	X	X	X		X	X
LACDMH Advance Health Care Directive Acknowledgement Form			X	X				X	X	X		X			
LACDMH Notice of Privacy Practices				X						X					
LACDMH Signage for New HQ Building				X						X					
LACDMH Strategic Plan				X						X					
Maintaining Health and Stability During COVID-19		X		X				X		X				X	
Mental Health Plan Beneficiary Handbooks	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Mental Health Promoters/Promotores de Salud Mental Brochure				X						X					
Multidisciplinary Assessment Teams Brochure				X						X					
My Wellness Toolbox				X						X					
Notice of Action A (Assessment)	X	X	X	X	X				X	X	X	X		X	X
Notice of Action E (Lack of Timely Service)	X	X	X	X	X				X	X	X	X		X	X
Older Adult FSP Annual Client Satisfaction				X	X					X	X			X	
Outpatient Medication Review	X	X	X	X	X			X	X	X	X	X		X	X
Portland Identification and Early Referral (PIER) Early Psychosis Program Brochure	X	X	X	X	X			X	X	X	X	X		X	X
PIER Early Psychosis Program Flyer	X	X	X	X	X			X	X	X	X	X		X	X
Promotores Survey				X						X					
Request for Change of Provider				X						X					

Forms, Brochures and Webpage Resources	THRESHOLD & NON-THRESHOLD LANGUAGES														
	Arabic	Armenian	Cambodian/Khmer	English	Farsi	Hindi	Japanese	Korean	Russian	Spanish	Simplified Chinese	Tagalog	Thai	Traditional Chinese	Vietnamese
Roybal Family Mental Health (MHC) Center brochure				X						X				X	
Service Area (SA) Provider Directories	X	X	X	X	X			X	X	X	X	X		X	X
Staying Connected during Physical Distancing		X		X				X		X				X	
Supportive Counseling Services				X						X					
Children and Young Adult FSP Brochure?	X	X		X	X			X		X		X			X
Telemental Health Services Brochure				X						X					
Understanding the Mental Health and Emotional Aspects of COVID-19		X		X				X		X				X	
Your Wellbeing on Your Terms -Online COVID-19 resource				X						X					
Maintaining Health and Stability during COVID-19 - Online resource		X						X		X				X	
Alleviating Fear and Anxiety during Essential Trips in Public - Online COVID-19 resource		X						X		X				X	
Coping with Stress during Infectious Disease Outbreaks - Online COVID-19 resource	X	X	X				X	X	X		X	X		X	X
Staying Connected during Physical Distancing - Online COVID-19 resource	X	X	X	X			X	X	X		X	X		X	X
Coping with the Loss of a Loved One - Online COVID-19 resource	X	X	X	X			X	X	X		X	X		X	X
988 FAQs				X						X					
988 Comparison Chart				X						X					

Data Sources: Quality Assurance Division and ARDI Division - Cultural Competency Unit.

Criterion 7 Appendix

Attachment 1: LACDMH Policy 602.01 – Bilingual Bonus

602.01 Bilingual Bonus

Attachment 2: LACDMH Policy 200.03 – Language Translation and Interpreter Services

200.03 Language Translation & Interp

Attachment 3: LACDMH Policy 200.02 – Interpreter Services for the Deaf and Hard of Hearing Community

200.02 Interpreter

Attachment 4: Request for Interpretation and Translation Services Form

CC P&P 602 01 Bilingual Bonus RITS.d

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

PREVENTION BUREAU

ANTI-RACISM DIVERSITY AND INCLUSION (ARDI) DIVISION

CULTURAL COMPETENCY UNIT

2023 CULTURAL COMPETENCE PLAN UPDATE REPORT

Criterion 8

Adaptation of Services

August 2023

Criterion 8: Adaptation of Services

I. Consumer-driven/operated recovery and wellbeing programs

The Los Angeles County Department of Mental Health (LACDMH) is committed to supporting and enhancing consumer-driven services and wellbeing programs that are recovery-focused and rich in peer involvement. Below are some examples:

1. **Peer Run Centers (PRCs):** LACDMH has implemented five (5) PRCs located in Service Areas (SA) 2, 3, 4, 6 and 7. The mission of the PRCs is to create connections with every visitor, following the "Peers-to-Peers model. The PRCs strive to be a comfortable, safe, and non-judgmental environment for community members who are seeking peer support, linkage to mental health services, and other community resources. The peer staff use their own lived experience with mental illness, homelessness, incarceration, domestic violence, and other life challenges to make visitors feel welcomed, accepted, and supported. Visitors leave with community referrals and develop a positive connection to LACDMH.

   The PRCs are staffed with employees who speak, read, and write in English, Spanish, and Korean. Other threshold languages are being explored to better match the demographic and linguistic needs of the neighborhood that they serve. The PRCs are strategically located in each SA in close proximity to LACDMH directed operated clinics. PRCs are equipped with Wi-Fi, phones, and charging stations that are available for public use. Resource information is available to the community members in English, Spanish, Korean, and other threshold languages in Los Angeles County.

   The services provided by the PRC are grassroots in nature, with the goal to effectively engage community members and create a welcoming and safe environment. All PRC focus on minimizing barriers to service accessibility, particularly mental health stigma. The staff at each of the PRC are skilled at building relations with visitors, using nonintrusive and person-centered strategies. This approach has encouraged many reluctant individuals to seek services and have resulted in linking them to mental health services.

   Some of the visitors at the PRCs are consumers already connected with a LACDMH mental health provider or other county entities. Visitors also utilize the PRCs as a platform to seek Peer Support and to supplement their mental health services. In addition, visitors come to the PRCs for advocacy. The PRC staff work closely with service providers to ensure visitors are receiving services to best meet their needs. Further, visitors are empowered to advocate for themselves. The staff at the PRCs encourage frequent visitors to volunteer as Peer Supporters.

   The PRC projects and staffing patterns are based on the diversity in the County. All PRCs are equipped to address the diverse cultural needs of the community served and incorporate culture-specific elements in their operations and special activities. The unique populations served throughout LA County vary by SA and the

cultural/linguistic needs of each community are highlighted by the regional cultural awareness events sponsored by the PRC. For example, the SA 2 PRC highlights events such as Cinco de Mayo, SA 4 PRC highlights Korean commemorations, and SA 7 PRC implement events focusing on the Native American community. Additionally, the five PRC cross-coordinate events through the larger Peer Academy so that staff can collectively support and assist in planning each other's events.

The PRC activities promote cultural awareness, their staff is involved in Anti-Racism and Diversity committees, that focus on unserved or underserved communities. By creating a safe space that is accessible to all, free of judgment, the PRCs inspire hope and empower visitors to reach for their goals and dreams. The mission of the PRCs is based on the premise that eliminating disparities is an important pursuit. In the words of PRC staff:

- "We value connection.
- We engage those who walk into the PRCs, ensuring they are safe and feel welcome in the PRC by listening first and sharing our lived experience.
- We value individuality.
- We empower those at the PRC to know they are visible, and they have a voice.
- We value community.
- We network with the community at large to provide referrals and resources for PRC members to use.
- We value opportunity.
- We model recovery because we understand the hiccups of life.
- We value change.
- We have found meaning and purpose in life as peers and we give back fostering change by a listening ear and a caring heart.
- We value education.
- We are givers of hope who inspire others with our unique experiences, support, and any tools we offer."

TABLE 1: OPERATING PRC BY SERVICE AREA

SERVICE AREA	PRC LOCATION	HOURS OF OPERATION
2	14238 Saranac Lane, Sylmar, CA 91342	8:00 a.m. to 4:30 p.m. Monday through Friday
3	330 E. Live Oak Avenue, Arcadia, CA 91006	8:30 a.m. to 4:00 p.m. Monday through Friday
4	510 S. Vermont Avenue, 1st floor lobby Los Angeles, CA 90020	8:00 a.m. to 5:00 p.m. Monday through Friday
6	12021 Wilmington Avenue, Building 18 Los Angeles, CA 90059	8:00 a.m. to 5:00 p.m. Monday through Friday
7	6330 Rugby Avenue, Suite 200 Huntington Park, CA 90255	8:00 a.m. to 5:30 p.m. Monday through Friday

TABLE 2: PRC STRATEGIES RELATED TO CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES FY 21-22

Strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
Peer Resource Academy	Set structure held every Thursday morning from 9:30-11:00 a.m. Initial opening inspiration and introductions Development and review of vision and mission statement Expansion of round table discussion topics.	Foundation and formatting created; first Peer Academy held June 2022 with a weekly schedule.	Co-facilitation and presentations from various leaderships on skills. Inclusion of reporting out and a safe space to express concerns to be delivered to management.	Created a baseline of understanding for outcome measures, understanding of roles and expectations of the program.
Peer Support Groups	Healthy Relationships Word-Up Art @ Home Jewelry Club Poetry	Developed initially per Service Area and combined topics added for countywide in hybrid groups. Continued development and individualization based on Service Area needs.	Co leadership and oversight by supervisor. Development of group rules and etiquette for online, in-person and hybrid groups.	Capturing the numbers of group attendees by modifying the data collection tool.
Peer Connect (Intentional Peer Support training curriculum)	Trained all Peer Support staff in the Intentional Peer Support model (40-hour curriculum). Topics included trauma, cultural humility, and peer support.	All staff trained in level 1 Intentional Peer Support, a new cohort of Advanced Peer Support training planned, and Co-facilitation training in progress.	Co-facilitation is a built-in process for monitoring Intentional Peer Support practice which is led by peers for peers. The structure keeps peers monitoring the core competencies of practice.	

Strategies	Activities addressing each strategy	Status/Progress	Monitoring practices	Quantifiable Outcomes
Cultural and Holiday celebrations monthly	Phenomenal Women's Group Spanish Healthy Relationships Work Readiness Spanish Word Up	Continued evaluation and progression toward a monthly provision at each Service Area.	Evaluation by participants on each event and staff debriefing for improvement.	Numbers of attendees and evaluations

II. Responsiveness of Mental Health Services

LACDMH actively engages in culturally relevant outreach targeting underserved communities in other to increase accessibility to services, fight stigma, and reduce Mental Health disparities. The efforts summarized below highlight the Department's responsiveness to the cultural and linguistic needs of our communities via traditional and non-traditional approaches in service delivery.

1. LACDMH 24/7 Help Line

LACDMH has a well-established 24/7 Help Line which serves as the primary entry point for Mental Health services and support within the County. It offers services to callers through three lines: the ACCESS Center, Emotional Support Services and Veteran or Military Family Member Support. The Call Center provides end-to-end assistance in an efficient and user-centered manner and provides:

- Information and Referrals
- Centralized Appointment Scheduling Pilot for Hospital Discharges in SA 3
- Warmline/Emotional Support
- Hotline/Crisis Response

The Call Center provides easy and equitable access for all people and the right care at the right time with efficient internal processes and coordinated across systems. In addition, access should be culturally and linguistically relevant. In addition to English, the Help Line's workforce provides services in multiple languages, such as Armenian, Cantonese, Cambodian, Korean, Mandarin, Spanish, and Tagalog. The Emotional Support Line staff is versatile in Spanish, Korean, Taiwanese, Cambodian, and Armenian. Finally, the Veteran's Line staff speaks Armenian and Spanish. In addition to hiring agents who are bilingual in various languages, the A Help Line also utilizes three language line interpreter services.

Call Center Modernization met and engaged stakeholders from the Community Leadership Teams (CLTs) to obtain feedback regarding how to design the Call Center to meet the needs of various cultural and linguistic groups. As a response to the COVID-19 Pandemic, the Emotional Support Line was initiated and is now funded by the Mental Health Services Act (MHSA) as a permanent part of the Help Line to address stress and anxiety within the LA County community.

Although the Help Line already provides services in multiple languages, it is hoped that the Call Center Modernization process will impact the work to provide culturally and linguistically competent access to care. By designing the modernized Call Center with our consumers' cultural and linguistic needs as a core central point, Help Line hopes to engage consumers who have typically found it difficult to reach out for help. The Help Line will be redesigned in the most engaging and user-friendly way to provide more easily accessible services, thereby increasing access to Mental Health and eliminating disparities.

Additionally, funding identified for the Call Center Modernization will focus on shifting the existing capacity of the Call Center to provide end-to-end assistance in an efficient and client-focused manner utilizing an agent- and client-centered design. Modernization goals include:

1) Reducing the number of software applications used by agents by developing a single view with end-to-end care visibility to best meet the needs of the caller
2) Integration with other systems (e.g., law enforcement) for receiving, assessing, triaging and mounting non-law enforcement responses to crises across the culturally and linguistically diverse communities of LA County
3) Integration of technology between the Call Center and service providers (including crisis response) to reduce time-to-care, maximize service capacity and improve coordination of services
4) Development of self-service capabilities and alternative access-points designed by feedback from the community
5) Automated calls and client analytics to ensure the Call Center is meeting the community's needs and responding promptly.

TABLE 3: LACDMH HEALTH HELP LINE PROJECTS AND STRATEGIES RELATED TO CULTURAL COMPETENCE AND ELIMINATION OF DISPARITIES, FY 21-22

Department wide strategies	**Activities addressing each strategy**	**Status/ Progress**	**Monitoring practices**	**Quantifiable Outcomes** **(Number of, percentages, etc.)**
Development and translation of public informing materials that address mental health education	Assisted with translation of ACCESS brochures in threshold languages.	Completed. Available in all threshold languages.	Will be updated as needed.	13 languages available

Department wide strategies	Activities addressing each strategy	Status/ Progress	Monitoring practices	Quantifiable Outcomes (Number of, percentages, etc.)
Evidence-Based Practices (EBP)/ Community-Defined Evidence Practices (CDE) for ethnic populations	All employees in ACCESS and ESL trained in Active Listening: Cognitive Behavioral Approach.	Trainings were edited and tailored to meet the needs of the Call Center agents. Continue to use.	Edited and tailored to meet the needs of the Call Center.	Decrease in number of crisis calls that would have been referred to the Psychiatric Mobile Response Team (PMRT).
Implementation of new technologies to enhance the Department's service delivery	Implemented Roundtrip Application for Countywide ambulance dispatching.	Continue to use the application for ambulance dispatch pending alternate plan with DHS.	Meet weekly with DHS and as needed.	Daytime average is 1.5 hour response. Afterhours average is 1.45 hour response.
Interagency Collaboration	Utilized Services Request Tracking System (SRTS) 1.0 for Mental Health referrals and appointments.	Upgraded to SRTS 2.0	Daily monitoring for incomplete SRTSs.	Decrease in number of referrals not transferred.

2. LACDMH Speakers Bureau (SB)

The SB continues to operate as the Departmental centralized public-speaking mechanism to serve the community and LACDMH programs during and beyond COVID-19 times. During CY 2022, the SB had approximately 75 licensed clinicians serving as Subject Matter Experts (SME) under the leadership of the Chief of Psychology team and the Ethnic Services Manager/Cultural Competency Unit Program Manager. Collectively, the SB provided presentations, trainings, public-facing speaking engagements, and media interviews on radio and television in ten languages inclusive of Armenian, Cambodian, Cantonese, English, Farsi, Hindi, Korean, Mandarin, Russian and Spanish. The SB data for CY 2022 indicates that, on average, the SB members delivered 33 activities per month.

Multiple Los Angeles County Board Offices, K-12 schools and institutions of higher learning, community, and faith-based organizations, professional associations, and other governmental agencies across all eight Service Areas, the State and the Country have benefited from the expertise of the Speakers Bureau. Additionally, various

LACDMH programs rely on the Speakers Bureau to deliver high-quality, culturally sensitive, and clinically sound trainings for staff.

Furthermore, the Speakers Bureau delivered its first community-focused Multicultural Mental Health conference held in December 2021. The conference brought together over 700 consumers, family members, parent advocates, and community members from all sectors of Los Angeles County. It included 41 virtual workshops in Amharic, Armenian, Cambodian, Cantonese, English, Farsi, Korean, Mandarin, and Spanish. The participants provided overwhelmingly positive feedback about it and requested it become an on-going annual conference.

Examples of community feedback regarding Speaker Bureau services include:

- “The Speakers Bureau is an awesome source.
- Exceptional speakers.
- We have been quite impressed with its various speakers' presentations.
- Thanks to the Speakers Bureau, we have been able to successfully implement several educational forums dealing with issues impacting community Mental Health and education.
- Very accommodating.
- Helpful for our volunteers' own health and service with at-risk youth.
- The speaker provided very useful information relevant for the community.
- I really appreciate that I had the opportunity to do this interview at a timely manner (because of my deadline) and that it was in Spanish. I'm thankful for SB Speaker’s time and knowledge.
- The Speakers Bureau was a lifesaver to my event. I wish that I had learned about them earlier when planning my event, but this was my first time organizing an event for Mental Health Awareness, and thanks to the Speakers Bureau support, it was easier to present the information to the event guests.
- The presentation was tailored to address specific Mental Health issues that affect the Black, Indigenous and People of Color (BIPOC) Youth & Young Adult population.
- Topics discussed were relevant to our everyday living.”

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TABLE 4: SAMPLE OF SPEAKERS BUREAU MAIN ACTIVITY TYPES CY 2022

Speakers Bureau Activity	Number of Activities	Number of Participants
Clinical - Group	16	230
Consultation	680	890,931
Information on Mental Health Resources	19	899
Material(s) development	56	1,689
Media Interview - Podcast	4	500
Media Interview - Print	18	1,971,756
Media Interview - Radio	143	55,491,453
Media Interview - Social Media	11	1,120,700
Media Interview - Television	30	10,698,200
Media Promotion (PSA and Ads)	6	100
Outreach - Group	28	1,339
Presentation/Training - Community Event Speaker	66	7,473
Presentation/Training - Conference/Seminar Keynote	9	198
Presentation/Training - Conference/Seminar Panelist	24	16,129
Presentation/Training - Conference/Seminar Workshop	69	6,841
Presentation/Training - Standalone Workshop	152	5,774
Translation Review (of departmental document translations)	127	1,918
Translation - Translated materials	61	558
Grand Total	**1,611**	**70,216,704**

Note: Grand total row includes CY 2022 SB activity that may not be specified in the table above.

Source: LACDMH ARDI Division, Data Team.

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TABLE 5: SB ACTIVITIES BY LANGUAGE
CY 2022

Language used for Activity	Number of Activities	Number of Participants
Armenian	41	136
Cantonese	25	194
Cantonese and Mandarin	1	15
English	525	1,053,605
Farsi	27	15
Korean	442	57,968,741
Korean and English	242	43,250
Korean and Spanish	2	80
Mandarin	64	530,401
Multilingual	2	55
Russian	4	102
Spanish	140	10,619,285
Spanish and English	14	620
Spanish, English, and ASL	1	50
Grand Total	**1,611**	**70,216,704**

Note: Grand total row includes CY 2022 SB activity that may not be specified in the table above.

Source: LACDMH ARDI Division, Data Team.

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TABLE 6: CLINICAL AND NON-CLINICAL PRESENTATIONS AND TRAINING TOPICS REQUESTED, CY 2022

2022 SB Request Topics and Themes
1. Children and Youth Mental Health Issues (various)
2. LGBTQ+ mental health (gender identity, sexual orientation, coming out process
3. Parents' Mental Health and/or Parenting*
4. Black, Indigenous, and People of Color mental health issues (various)
5. Seniors, Aging and/or Across Lifespan (various)
6. Mental health related to COVID-19 (Post Pandemic phase)
7. Domestic Violence and/or Relationships
8. General mental health and wellness*
9. Experience of Homelessness and Mental Health
10. Depression
11. Stress Management, Self-care and/or Mindfulness
12. Suicide Prevention
13. Caregivers' Mental Health*
14. Crisis Management
15. Health Career Exploration*
16. API Mental Health
17. Bullying and Mental Health
18. Cultural Sensitivity, Humility, and Implicit Bias
19. Grief and Loss
20. Latino Mental Health
21. Mental Health in the Workplace
22. Mental Health First Aid Training
23. Substance Use Issues
24. Veterans' Mental Health
25. Supporting Individuals with Mental Health Issues (e.g., navigation, advocacy)*
26. Elderly Abuse
27. Hoarding
28. Learning Disability- Children
29. Mindful Practice*
30. Mental Health and Financial Issues*
31. Mental Health Stigma*
32. Mental Health Resiliency*
33. Motivational Interview
34. Personality Disorder
35. Play Therapy
36. Sexual Harassment

2022 SB Request Topics and Themes
37. SOGI Data
38. Trauma-Informed Care
39. War in Ukraine and Impact on Mental Health

Notes:

1. * Most non-clinical and general topic requests were resourced by United Mental Health Promoters via partnership with the Speakers Bureau.
2. Whenever applicable, the expertise of specialized LACDMH programs was tapped into for some requests.
3. Requests including multiple topics are reported separately.

Source: LACDMH ARDI Division, Cultural Competency Unit.

3. Technological Advances: VSee Utilization in Telemental Health

VSee Technology provides consumers and program staff the opportunity to have virtual face to face sessions remotely. The VSee technology promotes equity in service planning, delivery and/or evaluation by providing client access to mental health services regardless to a client's geographic location. During FY 21-22, LACDMH continued utilizes VSee as its technological platform to engage in the following services virtually:

A. Psychiatric services

- Ongoing medication support for established consumers: Consumers are evaluated using a videoconferencing platform telephone for routine and urgent appointments to receive ongoing care during the pandemic.
- Remote assessment and management of new consumers: new consumers are evaluated, and telehealth treatment begins.
- Remote psychiatric consultations and evaluations for consumers living in shelters, including Isolation and Quarantine (IQ) sites: LACDMH is providing remote psychiatric consultation and appointments on an as-needed basis for consumers who reside in shelters and for some who are unhoused.
- Redistribution of psychiatric resources to underserved areas: Traditionally, psychiatrists are accustomed to working at a single clinic site and are often clustered in certain geographic areas of LA County close to where they live, leaving other regions greatly underserved. Using telehealth, we have been able to redeploy psychiatrists more equitably across the county. These psychiatrists no longer see consumers in one particular clinic but rather see consumers throughout the system.
- Psychiatric consultation within primary care clinics via DMH/DHS Collaboration Program: DMH psychiatrists provide remote consultation to Mental Health providers embedded in DHS primary care clinics.

B. Psychotherapy

- Remote individual therapy via telehealth
- Remote group therapy via telehealth

C. Case management

- Case managers have continued to provide support for consumers using regular telephone calls and audiovisual conferencing

D. Peer and community health worker support: Continuing client support and group programming via telehealth

E. Clinical pharmacists

- Providing telehealth services in the same manner as psychiatrists
- Provide medication services to consumers from all service areas who need immediate renewal of prescriptions for therapy continuation through telemental health
- Without the physical constraint of a geographic location, clinical pharmacists provide transition of care medication adherence education for consumers who have frequent admissions to hospitals
- Follow-up with these consumers on a regular basis via telemental health appointments until they are fully transitioned to and stay engaged with LACDMH outpatient services without requiring in-person visit

F. Nursing

- Psychiatric nurse practitioners are using telehealth for initial assessments, diagnosis, and client education medication management
- Registered Nurses (RNs) are using telephone services to screen for symptoms, assist with scheduling plans, and psychotropic medication needs

G. Education and supervision

- Continuation of psychiatric residency education and supervision via telehealth
- Providing supervised hours for unlicensed clinical staff using telemental health

LACDMH's post COVID-19 Telehealth plan involve strategies to increase client access to care, provide support resources and training for staff and Consumers, begin infrastructure expansion at clinics, implement customizations to the VSee Telehealth solution, and to implement Telemental health reporting to monitor quality of service and outcomes. Telehealth activities include:

- Provision of critical emergency therapeutic consultation via Telemental health.
- Assistance to consumers in obtaining phones and data plans so they can leverage Telemental health services.

- Conduction of weekly staff Telemental health training to comprehensively address all levels of Telemental health literacy. This effort has had a tremendous impact in providing Telehealth skills and knowledge to staff, which in turn helps them deliver quality mental health services to consumers.
- Installation of dedicated Telemental health Kiosks at designated sites, offering consumers the option to either engage in Telemental health services from home, or at these select LACDMH facilities.
- On-demand access to mental health services via dynamic scheduling. This method effectively leverages an automated scheduling system to provide real-time matching of available providers with consumers seeking appointments.
- Simplified Telemental health service access for consumers and participants by providing a browser-based link for calls into group sessions. Consumers are no longer required to download and configure software.
- Support LACDMH's Telemental health expansion by seeking grant funding whenever the opportunity presents itself. The Department has recently submitted applications for grant funding to expand its Telemental health infrastructure.
- Commitment to continued Telemental health excellence is evident at monthly management meetings, where dedicated attention is given to addressing issues and formulating strategies to effectively maintain a quality Telemental health presence for LA County consumers post COVID-19.
- VSee Utilization reports are discussed during monthly program staff meetings. The VSee utilization reports are used to monitor provider and client virtual service usage. If a program's utilization decreased from previous reports support options are provided.

III. Quality of Care: Contracted Providers

LACDMH Contractual Agreement

Section 8.15.3 of the LACDMH Legal Entity Contract instructs prospective Contractors to provide services that are consistent with the Department's Cultural Competence Plan and all applicable Federal, State, and local regulations, manuals, guidelines, and directives. Specifically,

- "The Contractor's Quality Management Program shall be consistent with the Department's Cultural Competence Plan. Contractor shall ensure that 100% of Contractor's staff, including clerical/support, administrative/management, clinical, subcontractors, and independent contractors receive **annual** cultural competence training in accordance to LACDMH Policy 200.09.

- Contractor shall monitor, track, document (e.g., training bulletins/flyers, sign-in sheets specifying name and function of staff, and/or individual certificates of completion, etc.) and make available upon request by the federal, State and/or

County government the annual cultural competence training provided to Contractor's staff, including clerical, administrative/ management, clinical, subcontractors, and independent contractors.

- Additionally, per the Federal Managed Care Network Adequacy Final Rule requirements, 100% of direct service practitioners (psychotherapists, psychiatrists, case managers, etc.) must complete cultural competence training within the past 12 months to meet annual reporting requirements. This information needs to be entered and updated in the Network Adequacy: Provider and Practitioner Administration application (https://lacdmhnact.dynamics365portals.us/) based on each practitioner specifying the hours of cultural competence training completed."

An extensive list of regulatory legislations is cited in the contractual agreement. The most significant guidelines for culturally and linguistically competent service delivery include:

The California Welfare and Institutions Code, Section 5600

- Mental Health services shall be based on person-centered approaches and the needs of priority target populations. Services shall also be integrated and inclusive of assertive outreach to persons experiencing homelessness and who are hard-to-reach

Title IX

- Objectives and strategies need to be in place to improve the organization's cultural competency
- Population assessment needs, and service provider/organization assessments are to be conducted to evaluate cultural and linguistic competence capabilities
- Specialty Mental Health services listings need to be made available to beneficiaries in their preferred language
- Cultural competence trainings need to be made available for all staff, including administration and management

LACDMH Organizational Provider's Manual for Specialty Mental Health Services under the Rehabilitation Option and Targeted Case Management Services (pages 15 and 18-19). Below are selected excerpts pertinent to cultural and linguistic inclusion in service delivery:

1. General documentation rules

   Special client needs as well as associated interventions directed toward meeting those needs must be documented (LACDMHH Policy 401.03):

   - Visual and hearing disabilities
   - Client's whose primary language is not English - Clients should not be expected to provide interpretive services through friends or family members. Oral interpretation and sign language services must be available free of charge (State Contract) NOTE: Just because assistance is documented, it does not necessarily mean it is claimable. Claimed notes for

services must show how the service assists the client in accessing services or is a service intervention. The assistance must be claimed in accord with the focus of the client contact and the staff providing the service. Simply translating for the client is not considered an intervention. NOTE: In order to obtain and/or transmit linguistically accurate information from clients who do not speak English as a first language, the Department has translated some of its forms into other languages. Whenever non-English forms are used, the English translation version must be printed on the back of the form. If that is not possible, the English version must be placed immediately adjacent to the non-English version in the clinical record. The English version should note that the document was signed on the non-English version.

- Cultural and/or linguistic considerations
  - When special cultural and/or linguistic needs are present, there must be documentation in the clinical record indicating the plan to address the cultural and/or linguistic needs.
  - If an exception is made to the identified plan for addressing cultural and/or linguistic needs, there must be documentation in the progress note addressing the exception and how it was handled. NOTE: Culture is "the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.
- Culture defines
  - How health care information is received
  - How rights and protections are exercised
  - What is considered to be a health problem
  - How symptoms and concerns about the problem are expressed
  - Who should provide treatment for the problem
  - What type of treatment should be given

Source: (U.S. Department of Health and Human Services, Office of Minority Health (2013); The National Culturally and Linguistically Appropriate Services (CLAS) Standards.)

Cultural considerations may include but are not limited to racial/ethnic/national origin, religious/spiritual background or affiliation, gender/sexual orientation, and other cultural considerations expressed by the consumer.

2. <u>Assessments</u>

Based on LACDMH Policy 401.03, Assessments are important in beginning to understand and appreciate who the client is and the interrelationship between the client's symptoms/behaviors and the client as a whole person. The Assessment enables the reader to see the role of culture and ethnicity in the client's life and documents the impact of significant supports, living situation, substance use, etc. on the Mental Health of the client. The Assessment identifies the client and his/her family's strengths and identifies the stages of

change/recovery for the client. The formulation collected in an Assessment allows the client and staff to collaborate in the development of a mutually agreed upon plan of treatment and recovery.

Assessments must contain the required seven (7) uniform Assessment domains as identified below. There is no requirement for the domains to be laid out in this manner. For clients under age 21, the Child and Adolescent Needs and Strengths (CANS) Assessment tool may be utilized to help inform the Assessment domain requirements but is not sufficient as the Assessment in-and-of itself. The domains shall be documented on an Assessment form or other documentation form (i.e., initial medication note) and shall be kept within the client's clinical record. The five domains are specified as follows:

- Domain 1
  - Presenting Problem(s)
  - Current Mental Status
  - History of Presenting Problem(s)
  - Client-Identified Disabilities
- Domain 2
  - Trauma
- Domain 3
  - Behavioral Health History (including substance use history) and Comorbidity (i.e., substance use and mental health)
- Domain 4
  - Medical History
  - Current Medications
  - Comorbidity (i.e., medical and mental health)
- Domain 5
  - Social and Life Circumstances
  - Culture, Religion, and Spirituality
- Domain 6
  - Strengths, Risk Behaviors, and Safety Factors
- Domain 7
  - Clinical Summary and Recommendations
  - Diagnostic Impression
  - Medical Necessity Determination and Level of Care and Access Criteria

IV. Quality Improvement and Quality Assurance

1. The Consumer Perception Survey (CPS)

LACDMH's Quality, Outcomes, and Training Division (QOTD) shares the responsibility with providers to maintain and improve the quality of services and delivery infrastructure. In addition to being required by State and Federal

mandates, a regular assessment of consumers' experience of services received and their providers is essential for improvement and innovation within LACDMH.

The Quality Improvement (QI) Unit is responsible for the formal reporting on the annual measurement of consumer perception of satisfaction in eight areas, namely: Overall Satisfaction, General Satisfaction, Perception of Access, Perception of Quality and Appropriateness, Perception of Participation in Treatment Planning, Perception of Outcomes of Services, Perception of Functioning, and Perception of Social Connectedness. The Mental Health Consumer Perception Survey (CPS) forms map on to each of these specific domains. CPS data is gathered once a year in May or June.

CPS forms were developed for each age group. The Youth Services Survey (YSS) form is administered to consumers ages 13 to 17. The Youth Services Survey for Families (YSS-F) form is administered to families/caregivers of consumers aged 0 to 17 years. The Adult Mental Health Statistics Improvement Program (MENTAL HEALTHSIP) Consumer Survey form is administered to consumers aged 18 to 59. The Older Adult CPS is administered to consumers aged 60 years and older.

The survey items that are common across the two sets of age groups are as follows:

YSS-F

- I felt my child had someone to talk to when he/she was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- My child gets along better with family members
- My child is doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

YSS

- I felt I had someone to talk to when I was troubled
- The location of services was convenient for me
- Services were available at times that were convenient for me
- Staff was sensitive to my cultural/ethnic background
- I get along better with family members
- I am doing better in school and/or work
- In a crisis, I would have the support I need from family or friends

Adult survey (ages 18-59 years)

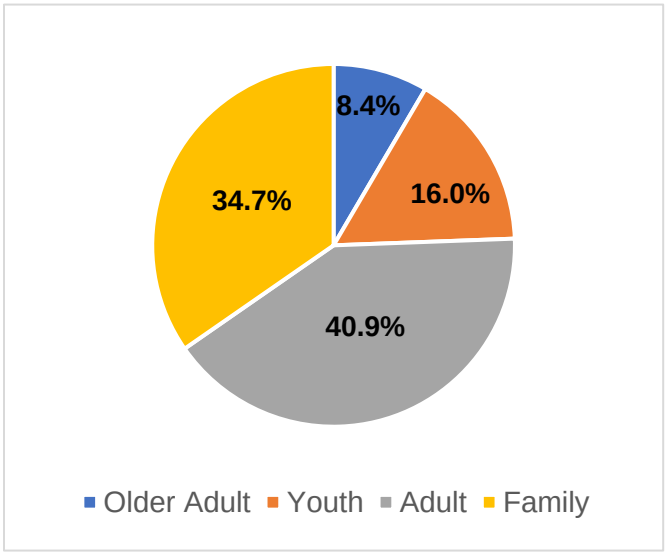
- The location of services was convenient for me
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems

- I do better in school and/or work
- My symptoms are not bothering me as much

Older Adult survey (ages 60 years and over)

- The location of services was convenient
- Staff was willing to see me as often as I felt it was necessary
- Services were available at times that were good for me
- Staff was sensitive to my cultural background
- I deal more effectively with daily problems
- I do better in school and/or work
- My symptoms are not bothering me as much

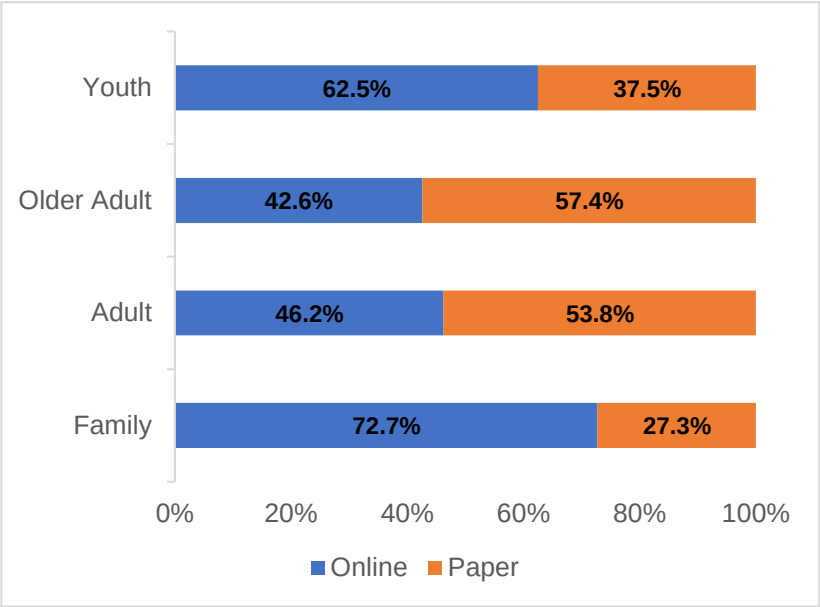
FIGURE 1: COMPLETED SURVEYS BY AGE GROUP



Data Source: Consumer Perception Survey data May 2022.

LACDMH conducts consumer satisfaction surveys once a year. During Spring 2022, CPS was utilized and administered to consumers served in Outpatient programs over a period of five days in May. Compared to Spring 2021, more surveys were completed during the Spring 2022 survey period. Figure 1 shows the percentages of completed surveys by age group. Most surveys came from Adults (40.9%), followed by Families (34.7%), Youth (16.0%), and Older Adults (8.4%). Most surveys were completed in English or Spanish, and respondents indicated high satisfaction with language availability.

FIGURE 2: COMPLETED SURVEYS BY FORMAT



Data Source: Consumer Perception Survey data May 2022.

Surveys were available for consumers to complete using different formats. These formats include paper surveys and two online options using LACDMH electronic surveys and UCLA survey links. Figure 2 summarizes percentages of completed surveys by format amongst the four age groups. Families (72.7%) and Youth (62.5%) completed most surveys using the online format. Older Adults (57.4%) and Adults (53.8%) completed the majority of surveys using the paper format.

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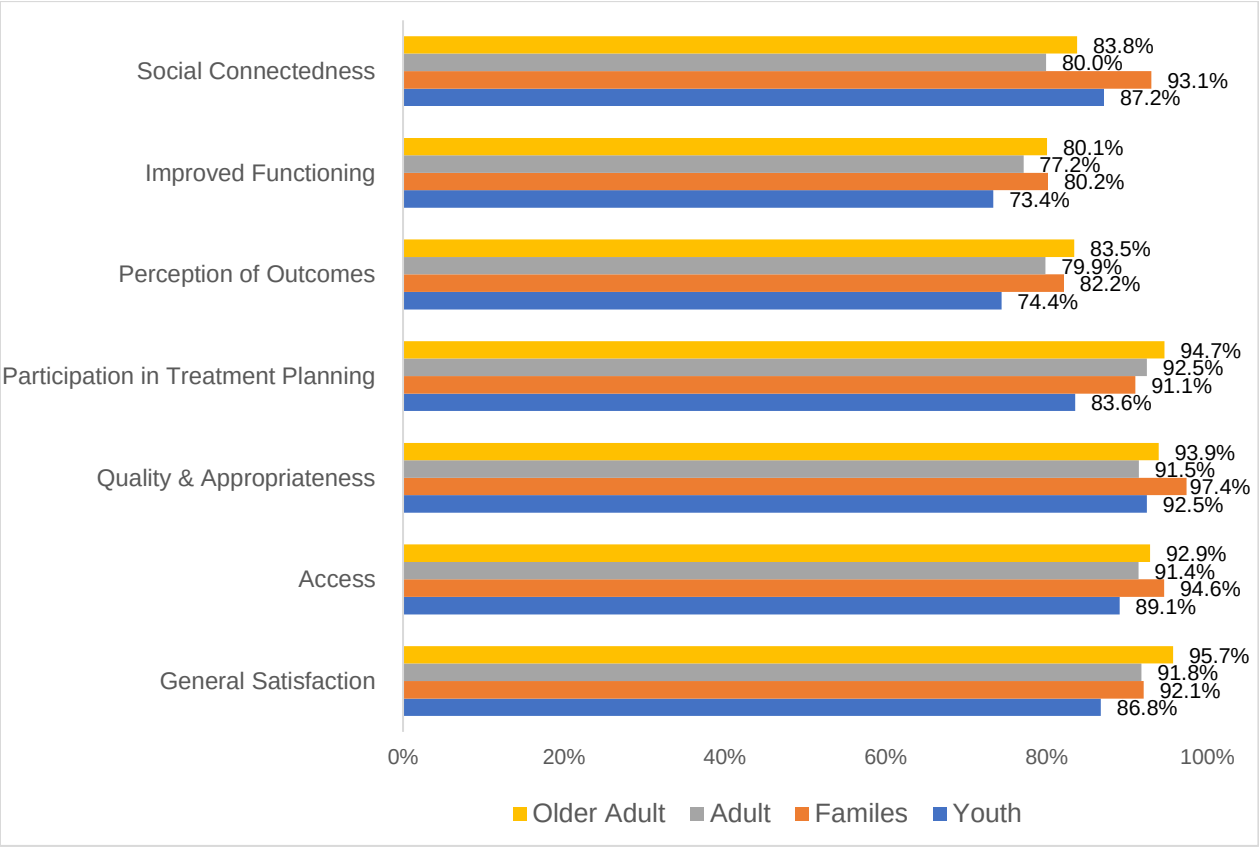
FIGURE 3: AGE GROUP COMPARISON OF SATISFACTION BY DOMAIN



Data Source: Consumer Perception Survey data May 2022.

For Spring 2022, the percentage of individuals that reported being very satisfied remained high for several domains. Figure 3 summarizes the age group comparison of satisfaction by domain. Families and Older Adults had the highest scores for the Quality and Cultural Appropriateness domain, with 97.4% and 93.9% of respondents agreeing or strongly agreeing with the items in that domain. Families also had the highest scores in the Social Connectedness domain (93.1%), the Access domain (94.6%) as well as the Improved Functioning domain (80.2%). Older Adults had the highest scores in the Perception of Outcomes domain (83.5%), the Participation in Treatment Planning domain (94.7%) and the General Satisfaction domain (95.7%). Youth demonstrated the lowest scores among the four age groups across all domains except for Social Connectedness and Quality and Cultural Appropriateness.

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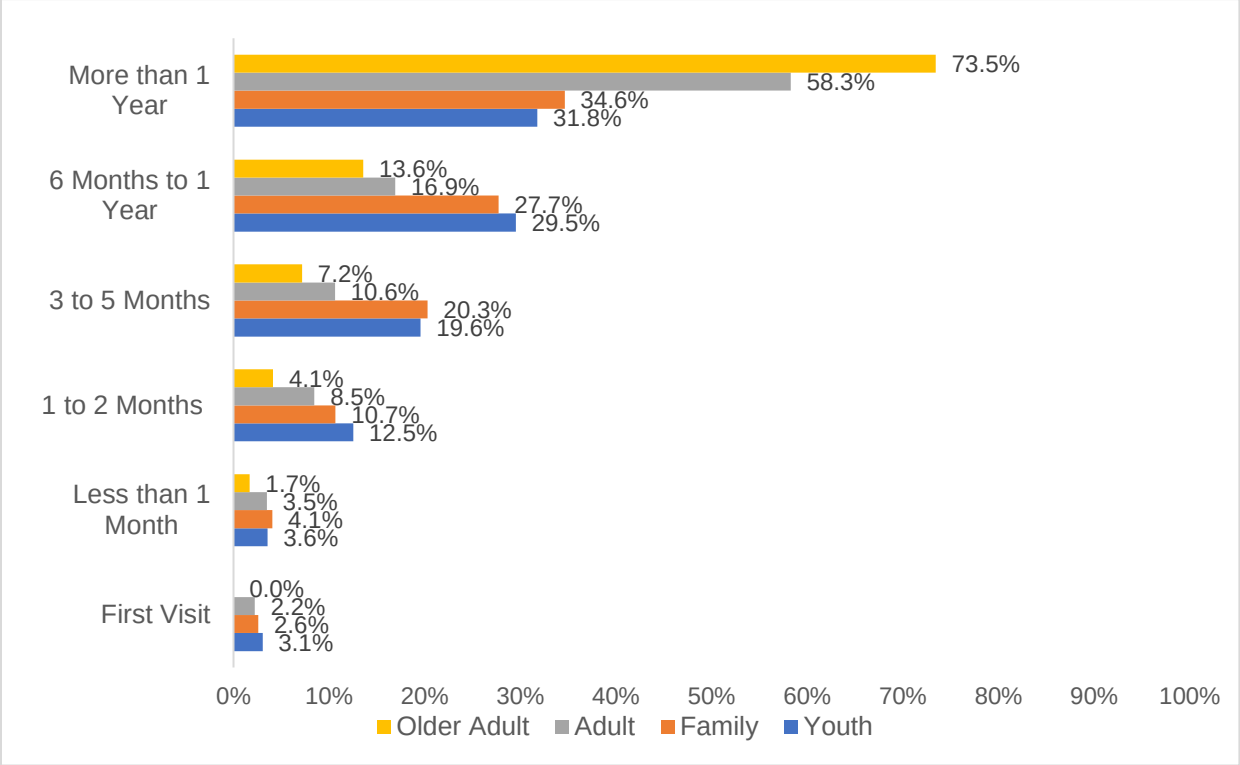
FIGURE 4: AGE GROUP COMPARISON OF LENGTH OF ENROLLMENT IN TREATMENT

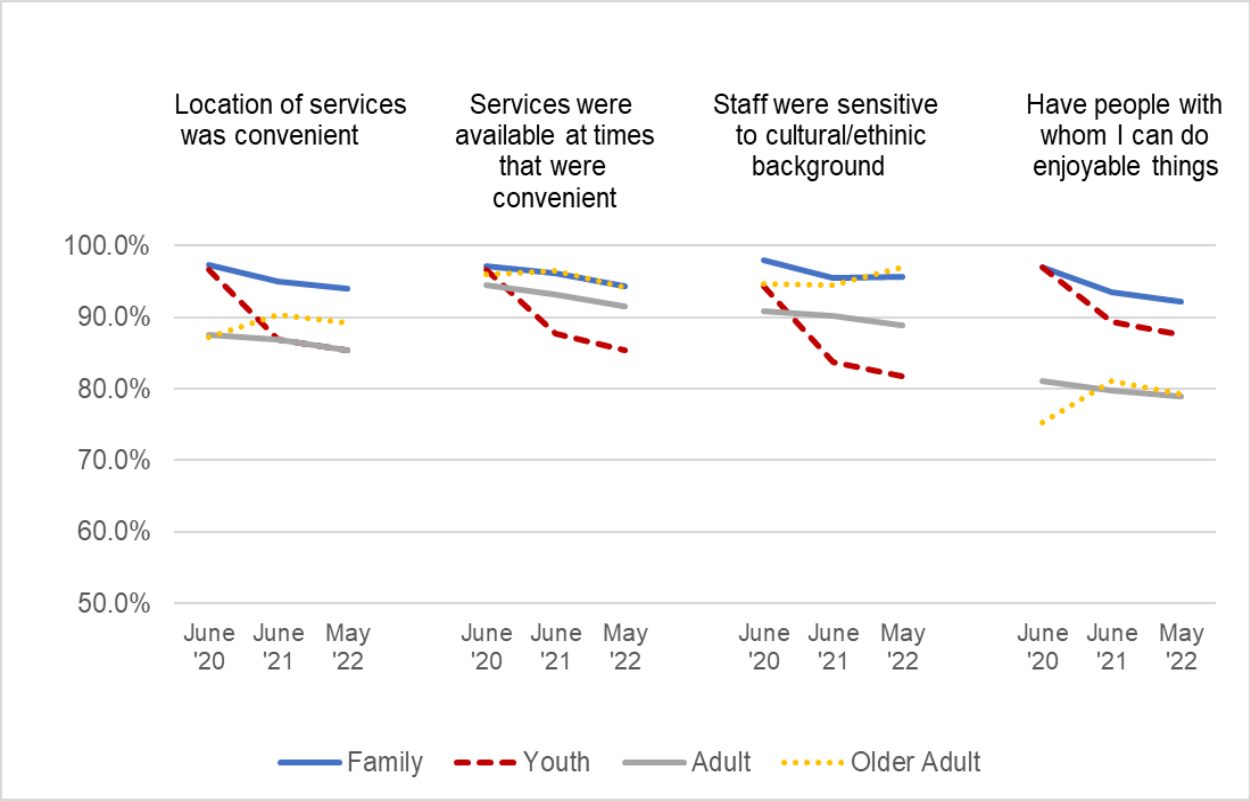


Data Source: Consumer Perception Survey data, May 2022

Figure 4 shows that most survey respondents had been in services for six months or more when they completed the survey. Most Older Adult and Adult respondents had been receiving services for more than one year. For Families and Youth, the largest percentages were also in services for six months or more at the time of the survey.

Trends for the common items across all four survey versions fluctuated across the last three survey periods (June 2020, June 2021, and May 2022). Families tended to have the highest percentage of respondents who agreed or strongly agreed with common items for the last three survey periods. Youth and Families had similar percentages for June 2020 and then decreased considerably for Youth in June 2021 and May 2022. Older Adults improved percentages on most items from June 2020 to June 2021 and then decreased on most in May 2022. Adult scores tended to be lower for most items in June 2020 to June 2021 and continued to show an overall decrease in May 2022. Youth tended to have the lowest percentages in May 2022 on most items with a considerable decrease from June 2021. The lowest percentage that agreed or strongly agreed for all age groups was for the functioning item related to “Doing better in school and/or work,” indicating this is a continued area for improvement. Figures 5 and 6 summarize Age Group Comparison of Common Survey Items.

FIGURE 5: AGE GROUP COMPARISON OF ACCESS, CULTURAL SENSITIVITY, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME



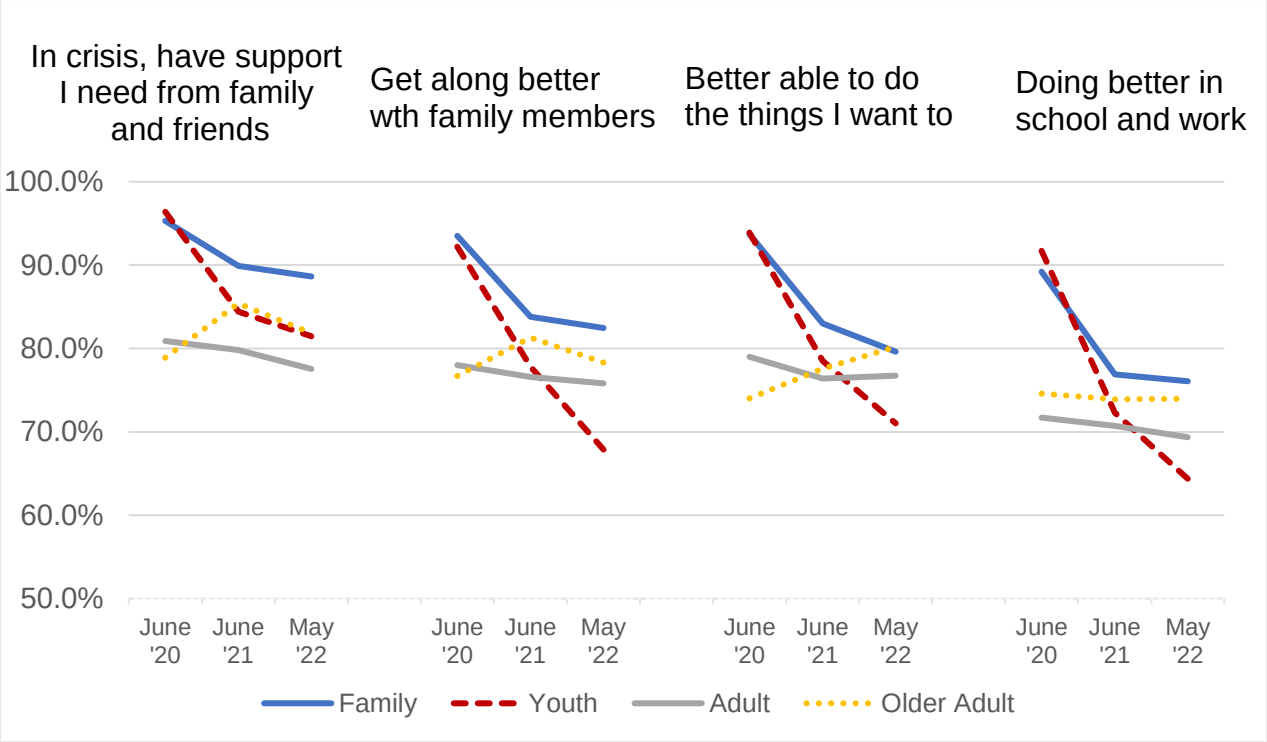
Data Source: Consumer Perception Survey data, June 2020, June 2021, and May 2022.

Figure 5 shows four of the CPS items common to the Families, Youth, Adult, and Older Adult surveys from June 2020 to May 2022. The percentages above reflect the number of respondents selecting either Agree or Strongly Agree for each item.

Families had the highest percentages on all four items compared to the other three age groups for all three time periods except for June 2021, where Older Adults were higher on "Services were available at convenient times," and May 2022, "Staff were sensitive to my cultural and ethnic background." Adult and Youth scores decreased on all items over time, with Youth showing a considerable decrease from June 2020 to May 2022. Notably, Older Adults and Adults had much lower scores on the item "I have individuals with whom I can do enjoyable things" than compared to Youth and Families.

Adults and Youth tended to have lower percentages, particularly for June 2021 and May 2022. Youth had the lowest percentage on the "Services were available at times that were convenient" and "Staff were sensitive to my cultural/ethnic background," items in June 2021 and May 2022. Adults also had the lowest percentage on the "Location of services was convenient" item at all three time periods except for June 2020, where they were slightly higher than Older Adults.

FIGURE 6: AGE GROUP COMPARISON OF OUTCOMES, FUNCTIONING, AND SOCIAL CONNECTEDNESS COMMON ITEMS ACROSS SURVEYS OVER TIME

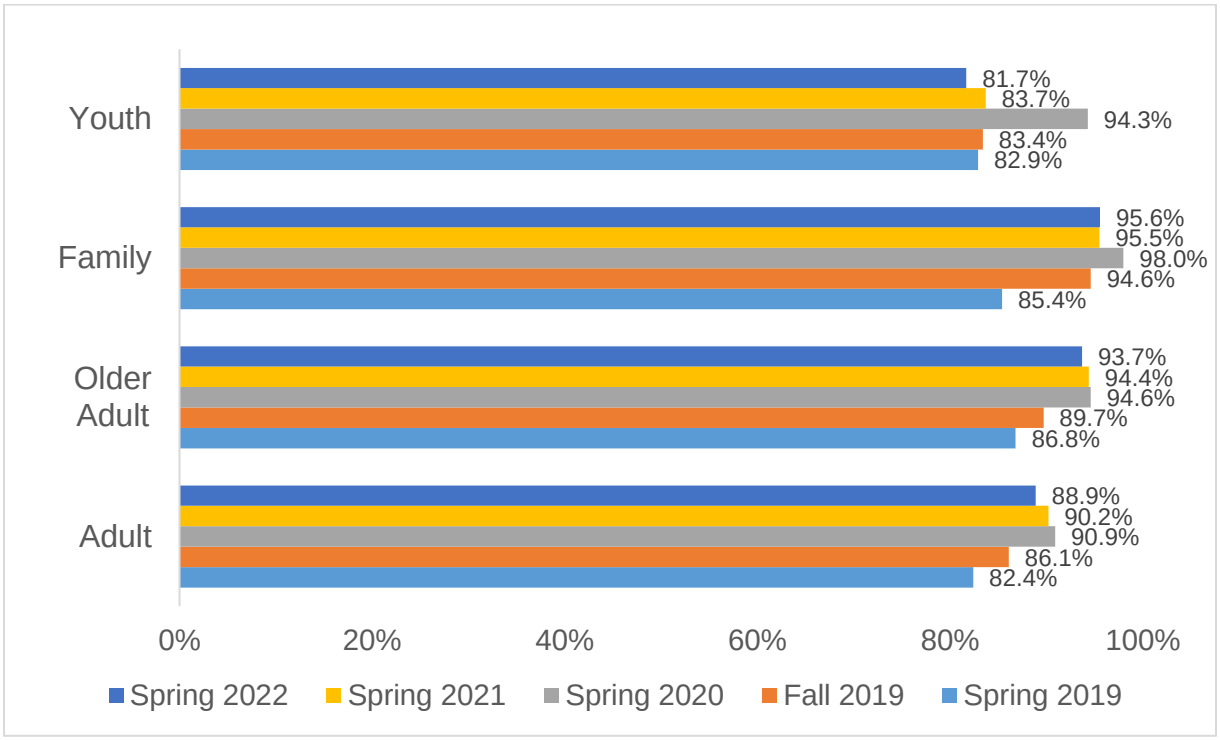


Data Source: Consumer Perception Survey data, June 2020, June 2021, and May 2022

Figure 6 shows the other four CPS items common to the Families, Youth, Adult, and Older Adult surveys from June 2020, June 2021, and May 2022. The percentages above reflect the number of respondents selecting either Agree or Strongly Agree for each item.

Youth and Families tended to have the highest percentages of agreement with the "In crisis, have support", "Getting along better with family members," "Being better able to do the things I want to do," and "Doing better in school or work items," in June 2020. From June 2020 to May 2022, Youth and Families percentages decreased for all items with Youth showing a considerable decrease from June 2020 to May 2022. Families scores tend to be higher than those of Youth, Adults and Older Adults. Youth scores tend to be lower than the other three age groups. Youth had the lowest percentages on the "Getting along with family members," "Better able to do the things I want to do," and Doing better in school or work items." Like the other common items in Figure 5, overall scores decreased for all age groups from June 2020 to May 2022 except for Older Adults and Adults who increased on "Better able to do the things I want to do," and Older Adults showing slight increase in "Doing better at school and work."

FIGURE 7: TRENDING DATA – PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM "STAFF WERE SENSITIVE TO MY CULTURAL BACKGROUND"



Data Source: Consumer Perception Survey data, Spring 2019, Fall 2019, Spring 2020, Spring 2021 and Spring 2022.

Figure 7 summarizes the percentage of survey participants who endorsed agree or strongly agree to the item "Staff being sensitive to their cultural ethnic background" across five CPS data collection periods, from Spring 2019 to Spring 2022. The highest percentage of agree responses was received from Family/caregivers of consumers for the Spring 2020 at 98.0%. The lowest percentage was received from Youth for the Spring 2022 at 81.7%. Overall, Spring 2020 showed the highest scores across the four age groups and Spring 2019 the lowest scores. In Spring 2022, Families have the highest percentage (95.6%).

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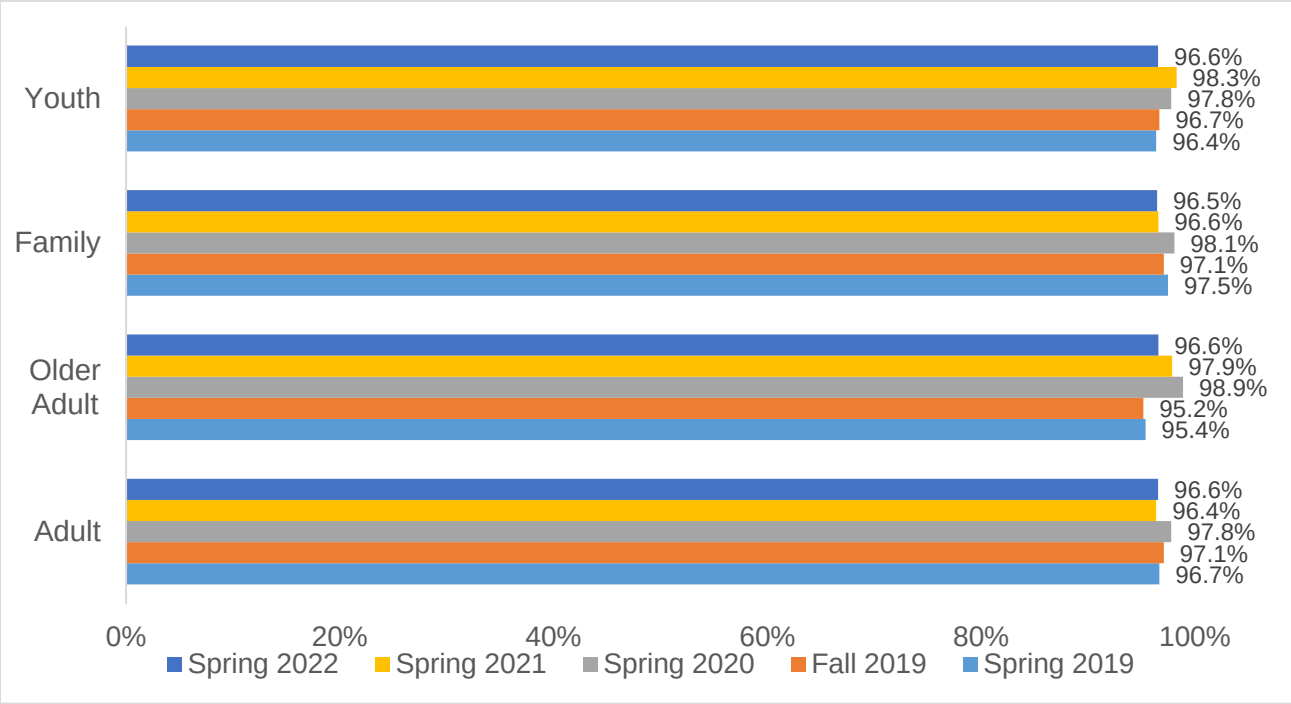
FIGURE 8: PERCENTAGE OF AGREE OR STRONGLY AGREE RESPONSES TO ITEM "WRITTEN MATERIALS PROVIDED IN MY PREFERRED LANGUAGE"



Data Source: Consumer Perception Survey data, Spring 2019, Fall 2019, Spring 2020, Spring 2021, and Spring 2022.

Figure 8 summarizes the percentage of survey participants who endorsed agree or strongly agree to the availability of written materials in their preferred language. Across the five CPS data collection periods, from Fall 2019 to Spring 2022, the highest percentage of agree responses was received from Older Adults for the Spring 2020 survey at 98.9%. The lowest percentage was from Older Adults for the Fall 2019 at 95.2%. Overall, scores all ranged above 95% across the 5 survey collection periods. In Spring 2022, percentages were similar among all 4 age groups.

Survey participants also reported on whether services received were provided in a language of preference. The majority of survey participants endorsed "Yes" with Older Adults reporting the highest percentage with 98.5%. Families endorsed yes with 98.4%, Youth with 98.2% and Adults with 97.8%.

Statewide, the annual administration of CPS is a premier source for information on client satisfaction. Consumers and their families are encouraged to rate the quality of their services and openly share what aspects of their outpatient treatment are going well or needs improvement. Although not required by the State, LACDMH recognizes the role qualitative feedback plays in continuous quality improvement by prompting a provider-led thematic analysis that parallels their CPS data collection.

Open-Ended Comments Collection Survey

An Open-Ended Comments (OEC) Collection survey was developed to guide providers through evaluating the OEC comments they received from consumers or caregiver who completed a CPS form(s) in Spring 2022. OEC Collection surveys were submitted to the QI Unit. CPS forms gathered open-ended comments from LACDMH's youth, families/caregivers, adult, and older adult consumers. The QI Unit received 113 OEC Collection surveys, with some providers completing OEC Collection surveys for up to six locations.

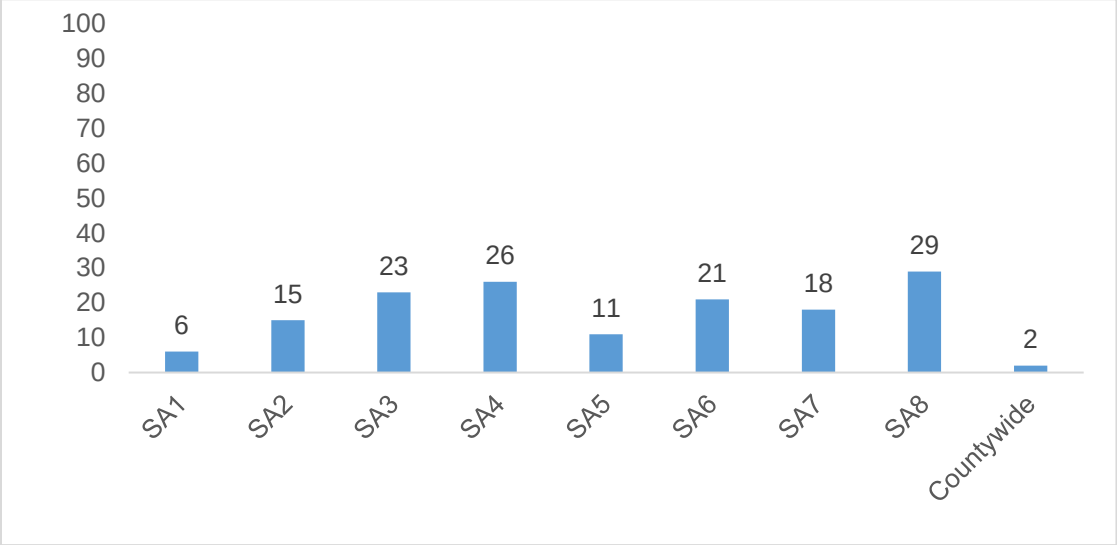
Open-Ended Comments Summary Report

The OEC Summary Report was completed to assess qualitative feedback collected from consumers/caregivers Department-wide. The summary report that follows is organized by category, starting with an overview of providers with completed OEC Collection surveys.

Any identifying information was removed to maintain confidentiality. It is important to note that the organization of comments is subjective. There may be variances among providers submitting the comments and QI staff reviewing the comments.

Figure 9 represents SA participation, Figure 10 shows age groups served, Figure 11 represents the format used to survey consumers, and Figure 12 reports the number of providers who received client/caregiver comments. Many providers reported having locations in multiple Service Areas (SAs). Of note, SA 8 had the highest number of providers who completed the OEC Collection survey (Figure 9).

FIGURE 9: NUMBER OF PROVIDERS WITH COMPLETED OEC COLLECTION SURVEYS BY SERVICE AREA

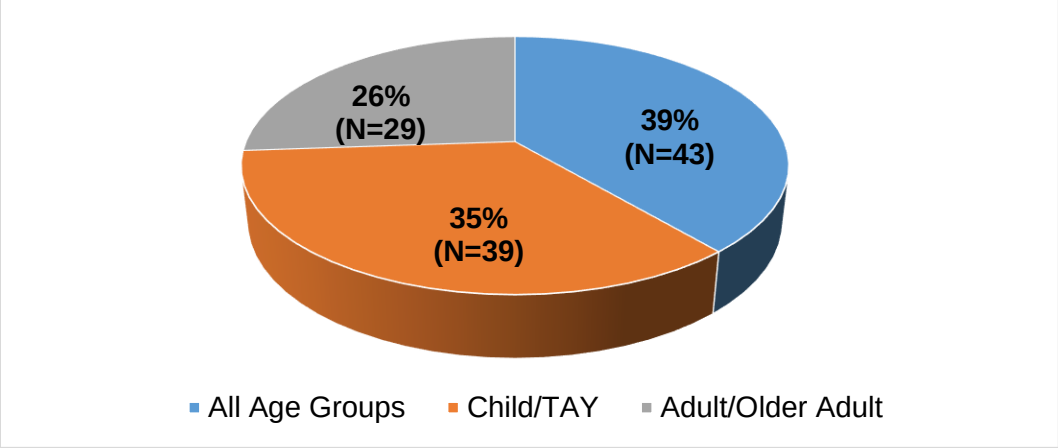


Note: Countywide providers deliver services throughout the county, not just in one designated SA.
Data source: Spring 2022 Consumer Perception Survey (CPS) Open-Ended Comments (OEC) Collection survey.

Open-Ended Comments Summary Report

Providers who completed the OEC Collection survey reported on age groups of consumers served. The age groups include Child, Transition Age Youth (TAY), Adults, and Older Adults. Figure 10 summarizes the number of providers with completed OEC Summary Collection surveys by age groups served. Providers serving all age groups made up the largest proportion of providers who completed the OEC Collection survey at 39% (N=43). Child and TAY providers receiving comments made up 35% (N=39). Adult and Older Adult providers completing collection surveys made up 26% (N=29).

FIGURE 10: NUMBER OF PROVIDERS WITH COMPLETED OEC SUMMARY COLLECTION SURVEYS BY AGE GROUPS SERVED



Data source: Spring 2022 CPS OEC Collection survey.

Most providers who completed the OEC Collection survey received comments (89%, N=101). Only 11% (N=12) reported not receiving comments. Figure 11 summarizes the number of providers who reported receiving comments. The number of comments reported by a single provider ranged from one to 76, with 1,451 comments reported.

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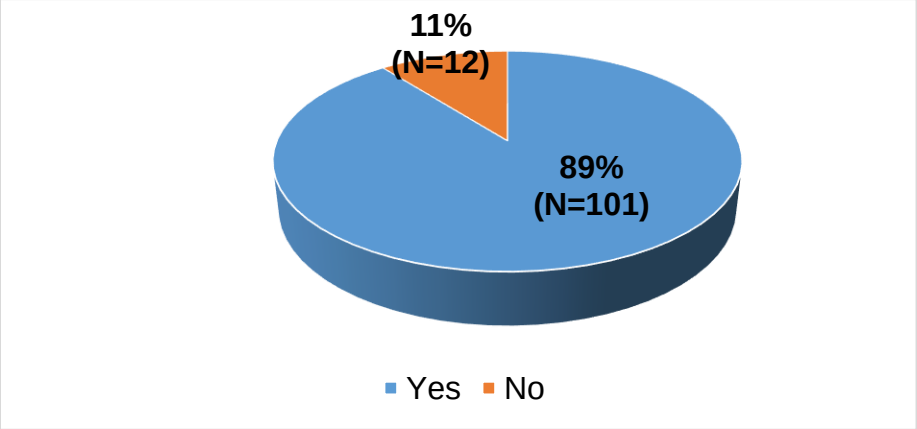
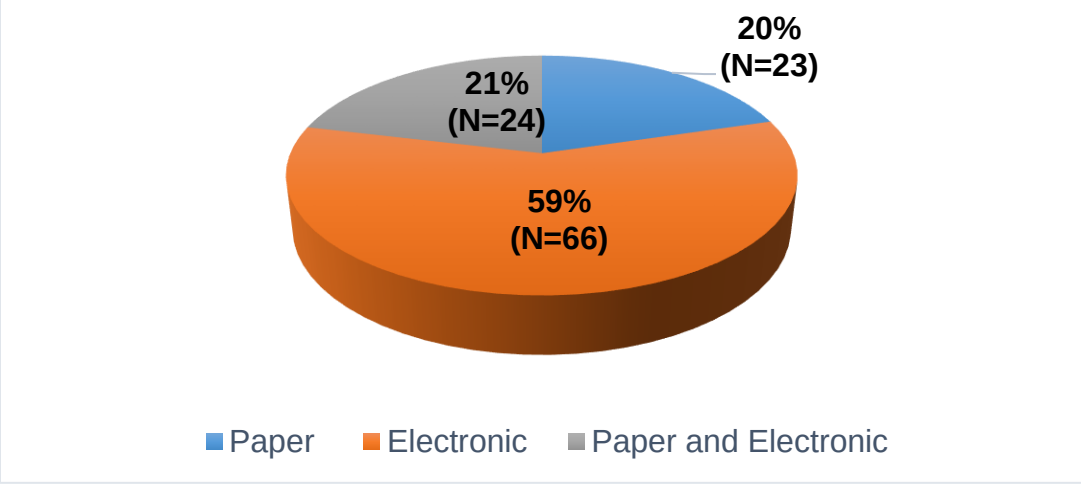
FIGURE 11: NUMBER OF PROVIDERS THAT REPORTED RECEIVING COMMENTS



Data source: Spring 2022 CPS OEC Collection survey.

Most providers who completed the OEC Collection survey reported they only used electronic surveys to collect survey data (59%, N=66). Providers had the option to provide consumers with CPS surveys to complete by paper or electronic surveys. Providers could use any combination of the three survey methods offered to collect CPS data. Twenty-one percent (N=24) of providers utilized both paper and electronic methods and 20% (N=23) utilized the paper method only. Figure 12 shows the number of providers who completed the OEC Collection survey by survey collection method.

FIGURE 12: NUMBER OF PROVIDERS WITH REPORTED COMMENTS BY SURVEY COLLECTION METHOD



Data source: Spring 2022 CPS OEC Collection survey.

Provider-led Thematic Analysis

Providers were instructed to work collaboratively on their OEC Collection survey with their internal quality improvement team and Program Managers/Directors for their respective programs to:

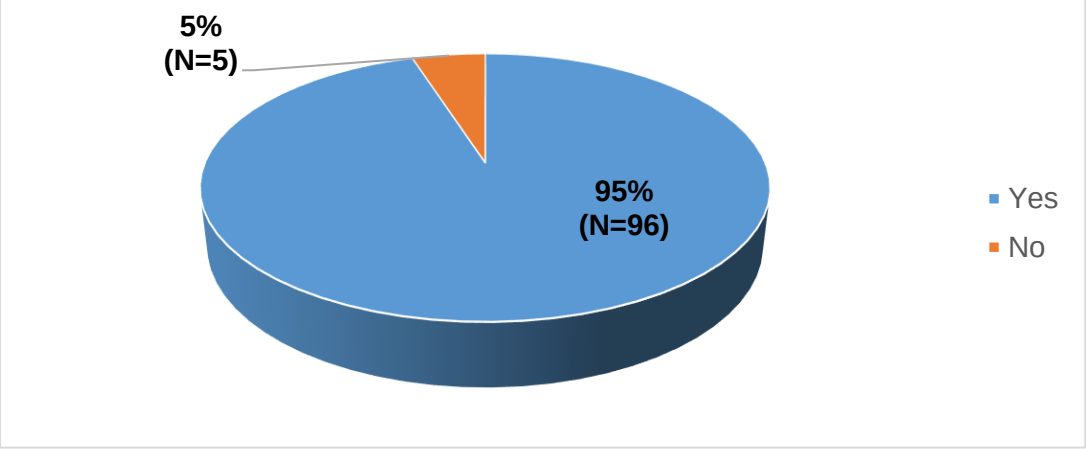
- Organize their client/caregiver comments into four categories: positive comments, negative comments, programming and staffing related comments, and general/recommendation comments.
- Identify strategies or workflow to address negative comments and/or new programming and staff-related feedback.

All completed OEC Collection surveys were submitted to the QI Unit through Microsoft Forms Survey software. The OEC Collection surveys were reviewed by internal QI staff and sorted into the identified categories. The findings are summarized in the following report.

Positive Comments

Positive comments were defined as comments on the good qualities of the program's elements, staff, environment, support, etc. Some examples include, "I really appreciate having services here." "I feel that the doctor really cares, helps a lot." or "My therapist is great. I am grateful to have the help I need for my child." Most providers who completed the OEC Comment survey identified positive comments (95%, N=96). Figure 13 summarizes the number of providers who identified positive comments.

FIGURE 13: NUMBER OF PROVIDERS THAT IDENTIFIED POSITIVE CLIENT COMMENTS

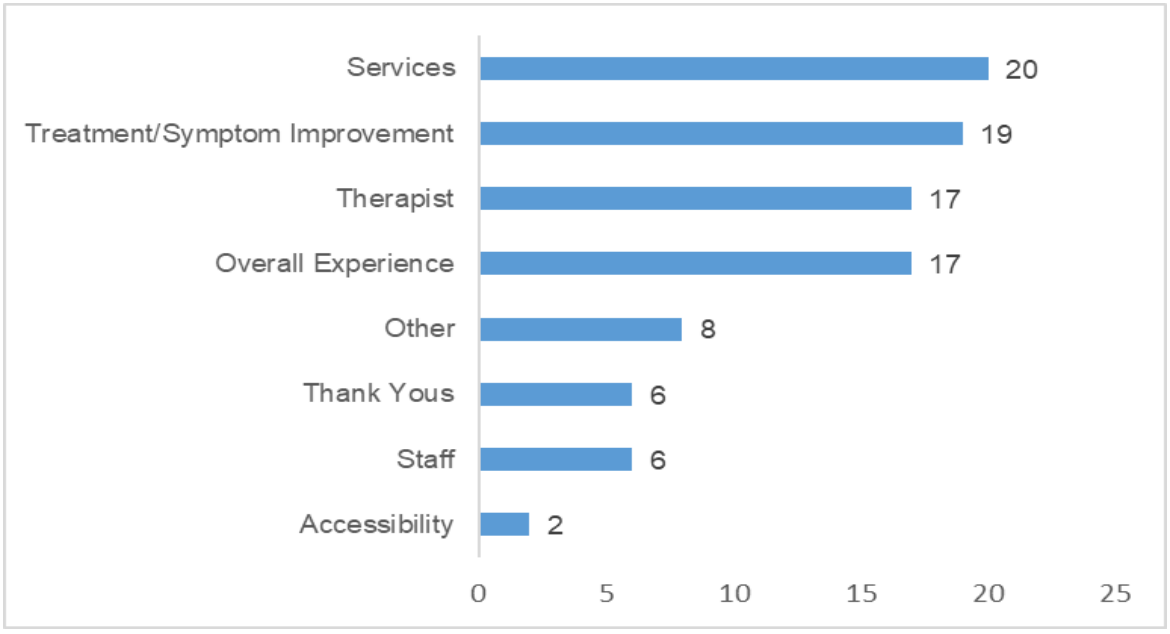


Data source: Spring 2022 CPS OEC Collection survey

Providers summarized positive comments received on completed OEC Comment survey reports and themes were identified. Positive categories identified include pleased with treatment/symptom improvement, pleased with staff, pleased with services, pleased with therapist, pleased with overall experiences, pleased with accessibility, general "thank you" comments to program staff and other.

Figure 14 summarizes categories of positive themes reported from providers who received positive comments. Most positive comments were regarding the category of pleased with services provided (N=20). Client comments also reported they were pleased with treatment/symptom improvement (N=19), pleased with their overall experience (N=17) and pleased with the therapist (N=17). Some consumers shared "thank you's" to providers and specific clinicians for "helping" and "caring".

FIGURE 14: NUMBER OF PROVIDERS THAT IDENTIFIED POSITIVE THEMES REPORTED BY CATEGORY

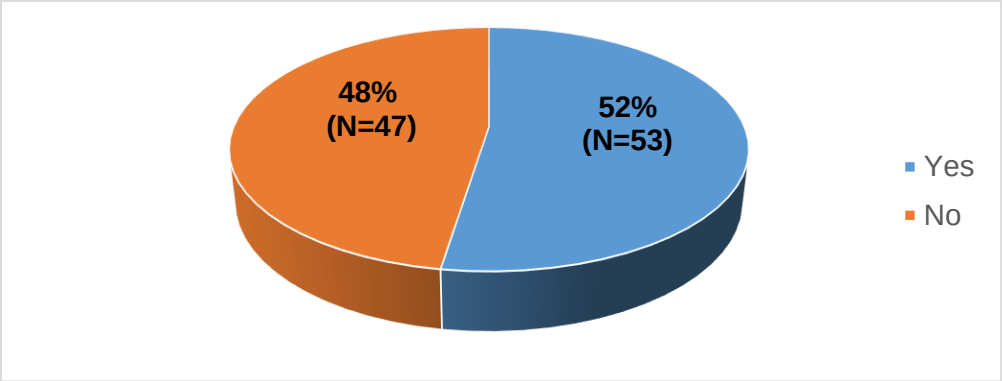


Data source: Spring 2022 CPS OEC Collection survey

Negative Comments

Negative comments were defined as comments on issues, concerns, negative experiences, unhappiness with staff, the program, the environment, etc. Some examples include, "Parking is horrible," "The waitlist to get services is long," or "My case manager has changed several times." There were 53 providers who reported receiving negative comments recorded in the OEC Collection survey. Figure 15 reports the number of providers who identified negative comments.

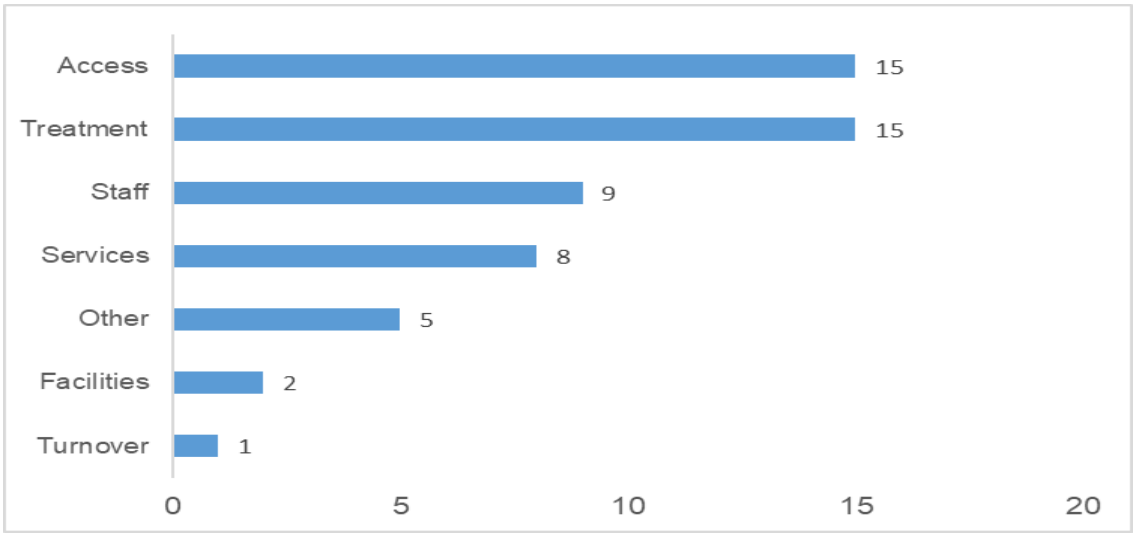
FIGURE 15: NUMBER OF PROVIDERS THAT IDENTIFIED NEGATIVE CLIENT COMMENTS



Data source: Spring 2022 CPS OEC Collection survey

Figure 16 describes the number of provider-identified negative comments divided into the most frequently occurring categories. These categories include access, staff, turnover, services, treatment, other and facilities. Providers reported majority of negative comments focused on issues related to treatment (N=15) and access (N=15), followed by issues/concerns with staff (N=9) and services (N=8).

FIGURE 16: NUMBER OF PROVIDERS THAT IDENTIFIED NEGATIVE THEMES REPORTED BY CATEGORY



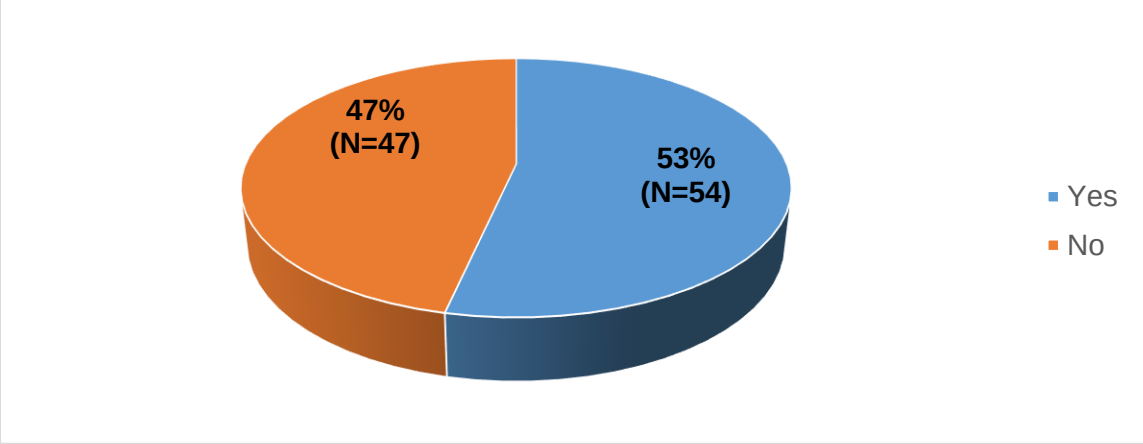
Data source: Spring 2022 CPS OEC Collection survey.

New Programming or Staff-Related Issues

New programming or staff-related comments were defined as comments specific to feedback regarding provider programs or staff. Some examples include, "Too many changes in therapists," "Something along the lines of anger management training for children," and "Wish you would offer groups and have more therapists that can take more consumers." There were 54 providers who reported receiving comments regarding programming or staff-related feedback in the OEC Collection survey.

Figure 17 summarizes the number of providers who reported receiving feedback regarding new programming or staff-related issues.

FIGURE 17: NUMBER OF PROVIDERS THAT IDENTIFIED NEW PROGRAMMING OR STAFF-RELATED COMMENTS



Data source: Spring 2022 CPS OEC Collection survey

Categories of Provider Reported Comments

Provider reported client/caregiver comments were qualitatively grouped into eight (8) thematic categories. These categories include accessibility of services, general customer service, staff supervision or coaching, treatment outcomes, types of services offered, service equity, facility concerns and other. The following provides a summary discussion of the categories and client comments reported by providers.

- *Accessibility of Services*
  Providers reported receiving many accessibility-related comments. Comments included wanting to be seen for appointments or services more frequently and on a consistent basis, including increased evening and weekend hours. Consumers reported an appreciation for flexibility of service delivery methods including use of telehealth services. Many consumers requested a return to in-person services. Some consumers commented on frequent cancellations

and/or rescheduling of appointments and others wanted services closer to their home.

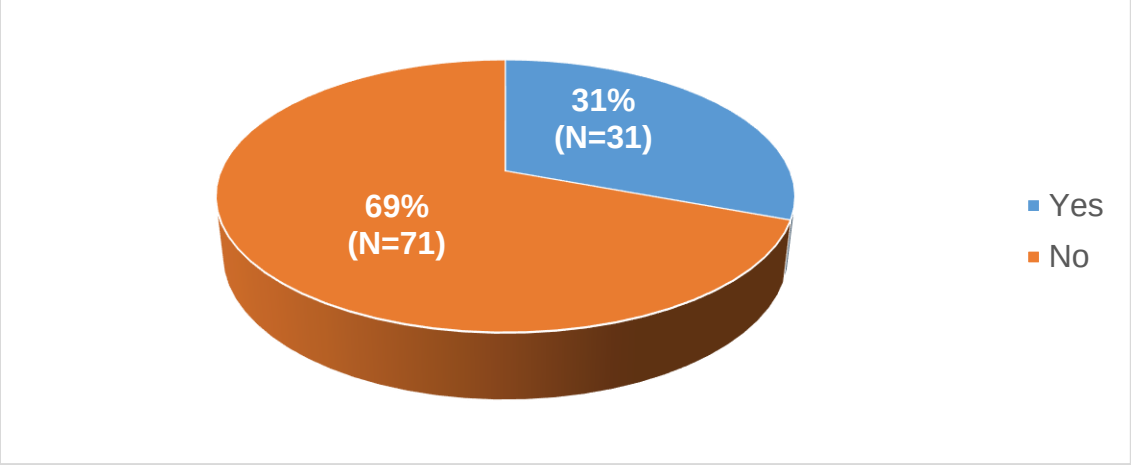
- *General Customer Service*
  Most General Customer Service comments were classified as positive. Client comments often noted the kindness, respectfulness, and care displayed by both clinical and support staff. Negative comments relating to general customer service noted poor interactions with specific provider staff members. The majority of comments regarding the overall experience of customer service from providers were positive.
- *Staff Supervision or Coaching*
  Many client comments noted clinicians and staff were knowledgeable and helpful. Comments spoke to the expertise demonstrated by staff regarding treatment. Some client comments suggested a need for increased cultural awareness and clinician training in specialty areas, including trauma, family therapy, substance abuse, and anger management.
- *Treatment Outcomes*
  The majority of client comments identified in this category were positive. Consumers noted general satisfaction improvement in specific symptoms and named specific clinicians as being essential to their progress. Of note, many comments provided by caregivers on improvements in their child's symptoms demonstrated improved overall functioning at school and home.
- *Types of Services Offered*
  Generally, consumers indicated they were pleased with the services offered. They identified individual therapy, medication services, and support from treatment teams as the most helpful. There were requests for more groups, family therapy, and substance abuse treatment.
- *Service Equity*
  Most client comments identified by providers remarked on good cultural sensitivity and availability of services in a preferred language. However, there were several requests to increase Spanish-speaking providers and some requests for a clinician of a client's same race/ethnicity, though specific race/ethnicity was not indicated.
- *Facility Concerns*
  Regarding facilities, client comments indicated a need for increased parking at some provider locations, better temperature control, repair of buildings, and building amenities, including restrooms. Comments addressed buildings that were not accessible for those living with disabilities and safety concerns at specific provider locations with encampments of persons experiencing homelessness near the building.
- *Other*
  Feedback that did not specifically fall into one of the above categories is grouped as Other. These include comments identified by providers regarding telehealth versus in-person services, changes in therapists and staff turnover, licensed versus unlicensed therapists, amenities including snacks and water, gratitude, and overall communication.

General/Recommendation Comments

General/Recommendation comments were defined as relatively neutral comments about suggestions for change. Some examples include, "Please add more groups for exercise," "Lobby to have more things for the kids," "There should be snacks and giving food," or "Larger variety of therapists," or "More time slots. "I would love it if services were available over the weekend." There were 31 providers who reported general/recommendation comments recorded in the OEC Collection survey.

Figure 18 reports the number of providers who identified general/recommendation comments. Of note, many general/ recommendation comments focused on the need for additional services, including assistance with housing and employment, increased accessibility of services, increased hours of operation and increased flexibility of method of service delivery, including options for in-person and telehealth appointments.

FIGURE 18: NUMBER OF PROVIDERS THAT IDENTIFIED GENERAL/ RECOMMENDATION CLIENT COMMENTS



Data source: Spring 2022 CPS OEC Collection survey.

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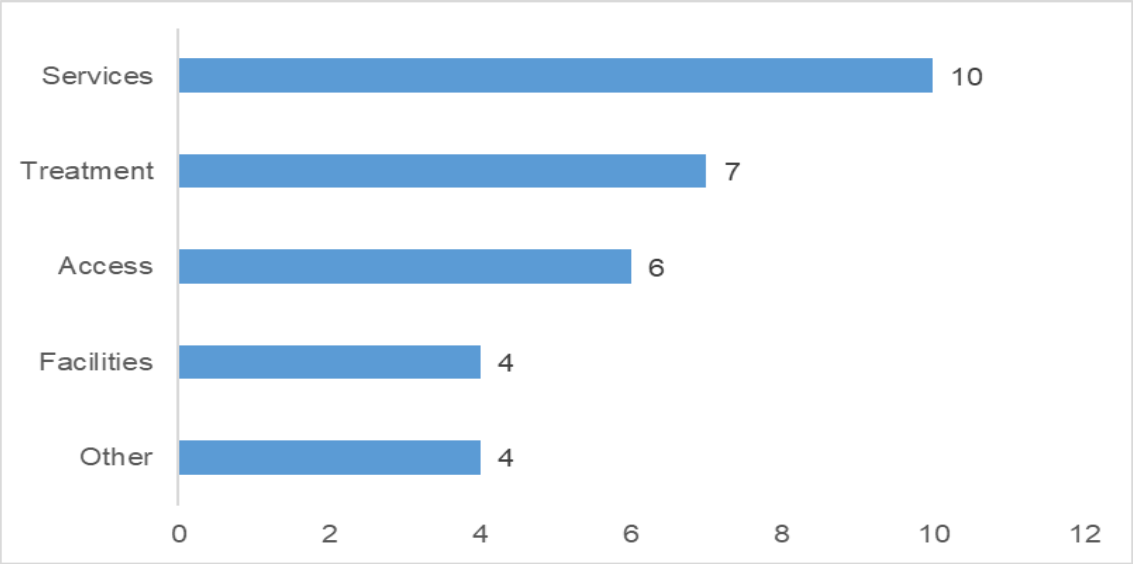
Figure 19 summarizes the number of general/recommendations providers reported by categories. Recommendations made regarding services were most frequent (N=10), followed by comments regarding treatment (N=7), access (N=6) and facilities (N=4).

FIGURE 19: NUMBER OF GENERAL/RECOMMENDATIONS BY CATEGORY



Data source: Spring 2022 CPS OEC Collection survey.

Provider-Led Action Plans

Providers were asked to briefly describe their Action Plans to address comments from consumers/caregivers. Of the 113 respondents to the survey that reported receiving comments, 71 entered some type of plan. The plans tended to vary widely depending on the type of comments received. Many of the plans indicated sharing the comments with Executive and managerial staff, QI and Quality Assurance (QA) staff, clinicians, and other program staff. Many of the plans also discussed addressing the comments directly with action or meeting individually with the client/caregiver. For those providers who reported only positive comments, several respondents indicated a plan to share the comments with staff to maintain communication and boost morale.

Open Ended Comments (OEC) Collection Survey

The OEC Collection survey facilitated the review of consumer experiences of youth, families, adults, and older adults. The OEC Summary Report was completed to assess qualitative feedback collected from consumers/caregivers in overall, positive, negative, and general/recommendation comments. Report findings are distributed to participating providers to assist with further development and improvement of services provided to consumers throughout Los Angeles County.

Nearly all comments regarding general interaction with staff were positive, yet there was a need for continued efforts for cultural awareness and maintaining respect. There were requests for more groups and specialty services, including family therapy, substance abuse treatment, anger management, additional Spanish-speaking providers, and additional efforts to align with client/caregivers' preferences culturally or linguistically. There were reoccurring facility concerns about adequate parking and safety, maintaining buildings, and adhering to standards that make buildings accessible to persons living with disabilities.

Nearly all responding providers reported the receipt of positive comments. Positive comments tended to focus on comprehensiveness and high quality of services, the client's/caregiver's perception of symptom improvement and functioning, the therapist and feeling staff were caring and supportive, and having a good overall experience. Approximately half of the providers responding to the survey reported receiving negative comments. Most of the negative comments focused on challenges with accessing appointments, having a poor match with treatment providers, and the high staff turnover rate. Additionally, approximately half of the providers reported comments regarding new programming or staff-related issues. Most of the comments regarding staff-related issues tended to be negative, focusing on staff turnover and challenges with transitions to new therapists.

General Recommendations were the least occurring category identified by the responding providers. Consumers who commented were seeking a return to in-person treatment and services. There were requests to expand group treatment and services, such as assistance with housing and employment, anger management, exercise groups, family therapy and school-based services. Consumers also suggested expanding the hours of service on weekdays and including weekend hours. Finally, providers appeared to use the information collected in the comments and made plans to address client/caregiver concerns directly. Comments were shared widely from executives to front office staff. Also, positive comments tend to be shared with staff to improve morale.

Summary or recommendations

- Outcomes from the Summary OEC Report to be reviewed at the provider-level and with each site's QIC and leadership team.
- Outcomes to be reviewed with clinical and support staff for staff education and collective involvement in improving service delivery for consumers.
- Providers to consider surveying their client community to identify and prioritize the improvement needs.
- Providers should consider expanding their service hours to meet the needs of consumers/caregivers.
- Providers to make available options of services to meet the client/caregiver's need, which includes telehealth, in-person, or a combination of services.
- Providers to explore and increase opportunities for the clinicians' and staff cultural awareness. Clinicians to be given the opportunity to expand their knowledge and practice of specialty areas.

- Providers to explore opportunities to add or increase the availability of groups, family therapy, substance abuse treatment and other specialty treatment areas.
- Providers to explore their ability to expand cultural and linguistically appropriate services and efforts to match a client with providers of their ethnicity if the client so desires.
- Providers to assess their facilities for repairs and upgrades, review and address their adherence to safety codes and protocols and adhere to standards for accessibility for consumers with disabilities.
- Action plans to be considered by each site's QI, management team, and Program Managers to target individualized areas for improvement.
- This report to be made available for public review by consumers, their caregivers, and other LACDMH stakeholders.

2. Performance Improvement Projects (PIPs)

As a part of the External Quality Review Organization (EQRO) requirements and mandated by the Code of Federal Regulations, Title 42, the Quality Improvement (QI) program is responsible for collaborating on SA QI projects and PIPs. Title 42 C.F.R. § 438.240(d) requires LACDMH to conduct a clinical and non-clinical PIP, which must be validated and reviewed by an EQRO annually.

The QI Unit is responsible for coordinating, organizing, and supporting PIPs from and throughout the organization. Each year, the QI Unit conducts a Clinical and Non-clinical PIP. The PIPs ensure that selected administrative and clinical processes are reviewed to improve performance outcomes.

A. Non-Clinical Performance Improvement Project (Non-clinical PIP)

In the FY 21-22 non-clinical PIP, Improving Referral Management and Efficiency Through an Online Provider Directory, the QI, Quality Assurance (QA), and Chief Information Office Bureau (CIOB) Units worked collaboratively to evaluate LACDMH's update of the existing Provider Directory system available to providers and the community on the LACDMH website, https://dmh.lacounty.gov/pd/. The study population included beneficiaries and incoming individuals seeking services – including individuals of any age and diagnosis. It impacted individuals requesting new enrollment and current beneficiaries seeking additional services or a higher/lower level of care. Both Legal Entity (LE)/Contracted and Directly Operated (DO) providers that provide services to beneficiaries and new enrollees were impacted by this PIP.

A review of the Service Request Tracking System (SRTS) data from CY 2022 pre-intervention, January 1, 2022, through March 8, 2022, and post-intervention, March 9, 2022, through August 31, 2022, was completed. Data was collected from the Cognos SRTS Transfer report and the new Microsoft Power BI SRTS Transfer report.

Objective 1: Decrease in the number of SRTS referrals with greater than two transfers from 6.1% to 5.0%.

The SRTS Transfer report data showed a small increase in transfer requests

during the first measurement period (March through May 2022) following the intervention of the updated Provider Directory which returned to pre intervention levels at the second measurement (June through August 2022). Referrals with multiple transfers decreased by approximately 1.4 Percentage Points (PP) in the second measurement period.

Objective 2: Decrease the number of business days to transfer request resolution from 6.9 days to 5.0 days.

The number of business days to resolution of a transfer request increased by one day at the second measurement. Transfer requests that required more than two business days remained stable until the second measurement with an increase of approximately 3.2PP.

Additionally, data was collected from providers regarding the use of the "New" Provider Directory in May 2022 and August 2022 with the LACDMH 2022 Provider Directory Satisfaction Survey – Provider Version. In May 2022, 131 providers responded to the survey and in August 2022, 55 providers responded to the survey.

Based on feedback collected from providers who responded, Specialized Foster Care (SFC) providers reported the most use of the updated Provider Directory. LE/Contracted clinic and DO clinic providers reported using the directory the least. Most responding providers reported increased satisfaction (Satisfied to Very Satisfied) with the updated directory: Other category providers were at 37.5% (+25PP), LE/Contracted clinic providers were at 28.8% (+11.9PP), and ACCESS Center/DMH Help Line and DO clinic providers were at 25% (+6.2PP). The overall average satisfaction rating for the "New" Provider Directory was 56.4% (+32PP). When satisfaction by age group served was reviewed, Older Adult providers reported the least satisfaction with the updated directory.

Providers that responded to the survey indicated that challenges with the updated directory increased over the two measurement periods. "Accurately identifying service provider availability" and "finding the information needed quickly" were the challenges identified most often by responding providers. "Challenging to use" and "other" challenges tended to steadily increase. Providers consistently identified issues with usability and accuracy of information. Most responding providers reported an increase (32.5%) or no change (30%) in referrals was seen.

Findings

During the measurement periods, there appeared to be limited to no improvements indicated in the SRTS transfer report. Providers likely tried to utilize the updated directory which increased the transfer requests. However, a longer period of measurement may be needed to display change as providers need more education and experience with the directory.

The updates to the Provider Directory appeared to increase provider satisfaction with the directory. However, changes to the tool created additional challenges that need to be addressed though updating provider information and the functionality of the directory's platform. It appears providers that serve specific populations have different needs of the Provider Directory and would benefit from separate search options or unique directory pages.

QA and CIOB continually reviewed provider feedback and worked to make minor updates though the PIP process. Larger changes were earmarked for Phase II of the project.

This non-clinical PIP concluded in October 2022. However, the project will continue through collaborative efforts of the QI, QA, and CIOB Units. Plans for follow up activities include a Phase 2 of updates to the Provider Directory, spot checking randomized calls to providers to ensure adherence to data update standards, and reviewing SRTS for disparities in age, cultural group, foster care, etc.

B. Clinical Performance Improvement Project (Clinical PIP)

The Clinical Performance Improvement Project entitled, "Improving Treatment Services for Individuals with Eating Disorders" began in June 2021 and will continue through June 2023. The improvement strategy is focused on (1) providing quality, evidence-based care to the increasing number of individuals with Eating Disorders (ED) in order to reduce the need for Higher Levels of Care (HLOC), and (2) improving screening and assessment methods to address the discrepancy between expected ED prevalence rates and diagnostic rates.

Objective 1: *Decrease the number of ED consumers that require HLOC.*

Both the number and percentage of consumers with EDs being treated in a HLOC increased over baseline of 17 (3.4% of those with EDs) in July 2021 to 25 (5.1%) in October of 2021. Subsequently, the number (percent) of consumers declined (with some minor fluctuations) to 16 (8%) in March 2023, the most recent month for which data are available at the time of this writing.

Objective 2: Increase the number of ED consumers that step down from HLOC.

The number and percentage of consumers with EDs who transitioned to outpatient care after being in a HLOC dropped from a baseline of one (7.1%) in Q4 of FY 21-22 to four (10.3%) in Q2 of FY 21-22, before rising dramatically and then leveling off at 16 (15.8%) in the most recent quarter for which data are available.

Objective 3: Increase screening and diagnosis of EDs at intake.

The number and percentage of consumers with EDs has increased steadily since baseline. In CY 2019, there were 744 individuals diagnosed with EDs

(0.29% of persons served by LACDMH). While in CY 2022, there were 980 individuals diagnosed with EDs, which accounts of 0.43% of those served.

Objective 4: Increase practitioner confidence in working effectively with consumers with E.Ds.
Practitioners who participated in the trainings CBT-e, ED101, ED102, and FBT between June 2022 and April 2023 were surveyed about their confidence and comfort working with consumers with ED. Where rating 2 is disagree, 3 is neutral, and 4 is agree, participants went from a 2.9 before the training to a 3.8 after the training (on average) for the item "I have confidence in my ability to *diagnose* consumers with Eds." For the item "I have confidence in my ability to *treat* consumers with EDs," participants went from 2.6 on average to 3.5 on average. The item "I have all the skills needed to treat consumers with EDs very well" increased from 2.3 to 3.1 on average.

Objective 5: Increase practitioner knowledge in working with consumers with EDs.
Participants in the different trainings mentioned above were given different knowledge assessments before and after their trainings, so scores were not aggregated. However, scores increased across the board, as the following examples from ED 102 show in March 2023. Before the training, only 29.3% of the participants responded correctly to the question "For diagnosis of Bulimia Nervosa in the DSM-5, what is the frequency of binge eating and inappropriate compensatory behaviors?" After the training, 77.3% got the correct answer. Similarly, prior to ED 102 training, 37.9% of participants responded correctly to the question "Which of the following is the first line of treatment for children and adolescents with Eating Disorders?" while 86.4% responded correctly after the training.

The Eating Disorder PIP will continue through the fourth quarter of FY 22-23. The very popular ED 101 webinar is available on-demand until January of 2024. In addition, ED 102 and Eating Disorders: Working with Children and their Families continue to be offered to reach a wider number of practitioners systemwide and consequently increase availability of quality care for individuals with Eating Disorders. In addition, the Best Practices Clinical Toolkit will be disseminated via the LACDMH public facing website, and the ED Practice Network and ED Consultation Group will continue indefinitely.

3. Grievances and Complaints

As mandated by the State Department of Health Care Services (DHCS) Program Oversight and Compliance, the Quality Improvement Division facilitates the annual evaluation of beneficiary Grievances, Appeals, and State Fair Hearings. Grievances and appeals are collected and reviewed by the Patients' Rights Office (PRO) and recorded on the Annual Medi-Cal Beneficiary and Grievance and Appeal Report (ABGAR) form. The ABGAR form is required for Medi-Cal beneficiaries only.

LACDMH monitors grievances, appeals, and requests for State Fair Hearings and their resolution. The following tables summarize the number and percentage of inpatient and outpatient grievances and appeals by category and disposition.

Beneficiary Problem Resolution

Grievances, appeals, expedited appeals, state fair hearings, expedited fair hearings, Notice of Actions (NOAs), and requests for change of provider are consumer and provider activities that LACDMH monitors, evaluate for trends, and report to the Departmental Quality Improvement Council. This is an on-going Quality Improvement Work Plan monitoring activity, as specified by our DHCS contract.

Notices of Action

NOAs are required when any of the following actions occur with a Medi-Cal beneficiary

- NOA-A: Denial of Services Following Assessment
- NOA-B: Reduction of Services
- NOA-C: Post Service Denial of Payment
- NOA-D: Delay in Processing a Beneficiary Grievance or Appeal
- NOA-E: Lack of Timely Services

In accordance with Title 9, CCR, Chapter 11, Subchapter 5, and the Mental Health Plan (MHP) Contract, LACDMH must have problem resolution processes that enable beneficiaries to resolve problems or concerns about any issues related to performance, including the delivery of SMHS. The Department is required to meet specific timeframes and notification requirements related to these processes.

As mandated by the DHCS, Program Oversight and Compliance (2012-2013), the QID facilitates the annual evaluation of beneficiary grievances, appeals, and State Fair Hearings. As a MHP, LACDMH shall insure that a procedure is in place where by issues identified as a result of grievance, appeal, or expedited appeal processes are transmitted to the MHP's QIC, the MHP's administration, or another appropriate body within the MHP (DHCS, Oversight and Compliance 2012-2013).

Tables 7 and 8 below provide a systemwide summary of grievances and appeals received and processed by the LACDMH Patients' Rights Office for FY 21-22.

TABLE 7: LACDMH GRIEVANCES AND APPEALS
FY 21-22

GRIEVANCES						
CATEGORY	**PROCESS**		**GRIEVANCE DISPOSITION**			
	Grievance	**Exempt Grievance**	**Grievances Pending, Unresolved as of June 30**	**Resolved**	**Referred**	**Timely Resolution**
ACCESS						
Services not available	0	0	0	0	0	0
Services not accessible	0	0	0	0	0	0
Timeliness of services	8	0	0	8	0	0
24/7 Toll-free access line	0	0	0	0	0	0
Linguistic services	1	0	0	1	0	0
Other access issues	10	0	0	10	0	0
TOTAL	**19**	**0**	**0**	**19**	**0**	**0**
Percent	**5.6%**	**0.0%**				**0**
QUALITY OF CARE						
Staff behavior concerns	72	0	1	71	0	0
Treatment issues or concerns	35	0	3	30	2	0
Medication concern	22	0	0	22	0	0
Cultural appropriateness	2	3	1	4	0	0
Other quality of care issues	24	0	2	22	0	0
TOTAL	**155**	**3**	**7**	**149**	**2**	**0**
Percent	**45.5%**	**50.0%**				
CHANGE OF PROVIDER						
CONFIDENTIALITY CONCERN						
Percent	**0.0%**	**0.0%**				
OTHER						
Financial	0	0	0	0	0	0
Lost Property	14	1	0	14	1	0
Operational	4	0	0	4	0	0
Patient's Rights	31	0	5	26	0	0
Peer behaviors	18	2	0	20	0	0
Physical environment	9	0	0	9	0	0
County (Plan) communication	0	0	0	0	0	0
Payment/Billing issues	0	0	0	0	0	0

Suspected Fraud	0	0	0	0	0	0
Abuse, Neglect or Exploitation	4	0	0	4	0	0
Other grievance not listed above	87	0	0	87	0	0
TOTAL	**167**	**3**	**5**	**164**	**1**	**0**
Percent	**49.0%**	**50.0%**				
GRAND TOTAL	**341**	**6**	**12**	**332**	**3**	**0**

APPEALS									
CATEGORY	**PROCESS**			**APPEAL DISPOSITION**			**EXPEDITED APPEALS DISPOSITION**		
	All Notice of Adverse Benefit Determination (NOABD) Issues	**Appeal**	**Expedited Appeal**	**Appeals Pending, Unresolved as of June 30**	**Decision Upheld**	**Decision Overturned**	**Expedited Appeals Pending, Unresolved as of June 30**	**Decision Upheld**	**Decision Overturned**
Denial Notice	0	0	0	0	0	0	0	0	0
Payment Denial Notice	0	0	0	0	0	0	0	0	0
Delivery System Notice	0	0	0	0	0	0	0	0	0
Modification Notice	0	0	0	0	0	0	0	0	0
Termination Notice	0	0	0	0	0	0	0	0	0
Authorization Delay Notice	0	0	0	0	0	0	0	0	0
Timely Access Notice	0	0	0	0	0	0	0	0	0
Financial Liability Notice	0	0	0	0	0	0	0	0	0
Grievance and Appeal Timely Resolution Notice	0	0	0	0	0	0	0	0	0
TOTAL	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Note: Data above reflects the grievances and appeals for/by Medi-Cal beneficiaries. Data Source: PRO June 2023.

Criterion 8 APPENDIX

Attachment 1: Short-Doyle/Medi-Cal Organizational Provider's Manual for Specialty Mental Health Services Under the Rehabilitation Option and Targeted Case Management Services

https://file.lacounty.gov/SDSInter/dmh/1132980_ORGANIZATIONALPROVIDER_SMANUAL.pdf